National **Suicide Prevention** Alliance

Summary of NSPA and emergency services discussion, 16th November 2021

<table>
<tr><th>Challenges</th><th>Ideas, plans, approaches</th></tr>
<tr><td>Data collection and responsibility
Need more standardised way of recording information at suspected suicides, can vary depending on officers
Police gather some data following a death by suicide, who should be responsible for analysis, gathering additional information, bereavement support information etc?
Ambulance service with data dashboard that could be helpful – unclear how to share it or make better use of it
If police responsibility, how can they collect data when not present – e.g. if ambulance to hospital
Who and how to collect data about wider family and friends who are also bereaved?
There is a lack of data around under represented communities such as LGBTQ+, particularly trans people, and BAME communities.
What information is available to help understand the scale of the problem? Still doesn't feel clear.</td><td>Standardised form for officers to complete to collect key information, including referral to bereavement support
Regularly attending local suicide prevention to build relationships and understanding
Building good relationships with coroners helps information sharing
Having a clear understanding about why data is being collected and how it feeds into the national picture helps clarity with who does what
Urgent care integration with ambulance service is helping to identify at risk populations, such as people who self-harm</td></tr>
<tr><td>Support for staff
What are the additional challenges of providing support to emergency services staff, and are there clinicians with the right skills and experience available?
How can an organisation respond to a staff suicide? What is good practice? How can people support each other?
How get continuity of support, if brief external support or one-off visit from chaplain, how maintain and continue that?</td><td>Internal crisis support service, stepped intervention with a mental health professional
In-house counselling and therapy service
If there's an incident that could affect well-being, have a process that watch manager has an initial conversation, then a few days later another opportunity to share and reflect. Moving from TRIM to CISM
Staff have appreciated pro-active contacts following traumatic incidents</td></tr>
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• Boundaries of bereavement or crisis support services don't match with boundaries of forces, so complicated referral process for staff • If setting up a bereavement service across a police force, how to refer people – opt-in or opt-out? Does it need to be suicide-specific, or for any bereavement? • Many people working in emergency services will face traumatic incidents – how provide tools early in role so are more prepared, have understanding and resilience? • Concern that some staff start retirement still holding on to trauma from work • How to approach conversations about mental health, suicidal thoughts, well-being – what to say and what not to say?	• Helpline for people who have witnessed a death by suicide, and a short guide 'First Hand' – support for witnesses (here) • Established force-wide bereavement service that provides support regardless of county boundaries etc • Postvention toolkit for workplaces (here) developed by Business in the Community and Public Health England helps organisations prepare and think in advance of a death by suicide • Work underway to think about how to prepare staff for experiencing trauma and resources being created to support development of coping tools
Culture, including help-seeking • Sometimes people don't feel they can be ill or take time to look after themselves; and 'I'm alright' attitude • Lack of confidence in how to have conversations around suicide, culture of worry about those conversations • How to move from people 'armoring up' to being open to conversations? • Internal issue with recognition of trauma and getting workforce to understand and accept their own mental health needs • Typical nature of people working in ambulance service is they give care, not look after themselves • Individuals struggling with their mental health are not routinely passed into occupational health for an	• United Minds staff network has been very successful • On World Suicide Prevention Day a firefighter shared their own experiences around mental health and suicidal thinking – very powerful • Well-being clinics have helped break down barriers • Reviewing culture of the organisation to understand where organisation can change to have more positive affect • Share information on social media – reaches more staff • More focus on staff support, self-care, help from local voluntary sector • Doing more work on resilience, sleep management, nutrition – maintaining well-being • Trying to introduce a culture of reaching out for help rather than keeping it to themselves

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<td>appropriate health assessment, HR and management often try to get involved first
• When worried about well-being of a colleague, how ensure right person takes responsibility, and initial contacts feel able to let go?</td>
<td>• Different training being put in place to tackle specific groups of staff – for example, new staff not prepared for the trauma, longer-serving staff not seeing reaching out as ‘the norm’</td>
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<td>Support for bereaved people
• How to increase skills of those telling bereaved families about their loss, so that they are confidence and capable, and do it well and as safely as possible?
• If ambulance services are present at an unexpected death, could they have conversations with bereaved people, rather than the police?
• People lost to suicide often aren’t known to services, this means assessing the risk when a person goes missing is difficult and bereavement support is a challenge because the family are unknown</td>
<td>• Introducing bereavement support officer to try and help and direct people who have been bereaved</td>
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<td colspan="2">Mental health as part of work of emergency services
• How to help workforce to understand mental health and its role in our work?
• How to prepare staff for speaking to vulnerable/at-risk people?
• How work with those who repeatedly use services, are at risk, and need more effective support?
• Crime seen as preventable, but some discuss suicide as inevitable – how shift that perspective?</td>
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<td colspan="2">Partnership working
• Lots of different groups locally, regionally, nationally – all with lots of ideas, but too many themes and not enough evidence
• Suicide prevention groups trying to do everything all the time, but need better evidence to prioritise
• Sometimes we (police force) can come in thinking something is our work, but might be better if done by someone else</td>
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