NHS Practitioner Health

RCGP Royal College of General Practitioners

Joined Up Care Derbyshire

SUICIDE POSTVENTION

SUPPORT PACK FOR GENERAL PRACTICE IN DERBYSHIRE – JUNE 2024

‘Providing support for primary care clinicians after the death of a patient by suicide’

NOW ALSO AVAILABLE - A NATIONAL TEMPLATE FOR USE BY ANY ICB

NHS

The Derbyshire VCSE sector Alliance

Derby City Council

DERBYSHIRE County Council

INTRODUCTION

Dear Practice Managers, General Practitioners and Primary Care Colleagues

- In England, between 2020 and 2022, there were 15,415 registered deaths from suicide. This equates to fourteen lives lost every day, each of them a painful, personal loss with effects that ripple out to impact far more people over years to come.

BOX 2 LOCAL STATISTICS

In **Derbyshire,** there are approximately **100 deaths** from suicide each year.
From 2020-22, the Derbyshire rate was 12.0 and the Derby rate 10.4/100,000 people compared to England at 10.3/100,000 people. Whilst the majority are males, the rate in females under 24 years old is rising at the fastest rate since ONS records began.

Suicide Prevention Profile - OHID (phe.org.uk)

- Males comprise 75% of these deaths. Middle-aged men have the highest incidence of suicide. Suicide is the leading cause of death in young people.

- Loss of a loved one through suicide is an **independent risk factor for suicide** in the person bereaved. This might be due to complex grief. Postvention is a means of providing support to those bereaved by suicide. It comprises both grief counselling and suicide prevention. A Pitman Bereavement by Suicide UK-wide study BMJ Open

- All told, 135 people will have known each person who dies by suicide. The number of people who report being severely impacted by grief, depression, or post-traumatic stress is between 15 and 30. Cerel et al. 2018

- A minority of those who die by suicide had been receiving mental health specialist care in the year preceding death. In contrast, 43% of men who die by suicide have seen their general practitioner in the three months before death. F Mughal et al BJGP 2023; 73 (732)

- Bereavement by suicide is not confined to family and friends, as clinicians can also be affected. The emotional impact on general practice staff is considerable. Some suicides have a major impact on the local community. Postvention support needs to be offered to anyone adversely impacted, including staff.

- The absence of formalised support or guidance for primary care following the suicide of a patient prompted the creation of the first primary care support pack for an integrated care system in Derbyshire in 2020.

The KEY AIMS of this document are to help the GP practice:

- **Navigate the processes and reporting** that follow a patient suicide.
- **Signpost to postvention services** for the bereaved family, friends, and colleagues.
- **Manage the impact on healthcare staff** through compassion and understanding.

Continuous reflective learning is needed to ensure a **safer from suicide practice.**

The Support Pack

The appropriate actions a practice should consider after a patient has died by suicide are presented in chronological order and match to the simple colour scheme in the document.

Immediate, Short-Term, Medium-Term, and Longer-Term Actions.

Immediate actions should be completed within **three working days** of the death notification, whilst the timescales for later actions will vary according to the circumstances.

In responding to a death by suicide, a non-judgmental, compassionate approach within and across healthcare teams is of paramount importance to promote a learning culture.

This document has included information about locally available suicide prevention training, public health strategy, real-time suicide surveillance and links to key national organisations that offer resources such as pastoral support and postvention training for professionals.

Suicide is complex, and each suicide is different. Yet we all must have the belief that suicides are not inevitable and may be prevented. The event of suicide might lead to a revaluation of the practice policies and awareness-raising programme for staff.

This pack has been created to support Primary Care in Derbyshire; and has been further developed into a template for use by any other ICB nationally.

The pack is routinely shared with primary care with positive feedback on its value. Furthermore, consulting stakeholders in producing this resource facilitated closer partnership working within the system.

Derby and Derbyshire Integrated Care Board (ICB) are pleased to offer it freely to any ICB in the country to adapt and adopt for their use. Each Integrated Care System will have its own local suicide prevention strategy and partnership forum. We hope you find it to be a valuable resource. Feedback is welcome as it will aid the continual update and improvement of the pack.

Author

Dr Sohrab Panday, MRCP, MRCGP

General Practitioner Clinical Lead Mental Health, Learning Disabilities & Autism

Derby and Derbyshire Integrated Care Board
Joined Up Care Derbyshire JUCD

Declarations of Interest

Suicide Prevention Training Lead for Primary Care JUCD
STORM CIC Consultant
Harmless CIC Ambassador

Organisation and Funding

All work has been done in authors' own time. JUCD have funded document IT support.

Acknowledgements

I am grateful for invaluable support, contributions, and editing from my esteemed colleagues.

Dr James Pumphrey
Suicide and Mental Health GP Fellow; Mile Oak Medical Centre, Brighton; for key contributions.

James Creaghan
Suicide Prevention Lead; Derbyshire County Council & JUCD; for inspiration and leadership.

Editors

Professor Dame Clare Gerada DBE
Former President of the Royal College of General Practitioners

Professor Carolyn A Chew-Graham OBE
Professor of General Practice Research at Keel University

Endorsements

The Royal College of General Practitioners

NHS Practitioner Health

"This comprehensive guide provides essential support and practical steps for managing the aftermath of a patient's suicide, addressing both the emotional impact on staff and the needs of the bereaved, which can be devastating and long-lasting."
Dr Helen Garr Medical Director

I wish to thank **Marina Fournier** for her unfailing support in creating this manuscript.

Postvention Support Pack

After a Suicide in Primary Care

Working towards

Safer from Suicide

General Practice

Postvention is an intervention conducted after a suicide, taking the form of support for the bereaved (family, friends, professionals, and peers).

Suicide has a ‘ripple effect’ on the community, and those most affected are at increased risk of suicide themselves.

A ‘survivor of bereavement by suicide’ is anyone who experiences high levels of self-perceived psychological, physical and or social distress after the suicide of a person they know, regardless of the social relationship.

The dual objectives of suicide postvention are to alleviate the effects of this complex grief and to prevent suicide in those left behind.

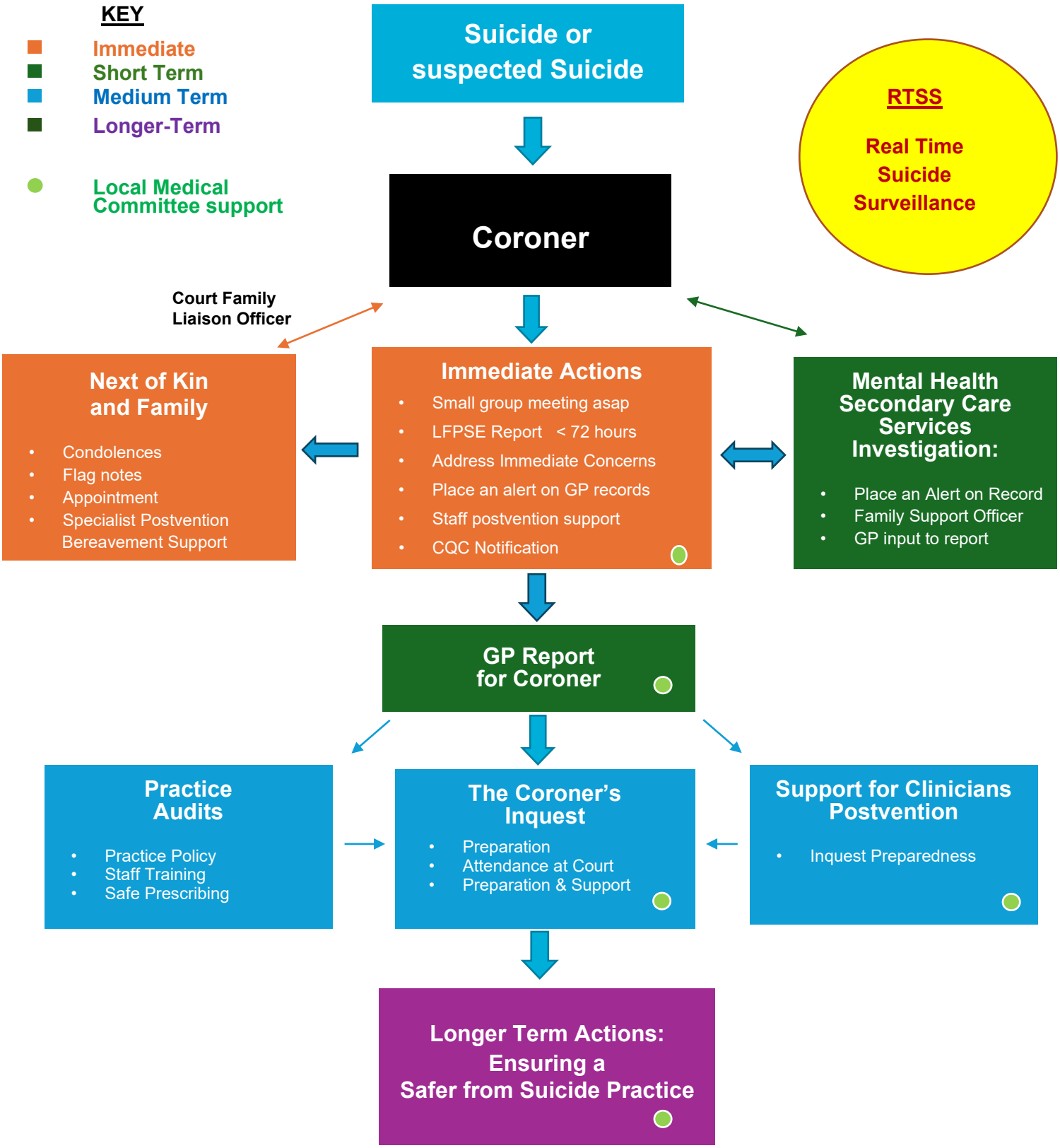
Practical tip

POSTVENTION SUPPORT ON A PAGE

PRINT PAGE 11 & SHARE DIGITALLY

CONTENTS

FLOWCHART


KEY
Immediate
Short Term
Medium Term
Longer-Term
Local Medical Committee support
Suicide or suspected Suicide
Coroner
RTSS
Real Time Suicide Surveillance
Court Family Liaison Officer
Next of Kin and Family
Condolences
Flag notes
Appointment
Specialist Postvention Bereavement Support
Immediate Actions
Small group meeting asap
LFPSE Report < 72 hours
Address Immediate Concerns
Place an alert on GP records
Staff postvention support
CQC Notification
Mental Health Secondary Care Services Investigation:
Place an Alert on Record
Family Support Officer
GP input to report
GP Report for Coroner
Practice Audits
Practice Policy
Staff Training
Safe Prescribing
The Coroner's Inquest
Preparation
Attendance at Court
Preparation & Support
Support for Clinicians Postvention
Inquest Preparedness
Longer Term Actions: Ensuring a Safer from Suicide Practice

(A) IMMEDIATE ACTIONS REQUIRED AFTER A SUICIDE

1. Practice Management and Clinical Group Meeting and Response

The Practice Response: The practice may learn of the suicide of a patient from a variety of sources, including the Coroner's Officer, a healthcare provider, the police, ambulance personnel or from the family. This may be some time after the event. It is key for the practice to have an initial meeting as soon as possible. This would include the practice manager and the key primary care staff involved in the person's care.

This meeting aims to share known information about what happened and establish what further information may need to be sought. It is also an opportunity to share the understandable emotional shock that may be felt, offer support, and agree on the next steps.

It is essential to have a non-judgemental approach to individuals, whilst being open to learning ways to improve the organisation. The most identified need for improvement is communication between professionals and organisations. If there are any immediately obvious needs, do not delay taking necessary action.

Specifically, ensure staff know they can approach the manager or lead GP if they need to talk about any aspect of the event at any future time. Silence does not necessarily mean that staff feel 'OK.' Grief reactions are individual, sometimes hidden, and often delayed. Sometimes, a whole practice team can be impacted. In some individuals, the impact is compounded because there has been a former close personal or family experience of suicide.

Patient Computer Records: The practice may wish to put an alert onto the patient's home page computer record until they feel they are 100% confident to code the patient as deceased (after which no changes can be made to the records). Example: Alerted by X that patient died, suicide, date, time & place; pending official confirmation of death.

Real-Time Suicide Surveillance RTSS

A recent development is to notify death by suicide through the real-time suspected suicide surveillance (RTSS) system. Police attending a death where suicide is considered a possibility will inform agreed elements of the integrated care system within 24 hours. The aim is to identify and react to patterns and to significantly improve the speed at which targeted support reaches the bereaved. Each area will have its approach, but public health, specialist mental health services, the coroner's office and local bereavement support services are notified.

See Appendix A Section A1 for Additional Information on RTSS

See Appendix B - List of Resources that Support Primary Care Clinicians and Staff

2. Report to the Learning from Patient Safety Events (LFPSE) system

It is a national requirement for GP practices to report incidents to the LFPSE system. The link is:

learn-from-patient-safety-events-service

Every death needs to be reported to the LFPSE system within 72 hours. The Integrated Care Board (ICB) will automatically receive this from the patient safety team.

Upon receipt of the above report, the ICB patient safety lead will review the patient's care in the preceding months using the information provided by the practice via LFPSE.

On occasion, when further information is needed, the ICB will contact the practice to seek it.

NHS England » Patient Safety Incident Response Framework

Primary care information on the new national learn from patient safety events service

The **LFPSE** system replaces the National Reporting and Learning System (**NRLS**) and Strategic Executive Information System (**StEIS**).

This new system is **universal and proactive**. NHS England and NHS Improvement manage LFPSE This major upgrade creates a central national NHS system for recording and analysing patient safety events. It is hoped to increase the reporting and recording of events.

In general, primary care staff are encouraged to **record any events where:**

- **A patient was harmed**
- **A patient could have been harmed**
- **Future risks** to patient safety have been identified
- **Safe, effective care** has been shown to improve safety.

A national learning system allows patterns and trends to be picked up more effectively as part of the national picture. This enables the NHS National Patient Safety Team to identify new or under-recognised issues and take NHS-wide action. For example, issuing an urgent alert to protect patients.

The LFPSE allows for positive local responses to patient safety events.

This supports effective management, mitigation, and learning activities. Events recorded in LFPSE can be used for significant event analysis. They can also be used for continuing professional development and reflective practice. The ICB will assess the LFPSE report and decide if a Significant Event Analysis is required. The ICB Patient Safety Team will contact the Mental Health Provider where relevant.

Practices should report suicide or self-inflicted death to the Integrated Care Board Patient Safety Lead within 72 hours of being aware – use the LFPE system

The Patient Safety Incident Reporting Framework (PSIRF) is a new national strategic approach for NHS providers to know how and when to respond to a reported safety event

See Appendix A Section A2 for details on PSIRF

3. Reporting to the Care Quality Commission (CQC)

Suicide is not always necessarily a notifiable death to the CQC. However, it will be notifiable in certain deaths in which a Statutory **Notification to CQC** must be made '**without delay'**.

The **CQC** would expect to be notified of a **suicide** in the following circumstances:

- if the person had received **regulated activities** within the previous two weeks
- if it occurred during the delivery of regulated activities
- if there is police involvement that involves the practice
- if there is the potential that the practice and CQC may be named in a coroner's report

Or *if the deceased is subject to any of the following:*

- The ***Mental Health Act***
- A ***Deprivation of Liberty Safeguard***
- A ***Notification to the Local Authority*** of actual or alleged abuse
- A ***Notifiable Safety Incident*** under ***Duty of Candour*** regulations
- A ***Never Event*** Never events: analysis of HSIB's national investigations — HSIB
- A ***Healthcare Safety Investigation Branch*** notifiable condition. About HSIB
- If a practice is **unsure**, it is advisable to **submit** a notification to the CQC.

For general information on when to refer to CQC see Appendix A Section A3

4. Postvention & Support for the Bereaved Family & Friends

A national survey of 7518 people who self-identified as bereaved by suicide identified 77% as being majorly impacted, including family, friends, or professional colleagues. A third of them had experienced suicidal thoughts, and 8% had made a suicidal attempt. Most had not accessed support. There was a disproportionate number represented from ethnic minority and LGBT communities. Disenfranchised grief is when stigma or exclusion is an additional component of complex grief. Link: **McDonnell et al. Suicide bereavement in the UK**

It is good practice for the Practice to proactively reach out to the family. This is a sensitive time because they will be in shock or even angry, but they need to know that the practice would like to express its condolences and offer to support them in their hour of need. The clinical staff most familiar with the family are best placed to decide how this is done. It is important to consider if the said member of staff is also distressed and needs support.

Primary care staff need to be receptive to contact from friends or even professionals affected by grief; and recognise disenfranchised grief when it presents.

Helpful advice and tools for consulting a bereaved person. **Appendix A Section A4**

Finding the words - NSPA and Support after Suicide Bereavement Suicide & Co

Remember that bereavement from suicide leads to complex grief, and the bereaved are at an increased risk of suicide themselves. The risk could be immediate or delayed and is often worse at the time of birthdays, holiday periods and key anniversaries.

An alert on the GP records on the **anniversary** of the bereavement may be a useful reminder.

POSTVENTION RESOURCES ON A PAGE PRINT & SHARE DIGITALLY

Coroner's Court

After a death by suicide, an inquest is inevitable, and a **Coroner's Liaison Officer** will contact the next of kin and support the family throughout the process.

Coroners Courts Support Service

A Guide to Coroner Services for Bereaved People

BOX 3 LOCAL SPECIALIST POSTVENTION SERVICE

For immediate and follow up help

Specialist commissioned support to help anyone manage a bereavement by suicide.

Any age. Any Derbyshire resident.

A suicide bereavement support officer will make contact and arrange to meet for on-going emotional and practical support.

Note: Available to any health care professional or GP for personal support.

Guidance and professional advice are also available to anyone concerned or caring for someone bereaved by suicide.

Self-referral or Professional referrals.

e-mail or Phone

bereavement.derbys@tomorrowproject.org.uk

0115 88 00 280 / 01246 541935

Home - Tomorrow Project

Survivors of Bereavement by Suicide (SOBS)

SOBS specialise in the provision of peer support specialist suicide support for those bereaved by suicide. A national organisation with online forums and in-person local groups.

email.support@uksobs.org

National Helpline: 0300 111 5065

UK SOBS & local support

First Hand

Support for anyone who has been affected by witnessing a suicide.

Home - First Hand (first-hand.org.uk)

Cruse Bereavement Care

This is a free, confidential bereavement support service available to the public.

Helpline: 0808 808 1677

Coping when someone dies by suicide

Help is at Hand Booklet

Immediate comprehensive guidance for people bereaved by suspected suicide. Free downloadable PDF created by the Support After Suicide Partnership.

HIAH_Booklet_2021_V5-1-2.pdf

Hope Again – Cruse Bereavement Care for Young People and Children

A website created specifically for young people, by young people. It offers online support and signposting.

Winston's Wish

Support for children, young families and professionals.

0808 802 0021 National Freephone

e-mail: ask@winstonswish.org

From Grief to Hope

An excellent report by The Support after Suicide Partnership portraying the voice of the bereaved.

From-Grief-to-Hope-Report

PAPYRUS UK HOPELINE247 0800 068 4141.
Text: 07860039967. Email: pat@papyrus-uk.org

1- A guide for schools **#SaveTheClass Papyrus**

2- **Bereavement- - a booklet for young people**

3- **Debrief service | Papyrus UK** for any professional needing support after a (near) suicide.

CALM Campaign Against Living Miserably

CALM) (thecalmzone.net)

0800 585 858 5pm–midnight, 365 days a year

IF U CARE SHARE FOUNDATION

The Road Ahead; for someone bereaved by suicide.

If U Care - The Road Ahead Guide

0191 387 5661

Finding The Words – Support After Suicide

A booklet of bereavement support. **UCL & SASP**

Suicide&Co | Support after Suicide Bereavement

Conversation Guide

Walk With Us Toolkit supporting young families

Sidekick App Free download support

Phoneline 0800 054 8400

The Compassionate Friends supporting parents

0345 123 2304 helpline helpline@tcf.org.uk

(B) SHORT TERM ACTION
FURTHER REPORTS

1. Report for the Coroner

The coroner has the power to call any witness they feel will assist in their investigation to give evidence in person at an inquest, provide a written witness statement or provide evidence documents in the custody of a person under **Schedule 5 of the Coroners and Justice Act 2009**. It is an offence not to comply or attend if there is a reasonable excuse. As a witness, you play an important role in helping the coroner establish the circumstances of death to enable them to conclude the inquest hearing.

Attendance at an inquest and cooperation with a coroner are also requirements of the GMC, as stipulated in **Paragraph 73 of *Good Medical Practice*.**

In general, a GP is called as a factual witness.

Being called to give evidence does not indicate that the GP will be criticised for their involvement. The GP may be called to assist the coroner in establishing the facts leading to the death. It is helpful to remember an inquest is not intended to be inquisitorial. Most coroners have legal backgrounds. Therefore, clinically complex cases may require medical witnesses.

Submitting a detailed and comprehensive statement will reduce the chances of you having to attend the court in person. On other occasions, and if the case is particularly complex, you may be required to give evidence in person.

What to include in your Witness Statement

The coroner will ask for a written report from the patient's usual GP about their medical history, including any mental illness, suicide attempts, self-harm or documented expressions of suicidal ideation or signs of suicidal intent. This information will include interventions and medication and which other organisations were involved. In some cases, the coroner requests the GP to attend the inquest to present the findings and answer questions for the coroner and the barristers representing the family or the organisations involved.

The GP may be named as an Interested Person.

An example could be when there is a criticism of the GP's clinical care related to the death.

Section 47(2) of the Coroners and Justice Act (CJA) 2009 defines an 'Interested Person'.

An Interested Person has the right to actively participate in the Inquest proceedings, whether by relationship to the deceased, involvement in the circumstances of the death or at the coroner's discretion.

Interested Persons listed under the Act include:

- spouse, civil partner, partner, parent, child, sibling, grandparents, stepparents, half-siblings
- personal representative of the deceased's Estate (i.e., the Executor of their Will)
- a beneficiary under a policy of insurance issued on the life of the deceased
- a person who may have caused or contributed to the death of the deceased
- any other person who the senior coroner thinks has a sufficient interest.

They are granted the right to full disclosure of all the documents relating to the Inquest and the right to legal representation. Occasionally, an organisation with no direct knowledge of the primary facts may be permitted to 'intervene' in an inquest if the coroner deems it appropriate, e.g., the Care Quality Commission.

If a GP is named an Interested Person.

In that case, the GP and their legal representative may question the other witnesses, address the coroner, and make submissions at the end of the inquest to assist the coroner in reaching his or her conclusion.

Doctors must self-report to the GMC if they are criticised by an official inquiry, which includes a Coroner's criticism. Therefore, what happens at an inquest can dictate what happens afterwards.

2. Information for the Mental Health Secondary Services Investigation Report

If a specialist mental health service had been involved in the care of the deceased, they would perform an internal peer review of the death. They may initiate a Patient Safety Incident investigation and report. Sometimes, the lead reviewer will invite the GP of the deceased to share any information that the GP may consider relevant to the person's care.

The mental health provider will also provide the bereaved of the deceased information and support in the form of a family liaison officer.

It is helpful if the mental health provider adds an **ALERT** to the patients records to state the patient is deceased and the case is under consideration by the coroner.

(C) MEDIUM TERM ACTIONS:
PREPARING FOR THE INQUEST

1. Post or Pre-Event Audits: Safe Prescribing & Safety Planning

After reviewing a Patient Safety Incident, practices may wish to take the opportunity to audit their internal practice concerning suicide prevention. Audits may be reactive to a significant event, secondary prevention, or initiative-taking to strengthen primary prevention. An audit and review of practice procedures and protocols is supportive evidence at the coroner's inquest.

Definitions

- Non-Suicidal Self Injury (NSSI): self-injury without suicidal intent.
- Attempted suicide: self-harm with intent to take life, nonfatal injury.
- Suicide: self-harm, resulting in death. Serious Incident.

It is worthwhile to consider the evidence on which patients are more likely to die by suicide. It is also worth remembering that there is **no evidence** that suicide can be predicted using any algorithm, screening tool, or checklist. Scoring individual risk as high, medium, or low risk should **not be used** to decide on treatment. Prevention should focus on awareness and mitigating risk factors. **NICE Guideline 225** September 2022.

'The characteristics of people who die by suicide' within primary care.

Research has shown certain common characteristics of the population who are attending primary care but are not receiving secondary mental health specialist care in the year preceding their death by suicide. Commonalities include polypharmacy of psychotropic, hypnotic, and analgesic medications; comorbidities, in particular, chronic pain; alcohol misuse; gambling disorder (up to 17 times risk increase); and bipolar disorder (up to 22 times risk increase). A significant number of people had psychotropic medication, yet no coded diagnosis of a mental illness or referral to secondary mental health. Only 8% of those who died by suicide had been referred for specialist mental health care in the preceding 12 months. Increasing frequency of attendance at the GP surgery correlated with a higher rate of suicide.

Primary Care Teams must ensure patients get assessment, diagnosis, coding, evidence-based therapy and prescribing, specialist referral, and structured care.

Males who present with an identified antecedent such as a mental health problem, recent self-harm, or suicidal ideation should receive a risk formulation, focusing on clinical need and a tailored treatment plan using a strengths-based approach.

Website links:

Primary care contact prior to suicide NCISH SUICIDES IN PRIMARY CARE 2014

Br J Gen Pract 2023 Recent GP consultation before death by suicide in middle-age

Suicide Prevention through Safe Prescribing and Withdrawal

Self-poisoning is the second most common cause of death by suicide. Uniquely, the prescriber has a direct influence on the potential for harm from prescribed medication. The commonest medication for a mood disorder is an SSRI, which is not without risk, especially in younger people. Z- drugs, benzodiazepines, tranquillisers, beta-blockers, opiates, and other antidepressants come with risk. Importantly, the following steps may mitigate that risk:-

- Safe Initiation of Medication commencing, especially with SSRIs in young people
- Prescription Safety Plans
- Regular reviews and limited medication supply when expressing suicidal thoughts
- Consent for Carers to oversee medication if appropriate
- Prescription Drug Dependency Avoidance (QOF Quality Improvement)
- Safe Withdrawal of Medication **Guidance NICE NG215**

See Appendix A Section C1
Tips and References for Safe Prescribing & Prescription Safety Plans

Suicide Prevention through Personal Safety Planning

Safety Plans reduce suicidal behaviour and death by suicide One suicidal act will be prevented for every 16 people with a personal safety plan. The plan offers a **43% lower chance** of suicide.
Safety planning-type interventions for suicide prevention: meta-analysis

The very act of introducing and helping to develop a safety plan is an effective **intervention**.
It is good clinical practice to encourage all people who self-harm or express suicidal ideation to create a personal safety from suicide plan. GPs and primary care professionals can play a key role in supporting patients by introducing the idea, co-creating the plan, and ongoing review. Practices should ensure they have a process for dealing with people who are distressed and expressing thoughts of suicide when they seek help. This includes requests for help from concerned family or friends as well as reasonable adjustments as needed.

www.stayingsafe.net Video demonstration & PDF of co-creation of a Personal Safety Plan.
HOPELINK Papyrus UK **Unique 2-way digital support** to make a safety plan, 24/7, secure.
Self-harm and suicide in adults (CR229) Royal College of Psychiatrists Report 2020
See Appendix A Section A for an extract

Information Sharing Best Practice

Clinicians are duty-bound to patient confidentiality. However, a lack of involvement of family or carers is often not in the person's best interest, especially where there are concerns about suicide. A consensus statement has been issued by the Department of Health and Social Care, England. It encourages clinicians to share information more often, yet still within the confines of the law. GPs should follow the below guidance.

Guidance for frontline workers: created by Zero Suicide Alliance
Information sharing and suicide prevention: consensus statement - GOV.UK
SHARE: consent confidentiality & info sharing in mental healthcare & suicide prevention

2. Postvention and Psychological Impact on Clinicians

In all of this, we must keep in mind that members of the Practice Team may be affected by the death of a patient or the prospect of an inquest. Postvention support is available to clinicians just as it is available to the public.

Many resources are available to help clinicians and staff. Some are local to your area, whilst some are nationally available. These are listed in **Appendix B**.

The impact of suicide on clinicians

Psychiatrists
A booklet for psychiatrists dealing with the loss of one of their patients to suicide was created by the Centre for Suicide Research, University of Oxford, led by Professor Keith Hawton; 2020. The booklet offers psychiatrists advice on how self-care after a patient has died by suicide.

When a patient dies by suicide a resource for psychiatrists RCPsych 2020

A qualitative study within this described the emotional responses of psychiatrists:

Sadness • Anxiety • Guilt • Shame • Anger • Fear • Feeling blamed or responsible.

The Royal College of Psychiatrists has published **a framework for supporting staff.**

CR234 Supporting mental health staff following the death of a patient by suicide: A prevention and postvention framework December 2022
Royal College of Psychiatry Report CR 234 Staff support following patient suicide

The key recommendations include that each organisation should have a senior clinical pastoral lead and a structured, initiative-taking response to caring for clinicians following a patient's suicide.

Further research has supported the need for post-intervention support for clinicians.

> 'Reflecting on the death and accessing good support helps clinicians process the emotional impact. It can also increase their resilience in the longer term by giving them a greater understanding of both their own and their patients' limitations, and in this way strengthen their capacity for compassion as clinicians.' Oates & Gibbons **https://doi.org/10.1192/bjb.2021.106**
>
> 'Actively supporting psychiatrists, by addressing the stigma they face and the sense of blame they feel, is extremely important for their mental health and well-being, and ultimately their capacity as professionals' Tamworth et al.: **Peer Support Group for Reflecting on Patient Suicide**

In 2023, a support booklet for all mental health professionals was created, a guide on managing the emotional impact and disenfranchised (unrecognised) grief after a patient dies by suicide.

If a patient dies by suicide for mental health professionals RCPsych 2023

General Practitioners

There is no comparable study of the impact of patient suicide on the general practitioner, and such research would be welcome. Despite the obvious differences between psychiatry and general practice, the guide for mental health practitioners is valuable and relevant since, in both cases, it is about a human professional who has lost a patient for whom they were caring and had a relationship. There is a bereavement, but often it is hard for oneself or others to validate that sense of loss; hence, the term ***disenfranchised bereavement*** is used. In 2016, a qualitative study published in the BJGP interviewed GPs who participated in discussing the suicide of a young person with the person's parents.

GP experiences of dealing with parents bereaved by suicide: a qualitative study

Authors: E Foggin, S McDonnell, L Cordingley, N Kapur, J Shaw & C A Chew-Graham

Suicide prevention is an NHS priority in England. Bereavement by suicide is a risk factor for suicide, but the needs of those bereaved by suicide have not been addressed, and little is known about how GPs support these patients or how they deal with this aspect of their work.

GPs described mental health as 'part and parcel' of primary care but disclosed low confidence in dealing with suicide and unpreparedness to face parents bereaved by suicide. Some GPs described feeling guilt and reluctance to initiate contact with the bereaved parents. GPs talked of their duty to care for the bereaved patients but admitted difficulties knowing what to do, particularly in the perceived absence of other services. GPs reflected on the impact of the suicide on themselves and described a lack of support or supervision.

GPs need to feel confident and competent to support parents bereaved by suicide. Although this may be facilitated through training initiatives, and accessible services to which bereaved parents can be referred; GPs also require formal support and supervision around significant events, such as suicide.

Eight Truths about Suicide

This insightful article offers insights into suicide from the experience of Dr Rachel Gibbons, a national expert on the effects of suicide on psychiatrists. The lessons learned are relevant to all healthcare workers seeking a nuanced understanding about suicide.
Eight 'truths' about suicide | BJPsych Bulletin | Cambridge Core

After-Death Reviews in Primary Care

There are unmet needs in Primary Care that need to be addressed. In Brighton and Hove this has prompted the development of After Death Reviews (ADR) offered to the primary care teams. Dr James Pumphrey, a GP and Suicide Prevention Fellow, offers an ADR to practices who have experienced a patient suicide. This provides an opportunity for non-judgemental reflection, learning and the offer of pastoral support where needed.

See Appendix A Section A4 or more on ADRs in Primary Care

3. The Coroner's Inquest

The process of an Inquest can be daunting for the family and healthcare professionals involved. It also can take some time to take place, so there is a need to understand the emotional difficulties of revisiting the tragic event to help the coroner establish how the person died, the relevant circumstances and any other contributory factors. The inquest is a fact-finding court process. It is not meant to be a fault-finding mission, although it may feel like that to some. Support is helpful for many, and being well-prepared makes the process easier.

Suicide has not been unlawful in the UK since 1961. However, it is only since 2017 that the burden of proof or threshold required for a conclusion of 'suicide' was lowered from the criminal threshold of 'beyond reasonable doubt' to the civil threshold of 'on the balance of probability'.

To reach a **conclusion,** previously known as a **verdict,** the coroner must find on the evidence that the deceased undertook **a deliberate act and** that the suicide was the **intention** of said act.

Where contributory factors need explanation, the coroner may return a **Narrative Conclusion**. Inquests are public hearings, and the press are entitled to attend. High-profile cases are likely to attract media attention, which will understandably add to the anxieties of inquest attendees.

Most media nowadays are aware of the Samaritan's Guidance on how to report suicide responsibly and without creating the risk of sensationalism or attracting the attention of vulnerable readers. Information and conclusions shared during an inquest can offer an opportunity to aid understanding of the issues surrounding suicide.

Guidance for reporting on inquests for England, Wales & Ireland: Samaritans

BOX 4 – LOCAL CORONER PROCESS

The Support for the Bereaved Family & Friends is covered in **Section 4** above (page10).

The Support for GPs: Derby & Derbyshire LMC: Coroner's Inquest Advice for GPs

The Coroner's Inquest Advice for GPs
The Coroners Pathway

Once a Coroner decides an Inquest is needed the LMC are informed directly, and they send a support pack to the GP practice. They proactively offer support via the GP-S Mentor Scheme. If following the Conclusion of the Inquest there has been any criticism of the GP by the Coroner, the LMC will contact the GP & guide them on self-referral to the GMC & NHSE and support available throughout any investigation done by the local NHSE Performance Advisory Group (PAG).

Professional Indemnity Organisations

For example, the **MPS** or **MDU** offer invaluable support to doctors who face criticism or complaint. They provide expert help with preparing statements and inquest preparedness.

The Coroners Courts Support Service (CCSS)

This independent voluntary organisation offers emotional and practical help to bereaved families, friends and clinicians called to witness at a Coroner's Court Inquest.
Home - Coroners Courts Support Service

A Guide to Coroner Services for Bereaved People created by The Ministry of Justice

This guide is for the bereaved family, or anyone called to witness, whatever the cause of death.
A Guide to Coroner Services for Bereaved People (publishing.service.gov.uk)

The Local Medical Committee is a source of support and advice always worth consulting.

Coroner's Inquest support

Support and Advice for Derbyshire and Derby GPs regarding a Coroner's Inquest.

It includes a flowchart illustrating the key processes pertaining to an inquest.

https://www.derbyshirelmc.org.uk/coronersinquestadviceforgps

NHS RESOLUTION

Inquests: A guide for health providers Supporting staff to prepare for an inquest

Inquests-films-and-guide.pdf (resolution.nhs.uk)

(D) LONGER TERM ACTIONS:

ENSURING A 'SAFER FROM SUICIDE' PRACTICE

1. Suicide Prevention Training for Primary Care Teams & GPs

1a. Organisations specialising in Suicide Prevention Training

Various organisations offer training courses in suicide and self-harm prevention.
Training can be provided in various formats; different modules suit differing needs.
Examples of familiar training courses include:

STORM® Skills Training - Suicide Prevention

4 Mental Health Training

Mental Health First Aid Training

ASIST Applied Suicide Intervention Skills Training UK

Papyrus UK Prevention of Young Suicide

The Ollie Foundation: One Life Lost Is Enough Includes Prescription Safe Plan Training

Grassroots -Suicide Prevention, Mental Health, Self-Harm Training Courses

Harmless & Tomorrow Project Training Courses

This list is not comprehensive and is not to be taken as a recommendation. Training modules are varied ; from suicide awareness, knowledge and consultation skills. Different staff have different roles and competency requirements. **See HEE Competency Frameworks; Section D 1b below**

BOX 5 – DERBYSHIRE TRAINING OFFER FOR PRIMARY CARE STAFF

Suicide Awareness, Prevention and Postvention

1- Derbyshire Emotional Health and Wellbeing JUCD website

Derby & Derbyshire - Emotional Health & Wellbeing

Suicide Prevention Training and Events

Provides information for public and professionals on mental health, suicide prevention training offers

2- Local Health Education England Training Hub

The HubPlus **thehubplus.co.uk**

Training aimed at Primary Care Staff offers a diverse range of courses led by expert instructors.

1b. Health Education England (HEE) Resources

HEE Online Resource

Website link: **Self Harm & Suicide Prevention Health Education England**

Modular 'e-learning for healthcare' or E-LFH is a HEE programme created in partnership with NHS organisations, which includes **MindEd** as one of its resources.

MindEd is a free e-learning resource funded by HEE, the Department of Health & Social Care, and the Department of Education. It aims to equip professionals and the public with evidence-based information about the mental health of all age groups.

MindEd is part of the **National Suicide and Self Harm Prevention programme (SSHP)**
https://www.gov.uk/government/publications/suicide-prevention-cross-government-plan

It aims to provide understanding to everyone on about how to approach all ages in such situations; including front-line staff, first responders, teachers, social workers, volunteers, carers, and parents.

MindEd SSHP skills-building scenarios and knowledge sessions teach ***the dos and don'ts*** in these demanding situations. All sessions can be used in workshop or single-learner settings.
Link for the HEE resources **HEE e-learning for healthcare**

Access to MindEd Options

Register with MindEd via the following link: **MindEd Hub**
Access via existing **e-lfhc** account **MindEd - eLearning for healthcare (e-lfh.org.uk)**
Go to the Programme: **MindEd Suicide and Self Harm Prevention**.
There are 3 courses.

1 Suicide and Self Harm Prevention, Skills for Schools (6 modules)
The *Post Suicide Bereavement and Postvention* which covers breaking bad news

2 Suicide and Self Harm Prevention, Young People (25 modules) A comprehensive list of modules for *Dealing with Young People*

3 Suicide and Self Harm Prevention, Skills for Adults (4 modules) The *Postvention Support for Staff & Organisational Response* module explores the impact of family, colleagues, and friends, by following the story of two people affected by a suicide.

HEE Competency Frameworks

HEE worked with the National Collaborating Centre for Mental Health (**NCCMH**) and University College London (**UCL**) to make competence frameworks for self-harm and suicide, bringing together evidence-based suggestions for best practice. There are three parallel frameworks and documents freely available via the below link:

- working with children and young people (from 8 years upwards)
- working with adults and older adults (from 18 years upwards)
- working with the public (community and public health)

Choosing a training package for staff: it is important to match the role of the member of staff to the competency framework and check an appropriate training package is selected.

Self-harm and Suicide Prevention Competence Framework UCL

1c. The Zero Suicide Alliance provide free online training for all NHS staff

Supported by the Department of Health, the Zero Suicide Alliance offers a free e-learning training session called **Suicide - Let's Talk**, which takes around **20 minutes** to do online. This training aims to enable staff, whatever their role, to identify when someone is presenting with suicidal thoughts or behaviour, to speak out in a supportive manner and signpost them to support.

ZSA Suicide Awareness Training (frank-cdn.uk)

1d. Psychological First Aid (PFA) digital training module e-learning

UK Health Security Agency (UKHSA) has two free courses on PFA available on Future Learn

CYP Psychological First Aid online course - FutureLearn

COVID-19: Psychological First Aid Training Course - FutureLearn

Psychological first aid is an evidence-based approach to providing humane and practical help during a crisis. Both modules were initially created about the Covid-19 pandemic. They cover effective listening practices and recognising common signs of distress across different age groups.

1e. Suicide Postvention Training

Local Training - See **Section D1(a)** for local offers for suicide bereavement or postvention.

HEE e-Learning - See **Section D1(b)** for HEE e-learning in postvention.

PABBS Training – Postvention Assisting those Bereaved By Suicide (PABBS) is an evidence-based postvention support training which is open to everyone, not just clinicians or even healthcare staff. This is a one-day course, delivered in person at locations around the UK.
PABBS | Postvention Support Training | Suicide Bereavement

Support After Suicide Partnership (SASP) – See section D6 for resources and training offers.

1f. Integrated Care Board Mental Health and Suicide Prevention Web Resources

BOX 6 JOINED UP CARE DERBYSHIRE WEB RESOURCES

Resources and Training on emotional health, wellbeing, suicide prevention and postvention.

Derby & Derbyshire - Emotional Health & Wellbeing

Let's Chat Derbyshire Free Resources 2024

Mental Health and Suicide Prevention's Card (hihello.me)

Promoting mental health and wellbeing » Joined Up Care Derbyshire

Help in a mental health crisis: Derbyshire Healthcare NHS Foundation Trust

Derbyshire Mental Health Pathfinder lists a range of resources for Primary Care accessible via the intranet for practices using SystmOne.

2. Derbyshire Self-harm and Suicide Prevention Partnership Forum

BOX 7 LOCAL PARTNERSHIP FORUM INFORMATION

The Derbyshire Forum comprises multiple stakeholders who work in partnership to deliver the strategic aims as set out by national strategy and public health. It enables oversight and coordination of various pieces of work, including training, bereavement support and community outreach.

The Chair is James Creaghan, Public Health Lead for Mental Health and Suicide Prevention, Derbyshire County Council. Primary Care representatives are very welcome to contribute or join the forum. Contact the Public Health Suicide Prevention Team via e-mail ASCH.Suicide.Prevention@derbyshire.gov.uk.

3. Public Health: Real-Time Suspected Suicide Surveillance RTSSS

RTSSS allows the identification of and response to trends in suspected and completed suicides by recording them in real-time. This could be a location, a cohort of the population or a method of suicide. The purpose is to implement rapid preventative or mitigation measures . This crucially includes rapid contact with the bereaved to offer specialist postvention support. RTSSS cannot be shared locally unless it is part of a suicide cluster response. In such an event, the local intelligence will only be shared with key stakeholders.

Derbyshire Observatory
Data and statistics for Derbyshire

BOX 8 LOCAL PUBLIC HEALTH OBSERVATORY Data on suicides and mental health.

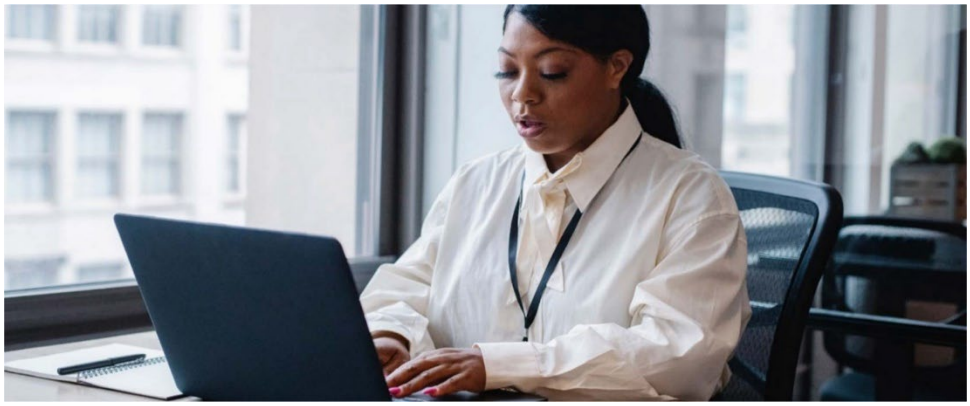
A report on Deaths from Suicide and Injury of Undetermined Intent is produced annually: **Derbyshire Observatory**

Fingertips - Public Health England ONS data (not real-time data) can be found here.

Statistical report: near to real-time suspected suicide surveillance (nRTSSS) England

Derbyshire Joint Strategic Needs Assessment - Mental Health

Zero Suicide Alliance Resources Dashboard



4. Suicide Clusters & Response

The term "suicide cluster" describes a situation in which more suicides than expected occur in terms of time, place, or both. It is not easy to define a cluster precisely. A suicide cluster usually includes three or more deaths; however, two suicides occurring in a specific community or setting in a brief time should also be taken very seriously in terms of links and impacts, particularly in the case of young people. It is important to establish at the earliest stage possible if there are connections between the suicides. There do not have to be clear connections, however, for multiple deaths to constitute a cluster.

Multiple unconnected deaths in a community can have similar consequences to a cluster in which links between deaths are apparent, such as media response, heightened local concerns and speculation, and influence on methods used for suicide. Also, there may be unrecognised connections between deaths.

It is also important to respond to concerns around suicide clusters and to pay attention to groups vulnerable to imitation and at risk of contagion in the case of a single suicide.

Types of Clusters

Point Clusters (or spatial-temporal clusters)
A greater than expected number of suicides within a period in a specific geographical location. Might be in a community or an institution e.g., school, university, workplace, psychiatric ward.

Mass Clusters (or temporal clusters)
A greater than expected number of suicides within a period of time spread out geographically.

Method Clusters
A particular method of suicide is involved. This can occur within point and mass clusters.

Echo Clusters
Two or more clusters occur in the same location but separated by time.

Suicide clusters may result from 'contagion,' whereby one or more than one person's suicide influences another person to engage in suicidal behaviour or increases their risk of suicide ideation and attempts. Various mechanisms may be involved, such as modelling and vulnerable individuals tending to come together in social groups. The 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 or previous bereavement.

There are times when Primary Care Teams may need to be alerted to the presence of a cluster by the Response Group to facilitate greater awareness and prevention. Examples might include practices that support University Students or practices that have a geographical location where suicides are frequent.

Source: **Identifying and responding to suicide clusters**

5. The National Suicide Prevention Alliance NSPA

This is an alliance of small and large organisations as well as individuals who are committed to preventing suicide and mitigating the harmful impact of suicide on others.

The Samaritans and Public Health England jointly lead it. It has a small steering group that supports its function and guides the strategic direction.
NSPA website

One pivotal document that has been produced is called From Grief to Hope and is a study of over seven thousand people bereaved by suicide and can be found here:
McDonnell-et-al.-2020.-From-Grief-to-Hope.pdf (nspa.org.uk)

BOX 9 DERBYSHIRE NSPA MEMBERSHIP 2024

'Andysmanclub' - Derbyshire Community Health Services NHS Foundation Trust - Derbyshire County Council - Derbyshire Healthcare NHS Foundation Trust - Derbyshire Law Centre - Derbyshire Victim Services - Erewash Voluntary Action CVS - High Peak CVS - Joined Up Care Derbyshire Wellbeing Service - Rural Action Derbyshire – SAIL – 'Staywell Derby' - The Derbyshire Federation for Mental Health - Trent PTS.

6. The Support after Suicide Partnership UK

'Our vision is that everyone bereaved or affected by suicide is offered timely and appropriate support.'

The Support After Suicide Partnership is a special interest group of the National Suicide Prevention Alliance (NSPA) based at Samaritans. The group is a UK-wide network of over seventy members and supporters. Founded in 2013, it brings together national and local organisations that participate in delivering suicide bereavement support across the UK to address the need for formal, multi-agency, initiative-taking suicide bereavement support.

Support After Suicide has valuable resources and training offers.

Here is a link to a video from their annual conference including a poem about loss to suicide.
Suicide Bereavement UK - Jenny Berry - Poem 'In It Together' - YouTube

For a deeper insight into the impact of suicide on family and friends, please refer to the excellent report by The Support after Suicide Partnership called ***From Grief to Hope***
From Grief-to-Hope Report

PABBS evidence-based training equips professionals, including general practitioners, to deal with postvention effectively and confidently. See the website link:
Postvention Assisting those Bereaved By Suicide (PABBS) Training

7. Organisational Postvention after the suicide of a GP or colleague

GP Practices, Primary Care Networks, and GP Alliances are small businesses and employers. Along with larger NHS organisations such as ICBs and Provider Trusts, they should be prepared in the event of the suicide of one of their colleagues or staff. There is an increased risk in female doctors and nurses, so both suicide prevention and postvention are key.

NHS Employer Toolkit to prevent suicide in the NHS workforce

NHS England Toolkit for Workforce

Suicide prevention and postvention | NHS Employers

'Responding to the death by suicide of a colleague in Primary Care: A Postvention Toolkit.'

The Society of Occupational Medicine and **The Louise Tebboth Foundation** published this step-by-step guide.
Responding to the suicide of a colleague in Primary Care

The RCGP provides immediate practice support after the sudden death of a member of staff.

Sudden Bereavement Support Pilot (rcgp.org.uk)

How can we support staff after the death by suicide of a colleague? The BMJ

NHS Employee Suicide: a postvention toolkit after suicide of a member of staff

Created by **Samaritans and NHS Confederation**
NHS employee suicide: a postvention toolkit

'Crisis Management: A Postvention Toolkit for Employers'

The Prince's Responsible Business Network
A Postvention Toolkit for Employers - Business in the Community

'Responding to Suicide in the Workplace'

A guide created by the **Chartered Institute of Personnel and Development**
Responding to suicide risk in the workplace | CIPD

'Postvention Guidance for the Ambulance Service'

An evidence based postvention guide: support after a suicide within the paramedic community.
Samaritans_AACE-postvention-toolkit-June-2021.pdf

Universities UK guidance on ensuring Suicide – Safer Universities

A practical guide and checklist of recommendations for universities on managing the immediate aftermath of a death by suicide of a student.
Responding to a suicide: advice for universities (universitiesuk.ac.uk)

APPENDIX A ADDITIONAL INFORMATION

Section A1 Practice Management; Clinical Group Meeting &Response

Real-Time Suicide Surveillance (RTSS)

The British transport police originally set up real-time suicide surveillance and has completely revolutionised our ability to respond to suicides in a timely fashion.

Thrive London LDN Thrive LDN is the largest developed RTSS system in the UK.

- Designed & implemented the only whole region RTSS, covering nine million people
- The RTSS provides a system to share information on suicide for multiple agencies
- Included: Metropolitan Police, British Transport Police, the NHS & 33 London local authorities
- The system is all online and has been developed with QES, a data solutions company
- The Thrive LDN system is part of the national pilot for RTSS
- The System was launched in 2019 on World Suicide Prevention Day
- RTSS has been integral in London's Covid-19 response
- RTSS shares information quickly & securely, enabling vital services, e.g., bereavement support
- RTSS allows a greater understanding of suicide prevention input into prevention strategies.

The RTSS takes data from the police and other sources above about suspected suicides and now extends to include attempted suicide and self-harm. Work is done to identify clusters and ensure postvention is offered within 48 hours. GPs are offered postvention services and training.

(Provided courtesy of **Dr Phil Moore**, Deputy Chair, NHS Kingston Clinical Commissioning Group.)

Section A2 Report to Learning from Patient Safety Events (LFPSE)

The Patient Safety Incident Response Framework (PSIRF) is a proactive strategy supporting the Learning from Patient Safety Events (LFPSE) processes.

1. Compassionate engagement & involvement of patients, families, and staff
2. A proactive strategy for Learning from Patient Safety Events (LFPSE)
3. Considered proportionate responses

The new **PSIRF** is replacing the **Serious Incident Framework (SIF) (2015)** and **Route Cause Analyses (RCA),** as how we respond to patient safety incidents in the hope of learning from them. In some areas deaths by suicide must be reported under this policy.

PSIRF makes **no distinction between Patient Safety Incidents and Serious Incidents** negating the latter's threshold. The aim is to achieve a **Just Culture** whereby an investigative approach is replaced with a compassionate, proportionate response involving those affected by the incidents. It allows for greater data-informed system learning.

The **Patient Safety Investigation Response Framework** (PSIRF) **four key aims**:

1. Compassionate engagement & involvement of patients, families, and staff
2. A proactive strategy for Learning from Patient Safety Events (LFPSE)
3. Considered proportionate responses
4. Supportive oversight to strengthen responses & encourage continual improvement

PSIRF advocates an encompassing, data-driven approach to responding to incidents in healthcare. The framework moves away from defining a serious incident and focuses on patient safety incidents, to embed patient safety incident responses within the wider improvement culture.

The policy ensures that reportable incidents are appropriately managed within the Integrated Care Board's (ICB) commissioned and co-commissioned services.

PSIRF is compulsory for Acute, Community and Mental Healthcare providers as it is a contractual requirement under the NHS Standard Contract.

Primary Care Services in England and Wales do not have to adopt the PSIRF at present but may either choose to, or be mandated to, in the future as this new framework develops.

NHS England » Patient Safety Incident Response Framework

Organisations signed up to PSIRF will have specific National and Local Priorities on which they must report. The information is held nationally and shared with the ICB Safety Lead.

Section A3 Reporting to Care Quality Commission (CQC)

General Information on when to refer to CQC

When: Notification to the CQC should be ***without delay***

Who: Providers and managers of NHS GP need to notify CQC if:

The death occurred actually **during, or within two weeks of, regulated activity** being provided **and**
the death was or may have been **the result of the regulated activity** or how it was provided **and, if in your reasonable opinion,**
the death **could not be** attributed to the course which the illness or medical condition would **naturally** have taken if the deceased had been receiving appropriate care and treatment.

CQC Regulated Activities

Scope of registration: Regulated activities - CQC

Regulated activities are those activities that must be registered with the CQC.
For **GP services** these include:

- Treatment of disease, disorder, or injury
- Surgical procedures
- Diagnostics and screening.

Practices can **notify the CQC** using either the CQC provider portal or via the link below.

CQC Guidance for Providers on Notifications

GP myth buster 21: Statutory notifications to Care Quality Commission

'Notifiable safety incident'

A Notifiable Safety Incident is a specific term used in the Duty of Candour Regulations. It is distinct from other types of safety incidents or notifications and must meet **all three of the following criteria:**

1- It must have been **unintended or unexpected**.

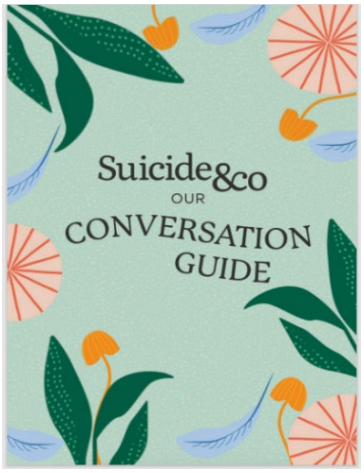
2- It must have occurred while providing an **activity CQC regulates.**

3- It already has, or might, result in **death, or severe or moderate harm** to the person.

Section A4 Postvention & Support for the Bereaved Family & Friends

Suicide & Co: Support after Suicide: Our Conversation Guide

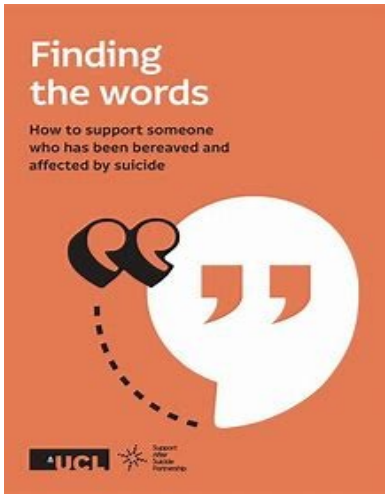
Helpful advice & tools on consulting a bereaved person.



The Conversation Guide has suggestions around language choices and collates the experiences of those bereaved, both positive and negative. Words Unspoken – a safe space to write to the loved one they lost.

Support after Suicide Bereavement (suicideandco.org)

Walk With Us Toolkit - a resource for children bereaved by suicide



Judi Meadows Memorial Fund

Finding the words

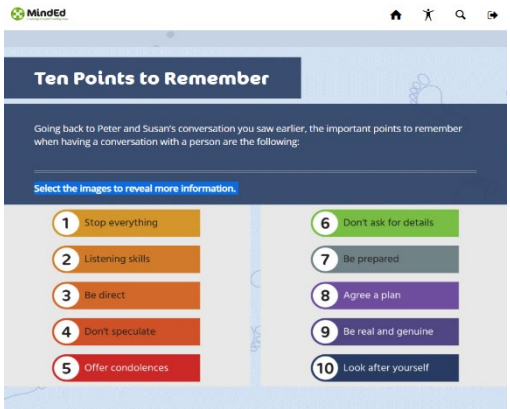
'Finding the words' was created by the Judi Meadows Memorial Fund alongside **UCL** and contains useful advice on how to communicate sensitively with anyone bereaved or affected by a suicide. Useful for the public and staff alike.

MindEd: 10 Points to Remember in a conversation with someone bereaved by suicide

The below is taken from the **MindEd** module on Postvention and was an attempt to distil the views and learning of the authors. The ten points provide a good framework for approaching a first conversation with someone after bereavement.

10 POINTS TO REMEMBER

1 Stop everything
2 Listening skills
3 Be direct
4 Do not speculate
5 Offer condolences
6 Do not ask for details
7 Be prepared
8 Agree a plan
9 Be real and genuine
10 Look after yourself



Reproduced with the permission of the authors.

Remember to offer the option of postvention support.

After-Death Reviews (ADR) in Primary Care – A Brighton and Hove initiative

A contribution kindly provided by Dr James Pumphrey GP Fellow Brighton & Hove

There are unmet needs in Primary Care that need to be addressed. In Brighton and Hove this has prompted the development of After Death Reviews (ADR) offered to the primary care teams. Dr James Pumphrey, a GP and Suicide Prevention Fellow, offers an ADR to practices who have experienced a patient suicide. This provides an opportunity for non-judgemental reflection, learning and the offer of pastoral support where needed.

''This process was established in Brighton and Hove in 2019 to try and improve the support offered to GPs in the immediate aftermath of a suicide. Deaths of this nature can often leave us with unanswered questions, and in primary care, there are not always easy opportunities to discuss the case or debrief with secondary care colleagues. This can leave clinicians working feeling isolated and vulnerable and risk missing the chance to capture any potential learning.

Using the real-time surveillance data, we proactively reach out to practices in the days following a suicide, initially to offer condolences and signposts to some of the resources contained in this leaflet. We then offer to meet with a clinical team member to go through the patient's story together in a safe, non-judgmental fashion. Sometimes, this debrief, and timeline construction is enough, but sometimes we try to arrange a comprehensive review with the wider stakeholder team.

The concept has been discussed with the coroner, who has endorsed it as good practice so long as the meetings take place after any statements for the coroner's court have been submitted. There is no obligation, and some practices may have their process, but staff have found it supportive and valuable where it has been taken up. Although the primary aim is to support the staff involved, once the ADR is completed, any relevant learning is anonymised and fed back to the System-wide Suicide Prevention Group by the practice as appropriate.''

Dr J Pumphrey

The above initiative builds on the foundation laid in 2005 by King et al in which 10 practices reviewed 12 deaths by suicide. Next of kin views were sought. All staff attending a critical incident review (CIR) were interviewed after the review.

Results: Ten practices reviewed 12 deaths. Twenty-six staff attended reviews; all were interviewed. Next of kin contributed to six reviews; only one criticised care. Changes following the reviews included steps to improve internal communication and bereavement support to set up internal CIRs and review prescribing policies. Communications between practices and other agencies were clarified.

Conclusion: Practices were willing to hold CIRs and appreciated the potential positive value but need reassurance that they will not be blamed for suicides, and that the cost in time and resources will be recognised.

General practice critical incident reviews of patient suicides: benefits, barriers, costs, and family participation - PubMed (nih.gov)

Section C1 Audits: Safe Prescribing & Safety Planning

The following advice is consistent with NICE Guideline NG225 Self-harm: assessment, management and preventing recurrence Published: 07 09 2022

A. Preventing Suicides through Safe Prescribing

The Key Messages for any person starting an antidepressant include:

- Antidepressants are widely used across the world as medication to treat depression and the benefits usually outweigh the risk of any unwanted or unpleasant symptoms.
- People can have an adverse reaction (ADR) to any medication, including any antidepressant.
- Antidepressants have many side effects as listed in the 'Patient Information Leaflet' (PIL). These include worsening deepening or anxiety, thoughts of self-harm or suicide, especially for people with previous suicidal thoughts or those aged below 30 years.
- Antidepressants take time to work- can take upto 4-6 weeks to get full benefit.

SSRI Medication and Suicides

SSRI drugs are the commonest antidepressants used today, and whilst much safer than the older generation of drugs. Overall, they benefit in lifting mood and reducing suicide behaviour and alongside talking therapies are widely used. However, there are reports that especially in young people, they may increase the risk of suicidal thoughts. Therefore, it is imperative that whenever they are prescribed a clear warning is issued to the patient by the GP and reinforced by the pharmacist. This should alert the patient to be aware that they may feel worse before they feel better, and that if they feel worried or suicidal to contact the GP again immediately. The Ollie Foundation create supportive materials and training on this specific topic. See below.

My Prescription Safe Plan The Ollie Foundation

This charity supports others to reduce the risk of suicide and has a particular focus on young adults and students. The Foundation has developed novel pathways for supporting those who are prescribed medication with side effects that include deteriorating well-being and or suicidal thoughts. Such side effects may increase distress and reduce hope in the person if they interpret it as a deterioration of their presenting condition. It is vital that the prescriber communicates the possibility of side effects to the person with clear advice to get back in touch without delay if their well-being is deteriorating.

The Foundation created a Prescription Safe Plan, an innovative key addition to the personal safety plan, to support that conversation. NICE NG215 Guideline supports this approach.

Free fillable PDF link here: **Prescription Safe-plan | The OLLIE Foundation.**

Choice of Medication

- The appropriate prescribing for **common mental health conditions** reduces the risk of suicide by effectively treating the mental illness and reducing access to means.
- Awareness that venlafaxine or tricyclic antidepressants have a higher risk of death in overdose.
- Avoiding benzodiazepines due to dependency and risk in overdose.
- Beware of concomitant use of analgesics or opiates, especially if alcohol misuse is present.

Medicines and Suicide Visual Aide Memoire

This visual tool, created by Derbyshire Healthcare Foundation Trust, may be used to support effective conversations between clinicians and patients or carers. It illustrates the balance between clinical benefit and suicide risk. **Medicines and suicide professional aide memoire**

Careful dynamic risk assessment and mitigation of risk.

Medication reviews should include risk-benefit assessments, and risk mitigation actions, which should be recorded in the notes by GPs, mental health workers and pharmacists.

Practical Tips for prescribers concerned about risk of suicide

- Changing from repeat to acute medication.
- Frequent review and limited supply.
- Entrusting carers to oversee the medication of patients who are actively suicidal.
- Close liaison between GP and dispensing pharmacist.
- Close liaison between GP and psychiatrist if medication concerns arise, or clarification needed.
- Doses, quantities, medication reviews, and judicious use of 'repeat' prescribing are all areas which require practice policy but also individual tailoring to a patient's risk.
- Beware of stockpiling medication whether prescribed, bought or accessed from a family member. The latter may be deceased, particularly from suicide, which raises the risk of an imitation suicide.
- Finally, consider Instalment Prescribing and Dispensing: Schedule 2 Controlled Drugs plus buprenorphine, buprenorphine/naloxone (Suboxone) and diazepam.

Safe Deprescribing (planned discontinuation) of Antidepressants

When discontinuing an anti-depressant, it is important the GP, prescriber or pharmacist involves the person in the decision and the potential outcomes. The patient should be made aware of the risk and features of a discontinuation reaction, over the following few days or weeks.
These scenarios are very distressing for the person and so awareness, and advice on seeking early help from primary care, improves safety and outcomes.

In addition, withdrawal of an SSRI can lead to increasing distress due to a discontinuation reaction or recurrence of mood disorder. Therefore, close monitoring and shared decision making is needed during any periods of changes in the dose. See **NICE Guidance NG215** below.

Overview | Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults | Guidance | NICE

Prescription Drug Dependency

In 2019, the Quality Outcomes Framework introduced Quality Improvement components, including Safe Prescribing. The Prescription Drug Dependency QI module was introduced in 2022/23. QOF is subject to annual review however there is a need for constant quality review of prescribing practice to avoid prescription dependency. Patients on high doses of certain medications, including opiates, gabapentinoids, benzodiazepines, and Z-drugs, need review. The primary aim of the QI PDD is to mitigate against dependency and adverse drug effects.

However, this group of patients with pain and comorbidities are also at high risk of depression, and many will also be on antidepressants. They are, therefore, vulnerable to suicide or accidental death by overdose, particularly where alcohol is misused. The GP and pharmacist use the medication review as an opportunity to assess the patient's mental health and proactively enquire about any suicidal thoughts or plans.

References for Safe Prescribing

Common mental health problems: identification and pathways to care | Guidance | NICE

Preventing suicide in community and custodial settings | Guidance | NICE

Depression in adults: treatment and management | Guidance | NICE

Self-harm: assessment, management and preventing recurrence | Guidance | NICE

Suicide prevention reducing access to medicines as a means of suicide. NICE

NHS England: Items which should not routinely be prescribed in primary care: guidance

Suicide Risk Mitigation: BMJ Best Practice

Antidepressant discontinuation & risk of suicide attempt: a case-control study

Withdrawing from SSRI antidepressants: advice for primary care | BJGP 2023

Medicines associated with dependence safe prescribing and withdrawal | Guidance | NICE

B. Preventing Suicides through Personal Safety Planning

The role of the general practitioner See CR229 Report RCPsych 2020

Along with emergency department staff, the general practitioner is the professional most likely to be the first point of contact for those who have self-harmed or experienced suicidal thinking. Often, the GP will have a good knowledge of the patient and their family background. The GP should aim to put the person at ease, take an initial history, conduct mental state, and appropriate physical examinations. The NCISH (2014) noted that mental illness was often recognised in primary care patients who later died by suicide.

Indicators of risk in these patients include frequent consultations and prescription of multiple psychotropic drugs. The self-harm/suicidal ideation may be an indicator of a psychiatric disorder, including depression, substance misuse and, less commonly, psychotic illness. In some individuals, self-harm may be associated with psychological and social factors such as current or past sexual or physical abuse, relationship problems or financial concerns.

The GP must also be mindful of the potential risk to children being exposed to adults who self-harm. If the person presents with self-cutting, the GP should establish when this started, its frequency, the parts of the body involved, and the effect on the patient, including its purpose in controlling painful emotions.

The GP should ask about specific triggers and whether the self-harm is becoming more frequent or escalating in severity. They should enquire about other self-damaging behaviours, such as misusing alcohol or drugs. The patient should be asked for the key symptoms of depressive illness, i.e., anhedonia, loss of energy, impaired sleep, appetite and concentration, and negative patterns of thinking. The GP should enquire about key relationships, those in whom the patient can confide, and how the person has coped in previous times of distress.

On mental state examination, it is important to assess the level of depression, your objective view, as well as the person's subjective view. The GP should check the level of self-esteem, the presence of guilt, hopelessness, and suicidal ideation.

The consultation should conclude with an agreed follow-up plan. This is likely to include a review by the GP, and advice on how to obtain help before the review, if necessary. For less severe cases, there may be a referral to counselling. If there is evidence of a mental illness, a prescription of medication may be appropriate.

This is a lot to do in a routine ten-minute consultation. Both digital consultations and GP appointment triage can help gather key information before the actual in-person appointment. Of course, not all appointments are ten minutes and information can be gleaned over several structured follow-up appointments.

The Importance of Safety Plans

A Safety Plan can be co-produced with the patient, who will identify many of the key elements. The plan needs to be person owned and, where appropriate, shared with a trusted carer.
.
If the patient is unable to articulate their wishes or when their psychological pain and wish to die prevents them from effectively engaging safely, the clinician may have to take a more directive role. The Royal College of Psychiatrists believes that every person with suicidal thoughts or who has self-harmed should have a Personal Safety Plan.
The Stay Alive website and app is ideal for anyone wishing to make a safety plan.

Stay Alive - Essential suicide prevention for everyday life

Making a Safety Plan

A Safety Plan should be co-produced, is owned by the person, and comprises:

- Individualised strategies/activities to instil hope
- Calming/distracting activities
- Restriction of access to common means of suicide
- Contacts for social and crisis support

StayingSafe.net is an innovative digital solution for people to make a Safety Plan.

- Reasons for living and ideas for getting through tough times
  Reminders of positive aspects of life: photos of people, pets, or special places, favourite music

- Making your situation safer
  Remove things that could be used for self-harm or suicide

- Identify and avoid distress triggers

- Things to lift or calm mood – a calming activity is anything relaxing
  Meditation, yoga or looking at a photo of a magnificent view or someone you love
  Writing down feelings in a diary or a letter
  Calming thoughts such as about a special place or happy memory

- Distractions - Anything that 'takes your mind away' from distressing feelings
  Distracting activities 'keeping you busy' (e.g., exercise, cooking, art, chores, connecting with meeting someone in person, via email, phone call or text or on social media)
  Distracting via thinking 'keeping your mind busy' (e.g., music, puzzles, TV, YouTube, Films)

Hub of Hope

Mental Health Support Network provided by Chasing the Stigma | Hub of hope

This website and App can point a person in distress to the nearest support services.

WRAP Planning

Patients receiving support from mental health services may have been supported to coproduce a wellness recovery action plan which details:

1. Simple safe effective tools to create and maintain wellness
2. A daily plan to stay on track with the person's life and wellness goals
3. Identify and mitigate known triggers of mental distress
4. Gain support and stay in control even in a crisis.

GPs and Primary Care can proactively support the person to use their plans effectively.

References for Safety Planning

Assessment of suicide risk in mental health practice: shifting from prediction to therapeutic assessment, formulation, and risk management - The Lancet Psychiatry

Self-harm and suicide in adults RCPsych Report CR229 2020 pages 48-50 Safety Plans

What Is WRAP? - Wellness Recovery Action Plan

C. The National Confidential Inquiry into Suicide & Safety in Mental Health NCISH

A toolkit for specialist mental health services and primary care

display.aspx (manchester.ac.uk) **see pages 23-28**

Primary Care Services are recommended to Annually Audit the below procedures:

Safe Prescribing (see NCISH)

There is a standard procedure in place for safer prescribing of opiate analgesics and tricyclic antidepressants in primary care which considers the toxicity of these drugs in overdose by:

(i) Considering reduced, short-term supplies
(ii) Asking about supplies of over-the-counter opiate-containing medications kept at home or prescribed to someone else in the household
(iii) Ensuring patients newly prescribed antidepressants are aware of the time taken to work.
Practice protocol for managing anxiety disorders and reducing prescribing of benzodiazepines.

Co-morbidities, depression, and suicide

Good physical healthcare may help reduce suicide risk. Health care professionals working across all medical specialties should be vigilant for signs of mental ill health, especially when treating major physical illnesses including cancer, coronary heart disease, stroke, or chronic obstructive pulmonary disease (COPD). Clinical services should also be aware of the increased risk of fatal overdose, particularly by opiates/opioids in older patients with long-term physical illness. Physical illness can increase the risk of suicide among mental health patients.

In the UK in 2009-2019, a quarter of patients who died by suicide also had a co-morbid physical health problem and the figure rises to 47% in patients aged 65 and over. Depression is linked to increased suicide risk among physically ill people.

Monitoring for depression

There is a mechanism in place to ensure that patients who present with major physical health issues are assessed and monitored for depression and risk of suicide.

There is a mechanism in place to ensure that patients with certain markers of risk (i.e. frequent consultations, multiple psychotropic drugs, and specific drug combinations) are further assessed and considered for referral to specialist mental health services.

There is a standard procedure in place for mental health staff to regularly review care with GPs or specialist clinics.

Additional measures for men with mental ill-health

Psychological therapies suited to the needs of men in mid-life which can be offered. There are measures in place to ensure services are responding to men's needs in a way that helps and engages them. This includes protocols for joint working with primary care, A&E, and the justice system. There is a standard procedure in place for men who may be uncomfortable seeking help (i.e. are disengaging) that signposts them to local informal sources of help.

APPENDIX B SUPPORT FOR PRIMARY CARE STAFF

SELF CARE

POSTVENTION RESOURCES ON A PAGE 11 PRINT & SHARE DIGITALLY

Resources for anyone bereaved by suicide; family, friends or professionals; page 11 of pack.

Personal Safety Plans for Staff

There is always a need for self-care and self-compassion, and more so after a bereavement or loss of a patient or colleague to suicide. The freely available accredited suicide prevention website **www.stayingsafe.net** includes a full guide on how to create a **Personal Safety Plan**. It is worth sharing with every person who has suicidal thoughts or has been bereaved by suicide.

Each healthcare worker is encouraged to create their own personal safety plan **before** any point of crisis or despair arises. This is especially true now with the added stressors caused by the current workforce and critical pressures from the NHS. Female doctors and nurses are at higher risk for suicide, and no one is immune from thoughts of suicide when faced with significant emotional distress and repeated moral injury. It is not a sign of weakness, and seeking and finding support from family, friends, and professionals is vital.

The personal safety plan is a vital guide and protection in times of despair.

Guide for staff

In 2023 a support booklet for all mental health professionals was created which is an excellent guide on how to manage the emotional impact and disenfranchised bereavement experienced.

If a patient dies by suicide for mental health professionals RCPsych 2023

There is not yet a comparable study of the impact of patient suicide of the general practitioners, such research would be welcome. Despite the obvious differences between psychiatry and general practice, the guide for mental health practitioners is valuable and relevant since, in both cases, it is about a human professional who has lost a patient for whom they were caring and had a relationship. There is a bereavement, but often it is hard for oneself or others to validate that sense of loss; hence the term **'disenfranchised bereavement'** is coined.

General Practitioners, clinical staff & managers may find this resource helpful.

LOCAL ORGANISATIONS

Contact your own GP for confidential medical advice and support.

Approach a trusted manager, or colleague, for support at work. .

Consider support available from your employer, General Practice or PCN

BOX 10 – LOCAL ORGANISATIONS

SUPPORT FOR STAFF IN DERBY AND DERBYSHIRE

JUCD Joined Up Care Derbyshire

The Integrated Care System provides a range of resources to support the general wellbeing of Primary Care Staff can be found here.

Staff support » Joined Up Care Derbyshire

Wellbeing - Your Self Care Pack » Joined Up Care Derbyshire

Local Medical Committees (LMC)

The local LMC provide an excellent list of available help including

Guidance for **Inquests** and access to the **GP-S Mentoring Support Scheme**

Website: **Derby & Derbyshire LMC: Wellbeing & Support**

Inquest support:
https://www.derbyshirelmc.org.uk/coronersinquestadviceforgps

Specialist Suicide Postvention and Bereavement Counselling

THE TOMORROW PROJECT

Specialist commissioned support to help cope with a bereavement by suicide. Any age. Any Derbyshire resident. Immediate and follow up help.

A suicide bereavement support officer will make contact and arrange to meet for on-going emotional and practical support.

Available to any health care professional or GP for personal support.

Guidance and professional advice are also available to anyone concerned or caring for someone bereaved by suicide.

Self-referral or Professional referrals.

e-mail or Phone
bereavement.derbys@tomorrowproject.org.uk
0115 88 00 280 / 01246 541935
Home - Tomorrow Project

NATIONAL ORGANISATIONS

Professional Indemnity Organisations

The MPS, the MDU and other similar organisations support doctors who face criticism or complaint, are facing an investigation or called to give evidence at an inquest.

The Nurse Lifeline – 0808 801 0455 – alex@nurselifeline.org.uk
The Listening Service provides a free confidential UK wide peer led support for nurses, midwives, health support workers, students as well as their friends and families

NHS Practitioner Health

NHS Practitioner Health (PH) is a confidential primary care treatment service for healthcare staff with mental health or addiction problems where these might impact on their work. We exist to help those members of the workforce who, due to confidentiality reasons or the seniority of their role, feel unable to access care or treatment locally. Access is via self-referral for Primary or Secondary Care Staff in England including nurses, doctors and dentists.

Telephone: 0300 0303 300 – 8am to 8pm Monday to Friday and 8am to 2pm Saturdays.
Website: www.practitionerhealth.nhs.uk/
Email: prac.health@nhs.net
Text: NHSPH to 85258 for the out-of-hours crisis text service

The RCGP, with support from PH if needed, offer immediate support when a practice has experienced the unexpected sudden death of a senior member of staff.
Sudden Bereavement Support Pilot (rcgp.org.uk)

BMA wellbeing support services

This is a confidential, nationwide, non-stop 24/7 advice, counselling and peer support and relevant signposting service for doctors and medical students regardless of BMA membership, plus their partners and dependants. Provides help for doctors in difficulty, especially in relation #to mental health problems and misuse of alcohol and/or drugs.

Phoneline: 0330 123 1245
Websites: **BMA Your Wellbeing**

Support 4 Doctors – now hosted by The Royal Medical Benevolent Fund

The RMBF is a charity that provides support for doctors and their families through all stages of their career and beyond. Our help ranges from financial assistance in the form of grants to a telephone befriending scheme for those who may be isolated and in need of support.

Telephone: 0208 540 9194
Website: www.rmbf.org

Doctors in Distress

A UK-based independent charity that focuses on the prevention of burnout, worsening mental health or suicide in health care professionals. They offer a variety of support groups, programmes, and webinars. They do not provide therapy or crisis services.

Home - Doctors in Distress - Support for Healthcare Workers (doctors-in-distress.org.uk)

DocHealth

A specialist psychotherapeutic service for doctors supported by the British Medical Association and the Royal Medical Benevolent Fund for any doctor in the UK. Self-referring doctors can access up to six face-to- face sessions with the service and further care can be advised.

Website: https://www.dochealth.org.uk/
Telephone: 0207 383 6533
Email: enquiries@dochealth.org.uk

Doctors' Support Network

A confidential peer support network for doctors and medical students with concerns about their mental health. We do not have a physical office and therefore do not have a postal address or telephone number. DSN is run by volunteer members in their spare time. Your email will receive a response as soon as possible.

Email: info@dsn.org.uk
Website: www.dsn.org.uk

The British Doctors' and Dentists' Group

A mutual support society for doctors and dentists who wish to recover from drug or alcohol dependency. It provides venues to meet for confidential, mutual support and encouragement.

Telephone: 07825 107970
Website: www.bddg.org

The Sick Doctors Trust

This is an independent and confidential organisation which offers support and help to doctors and medical students suffering any degree of dependence on drugs or alcohol. It offers early intervention, treatment, recovery and rehabilitation of affected doctors and their families.

Helpline 0370 444 5163 (24 hrs)
Website: www.sick-doctors-trust.co.uk
Email: help@sick-doctors-trust.co.uk

Alcoholics Anonymous

Telephone: 0800 917 7650
Website: www.alcoholics-anonymous.org.uk

Narcotics Anonymous

Helpline telephone: 0300 999 1212 – 10am to midnight
Website: www.ukna.org

British International Doctors' Association

Established to promote equality and fair treatment of all doctors working in the UK irrespective of race, gender, sexual orientation, religion, country of origin or school of graduation.

Telephone: 0161 456 7828
Website: Home | British International Doctors Association (bidaonline.org)

The Samaritans

The Samaritans provides confidential, non-judgemental emotional support, 24 hours a day, for people who are experiencing feelings of distress or despair, including contemplating suicide.

Telephone: 116 123 (freephone for callers in UK)
Website: **www.samaritans.org**
Email: **jo@samaritans.org** (for emotional support)

Wales only **Wellbeing support line for health and social care workers | Samaritans**

SHOUT

Shout - UK's 24/7 Crisis Text Service for Mental Health Support

Text SHOUT to 85258

First Hand

A support for anyone who has been affected by witnessing a suicide, when they did not know the person who died. This may be because they happened to be in a particular location, or because their job involved responding to such incidents. The support aims to help the person make sense of lasting memories or thoughts about their experience.
Home - First Hand (first-hand.org.uk)

NHS Resolution – further information and support links for all NHS staff

Support for healthcare staff - NHS Resolution

Medical Student Suicide Prevention Training

Dr SAMS - Suicide Awareness in Medical Students - Olly's Future (ollysfuture.org.uk)

Hub of Hope

Mental Health Support Network provided by Chasing the Stigma | Hub of hope

A useful map of local mental health resources found by postcode.

PAPYRUS HOPELINE247

HOPELINE247 | Papyrus UK | Suicide Prevention Charity (papyrus-uk.org)

1. A support service for young people and their carers who experience suicidal thoughts.

2. A debrief service for any professional who has had an experience with suicide or near suicide and would like support to talk it through with a trained professional.

Contact HOPELINE247 for confidential support & practical advice 0900-2400 every day all year. Call: **0800 068 4141**. Text: **07860039967**. Email: **pat@papyrus-uk.org**

CANOPI

Free mental health support scheme for NHS and Social Care workers in **Wales**.

https://canopi.nhs.wales/