Working with you to make Sheffield

HEALTHIER

Suicide and Self Harm Prevention

Protected Learning Initiative: Delegate Pack

Wednesday, 7 June 2017
1867 Lounge
Sheffield Wednesday Football Club

Sheffield City Council

NHS
Sheffield Health and Social Care
NHS Foundation Trust

NHS
Sheffield
Clinical Commissioning Group

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This is available free from https://get.adobe.com/uk/reader

Agenda

PLI Event: Suicide and Self Harm Prevention

Wednesday, 7 June 2017 - 1867 Lounge, Sheffield Wednesday Football Club

Plenary sessions		
2.05	Welcome and context for this event	**Dr Tim Moorhead** Chair, NHS Sheffield CCG **Dr Steve Thomas** Clinical Director for Mental Health, Learning Disabilities and Dementia, NHS Sheffield CCG
2.10	The changing trends around suicide - emerging patterns, nationally and locally	**Greg Fell** Director of Public Health, Sheffield City Council
2.25	A personal experience	**Catherine Carlick**
2.40	You could save a life - in ten minutes	**Dr Dave McAllister**, GP
Workshops		
2.55 - 3.35	Workshop session 1	Please select from the 7 choices listed overleaf
3.35 - 3.50	Refreshments - please move to the room for your second workshop and drinks will be served there	
3.50 - 4.30	Workshop session 2	Please select from the 7 choices listed overleaf
4.35 - 5.15	Workshop session 3	Please select from the 7 choices listed overleaf
5.15	Close	

Agenda

Workshops

There will be three workshop sessions.

Each delegate can select three of the following seven choices:

A - Postvention - Supporting Families, Friends and Staff

B - Communication and the Crucial Opportunities in the 10 Minute GP Consultation

C - Social Prescribing - tackling loneliness, isolation and suicide risk

D - Self Harm - a Primary Care Perspective

E - Depression - a perfect pathway

F - Children and Young People's Suicide & Self-Harm Prevention - early signs and intervention

G - Safety Planning & Risk Mitigation in General Practice

Learning Outcomes

As a result of attending this event, you will have:

- Enhanced skills and knowledge about what you can do to prevent suicide
- Practical knowledge about how to manage patient who self-harm in a clinical setting
- Understanding how proactive risk identification and use of practice systems can help to prevent suicides
- Up to date knowledge of current evidence, guidance and local/national support services you can signpost patients to where they can access support
- Greater insight into the effect that working with these issues and with vulnerable people can have on you, and how you can support your own mental health.

Sheffield City Council

Sheffield Health and Social Care NHS Foundation Trust

NHS Sheffield Clinical Commissioning Group

Introduction

Welcome to today's Protected Learning Initiative, where we will be looking at suicide and self-harm prevention.

Today you will have available a wealth of local expertise - people who have first hand experience of the devastating effects of suicide and of living with enduring mental ill health and repeated self-harm will be speaking. We also have GPs, nurses, public health specialists, psychiatrists and 3rd Sector experts who will be leading the interactive workshops.

We are profoundly grateful to all the people and organisations that have given of their time, energy and expertise to support this educational event.

We are also aware that subject matter such as this can have the effect of triggering our own experiences - personal or clinical - and as such we want to ensure that we have the opportunity to look after ourselves.

As well as the usual routes of seeking out support (family, friends, own GP etc.) we want people to be aware of the National Practitioner Health Programme (please see the chapter on on Mental Health in the Workplace, later in this pack).

Also for today and for a short time after the PLI, our Consultant Clinical Psychologist colleague Dr Rebecca Haines will be available to talk personally or respond to email about personal issues that may arise as a result of the PLI. Rebecca is contactable on 0114 271 6273 & rebecca.haines@shsc.nhs.uk.

Suicide is a major issue for society and a leading cause of years of life lost. Between 2013 and 2015 there were 159 suicides in Sheffield. That means someone died every 7 days in our city.

The National Suicide Prevention Strategy is clear that suicide prevention is not the sole responsibility of any one sector or of health services alone. Indeed, only around a third of people who die from suicide in Sheffield have been in contact with specialist mental health services during the previous year. However of those people who take their own life, between half and two thirds will have visited their GP in the month before doing so and up to 40% in the week prior to death.

Primary Care staff are therefore in a particularly important position in the detection and management of those at risk of suicide.

The national strategy specifies that interventions should target high-risk groups including:

- People currently, or who have been recently in contact with Mental Health services
- Those who have deliberately self-harmed within the last 12 months
- Young men
- Prisoners
- High-risk occupational groups (farmers, and agricultural workers, nurses and doctors)

There is clear evidence that there are medical and psychological interventions which can be very helpful to individuals who have considered or attempted to end their own lives.

The consequences of suicide are tragic and devastating and are estimated to have a direct impact on up to 60 people from family, work colleagues and wider community.

Introduction

My scars show pain and suffering, but they also show my will to survive. They're part of my history that'll always be there.

No one is immune to suicide. People with depression are at particular risk. Previous self-harm (i.e. intentional self- poisoning or self-injury, regardless of degree of suicidal intent) is a particularly strong risk factor. It should be noted that family history of suicide or self-harm is particularly important and substance misuse is also a significant risk factor.

Nearly half of Trans people under 26 said they had attempted suicide and the rate of suicide attempts is 4 times greater for LGB youth in the 10-24 year old age bracket.

Suicide is also a leading cause of maternal mortality in the UK.

In line with new guidance from PHE issued to support the local development and implementation of suicide prevention plans, the objectives in our local plan reflect the six priority areas identified in the national strategy. These are to:

- Reduce the risk of suicide in high risk groups
- Tailor approaches to mental health in specific groups
- Reduce access to the means of suicide
- Provide better information and support to those bereaved or affected by suicide
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour
- Support research, data collection and monitoring

Suicides are not inevitable. There are many ways in which services, communities, individuals and society as a whole can help to prevent suicides. Suicide affects all age groups and communities in fact, few people escape being touched by the devastating effects of suicidal behaviour in their lifetime.

In September 2012, the Government launched the current national policy; 'Preventing Suicide in England: a cross-government outcomes strategy to save lives'.

Sheffield is working towards the adoption of an ambitious and proactive vision for suicide prevention that reflects the national strategy and the Aiming for Zero Suicides report by the Centre for Mental Health.

Talking to doctors [about self-harm] hasn't always gone to plan. I've had mixed reactions over the years some just treating the wound and getting me on my way, being referred to A&E. I never turned up, it wasn't what I wanted.

Introduction

Sheffield is a city committed to a zero suicide approach. By stating this we mean:

- A city that supports people through the difficulties they face and at times of personal crisis, with the aim that suicide is not considered.
- A city which builds individual and community resilience.

Self-harm is much more common then assumed or even reported. It can affect people of any background and of all ages, although it is most prevalent amongst adolescents aged 12 - 24 and groups with high levels of poverty.

Suicide is now the leading cause of death directly related to pregnancy in the year after mothers give birth.

Confidential Enquiry Into Maternal Deaths 2016

Unfortunately, those bereaved by suicide tell us they do not always receive the support and help they need and this must be addressed.

Health Select Committee UK Parliament

The UK has one of the highest levels of self-harm in Europe with at least 10 per cent of young people thought to at some point try to hurt themselves, and up to 150,000 visits to accident and emergency departments being related to deliberate self-harm each year.

While for most people a problem with self harm tends to resolve before adulthood, it is thought that 10 per cent continue to harm into their adult lives.

Today's event is a key opportunity for us to:

- Reaffirm and emphasise the role we have as GP's and Practice Nurses in preventing suicide especially in recognising and responding to risk factors in our patients
- Develop our key skills in communication and consultation and the confidence to explicitly talk about suicidal thoughts and self-harm

We hope that this is a thought provoking PLI that will no doubt consolidate much existing excellent practice. We also hope that it may stretch us to think in new ways that will lead to different ways of working, ultimately for the good of the people we serve professionally and for ourselves as clinicians.

Dr Steve Thomas

Clinical Director for the Mental Health, Dementia and Learning Disabilities Portfolio Team, NHS Sheffield CCG

Suicide - the coroner's perspective

A personal view from Christopher Dorries HM Senior Coroner

I was grateful for an invitation to attend your conference today but unfortunately am already committed elsewhere. Instead I have been given the opportunity to contribute this page.

I suspect that in inviting comments from a coroner, medics might sometimes anticipate a torrent of criticism. That's not the case here. In fact, Identifying genuine and immediate risk in a busy surgery session possibly isn't quite as easy as it may sometimes sound in the quiet retrospective of a court.

If there is a point that the inquest often underlines about untoward deaths it is 'lack of effective communication' and mental health issues are no better or worse in that regard.

Questions sometimes arise as to what a GP should do when they get a letter or other communication saying that the patient hasn't attended for secondary assessment and is being referred back. Should they be expected to contact the patient?

What if the referral was particularly serious because of a specific fear of self-harm but the patient doesn't co-operate?

How is the joint responsibility between clinical agencies outworked?

Another point might be giving clarity as to the urgency of a referral, particularly if first contact is made by telephone.

Overall, it has been my experience that a GP is far more likely to be attending an inquest because they have seen the patient only a day or two before death and obviously that attendance forms a central part of the inquiry. It may be that the GP notes will show that appropriate questions were asked and reassuring answers given. Clear, thorough contemporaneous clinical notes indicating risk assessment and a jointly formulated and agreed care plan will always be helpful.

The suicide conclusion (no longer called a verdict) is subject to much law. To return such a conclusion the coroner must be satisfied beyond reasonable doubt (modern terminology is 'sure') that:

- the death occurred as a result of a deliberate act by the deceased and
- that in doing so (and at all material times) they intended to die.

The 'beyond reasonable doubt' test is strict, most other inquest conclusions are only judged on the 'balance of probabilities'.

The High Court has ruled that suicide can never be presumed; it must be affirmatively proved and based upon unambiguous evidence of an intention to die. The test has also been described as 'whether other possible explanations are totally ruled out'.

As recently as 2013 the High Court said that this high standard is deliberately set to ensure that serious findings are only made on the basis of absolutely clear and compelling evidence. It noted that a finding of suicide can cause distress, stigma and other consequences. We were also reminded that 'the complexities of human psychology can cause people to harm themselves seriously or put themselves in a very dangerous position without the clear intention to end their life'.

Given that, it is hardly surprising that the number of suicide conclusions found by coroners will never match the actual number of cases where the deceased was intending to die.

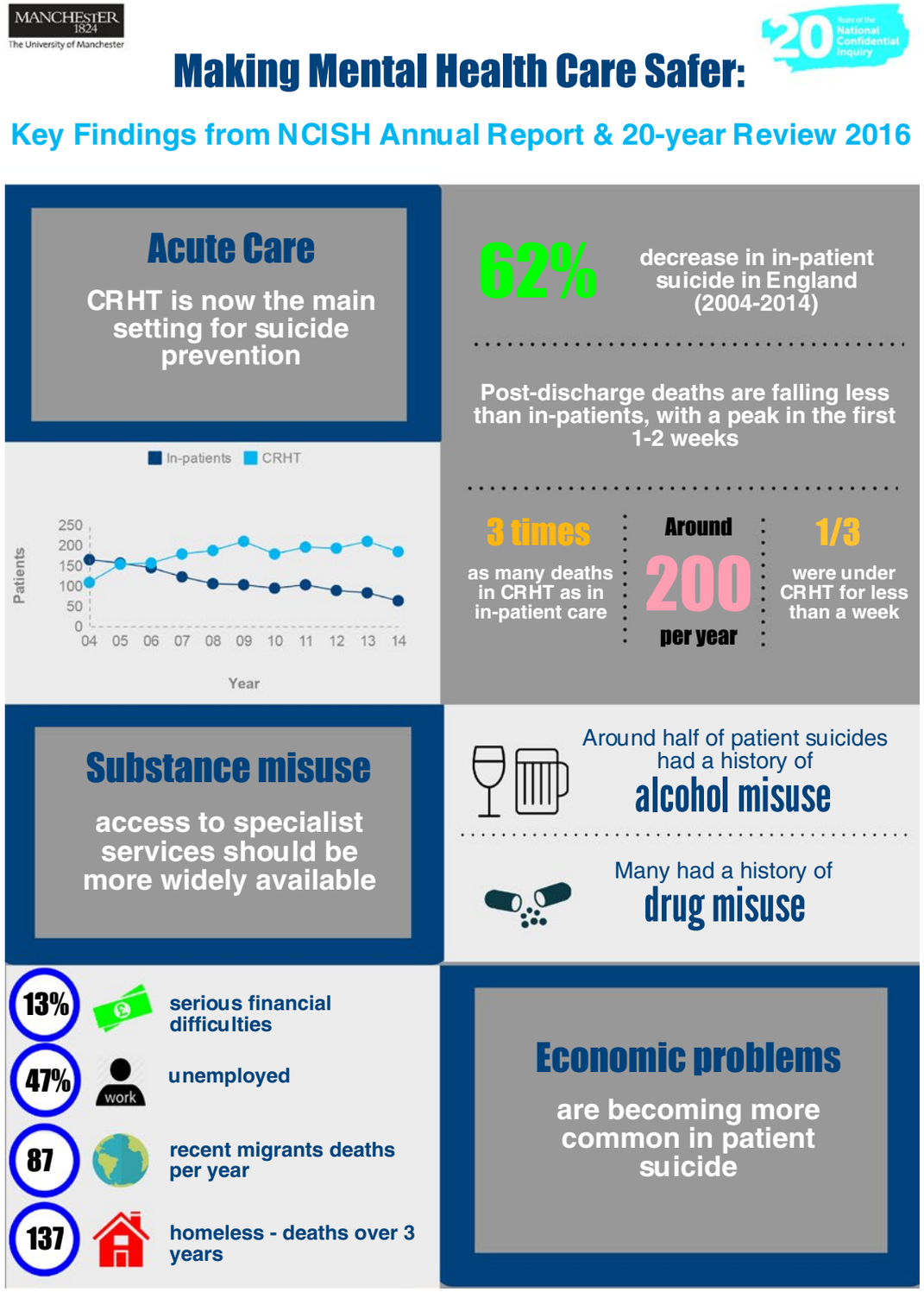
The coroner's perspective

A joint study between my office and the local mental health trust some years ago suggested a shortfall between official findings and reality of about 30-40%. Where the facts don't properly fit suicide, a so-called 'narrative conclusion' is more likely these days than the 'open verdict' which sometimes left a hint of suspicion.

This gives a strong inference that every suicide statistic is wrong. It may not be as bad as that because the Office for National Statistics works on the basis of 'deliberate self-harm' rather than the legal coronial definition of suicide.

There were 48 suicide conclusions recorded in my jurisdiction (Sheffield and Barnsley) in 2016 that is almost always just less than an 80% male split.

Finally, for a long time most coroners have tried to avoid the actual word 'suicide' which you might think ugly and distressing. Certainly in Sheffield I long preferred 'took his own life' whilst still maintaining the strict standard of proof. But guidance from the then Chief Coroner a couple of years ago states that this is the wrong approach in law and that the proper finding is the word suicide.



Biographies of our speakers and presenters

Key note speakers

Dr Steve Thomas

Steve been a GP in Sheffield for 16 years. He has always had an interest in mental health and was involved with developing the role of the Primary Care Mental Health Worker (now IAPT) both as a GP and a clinical academic. He took up the role of clinical lead for the Mental Health, Learning Disabilities and Dementia Portfolio for the then PCT in 2011 and subsequently as Executive Clinical Director for Sheffield CCG in 2015.

He has been involved in mental health and learning disability service redesign, delivery of primary care education and contract negotiation for the CCG. He is National Commissioning Adviser to the National Collaborating Centre for Mental Health & the RCPsych; He sits on the national steering committee for NHS Clinical Commissioners and am a member of NHSEs Adult Mental Health National Steering Group.

He is particularly interested in collaborative working importantly with other key organisations such as Local Authorities and he is a member of the Sheffield Suicide Prevention Strategy Group. He is particularly keen to see a reduction in the inequalities we see (for example, life expectancy) in mental illness and to see mental ill health treated on a par with physical illnesses.

steve.thomas5@nhs.net
Twitter: @DrSNThomas

Greg Fell

Greg Fell is a Director of Public Health in Sheffield. He graduated from Nottingham University with a degree in biochemistry and physiology in 1993. He has worked as a social researcher in a maternity unit; a number of roles in health promotion and public health before joining the public health training scheme. Greg worked as a consultant in public health in Bradford in the PCT then Bradford City Council. Since February 2016 he has worked for Sheffield as Director of Public Health.

Twitter: @felly500
www.gregfellpublichealth.wordpress.com

David McAllister

Dave is a GP at Meadow Green and one of the founders of STORMS (Strategies to Reduce Male Suicide) a local charity, created after the death of his son Dan.

Catherine Carlick

Catherine currently works in the RESPECT training team at Sheffield Health and Social Care (SHSC) and delivers training at Sheffield Hallam University. She has vast experience in delivering training throughout the many directorates in SHSC. Catherine has a diagnosis of borderline personality disorder, has been in psychiatric services since the age of 12 and has also experienced being in the prison system.

Catherine is outspoken and honest and is a pivotal part of training in the Trust. She has won many awards and is currently the only person on a Section 41 (Mental Health Act) to be employed by the NHS. Catherine has a wealth of knowledge and experience about being in the prison and the psychiatric services and works closely with professionals to deliver training.

Biographies of our speakers and presenters

Workshop presenters

Postvention: Supporting families, friends and staff:

June Boorman

June lives in Sheffield and worked in the NHS for over 20 years as a counsellor in GP practice. She is also a relationship therapist. June has retired from the NHS and runs a private practice for counselling and therapy.

June lost her mother to suicide 38 years ago and her husband Terry took his own life 10 years ago. June facilitates the Survivors of Bereavement by Suicide group (SOBS) in Sheffield with Nick Cocking. The group has been running 7 years.

Nick Cocking

Nick lives in Sheffield and is a Chartered Engineer By profession. In 2007, his life was changed forever when his wife Helena took her own life. After finding out about SOBS he attended the group in Bradford for two years. In 2010, he and June started the Sheffield SOBS group.

Social prescribing

Debbie Mathews

Debbie has been the Chief Executive of Manor and Castle Development Trust (MCDT) from 2005. Prior to becoming CEO of MCDT Debbie was employed in the NHS in Health Promotion.

MCDT is a charitable company which was established in 1997 to deliver the first community led Single Regeneration Budget programme, with Health as one of the key programme areas.

MCDT has 69 staff and a turnover of around £2m and approximately £7m of assets including shops, flats, land and the Quadrant, our prestigious managed workspace.

MCDT delivers a range of local services including public health, employment, training, learning and positive activities for children and young people, including young people with Learning Development Difficulties, coordination of the volunteers in Park Library, we run a nursery in Woodthorpe, deliver low level support to people with chronic health conditions, support over 50's groups and underpinning all of our work is a commitment to community development principles and practice. MCDT delivers a range of neighbourhood public sector contracts. For more information see www.manorandcastle.org.uk

Debbie is also a Director of Sheffield Cubed Consortium, the Green Estate Ltd, Parkway Business Centre Ltd, and sits on the city's strategic partnership – Sheffield Executive Board ,representing the voluntary and community sector on the Fair City Advisory Board and the Tackling Poverty Group. Debbie is also the chair of Voluntary Action Sheffield. Debbie is also a volunteer trustee and treasurer with Victoria Community Enterprise.

Guy Weston

Guy is SOAR Health Services Manager and is responsible for the overall running of SOAR's Health and Volunteering Services; including staff management, service development and evaluation.

At present he is leading on three main service developments across North Sheffield:

- People Keeping Well - Community Partnerships
- Enhanced Social Prescribing Service
- Management Information Systems including Patient Reported Outcome Measures tools (PROMs).

Biographies of our speakers and presenters

He is also responsible for creating SOARs annual Social Accounts and sit on Healthwatch Sheffield Advisory Board.

Lucy Melleney

Lucy is Manager & CEO of Darnall Well Being (DWB), a local, not-for-profit health organisation with a 17-year track record in community development and health. It works in partnership with other organisations to help people stay well and tackle inequality.

DWB offers a combination of group activities, 1-to-1 support, Social Prescribing, peer mentoring and volunteering, as well as delivering local health campaigns, training and talks.

Its services help to remove barriers, are culturally sensitive where appropriate, build trust, listen and respond to local need and are underpinned by our volunteers.

Its approach is collaborative, consistent and client-led and through increasing access to services, we can help mitigate risks such as loneliness, isolation and poor integration.

A core element of DWB's approach is its unique, long-standing alliance with primary care. As a local anchor organisation, DWB can bridge the gap between community and services, ensuring local people (particularly those new to the area) get the right support quickly.

Lucy joined DWB in November 2008, taking a strategic and operational lead, broadening DWB's portfolio and developing a skilled workforce that now includes a team of Health Trainers, Development and Link Workers, as well as local volunteer Practice Health Champions. Lucy has overseen the development of DWB's close relationship with primary care, which resulted in a move to Darnall Primary Care Centre in May 2013 and is now co-located with general practice.

Following the successful delivery of the Public Health's Community Wellbeing Programme, Health Trainer Service and Community Health Champion Scheme for almost a decade, in 2016 DWB became the VCF Lead for the Council's People Keeping Well Partnership in Darnall/Tinsley and aligns the development of the local Social Prescribing model with the Active Support & Recovery- Darnall Neighbourhood.

Waqas Hameed

Waqas is Senior Health Trainer at Darnall Well Being.

Following a volunteer placement with Shipshape as a Health Champion, Waqas became a member of the DWB team in January 2010. As well as being a Health Trainer working on the Regional Innovation Fund Diabetes Project, he also trained as a Community Stop Smoking Adviser. After being involved in several other successful pilot projects (e.g. the Chronic Pain Initiative and Enhanced Primary & Community Care Programme), Waqas is now a Senior Health Trainer.

Waqas continues to support patients on a 1-to-1 basis, often with complex health & social care needs, including those with depression and long-term conditions. His current role involves the facilitation of DWB's Diabetes Peer Support Group and Men's Health Group as well the mentoring of trainee Health Trainers. Working alongside the Project Manager and Coordinator, he also supports the development of DWB's Social Prescribing Scheme with particular focus on measuring impact, building closer links with primary care and developing enhanced community interventions that support people to manage their own health and wellbeing.

Biographies of our speakers and presenters

Self harm – a primary care perspective

Julie Sheldon

Julie qualified in 1987 as an RMN and completed nursing degree in 2000. She has worked in liaison psychiatry, crisis and community mental health services for 16 years. She has taught at Sheffield University to postgraduate and undergraduate nursing students and also worked part time as a research nurse. Currently Julie works as a Senior Practitioner within the Sheffield Liaison Psychiatry Team.

Dr Abhi Shetty

Abhi was appointed as a Consultant Psychiatrist in 2011 and as a Liaison Psychiatrist in Sheffield in 2014. He also consults at the Sheffield Gender Identity Clinic. He is a member of the Faculty of Liaison Psychiatry Executive Group, Royal College of Psychiatrists. He is the Director of Postgraduate Medical Education for Sheffield Health and Social Care NHS FT.

Catherine Carlick

Catherine is an expert by experience and trainer at Sheffield Health and Social Care NHS Foundation Trust.

Depression pathway

Dr Karen O'Connor

Karen has have been a GP in Sheffield for 25 years, and a GPCA in Neurology for 15 years. She works with NHS Sheffield CCG Mental Health and Learning Disability Portfolio Team one session a week, and sits on Sheffield LMC. She has recently been part of the Expert Reference Group (NICE/RCPsych) developing the guide for Crisis and Planned Mental Health Services for Children and Young People.

Heidi Taylor

Heidi is currently Clinical Effectiveness Pharmacist at Sheffield CCG. She has worked with the Medicines Management Team for eight years and is an active member of the Area Prescribing and Medicines Safety Groups. She provides medicines management support to both the Mental Health and Children's and Young Peoples portfolios. Prior to joining the CCG she worked for many years as a community pharmacist (home and abroad) and also enjoyed a short period of time working as a teaching assistant supporting the integration of children with Special Educational Needs in main stream schools.

Dr Rachel Warner

Rachel has been a Consultant Psychiatrist in Sheffield since 1997, working mostly in a Community Mental Health Team with adults of working age. She currently works 3 days a week with the SW Recovery Team at Argyll House. Her clinical interest is working with people with diagnoses of complex trauma, personality difficulties, depression and anxiety.

Rachel has worked as Clinical Director of Adult Inpatient and Access services, Deputy Medical Director, and Acting Medical Director in SHSC FT, before retiring to work part time.

Email rachel.warner@shsc.nhs.uk
Telephone: 0114 271 1168

Children and Young People's Suicide & Self-Harm Prevention

Dr Girish Vaidya

Girish is a Consultant Child and Adolescent Psychiatrist and Clinical Director of Community Wellbeing and Mental Health Division at the Sheffield Children's NHS Foundation Trust. Working with children in care, those who offend or are at risk of offending, he works in the community and in the secure estate. Many of the young people that he and the service support present with self harming behaviours.

Biographies of our speakers and presenters

Their assessment and management is crucial for sustaining emotional wellbeing.

Girish works with third sector organisations and believes that with the right governance, such a relationship can help improve outcomes.

Girish also believes in the power of social media to destigmatise mental health. He is on Twitter (@DrGirishPsych) and on LinkedIn.

Carol Fordham

Carol is a commissioning manager for children's public health with a focus on vulnerable children and young people. She works with schools, CAMHS, voluntary sector and children's services to develop support for children and young people's emotional wellbeing, including the local services for young people's substance misuse needs, hidden harm, young carers, counselling and YIACS (Youth Information Advice and Counselling Service).

Carol was part of the multi-agency group that developed the CYP suicide prevention pathway launched in March 2017.

Rebecca Batley

Becky has been an active member of STAMP (a mental health participation group run by Chilypep) for over three years and in that time has worked with other young people to develop local and national mental health campaigns. Through the group she has worked alongside mental health services, such as CAMHS, and with commissioners within Sheffield to use her lived experience around mental health to help design and shape services to better meet the needs of other young people.

Becky is passionate about campaigning and is now working for Rethink Mental Illness as a regional campaigns coordinator, engaging young people in mental health campaigns work.

Sian Beynon

Sian is a participation worker with Chilypep (Children and Young People's Empowerment Project). She works with children, young people and parents across Sheffield to raise awareness about mental health, understanding young people's experiences of mental health and highlighting issues, supporting young people to influence service development and delivery.

She runs STAMP, a regular focus group for young people who are passionate about making a change to mental health services. For more information about this work contact sian.beynon@chilypep.org.uk

Safety planning and risk mitigation in primary care

Dr Helen Winter

Helen is a GP at the University Health Service, Sheffield. She started working as a Salaried GP in Chesterfield in 2003. From 2009-2016 she worked as a Specialty Doctor in Psychiatry for SW Sheffield CMHT.

Dr Terry Hudsen

Terry is a GP at the University Health Service, Sheffield. He has a clinical interest in the health of young adults and the use of technology to improve health.

Gerry 1926 and Janet 1936

Gerry and Janet have been active listening volunteers with Sheffield Samaritans since 2014. Gerry leads on outreach for the branch and Janet is a member of the Sheffield Suicide Prevention Group.

Plenary sessions

2.10	The changing trends around suicide - emerging patterns, nationally and locally	**Greg Fell** Director of Public Health, Sheffield City Council
2.25	A personal experience	**Catherine Carlick**
2.40	You could save a life - in ten minutes	**Dr Dave McAllister**, GP

Plenary session - Greg Fell - the changing trends around suicide

The changing trends around suicide

Greg Fell
Greg.fell@sheffield.gov.uk
@felly500

National Picture – come a long way

- UK's first health strategy, launched in 1992, included mental health as one of its four priorities
- due to rising suicide rate in young people.
- Nobody knew what to do.
- Cutting edge was train GPs in better diagnosis and use of anti depressants.

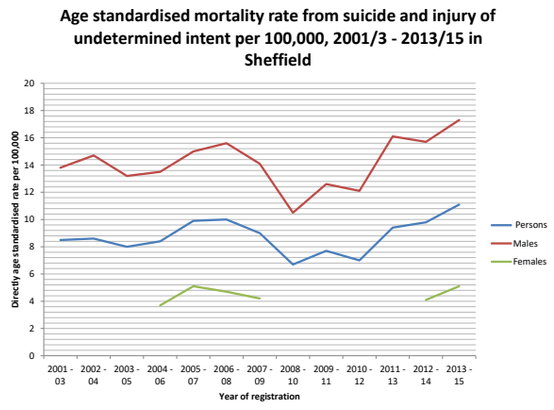
National strategy. Health scrutiny

https
ees/committees-a-z/commons-select/health-committee/inquiries/parliament-2015/suicide-prevention-inquiry/

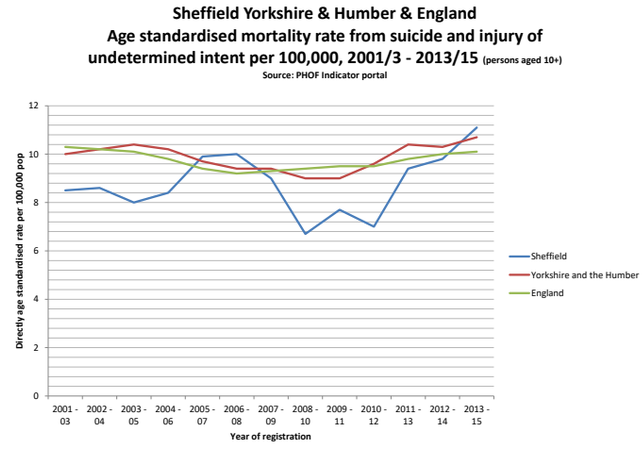
HSC criticisms - 'too little, too late'

- The current rate of suicide is "unacceptable and likely to **under-represent the true scale",**
- provision of **suicide-prevention funding will be too little, and too late**, to implement strategy effectively.
- **effective QA & implementation** at local and national level is needed
- joined-up approach to **coordinate voluntary and non-clinical sector activity.**
- **reaching those unlikely to access traditional services** – particularly men
- all patients discharged from inpatient care receive **follow up support within three days –**
- information sharing – **many who commit suicide are at known risk, and this must be communicated**

Numbers and trends – Sheffield



Comparing Sheffield



Plenary session - Greg Fell - the changing trends around suicide

Myths – volume 1

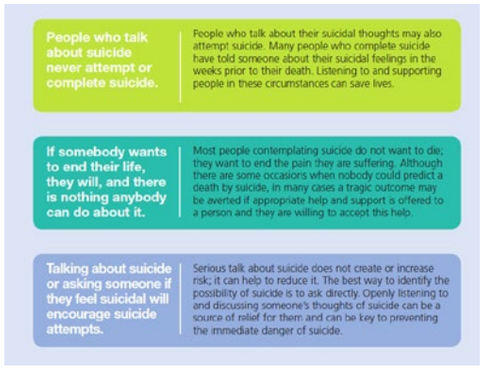
There isnt "a type". Be vigilant re warning signs

If a person has made one attempt – at higher risk of further

Risk may be highest when depression lifts or life calms

http://www.healthscotland.com/uploads/documents/2842-The%20Art%20Of%20Conversation_2.pdf

Myths volume 2



Many who complete suicide have talked to others about their feelings

Most attempting want help.

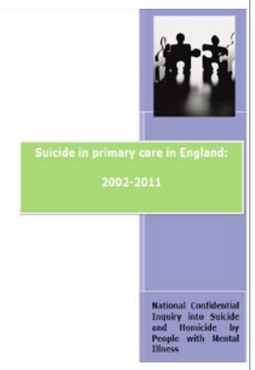
The best way to identify risk is to ask. Open skilled listening helps

http://www.healthscotland.com/uploads/documents/2842-The%20Art%20Of%20Conversation_2.pdf

Primary care audit

Key messages for services

1. In primary care patients who die by suicide, **mental illness is frequently unrecognised.**
2. Suicide **risk is associated with frequent attendance**, increasing attendance, and non-attendance.
3. Markers of risk in **those attending include frequent consultation, multiple psychotropic drugs, and specific drug combinations** such as benzodiazepines with antidepressants.
4. **These markers could be the basis of a "flag" alert** in primary care records, leading to further assessment.
5. The current **Health Check in primary care should be amended to include mental health**, as a step to identifying risk in non-attenders.
6. Suicide prevention in primary care non-attenders will have to **rely on other agencies including the voluntary sector and internet based supports who may be better able to maintain contact with young people at risk**.



How well we manage the risks? Primary prevention of risks

- Suicide prevention in a population context for mental health
- risk areas that can have the biggest impact on suicide prevention;
  - Identifying and treating depression and isolation. "'perfect depression care' models inspired by US zero suicides approach)
  - Reducing harmful drinking
  - Improving acute mental health care
  - Reducing self harm
  - Welfare state, reform, social prescribing,

Four local priorities

- suicide prevention awareness and training
- media campaign targeting men to encourage them to seek support for mental health issues
- Increasing the awareness of suicide prevention in GP's. Focussed work on perfect depression care
- Work with SYP about the response and follow up after a suspected suicide.

Key messages

- suicide is **preventable**
- **primary care is a key setting for supporting patients with key risk factors** (including depression, social isolation/loneliness and harmful drinking)
- **Primary care has a key role in supporting families of people who take their** own lives – people talk to their GP. How can we best help GPs help families.

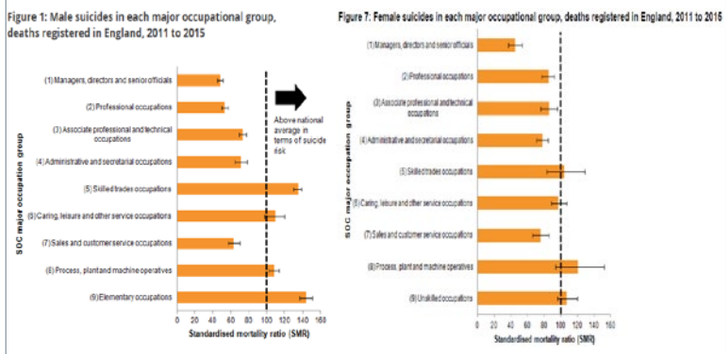
Plenary session - Greg Fell - the changing trends around suicide

Other resources + backup

Samaritans – suicide and socio economic factors

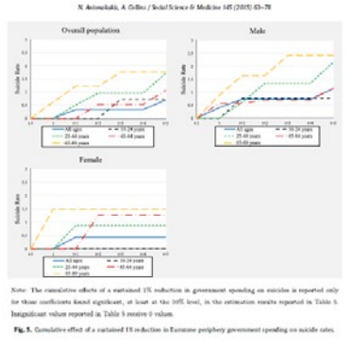
- Areas of higher socioeconomic deprivation tend to have higher rates of suicide.
- Men are more vulnerable to the adverse effects of economic recession, including suicide risk, than women.
- People who are unemployed are two to three times more likely to die by suicide than those in employment.
- Increases in suicide rates are linked to economic recessions.
- The greater the level of deprivation experienced by an individual, the higher their risk of suicidal behaviour.
- The least skilled occupations (eg construction workers) have higher rates of suicide.
- A low level of educational attainment and no home ownership increase an individual's risk of suicide.

http://www.samaritans.org/sites/default/files/kcfinder/files/Samaritans%20Dying%20from%20inequality%20report%20-%20summary.pdf



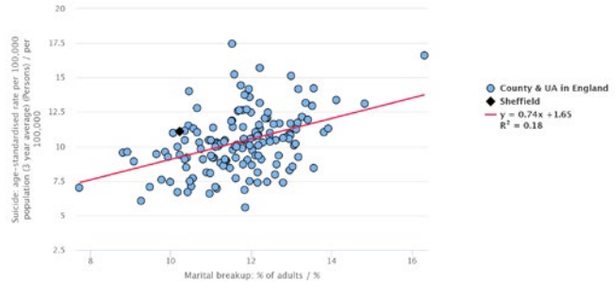
Source: Office for National Statistics

Austerity – clearly implicated in suicide rate



Antonakakis 2015
Much other literature

Marital breakup is a commonly cited risk factor. The correlation between breakup and suicide rate is poor



PHE focused on population context

https://www.gov.uk/government/collections/suicide-prevention-resources-and-guidance

Plenary session - Greg Fell - the changing trends around suicide

Aiming for zero

Programme

Training key public service staff

Training others - pub landlords, coroners, private security staff, faith groups and gym workers

Creating 'community champions' to put local people in control of activities

practical suicide prevention measures in 'hot spots'

Working with local newspapers, radio and social media to raise awareness

Supporting safety planning for people at risk of suicide, involving families and carers

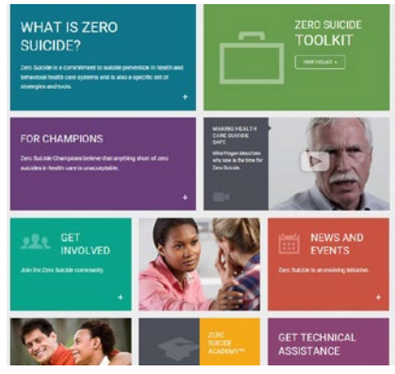
Linking with local crisis services to ensure people get speedy access to evidence-based treatments.

https://www.centreformentalhealth.org.uk/zero-suicides

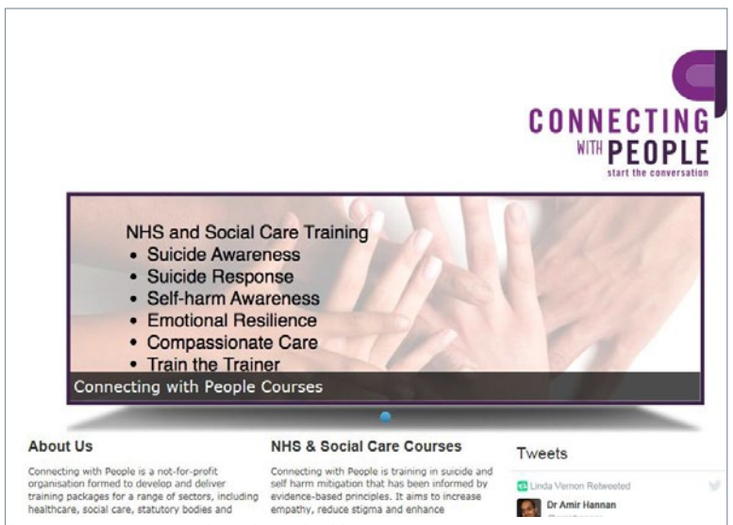
Glasgow suicide lab

http://www.gla.ac.uk/researchinstitutes/healthwellbeing/news/headline_302293_en.html

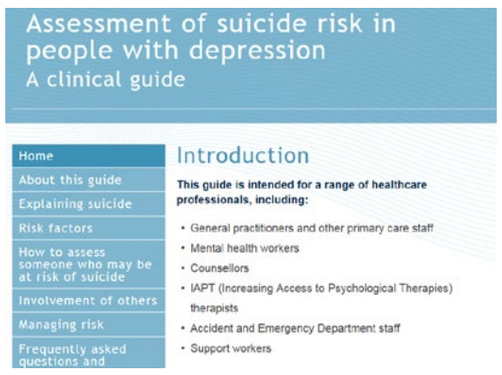
What IS zero



http://zerosuicide.sprc.org/



http://www.connectingwithpeople.org/healthcare-front

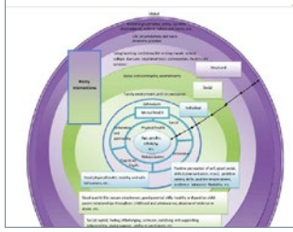


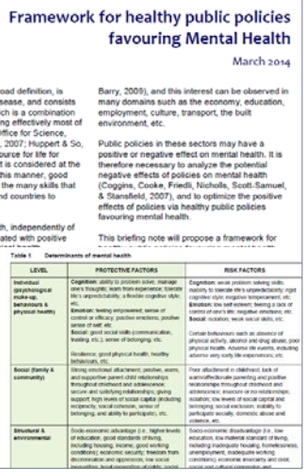
http://cebmh.warne.ox.ac.uk/csr/clinicalguide/index.html

http://tasc-uk.org/background-aims-purposes/

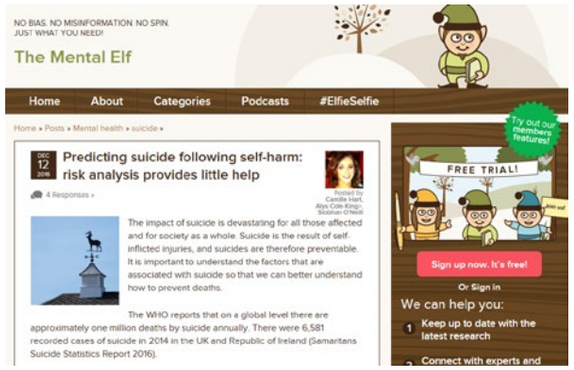
Plenary session - Greg Fell - the changing trends around suicide

Public mental health context





Self harm & suicide link. But be careful re risk analysis tools



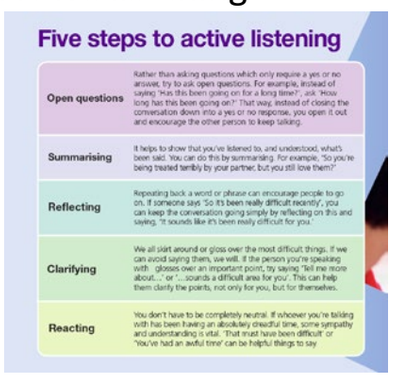
https://www.nationalelfservice.net/mental-health/suicide/predict-suicide-self-harm/

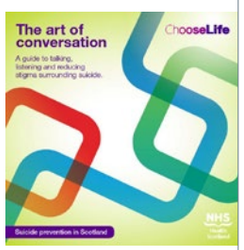
Some helpful evidence

- LSE work on mental health ROIs and
- population level suicide prevention awareness raising, training and intervention here – chapter 2.11
- Key findings: *Investment in GP suicide prevention training is cost-saving overall from year 1 even if only very modest reductions in productivity losses are factored in*
- *The intervention appears highly cost-effective from a health system perspective alone*
- based on ASIST training

https://www.gov.uk/government/collections/suicide-prevention-resources-and-guidance
http://www.lse.ac.uk/businessAndConsultancy/LSEEnterprise/pdf/PSSRUfeb2011.pdf

Much to learn from the Scots Active listening





http://www.healthscotland.com/uploads/documents/2842-The%20Art%20Of%20Conversation_2.pdf

Success can be seen. But don't under estimate the implementation effort

http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2016.303453?journalCode=ajph
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2978162/

ONS interactive tool showing leading causes of death by age and gender

http://visual.ons.gov.uk/what-are-the-top-causes-of-death-by-age-and-gender/

Plenary session - David McAllister - why *I'm* here

PLI
Wed 7/6/17
Suicide Prevention

Dave McAllister GP Meadowgreen Health Centre
Why I'm Here

I lost my son to suicide May15

- Outwardly happy
- Self -caring
- Fit + healthy
- Popular
- Friendly
- Academically sound
- Funny
- No drugs occasional alcohol
- Musician

- Occasionally grumpy
- angry
- impulsive

NO-ONE SAW THIS COMING

- No classic warning signs

- "only 14% of under 20's who died by suicide
- were in contact with MH services "
  - *National confidential enquiry into suicide by people with mental health problems 2013*

- Upstream prevention for all
- SToRMS
  - www.stormsdmc.org

No-one saw this coming

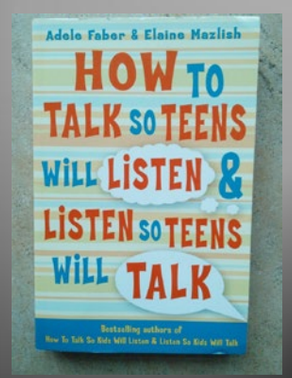
"other peoples lives"
Re-analyse
Warning signs can still be there

" for families of those who took their own lives the warning signs were a daily fact of life not a new red flag"
Rajeev Ramchand - RAND corporation blog May 8 2017

Challenge to increase awareness

Listening is a skill

- *How to talk so teens will listen and listen so teens will talk*
- Adele Faber and Elaine Mazlish
  - Piccadilly press 2006

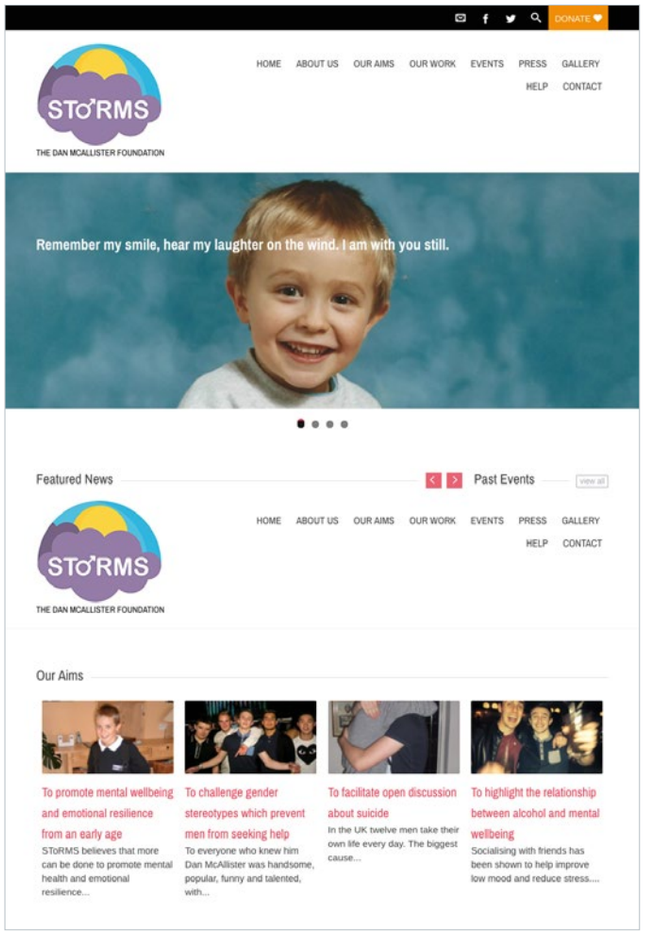


WORKSHOP

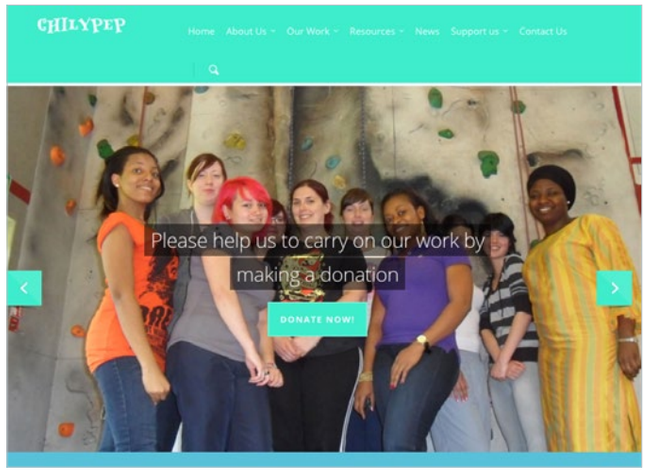
- Opportunities in the consultation
- Relevant to all Health professionals
- Ask/listen/validate/respond
- Clinical case
- Feedback from Chilypep and Interchange
- Interactive bit.

Plenary session - David McAllister - why *I'm* here

www.stormsdmc.org

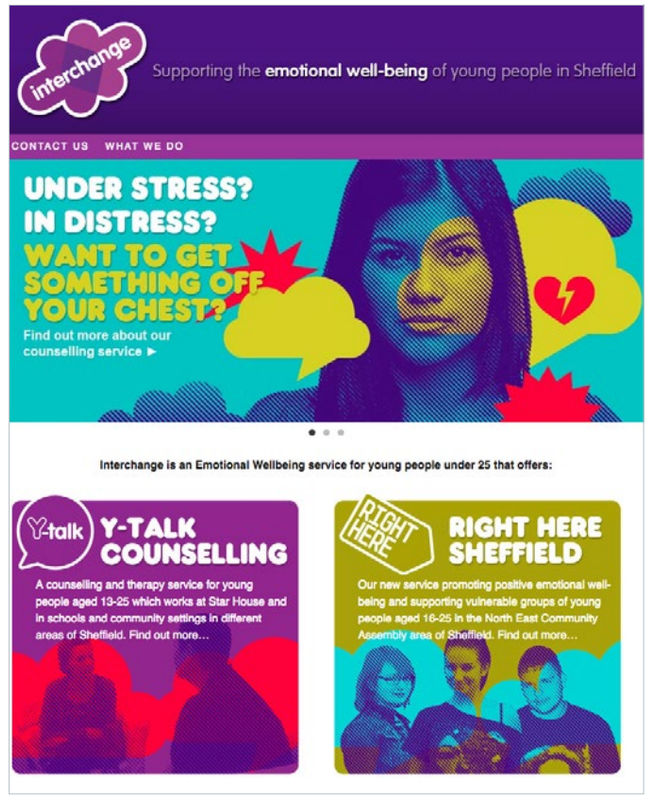


www.chilypep.org.uk



www.papyrus-uk.org

www.interchangesheffield.org.uk



Workshops

Workshops		
2.55 - 3.35	Workshop session 1	Please select from the 7 choices listed below
3.35 - 3.50	Refreshments - please move to the room for your second workshop and drinks will be served there	
3.50 - 4.30	Workshop session 2	Please select from the 7 choices listed below
4.35 - 5.15	Workshop session 3	Please select from the 7 choices listed below
5.15	Close	

Workshops

There will be three workshop sessions.

Each delegate can select three of the following seven choices:

A - Postvention - Supporting Families, Friends and Staff

B - Communication and the Crucial Opportunities in the 10 Minute GP Consultation

C - Social Prescribing - tackling loneliness, isolation and suicide risk

D - Self Harm - a Primary Care Perspective

E - Depression - a perfect pathway

F - Children and Young People's Suicide & Self-Harm Prevention - early signs and intervention

G - Safety Planning & Risk Mitigation in General Practice

Workshop abstracts

Postvention

Aims:

- To develop understanding of the experience of people bereaved by suicide
- To show how postvention can help provide support within GP practices

Objectives:

- Exploring how the grief experienced following death by suicide is different from other deaths
- Developing awareness & skills to support individuals after a bereavement - emotional and practical.
- Introducing practical postventions
- Normalising the impact of the suicide bereavement experience.
- Sign posting the bereaved to further help and resources.

Each year more people are taking their own lives by suicide - each suicide has a devastating and long lasting impact on the families, friends, health professionals, colleagues and communities left behind.

Those bereaved by suicide experience a long, complex and confusing grieving process, are often isolated and can be especially vulnerable to suicide or mental health issues.

This workshop will be delivered by **June Boorman** and **Nick Cocking**, who started the Sheffield SOBS group.

Communication and the Crucial Opportunities in the 10 Minute GP Consultation

Practical advice from a GP on how to talk, how to listen, what to say and how to respond. You can make a huge difference - make the most of the opportunity, you could save a life. You will also hear from young people about their experiences of mental health.

This workshop will be delivered by **Dr Dave McAllister**, GP at Meadow Green and one of the founders of STORMS (Strategies to Reduce Male Suicide) a local charity, created after the death of his son Dan.

Dave will be joined by representatives from

Chilypep - Sheffield based children and young people's empowerment project www.chilypep.org.uk

Interchange - a local Community Interest Company supporting the emotional wellbeing of young people in Sheffield http://interchangesheffield.org.uk/home/what-is-mental-health

Social Prescribing - tackling loneliness, isolation and suicide risk

Aim:

To gain a clear understanding of the role social prescribing can play in supporting patients who are experiencing loneliness and isolation, two key risk factors for suicide.

Objectives:

To understand the impact social prescribing can have on patients experiencing loneliness and isolation though lived experiences examples

To gain a better understanding of how Social Prescribing works in Sheffield and know how to connect with it locally.

This workshop will be delivered by **Debbie Mathews** from the Manor and Castle Development Trust, **Waqas Hameed** and **Lucy Melleny** from The Darnall Wellbeing Project and **Guy Weston** from SOAR.

Workshop abstracts

Self harm: a primary care perspective

Aims:

- Improve the confidence of primary care professionals when assessing someone who has harmed themselves or is expressing intent to harm themselves.
- For primary care professionals to feel that they have the knowledge and skills to collaboratively agree an appropriate plan with someone who is expressing mental distress and thoughts, plans or intent to self harm

Objectives:

- Undertake a brief but meaningful assessment of the patient and understand their needs
- Collaboratively form a plan of action with the patient following assessment.
- Have knowledge of the full range of resources available so that the plan can reflect the identified needs and the level of urgency

This workshop will be delivered by a team from SHSC, comprising **Catherine Carlick**, **Dr Abhi Shetty** and **Julie Sheldon**.

Depression Pathway

Aim:

To support primary care colleagues to recognise and manage depression, particularly as a leading cause of suicidal thoughts and actions.

Objectives - colleagues will feel more confident:

- in assessment, including risk assessment
- in management in primary care including prescribing
- in knowing when and where to refer to
- identifying and reducing risks that might increase or decrease suicide

This event will be presented by:

Dr Rachel Warner, SHSC

Dr Karen O'Connor, GP

Heidi Taylor, CCG Medicines Management Team

Sally Kirby, Clinical Pharmacist in Primary Care, and SHSC.

Children and Young People Suicide Prevention

Aims:

- Introduce the multi-agency pathway and plan
- Explore the issues that a child or young person presenting with suicidal thoughts or intent presents
- Discover what responses are helpful or unhelpful
- How to spot the danger signals
- How to refer to specialist services
- What to expect following referral

The workshop will be facilitated by:

Girish Vaidya, CAMHS clinical lead consultant psychiatrist

Rebecca Batley, representative from STAMP, children and young people's mental health project

Sian Beynon from Chilypep, young people's advocacy project

Carol Fordham, Children's Public Health Vulnerable Children and Young People Commissioning Manager.

Workshop abstracts

Safety Planning & Risk Mitigation in General Practice

Using case studies, the workshop will explore risk factors and warning signs, how to make an assessment, and how to create and use safety plans. The session will also discuss external sources of support, and how to support people to develop their own coping mechanisms.

The workshop will be delivered by **Dr Terry Hudsen** and **Dr Helen Winter** of the University Health Service, and **Gerry 1926** and **Janet 1936** from Samaritans.

Workshop A - Postvention

Postvention – Supporting Families, Friends and Staff

NHS Sheffield Clinical Commissioning Group
PLI Event: Prevention of Suicide
Sheffield, 7th June 2017

SURVIVORS OF BEREAVEMENT BY SUICIDE

Introductions

- June Boorman – Sheffield SOBS group leader
- Nick Cocking – Sheffield SOBS group leader
- Rebecca Haines – Consultant Clinical Psychologist

Aims of the workshop

- To develop understanding of the experience of people bereaved by suicide
- To show how postvention can help provide support within GP practices

Objectives

- To explore how the grief experienced following death by suicide is different from other deaths
- To develop awareness & skills to support individuals after a bereavement – emotional and practical
- To introduce practical postventions
- To normalise the impact of the suicide bereavement experience
- To signpost the bereaved to further help and resources

Definitions

"Postvention refers to *activities which reduce risk and promote healing after a suicide death*…

Although postvention is implemented after a suicide it is essential that we prepare for postvention *before* a suicide - by, for example, training first responders, coroners, funeral directors, faith leaders, emergency departments, clinicians, and journalists."

The Suicide Prevention Resource Center (SPRC)

Suicide is different

A death by suicide is often sudden, unexpected and may be violent. These factors increase the degree of shock and trauma experienced compared to many other types of bereavement. Survivors may struggle to make sense of what has happened and fundamental beliefs may be challenged.

- Survivors struggle more with questions of meaning-making around the death
- Struggle to make sense of the motives and mind-frame of deceased
- High levels of guilt, self-blame and responsibility
- Heightened feelings of rejection, abandonment and anger (towards deceased)

Workshop A - Postvention

Emotional and physical reactions

Bereavement by suicide can bring an intensity and range of emotions and physical reactions which may be unfamiliar, frightening and uncontrollable.

- Physical sensations - tightness in body, stomach pains, sleeplessness and poor concentration
- Shock and disbelief
- Anguish, longing and searching
- Anger
- Guilt
- Relief
- Shame
- Depression
- Fear and anxiety
- Sadness
- Trauma
- Suicidal thoughts

Emotional and physical reactions II

"Trauma refers to experiences or events that by definition are out of the ordinary in terms of their overwhelming nature. They are more than merely stressful.

They are also shocking, terrifying and devastating to the victim, resulting in profoundly upsetting feelings of terror, shame, helplessness and powerlessness."

The survivor's questions – "Why?" and "What could I have done?"

Most people bereaved by suicide are haunted by two questions:

- "Why did the person take their life?"
- "Could I have somehow prevented it?"

It is natural that the bereaved person will take some considerable time in exploring these questions and it is an important part of the grieving process. However, it can also be damaging if they are unable to reach a stage where the questions occupy less of their thoughts or if they cannot find an answer they can accept. Self-esteem, confidence and hope can be severely compromised.

Wider issues

Stigma and isolation

- Still a stigma attached to suicide - can prevent people from seeking help when they need it and others from offering support when they want to
- There may be a desire to deny that the death was a suicide – this may be driven by cultural values or from a sense of denial or of shame. This can create further confusion in an already complex situation
- Many bereaved by suicide find that they feel isolated
- Bereaved person may avoid contact themselves

Family and community tensions

- Family and friends can be a source of tension and conflict
- struggle to communicate
- Protective instincts kick in
- Existing tensions and difficulties in family relationships can surface
- Blaming another person for the death

Wider issues II

Other prejudices

Other factors can create additional stigma, e.g.

- the death happening whilst in custody
- the sexuality of the person who died or that of their family or friends

These exclusions or blame may mean that the person feels further hurt or isolated.

How to support – things to do

- Recognise, acknowledge, allow them to feel what they are feeling
- Respect their needs, allow the survivor to control the pace of conversations and decisions to be made
- Visit them – don't ignore - make time and space for them
- Listen! Let them know you are there
- Let them share only IF they want to, don't force
- Consider appropriate use of language
- Offer practical help (e.g. lifts, meals)
- Attend the funeral
- Share memories
- Remember them and the anniversaries/milestones
- Signpost to other support – SOBS, Cruse, Samaritans, Papyrus, Winston's Wish as well as those who have supported them in past

Workshop A - Postvention

How to support – things to avoid

- Don't ignore the issue, don't isolate them
- Saying nothing because you don't want to upset them or because you don't know what to say
- Don't think there is nothing you can do to help
- Don't presume what will help them – ask
- Some statements are made with good intent but can be very distressing – "I know how you feel", "at least you have another child"
- Don't assume that they will be "back to normal" in 3 - 6 months
- Asking questions that they cannot answer – "why do you think they did it?"

Towards practical postvention

Immediately
- Manage the crises
- Inform staff
- Communicate
- Identify support

Shorter term
- Link to support
- Support healthy grieving
- Encourage and support working as 'normal'
- Lead by example

Longer-term considerations
- Ongoing support - prepare for anniversaries, reactions to them and other milestone events

Case Study

John is a member of the staff at your practice.

The receptionist takes the phone call from John's sister to say that John's son killed himself by hanging last night.

Obviously he won't be at work today. John says he is all right and "…no need to worry".

As an individual and as a member of the practice team what is your response?

In small groups discuss your immediate response (5 mins)

Formulate a question that will help us make sense of our own experience and how we can support each other (5 mins)

Sheffield SOBS – what we do

- Monthly self-help group
- Local telephone helpline
- Light touch – people don't have to 'join'
- Not counselling or therapy, but facilitated discussion
- Resources available to take away or borrow
- Signposting to further help where necessary

Sheffield SOBS – why it works

- Welcoming environment
- Personal invitation
- Safe space to share
- Mutual understanding
- Ground rules - confidentiality
- Normalisation of experience
- Shared language
- Humour

Wrap-up and questions

Over to you!

Workshop A - Postvention

Useful information

- SOBS resources – see our stand
- "Help is at Hand" booklet (Public Health England)
- Papyrus (young suicide)
- Winston's Wish (bereaved children)
- Samaritans

05/06/2017 Survivors of Bereavement by Suicide 19

How we can help you locally

- Sheffield group meets monthly at a central location
- Self-help ethos
- Clients do not need to "join" but can drop in and out
- Referrals welcome
- First step is for clients to call 0114 221 5350 or email

05/06/2017 Survivors of Bereavement by Suicide 20

Postvention – Supporting Families, Friends and Staff

NHS Sheffield Clinical Commissioning Group
PLI Event: Prevention of Suicide
Sheffield, 7th June 2017

SURVIVORS OF BEREAVEMENT BY SUICIDE

https://vimeo.com/133131650

Workshop B - Crucial opportunities in the consultation

- *" There is no evidence that asking a young person whether they are having suicidal thoughts will put the thought into their mind if it were not there before.*
- *There is however, a great deal of evidence to suggest that being able to talk to clients about suicide is extremely important in providing a safe place for them to explore their feelings"*

Rudd(2008) Barrio(2007)

Suicide Prevention

- ***Of people taking their own lives***
- 18% seen GP in previous week
  - and FURTHER
- 21% seen GP in previous month
  - ie
- Nearly 40% present an opportunity to affect the outcome
  - Sheffield Public Health Audit 2001-2010

Opportunities in the consultation

Learning points

- Patients engage better when they feel heard
- If you don't ask the question you won't find out
- Don't leave it to someone else (alone) to follow up
- Make good records – embed own behaviour
- Risks exist outside the accepted risk factors eg impulsivity

Vital first 10 mins

- Patient journey before consultation
- May be only chance
- Limitations of 10 mins
- Make sure they come back
- Risks harder to identify in young

DOH Preventing suicide in England 2012

FIRST CONVERSATION

- Patient the sole focus
- Listen not talk
- Let them tell their own story
- Acceptance and support not judgement
- Validate

Beware

- Self harm is NOT attention seeking
- Unrealistic promises – confidentiality

Workshop B - Crucial opportunities in the 10 minute consultation

Risk Assessment

- MUST ask the question directly
  - " Have you been thinking about taking your own life?"
- Triggers -loss
- Trusted confidante

Next Steps

- Identify clear next steps
- Follow-up promptly
- DNA policy
- Make good records

Key Behaviours

- ASK
- LISTEN
- VALIDATE
- RESPOND
- RECORD

Sources

- Young Minds
  - www.youngminds.org.uk
  - No Harm Done
- RCPsych Self Harm
  - www.rcpsych.ac.uk/healthadvice/problems
- RCGP Mental Health Toolkit
  - www.rcgp.org.uk/clinical-and-research-toolkits
- Morriss et al - Assessing risk of suicide
  - BMJ 2013;347
- Suicide Prevention Pathway (C&YP)
  - Sheffield multiagency March 2017
- Gponline Suicide risk assessment and management 18/5/16
  - http://www.gponline.com/suicide-risk-assessment-management/neurology/article/1282716

Clinical Case

- Under 25 male student. 1 Year history of low mood sleep disturbance thoughts of hopelessness and worthlessness with academic decline.

What questions would you want to ask next?

Questions

- Self harm/suicidal thoughts or past Hx of suicide attempts
- Behaviour changes - anxieties/loss interest/anhedonia
- Triggers - loss self esteem/bereavement/relationship/job etc
- Financial/homelessness/isolation
- Addictions /use alcohol/drugs/gambling
- Self care -feeding /cleanliness/exercise/academia/sleep
- Gender issues/ sexual orientation issues
- Domestic or other abuse or Hx of such/bullying
- Anger /hostility /antisocial behaviours
- Communication issues/pre-occupations with death
- Protective factors -family /friends/ support/tutor/confidante
- Physical illness/weight loss
- Family Hx suicide or mental illness

Workshop B - Crucial opportunities in the 10 minute consultation

Consultation

- With GP locum 10 mins Completed in 11m30s
- History notes : reflect presenting Hx with little else recorded of risk factors
- Exam notes : clean, well presented, coherent speech. Intelligent and engaging. Good eye contact
- Advised : general self care help from tutors, MIND, sleep hygiene, exercise and alcohol
- Follow up : patient to arrange follow-up appointment "when feels able to in a few weeks"

What could have been done better?

- Better risk assessment?
- More history?
- More comprehensive exam notes?
- Follow up?
- Support resources?

Outcome

- Suicide
- 24-36 hours later
- Found by parents 24 hours later
- Coroners case pending

Background

- High achiever academically
  - A levels + 1st year University
- Decline 2nd year
  - attendance/work completion + quality
- Heavy user Skunk
  - ran out of funds 1 week prior
- Gambling problem
  - significant debts
- Saw parents 2 days before saw GP
  - they were concerned but he reassured them he would attend GP
- Internet usage analysis
  - gambling sites
  - suicide sites

Lessons?

- Avoidable/missed opportunity?
- Individual performance issues?
- Systemic failures?
- Attitudes?

The thoughts of Chairman Dave

- *"uneasy lies the head who wears a crown"*
- If you do nothing else in the 10 minutes….
- ASK -the question directly
- LISTEN - actively + give your full attention
- VALIDATE - do not dismiss as attention seeking
- RESPOND - with resources and follow-up
- RECORD - embed behaviour and sleep easier…

Workshop C - Social prescribing

PLI Event

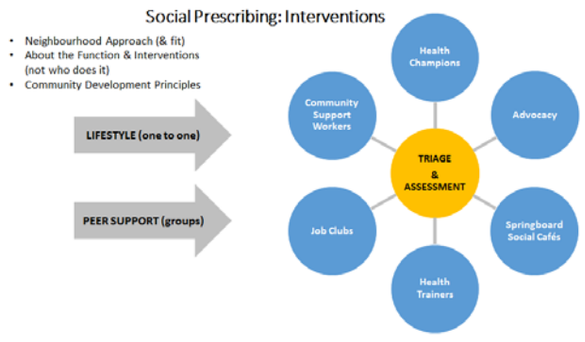
Social Prescribing: tackling loneliness, isolation and suicide risk

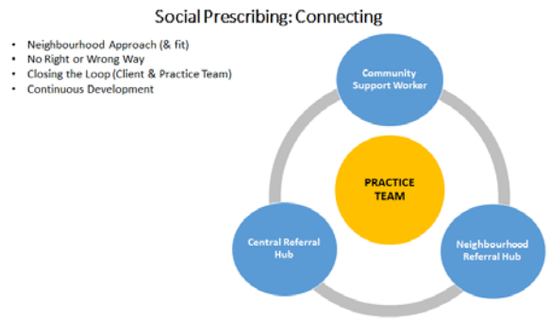
Aim of the session

To gain a clear understanding of the role social prescribing can play in supporting patients who are experiencing loneliness and isolation, two key risk factors for suicide

Learning Outcomes

- To understand the impact social prescribing can have on patients experiencing loneliness and isolation though lived experiences examples
- To gain a better understanding of how Social Prescribing works in Sheffield and know how to connect with it locally





Social Prescribing: Case Story

SOAR

https://vimeo.com/213839775/94962703ab

Workshop C - Social prescribing

Social Prescribing: Challenges

- It is not a coherent system across the city.
- PKW partnerships are not all co-terminus with Neighbourhoods / Localities.
- Investment in the **activity** is limited – not enough to meet capacity, gaps in coordination of community and voluntary sector offer in some neighbourhoods.
- Keeping up to date with what is available in communities.

Social Prescribing: Opportunities

- Route into a wide range of wrap around non medical services – employment support, debt management, housing .
- There is investment in developing a city wide approach.
- We have the architecture for co-designing community based interventions that meet local needs through People Keeping Well Partnerships, networks of community and voluntary sector organisations – local and city wide.
- Some targeted investment in disadvantaged communities : we have health trainers, community based activity, health champions, social cafes, health development workers facilitating new and growing community groups.
- 5 Ways to Well Being has traction in communities.
- Models of good practice in communities to scale up with some investment including VCS and GP partnerships.

Springboard Social Cafés
Report 2015-16

570
registered
service users

1 in 4 people will experience a mental health problem at some time.

This is often tied in with them being isolated, and made worse by the stigma that can come with mental health conditions.

What is a Springboard Social Café?

A Springboard Social Café is a regular event, run by experienced staff and trained volunteers, where people can drop-in as they need to and talk with others in a similar situation.

The Springboard Social Cafés provide activities and information that enable people to access services more effectively and to manage their specific conditions.

The aim of the Springboard Social Cafés is to provide a safe and positive place for people with low level mental health conditions to meet new people and be helped on their journey to recovery.

"The great thing about Springboard is knowing that it is there if I have a dip. I can go back and get some support without having to reach crisis point again."

Donna McGrail (Service User)

OBJECTIVE 1

To **reduce social isolation** which makes people more vulnerable to breakdown and depression and help with maintaining friends and a social life.

OBJECTIVE 2

To help **build resilience** so that people are better able to cope with their circumstances through access to information, signposting onto appropriate services.

OBJECTIVE 3

To **promote a recovery approach** that includes access to volunteering, work and training.

£25,247
volunteer value*

**Source: The Volunteer Impact Assessment Toolkit: Institute of Volunteer Research - an Initiative of Volunteering England and the Birbeck, University of London.*

Providers support local people through partnership working

The providers

SOAR (North East)

Manor & Castle Development Trust (MCDT) (East)

Sheffield Mind (Central)

The strength of the providers running the Springboard Social Cafés is that they are established mental health and community based organisations that embed delivery within existing services and have strong links with other projects and organisations.

These links with GP's, libraries, community groups and agencies mean that people can be initially referred into the Springboard Social Cafés and then signposted on to other services and activities that can help them in their recovery.

Springboard Social Cafés are funded by Sheffield City Council.

"Staff and volunteers provide opportunities to service users to expand their horizons, develop new social connections and skills."

Teresa Ravenshaw - Sheffield Mind

Volunteers

At the heart of Springboard Social Café are trained volunteer Recovery Coaches.

They show a tremendous dedication and commitment to helping others help themselves, as well as their willingness to talk about mental health, and thus fight stigma around it. Many service users have progressed to become volunteers and then gone onto achieve employment.

This shows the project really helps develop confidence and skills for those who access it.

Examples of partnership working

SOAR Social Prescribing Service

Occupational Therapy MSc student placements (Sheffield Hallam University)

Referral pathway via Northlands Community Health Centre & Longley Centre.

Case Story
Maureen Wilson
Age: 80

NATURE OF PROBLEM:
Loneliness and social isolation

REFERRAL:
Social Prescribing Service, Shiregreen Medical Centre

INTERVENTION/S:

Health Experience Course

A 6 week course aimed at Reducing Social Isolation, developing friendships and social networks, people aged 50+.

Lean on Me Befriending

A short term intervention led by Shiregreen MC Practice Champions, aimed at building confidence in an individual and making social links with others from their community.

Delivery Point:

Jedburgh Drive Community Room, Wincobank.

Client Story

Before joining the Health Experience course Maureen felt isolated, had limited mobility and was beginning to feel depressed. She went out just once a week and needed to rely on others if she wanted to go out.

REASON FOR SUPPORT

She joined the course to get out of the house and meet people.

ACTIONS TAKEN

Having spent a few days in hospital 6 months earlier Maureen didn't feel confident about getting to the course without help.

The 'Door to Door' taxi service was booked and she used her wheelchair to make her way along the path to the Community Room. The following week she used her walking frame to make her way along the path, supported by a Volunteer Befriender.

THE NATURE OF CHANGE

After 2 sessions Maureen felt that her confidence was increasing and she was able to make her own way to the Community Room.

She managed to make her way to the class using her walking stick and happy to make her way back too.

LEANonME

NEXT STEPS

Maureen is still going to the group every week and enjoying her independence and getting out of the house. She also feels more confident about going out and socialising.

Interaction between SOAR and NHS. Other orgs/services involved include:

- SOAR
- SHIREGREEN MEDICAL CENTRE
- SOUTH YORKSHIRE ENERGY CENTRE
- SHEFFIELD 50+

Workshop D - Self-harm - a Primary Care perspective

SELF HARM WORKSHOP

CATHERINE CARLICK
Dr ABHI SHETTY
JULIE SHELDON

Format

- Brief introduction of workshop facilitators
- Overview of session
- Aims/objectives inc. any additional from the participants
- Defining self harm
- Role plays and discussion
- Questions/feedback/check aims objectives met

AIMS

- Improve the confidence of primary care professionals when assessing someone who has harmed themselves or is expressing intent to harm themselves.
- For primary care professionals to feel that they have the knowledge and skills to collaboratively agree an appropriate plan with someone who is expressing mental distress and thoughts, plans or intent to self harm

Objectives

- Undertake a brief but meaningful assessment of the patient and understand their needs
- Collaboratively form a plan of action with the patient following assessment.
- Have knowledge of the full range of resources available so that the plan can reflect the identified needs and the level of urgency

ROLE PLAY 1 - DISCUSSION

- How did you feel about this intervention?
- What was good?
- What could have been improved?
- How do think the service user felt about the interaction?
- Are you confident that the service user's needs were met?
- Is this a typical reflection of how this presentation would be dealt with?

ROLE PLAY 2 - DISCUSSION

- How did this intervention make you feel? – Comfortable, uncomfortable?
- Was this a more positive/negative intervention than the 1st one?
- Would you feel comfortable asking these questions?
- Did you feel that this was better/worse than the 1st outcome for the service user?

Workshop D - Self-harm - a Primary Care perspective

ROLE PLAY 2 – FURTHER DISCUSSION

- What else would you have done?
- Has this helped your confidence to mange self harm?
- What are the barriers in your practice for this level of intervention?

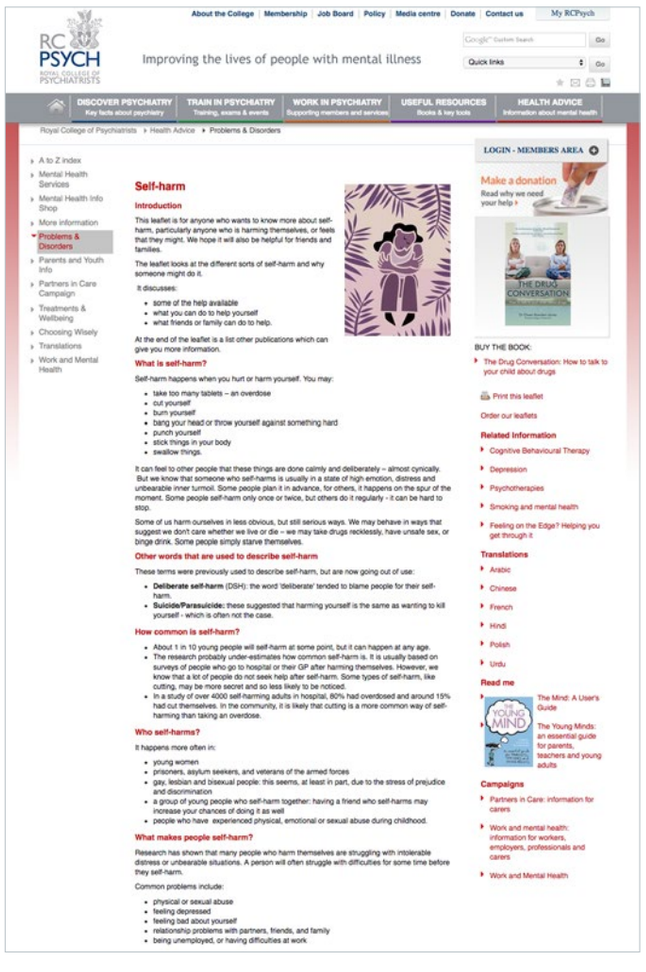
CONCLUSION

- Summing up
- Check aims/objectives met
- Questions and comments
- Thanks for participating
- Resources available in your packs

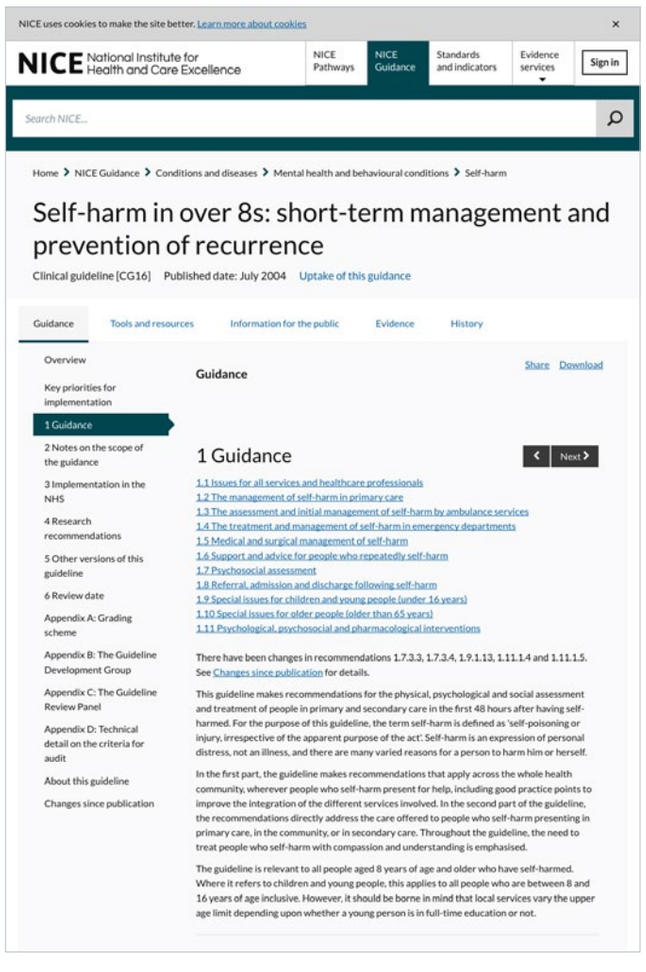
Workshop D - Self-harm - a Primary Care perspective

Resources for professionals

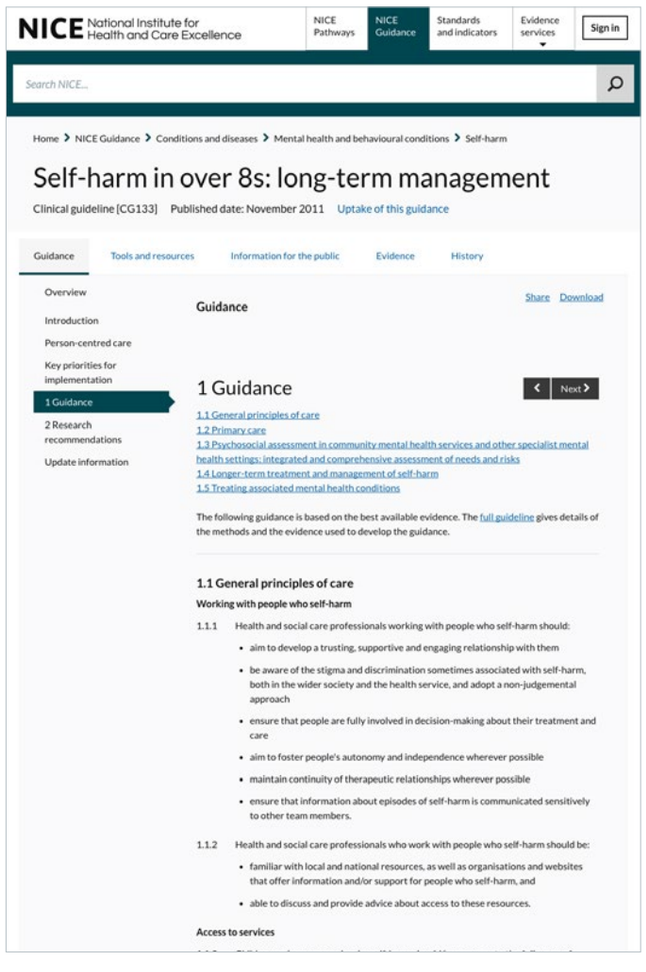
www.rcpsych.ac.uk/healthadvice/problemsdisorders/self-harm.aspx



www.nice.org.uk/guidance/cg16/chapter/1-Guidance#the-management-of-self-harm-in-primary-care



www.nice.org.uk/guidance/CG133/chapter/1-Guidance#primary-care



Workshop D - Self-harm - a Primary Care perspective

Services who accept referrals from Primary Care professionals or self referral:

Rethink 24 hour helpline for people with mental health issues 0808 810 1440

MIND advice, support, 1-1 and groups 0114 258 4489

SEAP single point of access for drug and alcohol referrals 0114 305 0500

SAAS - Alcohol support - open Mon to Fri 8am - 8pm 0114 258 7553

Age Well Drink Wise Alcohol support services for over 50's 0800 0323 723

Adaction Support for adults with drug addiction 0114 253 6830

The Corner for people age 19 and under who have a drug and alcohol problem 0114 275 2051

Together women - advice for alcohol, sexual problems, financial problems - groups and key workers 0114 275 8282

Help for Armed Forces Veterans Mental Health - Combat Stress Charity 0800 138 1619

Archer Project - Homeless support - 0114 263 6970

CAB Citizens Advice Bureau 0344 411 1444

Shelter legal advice for housing and finances 0344 515 1515

SHSC resources for adults aged 16 and above:

SHSC Out of hours number for support/advice for staff and service users - 0114 271 6310

Operates from 4pm to 8am on weekdays and 24 hours on weekends

SHSC Community Mental Health Teams for support/advice/urgent referral

Operates 9am - 5pm Monday to Friday. Speak to the duty worker in the first instance.

West Sector: Wardsend Road 0114 271 6100

South West Sector: Argyll House 0114 271 8654

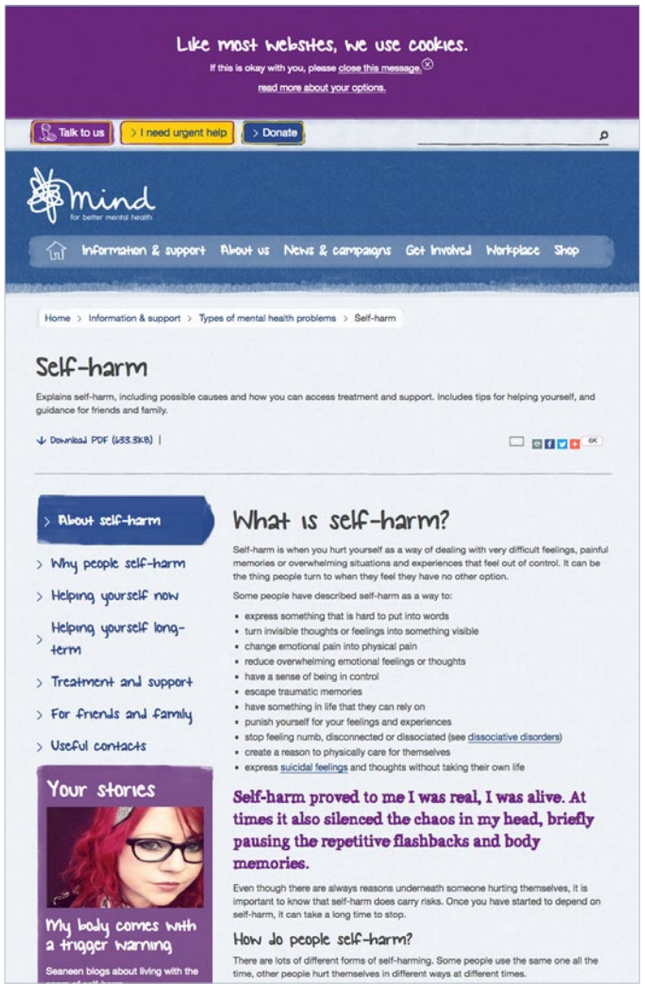
South East Sector: Eastglade 0114 271 6451

North Sector: Northlands 0114 271 6217

Workshop D - Self-harm - a Primary Care perspective

Resources for service users/carers:

www.mind.org.uk/information-support/types-of-mental-health-problems/self-harm/#.WSFo41LSmM8

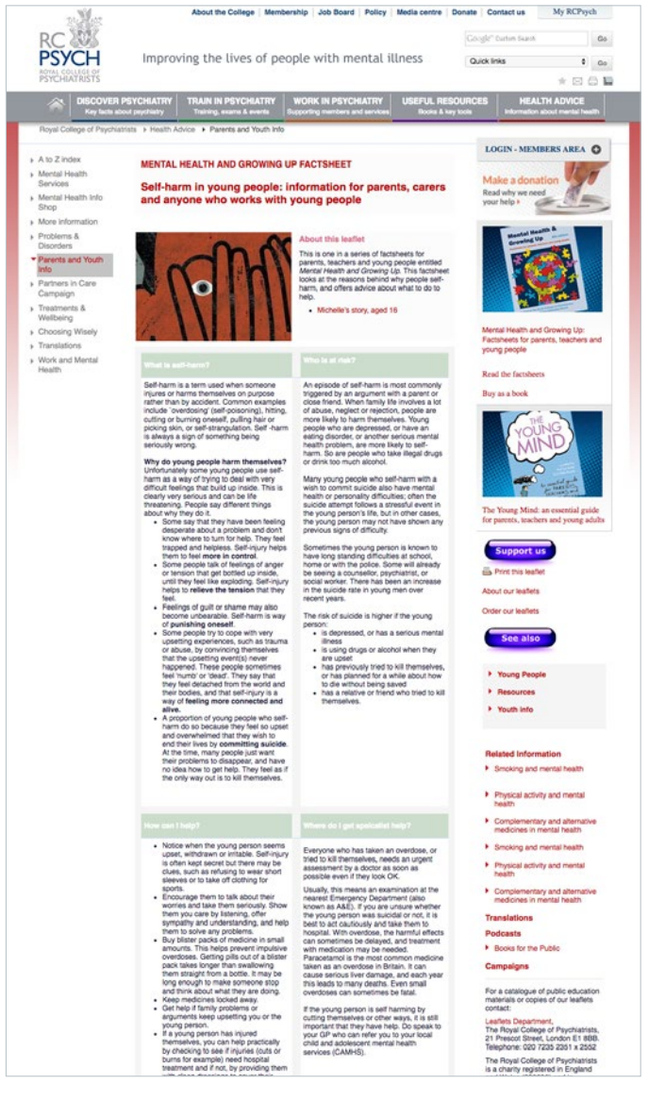


A very good resource for patients - excellent guided self help on a range of mental health issues including anxiety, depression etc.

www.ntw.nhs.uk/pic/selfhelp/

Advice for young people and their families:

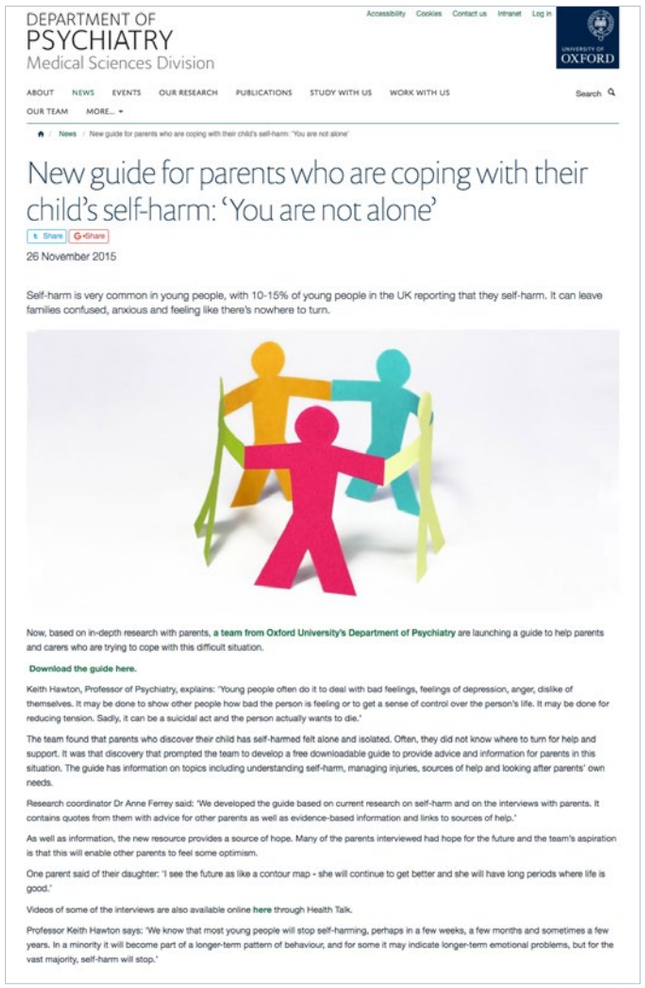
www.rcpsych.ac.uk/healthadvice/parentsandyouthinfo/parentscarers/self-harm.aspx



Workshop D - Self-harm - a Primary Care perspective

This was launched recently by the University of Oxford Department of Psychiatry and is available for free download.

www.psych.ox.ac.uk/news/new-guide-for-parents-who-are-coping-with-their-child2019s-self-harm-2018you-are-not-alone2019



DEPARTMENT OF PSYCHIATRY
Medical Sciences Division

New guide for parents who are coping with their child's self-harm: 'You are not alone'

26 November 2015

Self-harm is very common in young people, with 10-15% of young people in the UK reporting that they self-harm. It can leave families confused, anxious and feeling like there's nowhere to turn.

Now, based on in-depth research with parents, **a team from Oxford University's Department of Psychiatry** are launching a guide to help parents and carers who are trying to cope with this difficult situation.

Download the guide here.

Keith Hawton, Professor of Psychiatry, explains: 'Young people often do it to deal with bad feelings, feelings of depression, anger, dislike of themselves. It may be done to show other people how bad the person is feeling or to get a sense of control over the person's life. It may be done for reducing tension. Sadly, it can be a suicidal act and the person actually wants to die.'

The team found that parents who discover their child has self-harmed felt alone and isolated. Often, they did not know where to turn for help and support. It was that discovery that prompted the team to develop a free downloadable guide to provide advice and information for parents in this situation. The guide has information on topics including understanding self-harm, managing injuries, sources of help and looking after parents' own needs.

Research coordinator Dr Anne Ferrey said: 'We developed the guide based on current research on self-harm and on the interviews with parents. It contains quotes from them with advice for other parents as well as evidence-based information and links to sources of help.'

As well as information, the new resource provides a source of hope. Many of the parents interviewed had hope for the future and the team's aspiration is that this will enable other parents to feel some optimism.

One parent said of their daughter: 'I see the future as like a contour map - she will continue to get better and she will have long periods where life is good.'

Videos of some of the interviews are also available online **here** through Health Talk.

Professor Keith Hawton says: 'We know that most young people will stop self-harming, perhaps in a few weeks, a few months and sometimes a few years. In a minority it will become part of a longer-term pattern of behaviour, and for some it may indicate longer-term emotional problems, but for the vast majority, self-harm will stop.'

If you have any non-urgent enquiries for support or advice please email Julie Sheldon at julie.sheldon@shsc.nhs.net

Patient quotes on self harm

"Other times, I look at my scars and see something else: a girl who was trying to cope with something horrible that she should never have had to live through at all. My scars show pain and suffering, but they also show my will to survive. They're part of my history that'll always be there."

"In case you didn't know, dead people don't bleed. If you can bleed-see it, feel it-then you know you're alive. It's irrefutable, undeniable proof. Sometimes I just need a little reminder."

"You might imagine that a person would resort to self-mutilation only under extremes of duress, but once I'd crossed that line the first time, taken that fateful step off the precipice, then almost any reason was a good enough reason, almost any provocation was provocation enough. Cutting was my all-purpose solution."

How can you help:

- Deal with your own feelings - shock, disgust, fear, confusion, sadness are all natural responses
- Be supportive and accept the person and what they are telling you
- If there is immediate danger
  - make sure someone is with them or get help to them
  - ensure your own personal safety - do not get physically involved
- Don't make any promises you cannot keep and follow up any commitments that you agreed to
- Don't judge
- Encourage communication
- Consider whether help is needed from other services

Workshop E - Depression

DEPRESSION – Recognition and Management

Dr Rachel Warner – Consultant Psychiatrist
Heidi Taylor - Clinical Effectiveness Pharmacist NHSS CCG
Sally Kirby – Clinical Pharmacist in Primary Care and SHSCFT
Dr Karen O'Connor – GP
7th June 2017

WORKSHOP COVERS:

- Diagnosis of Depression
- Assessment of risk
- Non-pharmacological interventions
- Pharmacological interventions
- Referring to IAPT, Secondary Care, Third Sector
- Case discussion
- Sheffield Mental Health Protocols as a resource for Primary Care

1 in 4 of us will experience Mental Ill-Health (MIND 2016)

- 3.3 in 100 – Depression
- 5.9 in 100 – Generalised Anxiety Disorder
- 7.8 in 100 – Mixed Anxiety and Depression
- 0.7 in 100 - Psychosis

Over Our Lifetimes (MIND 2016)

- 20.6 in 100 will have suicidal thoughts
- 6.7 in 100 will make a suicide attempt
- 7.3 in 100 will self harm

At April 2017 on Sheffield GP QOF Registers

- 5196 coded as having Serious Mental Illness
- 2528 of those had at least 1 physical LTC
- 1237 also had co-morbid Depression
- 49% of those with SMI and at least 1 LTC also had Depression

Assessment

- Symptom check list
- Cognitions and affect – shame, guilt hopelessness, entrapment
- Co - morbid anxiety disorders, substance misuse, physical health problems
- Context and levels of social support
- Resilience
- Patient choice

Workshop E - Depression

Management

- You are the most effective medicine
- Instill hope and trust
- Work collaboratively - What questions might you ask to support engagement in treatment?
- Look at the long term as well as the immediate situation
- Engage family and other sources of social support

Do not be afraid to ask

"I kept my mental health issues secret from everyone I knew for ten months. It was a mental problem, but I could feel the weight of that problem physically weighing me down every single day. Contemplating suicide, alone, as a 20-year old who was meant to be out enjoying the "best years of his life", was an incredibly difficult thing to have to wake up to and think about everyday. I may be able to laugh about it now, but that all started from a couple of tough, difficult, awkward conversations that I was forced to have. But I'll always be grateful for that first conversation because there's no doubt that it saved my life."

"I think it's inevitable, if you've got a serious mental illness, that suicide is a big option because why go on with this horrible life? ... I think if you speak to most people who've had a mental illness, suicide has been a big part of their thinking because it's a disastrous illness to have. It not only takes your dignity away, it takes your mind away and you become isolated, and you're scared, and your life's ruined. It's a terrible thing to have."

What does NICE say?

- Treatment and care should take into account patients' needs and preferences
- Good communication between practitioners and patients is essential. It should be supported by evidence-based written information tailored to the patient's needs.
- If the patient agrees, families and carers should have the opportunity to be involved in decisions about treatment and care

Key risks

- Isolation
- Economic adversity
- Alcohol and drug misuse
- Recent self harm

(National Confidential Enquiry 2015)

- NATIONAL GUIDANCE - Department of Health –Best Practice in Managing Risk, December 2008
  - Risk management should be conducted in a spirit of collaboration and based on a relationship between the service user and their carers that is as trusting as possible.
  - Risk management must be built on a recognition of the service user's strengths and should emphasize recovery.

Workshop E - Depression

Management

- **Low-intensity psychosocial interventions** : For people persistent subthreshold depressive symptoms or mild to moderate depression,
- For people with moderate or severe depression, provide a combination of antidepressant medication and a high-intensity psychological intervention (CBT or IPT).
- Refer complex cases – focussed depression team and/or CMHT (where MDT approach needed)

IAPT

When to consider prescribing?

Antidepressants should be reserved for people with moderate to severe depression

Antidepressants should not be routinely prescribed for those with sub-threshold or mild depression unless;

- with a history of moderate or severe depression
- who initially present with sub-threshold depressive symptoms that have been present for at least two years
- Depression complicating physical illness
- with sub-threshold depressive symptoms or mild depression which persist after other interventions have been tried.

Consider / offer psychological interventions (IAPT)

Side effects

"It's like a breeze-block being lowered on your head and you can't, like, be yourself."

"You feel a little bit plasticated, sort of thing.... Sort of like a cardboard cut-out of a person."

Pharmacological Management

- Aims of next few slides;
  - Raise awareness of local prescribing pathway (based on NICE guidance and local current formulary choices).
  - Highlight risk and benefits of different antidepressants
  - Managing risks – Reducing access to the means of suicide

Which Antidepressant?

Informed discussion with patient, covering:

- anticipated adverse events – side effects and discontinuation symptoms
- potential interactions with other medication or physical illness
- the person's perception of antidepressants they have previously taken

A generic Selective Serotonin Reuptake Inhibitor (SSRI) **normally first-line** - generally better tolerated and safer in overdose than other antidepressants

How to prescribe?

- Side effect profile of each (eMC) – anxiety may worsen in first instance
- Counsel on expected time to respond and duration of treatment
- Provide written information
- Follow up
- Discontinuation

Workshop E - Depression

Which SSRI

- Age of the patient
- Chronic physical health problem
- Sertraline first line for GAD (off – label). Co-existing anxiety?
- Paroxetine is associated with a higher incidence of discontinuation symptoms
- Interactions, some examples;
  - Aspirin and NSAIDs increase risk of bleeds - offer PPI.
  - Protein bound (warfarin – enhanced effect)
  - Serotonin syndrome

Review response

Review after 2 weeks then every 2-4 weeks for first 3 months
Young people or at greater risk of suicide review after one week

If no improvement after 3-4 weeks (compliance checked? Engaging with psychological support?)

- **Increase the dose of the SSRI**, if side-effects permit or
- **Switch to a different** antidepressant

When switching antidepressants, consider:

- initially, a different SSRI or a better-tolerated newer-generation antidepressant
- subsequently, an antidepressant of a different class that may be less well tolerated (such as venlafaxine or a TCA).
- Non-reversible MAOIs, combined antidepressants and lithium augmentation of antidepressants should only be prescribed by specialist mental health professionals

Newer generation antidepressant, TCA and venlafaxine – considerations.

- **Toxicity** (the greatest risk in overdose is with venlafaxine and TCAs, except for lofepramine)
- Side-effects - beneficial or troublesome? Start slow and titrate
- Interactions
- Alcohol and substance misuse (drowsiness, liver function, toxicity risk)
- **Do not switch to, or start, dosulepin**

Costs

Costs for one month;

Citalopram, fluoxetine and sertraline – 76p-£1.22
Lofepramine - £12.23
Trazodone - £20-24
Mirtazapine - £1.25-£2.60
Doxepin 25/50mg - £97/£154
Tranylcypromine - £235 (specialist initiation)
Do not switch to, or start, dosulepin

Restricting access to the means for suicide works

- This is one of the most evidenced aspects of suicide prevention
- UK legislation to reduce pack sizes of paracetamol was followed by significant reductions in deaths due to paracetamol overdose
- In practical terms, consider;
  - any drugs prescribed for them or their household relatives are least dangerous in overdose
  - need and quantities of high risk meds (e.g. opioids, pregabalin – no co-proxamol)
  - consider prescribing few tablets at one time

Stopping treatment – when?

Continue for at least 6 months following remission, consider longer periods of treatment depending on an assessment of:

- risk of recurrence.
- risk of severe recurrent depression
- consequences of recurrent depression

Duration of any continued treatment will depend on clinical judgement / patient, if the risk of relapse or consequences significant:

- Continue treatment for at least 2 years, maintained at the effective treatment dose.
- Consider psychological interventions
- Social support

Workshop E - Depression

Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Stopping treatment – How?

In general, reduce the dose or frequency of the antidepressant gradually over a 4-week period

A shorter or longer tapering period may be required for example:

- Severe adverse reaction to treatment
- Longer-term maintenance treatment — taper the dose over 6 months.
- Think of the wrap around care

If discontinuation symptoms do occur and are severe and persistent, the antidepressant should be restarted and tapered more slowly than before.

Working with you to make Sheffield HEALTHIER

Sheffield Health and Social Care NHS NHS Foundation Trust

NHS Sheffield Clinical Commissioning Group

Case study 1

- 72 year old male, recently bereaved (wife)
- Care role for wife for several years
- No nearby or close family
- Daily visits from Community teams cease
- 4 weeks later a (shocked) Practice is asked to write a Coroners Report
- Upon reflection, most of his contact with Health Workers had focussed on his wife

Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Case study 2

- 58 year old single male, history of Depression
- Called to brother's house by CMHT to gain access
- Finds brother has committed suicide by hanging (tries in vain to revive him)
- CMHT arrange for his own GP to see him
- Prescribed SSRI, declines IAPT, regular GP review
- Describes daily suicidal ideation but concerned for brother's children
- Recovers over 3 years

Working with you to make Sheffield HEALTHIER

Sheffield Health and Social Care NHS NHS Foundation Trust

NHS Sheffield Clinical Commissioning Group

Thanks and questions?

Working with you to make Sheffield HEALTHIER

Sheffield Health and Social Care NHS NHS Foundation Trust

NHS Sheffield Clinical Commissioning Group

Useful resources and references

- Sheffield primary care guidelines for the management of depression and pharmacological treatment (adults)
- IAPT
- Sheffield Mental Health Guide
- The Sheffield Directory
- PHE – Local suicide prevention planning – a practice resource.
- CKS - Self harm
- Long term effect of reduced pack sizes of paracetamol on poisoning deaths and liver transplant activity in England and Wales
- Depression in adults - NICE CG90
- Depression in adults with a chronic physical health problem - NICE CG91

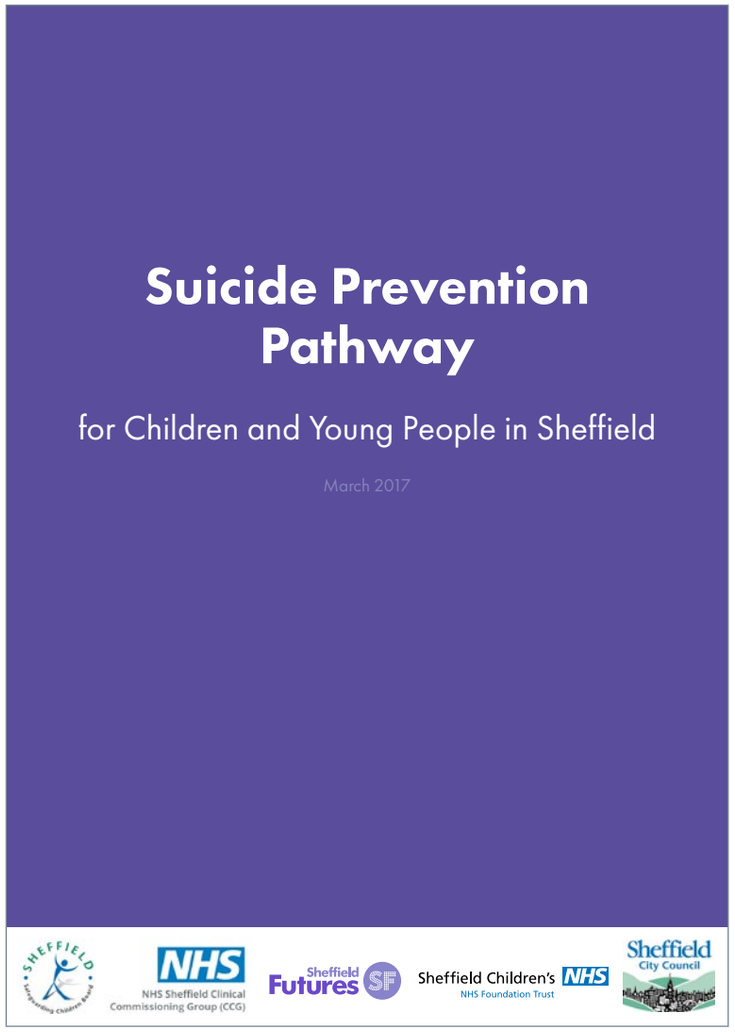
Sheffield Guidelines for Primary Care Management of Depression

www.sheffieldccgportal.co.uk/pressv2/index.php/component/zoo/item/sheffield-guidelines-for-primary-care-management-of-depression

Pharmacological Treatment Flowchart - www.sheffieldccgportal.co.uk/pressv2/index.php/component/zoo/item/depression-pharmacological-treatment-adults

Workshop F - Children and Young People

Children and Young People's Prevention Pathway



www.sheffieldfutures.org.uk/wp-content/uploads/2017/03/Suicide-Prevention-Pathway-SML.pdf

1 in 10

suicides in the UK are by 15-24 year olds.

Samaritans suicide statistics report 2014

One in four young people experience suicidal thoughts.

The Princes Trust Maquarie Youth Index 2014

Workshop G - Safety planning and risk mitigation

SUICIDE SAFETY PLANNING & RISK MITIGATION IN GENERAL PRACTICE

Dr Helen Winter & Dr Terry Hudsen

University Health Service

Janet 1936 & Gerry 1926

The Samaritans

CAN WE MAKE A DIFFERENCE IN GP?

- Of those patients who take their own life, half to two thirds will have visited their GP in the month before, and 10-40% in the preceding week.
- GPs are very often the first point of contact for patients, and may be the only contact- having the opportunity to consider mental health difficulties and social problems alongside physical health problems.
- The WHO estimates that approximately one million people die from suicide each year, the incidence is increasing in the younger population, and suicide is among the 3 leading causes of death in 15-44 year olds.

CHALLENGES TO THE GP ASSESSMENT

- Time constraints
- Lack of confidence / knowledge- wide variation in level of training
- Weighing up risk factors to gain balance of risk
- Distinguishing between imminent risk and expression of emotional distress
- GP attitude and beliefs can be a barrier- "is suicide preventable?"
- Fear of discussing suicidal thoughts or plans
- Potential barriers from secondary care
- Are risk assessment tools helpful?

WHAT WE CAN DO:

Effective communication skills, empathic interaction allowing understanding of the patient's mental anguish, and application of risk prevention measures.

- Listen- show interest and support
- Talk openly about suicide- this will not 'put ideas into peoples heads'
- Be non-judgemental
- Offer empathy, not sympathy
- Express your concerns for the patient's safety
- Offer hope that alternatives are available
- Take action and involve the patient in decision making
- Consider safe prescribing
- Arrange appropriate follow up +/- referral

WHAT ARE THE RISK FACTORS FOR SUICIDE?

- A combination of individual, relationship, community and societal factors contribute to an increased risk of suicide.
- Mental health disorders (particularly depression and substance abuse) are associated with more than 90% of all cases of suicide.
- Loss of relationships, occupation, finances and social networks are important risk factors.
- Physical illness, alcohol and drug use, difficulties around sexuality and gender dysphoria may also increase risk.
- Demographics: more common in males, certain professions including healthcare professions, vets, farmers.
- Suicide most often occurs when stressors overwhelm current coping abilities of someone with a mental health condition.

ANDY: 21 YEAR OLD MALE

- "I wonder if I could get a sick note please doctor. I'm having real trouble sleeping too"

Workshop G - Safety planning and risk mitigation

HISTORY

- Trouble getting off to sleep and waking early
- Recently split with his girlfriend
- Made redundant 3 months ago from his job
- Been drinking more than usual (4 cans of beer/night)
- Not seeing his friends or family much any more
- Used to play five-a-side but hasn't been since he split with his girlfriend

- What more do we need to know?
- What are the risk factors for suicide?
- What puts Andy at risk?

"I'M FEELING AT ROCK BOTTOM AT THE MOMENT"

- Feeling really low
- Behind with rent payments and landlord is threatening eviction
- Ashamed about losing his job and splitting up with girlfriend – cannot face his friends or family
- Not able to find work and job centre are "on my back"
- " I sometimes just feel like ending it all, doctor. At times I can't see any other choice"
- No drug use
- No past history of mental health problems, generally physically well, hardly ever visits GP.

ASSESSING RISK

What puts Andy at risk?

- Male
- Recent adverse life events
- Single
- Unemployed
- Increased alcohol use
- Social isolation
- Lack of positive daily routine
- Withdrawal from pleasurable activities
- Feeling hopeless about future

RISK FACTORS & PROTECTIVE FACTORS

List of risks

- Reduced sleep with EMW, Feeling low, ? Depressed
- Recent loss of relationship
- Loss of job- loss of role, self esteem, regular routine
- Financial concerns ? Threat to accommodation
- Increased alcohol intake
- Self isolation, withdrawing from family support
- Withdrawal from social and leisure activities
- Reduced exercise
- Feeling hopeless, shame
- Suicidal thoughts and planning

List of protective factors

- No previous suicide attempts
- No history of self harm
- Would not want to upset mum
- No history of drug use
- No past history of mental health problems
- No past history of severe physical health problems
- Does have network of friends and family, access to support and positive activities that has previously enjoyed
- Has attended GP, appears willing to engage, asking for help

WHAT HELP CAN YOU OFFER?

Workshop G - Safety planning and risk mitigation

WHAT CAN THE GP DO IN THE CONSULTATION?

- Listen, show empathy and understanding, validate feelings of emotional distress
- Assess risk factors
- Consider past medical/ psychiatric history
- Consider mental health 5 area CBT framework (SHARP self help leaflets), help patient to explore self help options, assist with problem solving.
- Safety planning- consider completing support plan together
- Arrange soon review
- Signposting to external support
- Consider referral to CMHT/ crisis team

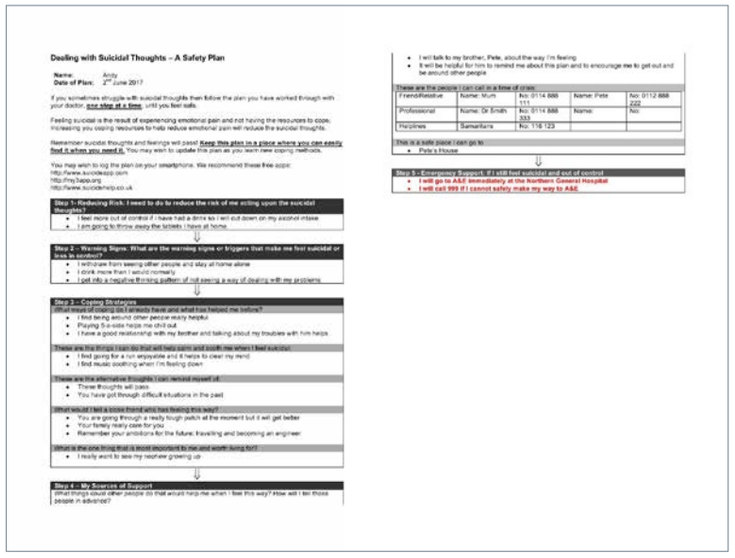
SAFETY PLANNING

- Brief intervention that provides an individual with a set of steps that can be used progressively to reduce suicide risk or self harm risk
- Collaborative process between clinician and patient
- Provides a structure to the consultation
- Provides the patient with a WRITTEN PLAN
- Aids risk assessment
- Emerging evidence base to support this intervention
- Not harmful, if it saves one life then it is worth doing!

WHAT SHOULD A SAFETY PLAN INCLUDE?

- Step 1 – Immediate risk reduction
- Step 2 – Warning signs
- Step 3 – Internal coping mechanisms
- Step 4 – External sources of support
- Step 5 – Emergency support

- SHOULD BE A DYNAMIC DOCUMENT
- Smartphone apps available for portability
- A template will be on the PRESS Portal for all practices to mail merge in to EMIS or SystmOne



Dealing with Suicidal Thoughts – A Safety Plan

Name: Andy
Date of Plan: 2nd June 2017

If you sometimes struggle with suicidal thoughts then follow the plan you have worked through with your doctor, **one step at a time**, until you feel safe.

Feeling suicidal is the result of experiencing emotional pain and not having the resources to cope. Increasing you coping resources to help reduce emotional pain will reduce the suicidal thoughts.

Remember suicidal thoughts and feelings will pass! **Keep this plan in a place where you can easily find it when you need it.** You may wish to update this plan as you learn new coping meth'ods.

You may wish to log the plan on your smartphone. We recommend these free apps:
http://www.suicideapp.com
http://my3app.org
http://www.suicidehelp.co.uk

Step 1- Reducing Risk: I need to do to reduce the risk of me acting upon the suicidal thoughts?
- I feel more out of control if I have had a drink so I will cut down on my alcohol intake
- I am going to throw away the tablets I have at home

Step 2 – Warning Signs: What are the warning signs or triggers that make me feel suicidal or less in control?
- I withdraw from seeing other people and stay at home alone
- I drink more than I would normally
- I get into a negative thinking pattern of not seeing a way of dealing with my problems

Step 3 – Coping Strategies
What ways of coping do I already have and what has helped me before?
- I find being around other people really helpful
- Playing 5-a-side helps me chill out
- I have a good relationship with my brother and talking about my troubles with him helps

These are the things I can do that will help calm and sooth me when I feel suicidal:
- I find going for a run enjoyable and it helps to clear my mind
- I find music soothing when I'm feeling down

These are the alternative thoughts I can remind myself of:
- These thoughts will pass
- You have got through difficult situations in the past

What would I tell a close friend who has feeling this way?
- You are going through a really tough patch at the moment but it will get better
- Your family really care for you
- Remember your ambitions for the future: travelling and becoming an engineer

What is the one thing that is most important to me and worth living for?
- I really want to see my nephew growing up

Step 4 – My Sources of Support
What things could other people do that would help me when I feel this way? How will I tell those people in advance?
- I will talk to my brother, Pete, about the way I'm feeling
- It will be helpful for him to remind me about this plan and to encourage me to get out and be around other people

These are the people I can call in a time of crisis

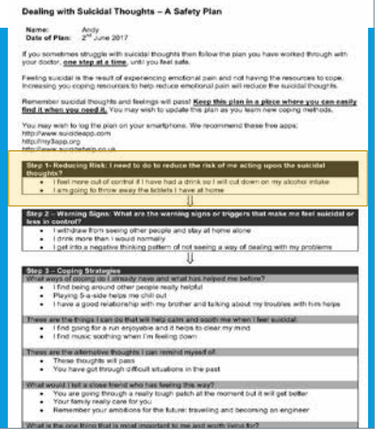
Friend/Relative	Name: Mum	No: 0114 888 111	Name: Pete	No: 0112 888 222
Professional	Name: Dr Smith	No: 0114 888 333	Name:	No:
Helplines	Samaritans	No: 116 123		

This is a safe place I can go to
- Pete's House

Step 5 - Emergency Support: If I still feel suicidal and out of control
- **I will go to A&E immediately at the Northern General Hospital**
- **I will call 999 if I cannot safely make my way to A&E**

STEP 1 – RISK REDUCTION

- Make the environment safe
- Removal of any immediate means of suicide
  - Throw away tablets/give to someone else
  - Remove knives, ropes etc
- What is the one thing that is most important to me and worth living for?



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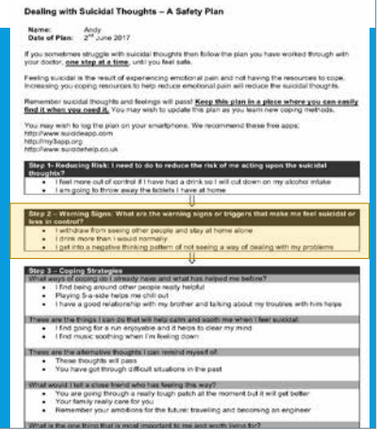
- Remember your ambitions for the future: travelling and becoming an engineer

What is the one thing that is most important to me and worth living for?

STEP 2 – WARNING SIGNS

- What are the warning signs that make the person feel less in control of their thoughts?
- How will you know when to use the safety plan?
- Withdrawing socially
- Ruminating on certain thoughts
- .....



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What is the one thing that is most important to me and worth living for?

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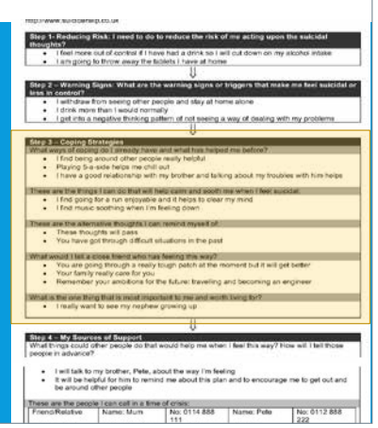
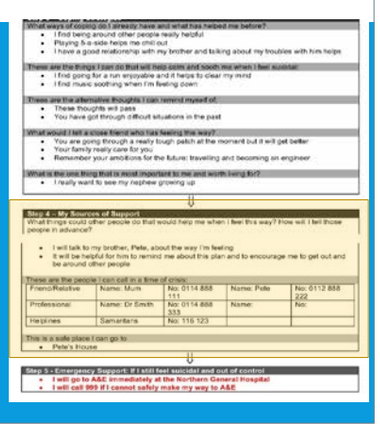
STEP 3 – INTERNAL COPING MECHANISMS

- What ways of coping with these thoughts do you already have?
- What things have you done before that have helped?
- What can I tell myself as alternatives to these troubling thoughts?
- What would you tell a friend in this situation?
- Any distractions
- Relaxation techniques



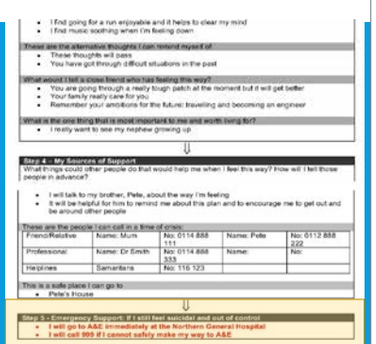
STEP 4 – EXTERNAL SUPPORT

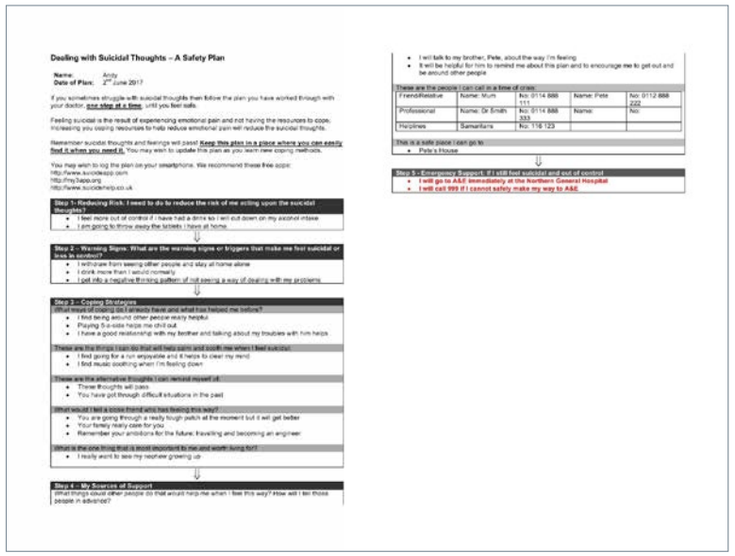
- What can other people do that will be helpful?
- Who can you call in a time of crisis?
  - Important to list the names and numbers on the plan!
- Where is a place of safety I can go to?
  - A friend? A relative? A public space?



STEP 5 – EMERGENCY SUPPORT

- If I still feel suicidal or out of control then this is what I will do:
  - Mental health tel no
  - 999
  - A&E?

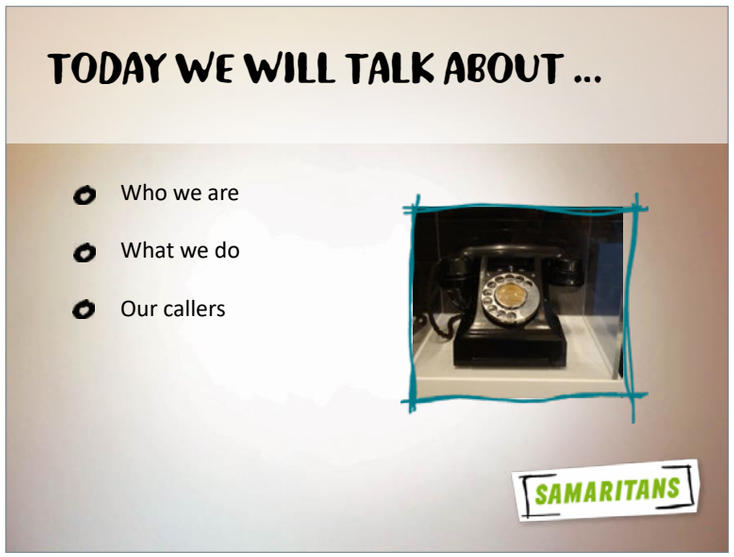


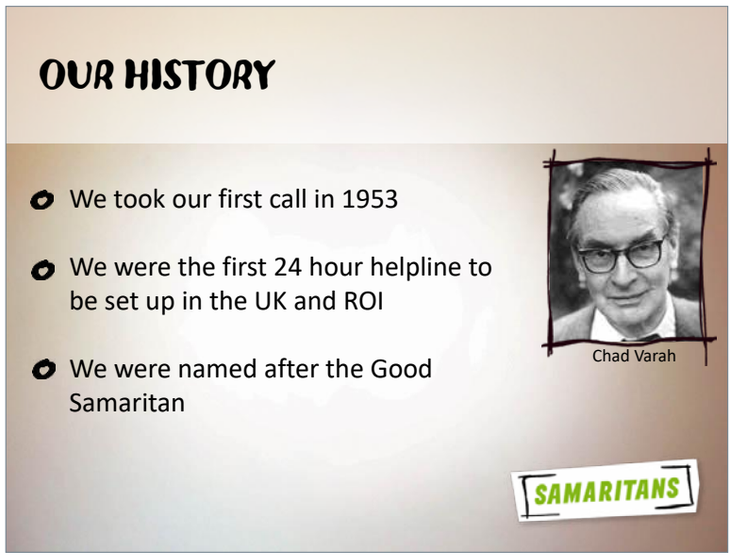


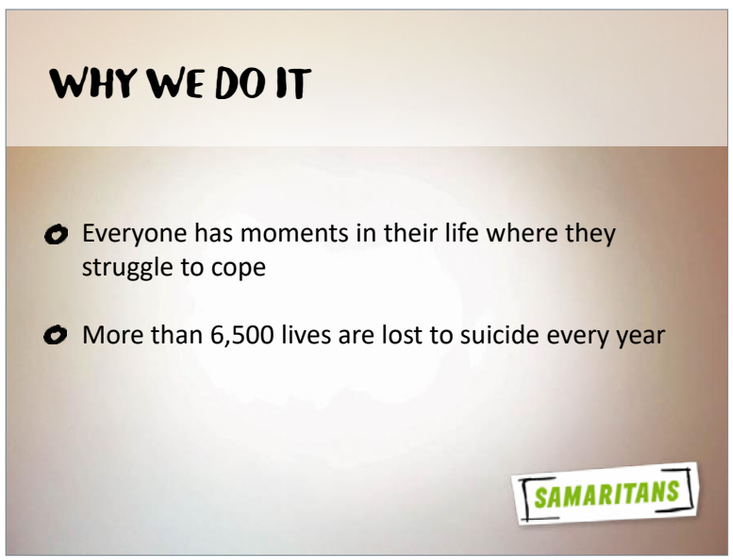
SMARTPHONE APPS

- http://www.suicideapp.com
- http://my3app.org
- http://www.suicidehelp.co.uk

Workshop G - Safety planning and risk mitigation







Workshop G - Safety planning and risk mitigation

HOW WE DO IT IS ...

UNIQUE

SAMARITANS

OUR CALLERS

- There's no typical person who contacts us and no typical problem that people talk to us about
- You can talk to us about anything that is getting to you – and it stays between us

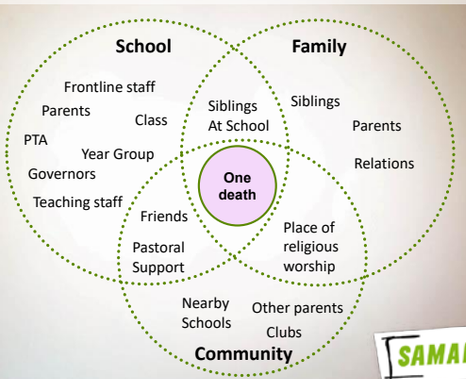
SAMARITANS

OUR CALLERS

78% OF CALLERS ARE NOT SUICIDAL

SAMARITANS

Echoes



SAMARITANS

WE ARE VOLUNTEERS

- We are ordinary people
- We give our time freely
- We aren't professionals and don't provide counselling
- Our 201 branches are run by volunteers

SAMARITANS

HOW PEOPLE CONTACT US

- Call us
- Email us
- Text us
- Write us a letter
- Come and visit us in branch

SAMARITANS

Workshop G - Safety planning and risk mitigation

Dealing with Suicidal Thoughts – A Safety Plan

Name
Date of Plan:

If you sometimes struggle with suicidal thoughts then follow the plan you have worked through with your doctor, **one step at a time**, until you feel safe.

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Remember suicidal thoughts and feelings will pass! **Keep this plan in a place where you can easily find it when you need it.** You may wish to update this plan as you learn new coping methods.

You may wish to log the plan on your smartphone. We recommend the free app www.suicideapp.com

What do I need to do to reduce the risk of me acting upon the suicidal thoughts?
(eg: remove medications, throw away blades)

⇓

What warning signs or triggers are there that make me feel less in control?
(eg: staying at home alone, ruminating on thoughts)

⇓

What ways of coping do I already have? What have I done before that has helped?
(eg: getting out, being with other people, writing down thoughts, talking to friends)

⇓

This is what I will do to help calm and soothe myself when I feel suicidal:
(eg: distractions, breathing exercises)

⇓

What will I tell myself as alternatives to these troubling thoughts?
(eg: this will pass, I have got through this before)

⇓

If a close friend was feeling this way, what would I tell them?
(eg: you will get through this, you have plans for the future, people care for you)

⇓

What things could others do which would be helpful? How will I discuss that with them in advance?
(eg: friend to remind me of this safety plan)

⇓

Who can I call in a time of crisis?

Friend/Relative	Name:	No:	Name:	No:
Professional	Name:	No:	Name:	No:
Helplines	Samaritans	No: 116 123	Nightline:	0114 2228787

⇓

Where is a safe place I can go to?
(eg: a friends house, student union lounges, 24 hour cafes)

⇓

If I still feel suicidal and out of control

- **I will go to A&E immediately at the Northern General Hospital**
- **I will call 999 if I cannot safely make my way to A&E**

Resources

MHLD Portfolio Team

Local sources of help and information

RCGP online training about suicide

Useful resources

Mental Health in the workplace

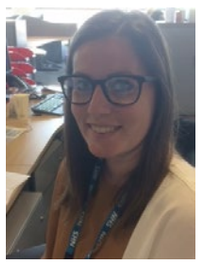
Links to guidance and training

MHLD Portfolio Team

Peter Moore p.moore2@nhs.net	Executive Director	
Dr Leigh Sorsbie leighsorsbie@nhs.net	CCG Governing Body Representative	
Dr Steve Thomas steve.thomas5@nhs.net	Clinical Director	
Heather Burns heather.burns@nhs.net	Head of Commissioning	

Robert Carter robertcarter@nhs.net	Senior Commissioning Manager	
Jim Millns j.millns@nhs.net	Deputy Director (Interim) Mental Health Transformation & Integration	
Chris Cotton chriscotton@nhs.net	Senior Finance Manager - Lead for MH/LD and CYP portfolios	
Melanie Hall melanie.hall@sheffield.gov.uk	Commissioning Manager for Mental Health Sheffield City Council	

MHLD Portfolio Team

Rachel Dillon rdillon@nhs.net	West Locality Manager NHS CCG	
Dr Karen O'Connor karen.oconnor1@nhs.net	GP Representative for MH Commissioning Team	
Dave Luck David.Luck@sheffield.gov.uk	Commissioning Officer, Mental Health, Sheffield City Council	
Vivien Szabo vivien.szabo@nhs.net	Business Support Officer	

Key Portfolio Input from the wider CCG

Tony Moore tonymoore@nhs.net	Senior Quality Manager
Joanna Rutter joanna.rutter1@nhs.net	Public Health
Heidi Taylor heiditaylor@nhs.net	Clinical Effectiveness Pharmacist Medicines Management

Local sources of help and information

Survivors of Bereavement by Suicide (SOBS)

SOBs exist to meet the needs and break the isolation experienced by those bereaved by suicide. They are a self help organisation and aim to provide a confidential environment in which bereaved people can share their experiences and feelings, so giving and gaining support from each other. They also strive to improve public awareness and maintain contacts with many other statutory and voluntary organisations.

Sheffield (support group)

Location: Sheffield

Meeting day: 1st Wednesday of every month

Phone: June on 0114 221 5350

Email: sheffieldsobs@gmail.com

CRUSE Bereavement Care

Cruse Bereavement Care is the leading national charity for bereaved people in England, Wales and Northern Ireland. They offer support, advice and information to children, young people and adults when someone dies and work to enhance society's care of bereaved people.

Cruse offers face-to-face, telephone, email and website support. They have a Freephone national helpline and local services, and a website (hopeagain.org.uk) specifically for children and young people. Its services are provided by our network of 5,000 trained volunteers and are confidential and free. Cruse also provides training and consultancy for external organisations and for those who may encounter bereaved people in the course of their work

The helpline is open Mon - Fri 9.30 - 5.00pm (excluding bank holidays), with extended hours on Tuesday, Wednesday and Thursday evenings, when it is open until 8pm.

The helpline number is 0808 808 1677

Sheffield branch tel: 0114 249 3328

sheffield@cruse.org.uk

Sheffield Samaritans

Samaritans' vision is that fewer people die by suicide. To bring this about, we make a big impact on the world around us:

How we make a difference

We reduce feelings of distress and crisis that can lead to suicide

Our approach to supporting people has been developed over time specifically for those in distress and experiencing suicidal feelings. We believe that through our support people feel calmer, understood and less alone, gain perspective and see new ways of dealing with their situation.

We reduce the risk of suicide in specific settings and vulnerable groups

Certain groups of people have heightened vulnerability to suicide and certain settings contribute to increased suicide risk; these require a tailored range of interventions. We offer expertise and collaborate with organisations to develop interventions for specific settings and vulnerable groups.

Local sources of help and information

We increase access to support for people in distress and crisis

We do everything we can to make it as easy as possible for people to contact us for help. People can talk to us without telling us who they are and be reassured that we won't pass on their information to anyone else or intervene against their wishes.

We influence governments and other agencies to take action that reduces suicide

There are many factors which contribute to suicide, including the conditions of society and communities, public health and the provision of health and social care. We work closely with policy-makers, decision-makers and practitioners to strengthen action which addresses the causes of suicide.

Through these four areas, Samaritans is taking action against the multiple causes of suicide and at various levels: providing help for individuals; addressing suicide risk in particular groups and settings; and influencing policymakers and practitioners to bring about change in mental health, social care and other services and in public policy.

Local telephone 0114 276 7277

National tel: 116 123 (free to call)

Email: jo@samaritans.org

Samaritans Sheffield
272 Queens Road
Sheffield S2 4DL

Usual hours open to receive callers at the door: 10:00am - 10:00pm

SToRMS

The Dan McAllister Foundation

SToRMS is a small organisation based in Sheffield, South Yorkshire and set up in July 2015. It is a fund within the South Yorkshire Community Foundation, a registered charity whose goal is to improve the lives of local people.

SToRMS was set up in memory of Dan McAllister who unexpectedly took his own life in May 2015 aged nineteen.

SToRMS' Mission is to reduce young male suicides by:

- Facilitating widespread open discussions about suicide
- Promoting mental well-being and emotional resilience from an early age
- Challenging gender stereotypes that prevent men from accessing help,
- Highlighting the relationship between alcohol and mental wellbeing

E-mail: enquiries@stormsdmc.org

Website: www.stormsdmc.org

Sheffield Mental Health Guide

Sheffield Mental Health Guide is an online resource featuring a comprehensive searchable directory of mental health and wellbeing related services and groups in Sheffield, as well as providing other useful information and self-help resources

Tel: 0114 273 7009

E-mail: mhguide@sheffieldflourish.co.uk

Website: www.sheffieldmentalhealth.org.uk

Sheffield Helpline

A free telephone support service for anyone in Sheffield affected by mental illness. The service runs 24 hours a day, 7 days a week.

Tel: (0808) 801 0440

Local sources of help and information

Sheffield MIND

Services for people experiencing mental health problems, information, advice, counselling and groups. Information leaflets are available on the website.

Tel: 0114 258 4489

Website: www.sheffieldmind.co.uk

Sheffield Occupational Health Advisory Service

Provides information and advice for employed and unemployed people with work-related health problems.

Tel: 0114 275 5760

Website: www.sohas.co.uk

CHILYPEP: Children and Young people's Empowerment Project

Chilypep's overall aim is to 'develop models of best practice and promote the participation of children and young people in the decisions that affect their lives, as well as empowering them to take forward their own ideas and projects to meet their own and other young people's needs and aspirations'.

Some of their key areas of work include the development of a mental health manifesto; the production of two short films highlighting young people's experiences of crisis support for mental health; mental health awareness campaigns including #nottheonlyone

Tel: 0114 234 8846

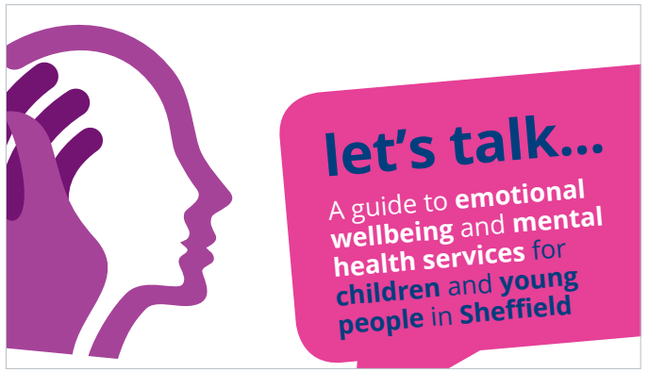
Email: info@chilypep.org.uk

Monday - Friday 9am - 5pm

11 Southey Hill
Sheffield S5 8BB

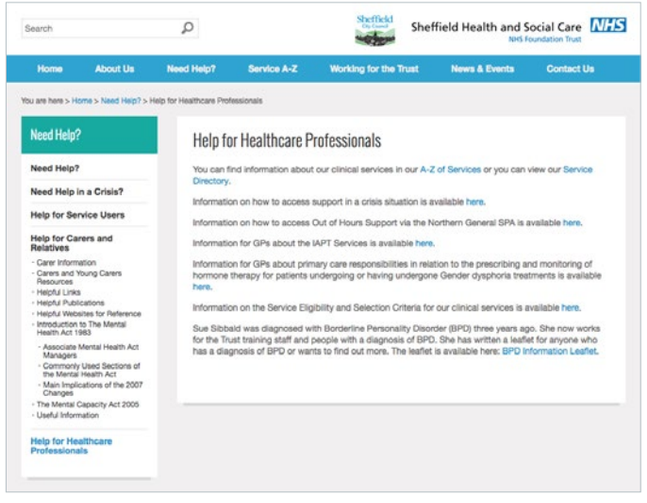
Let's Talk

www.sheffieldccg.nhs.uk/Downloads/Your%20Health%20docs/Lets%20talk%20directory/lets%20talk%20v2.pdf

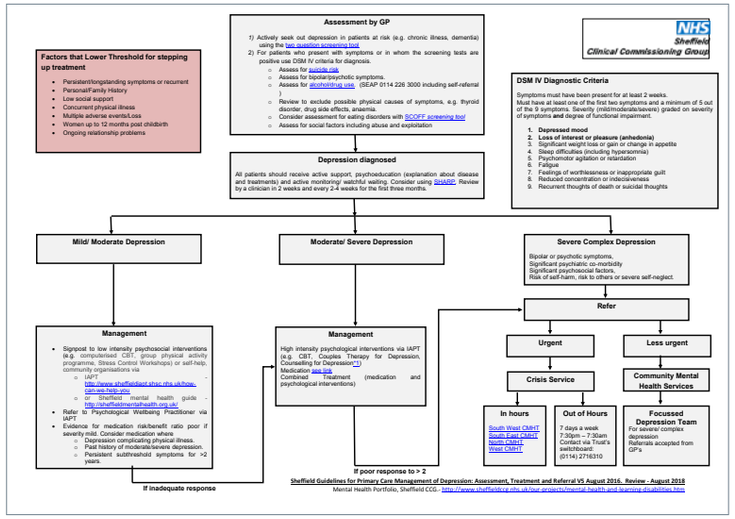


Help for Healthcare Professionals

www.shsc.nhs.uk/need-help/help-for-healthcare-professionals

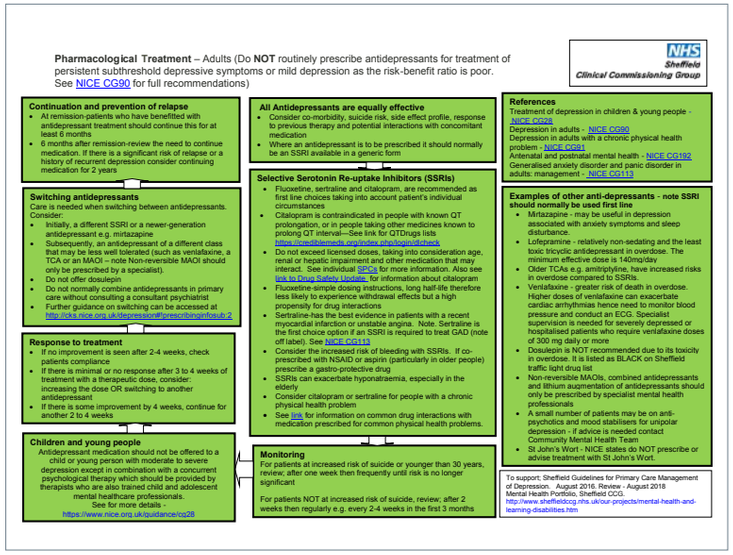


Local sources of help and information

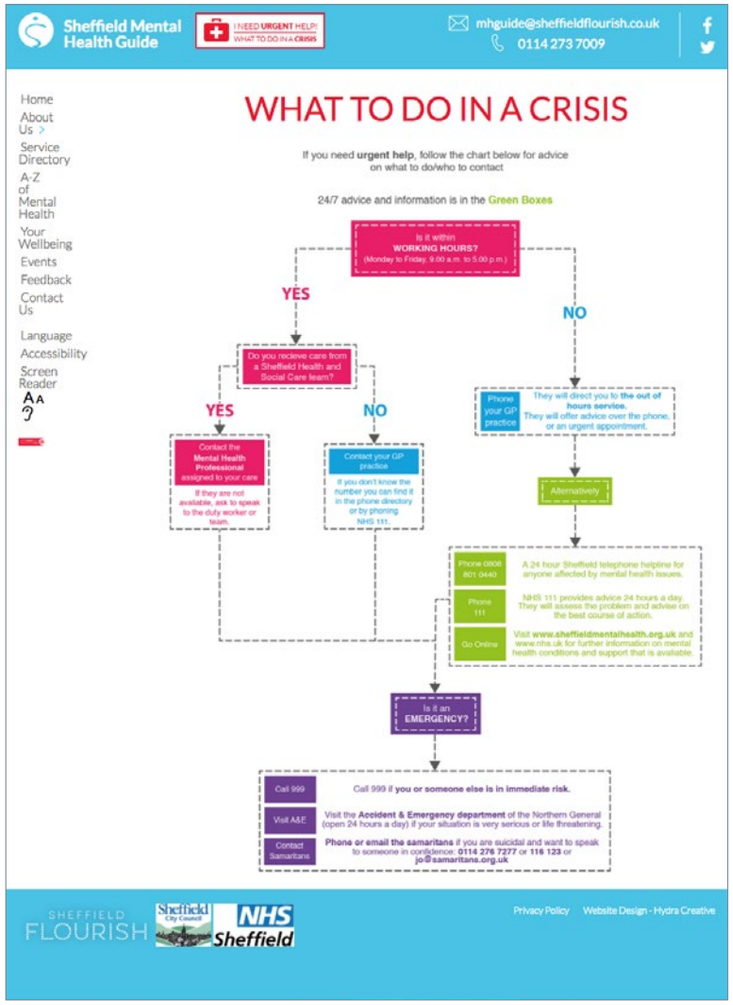


Sheffield Guidelines for Primary Care Management of Depression

www.sheffieldccgportal.co.uk/pressv2/index.php/component/zoo/item/sheffield-guidelines-for-primary-care-management-of-depression



Pharmacological Treatment Flowchart - www.sheffieldccgportal.co.uk/pressv2/index.php/component/zoo/item/depression-pharmacological-treatment-adults



What to do in a crisis - flowchart

www.sheffieldmentalhealth.org.uk/urgent-help

RCGP online training about suicide

Mental Health Toolkit

Approximately a quarter of all people will experience a mental health problem in the course of a year, and 23 out of 30 who experience mental health problems will visit their GP. The Royal College of General Practitioners believes that accessible, high quality primary care is vital to keeping patients healthy for longer. As such, a holistic approach is required promoting mental health equally and in partnership with physical health.

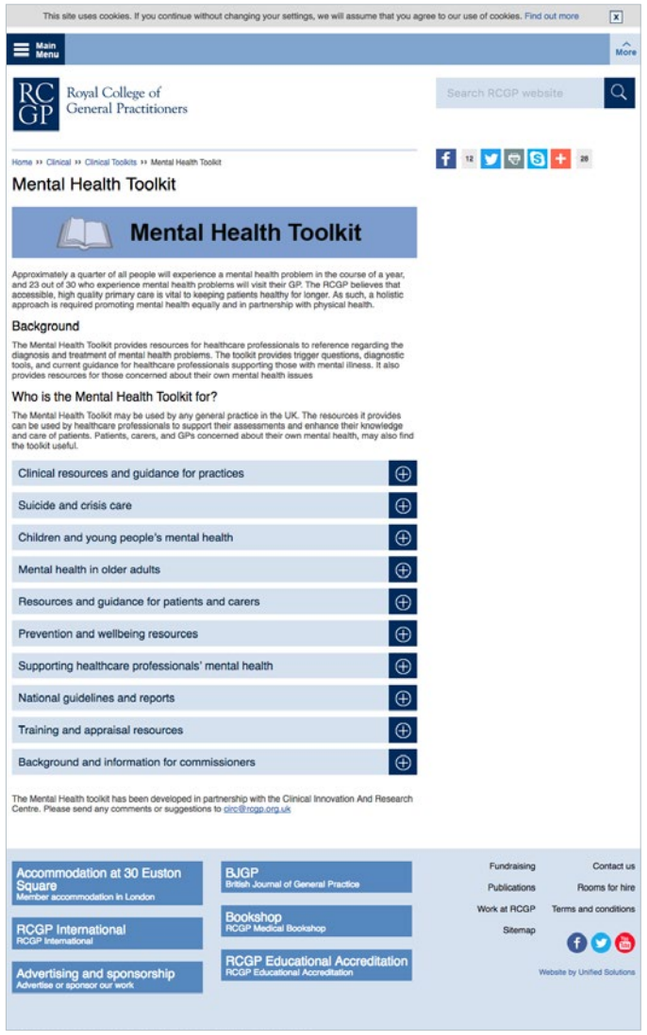
Background

The Mental Health Toolkit provides resources for healthcare professionals to reference regarding the diagnosis and treatment of mental health problems. The toolkit provides trigger questions, diagnostic tools, and current guidance for healthcare professionals supporting those with mental illness. It also provides resources for those concerned about their own mental health issues

Who is the Mental Health Toolkit for?

The Mental Health Toolkit may be used by any general practice in the UK. The resources it provides can be used by healthcare professionals to support their assessments and enhance their knowledge and care of patients. Patients, carers, and GPs concerned about their own mental health, may also find the toolkit useful.

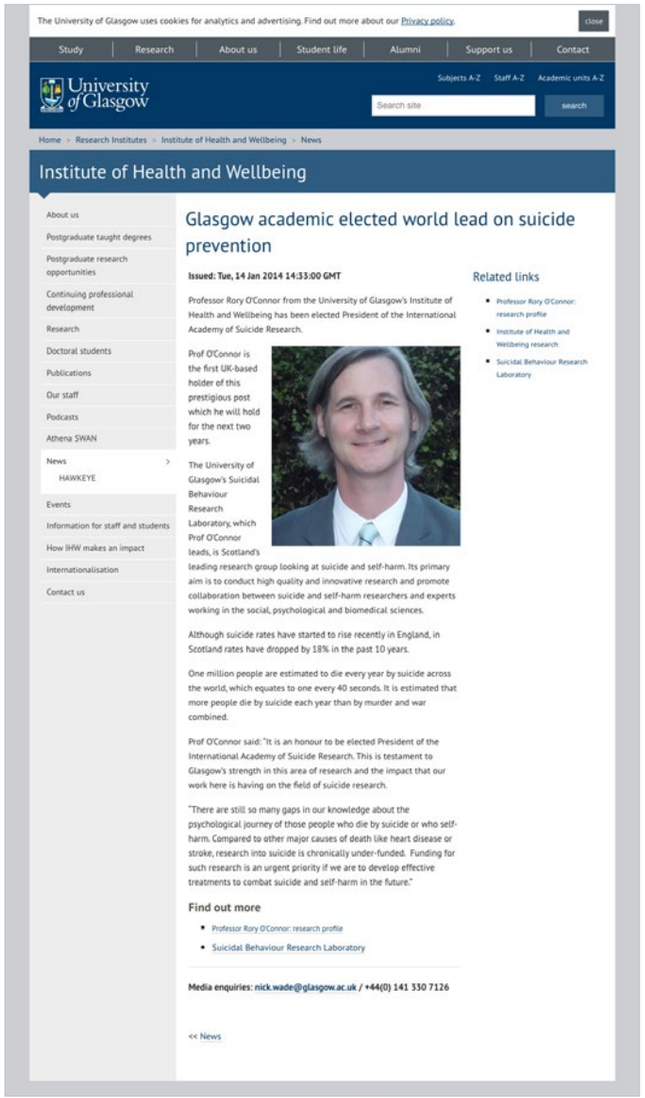
www.rcgp.org.uk/clinical-and-research/toolkits/mental-health-toolkit.aspx



Useful resources

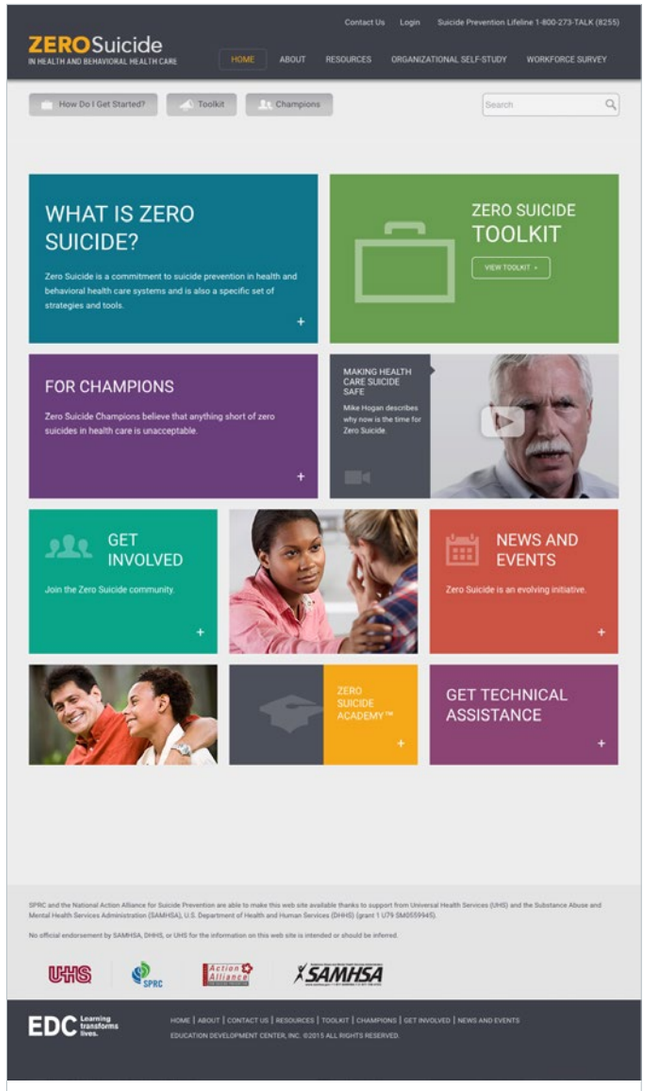
Glasgow Research Lab on suicide

www.gla.ac.uk/researchinstitutes/healthwellbeing/news/headline_302293_en.html



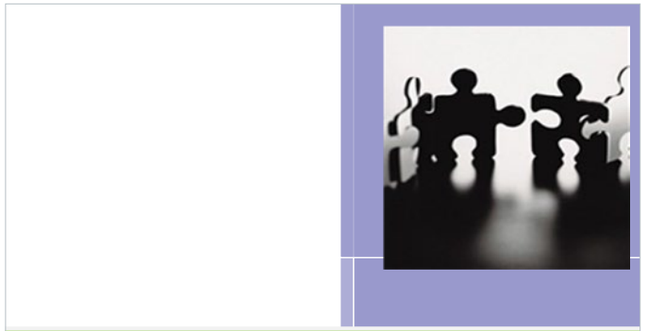
Centre for Mental Health report

www.centreformentalhealth.org.uk/zero-suicides



National Confidential Enquiry

www.hqip.org.uk/public/cms/253/625/19/209/Mental-Health-Suicide-Primary%20Care-2002-2011-Published%202014.pdf?realName=vSnung.pdf



Suicide in primary care in England:

2002-2011

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

March 2014

Useful resources

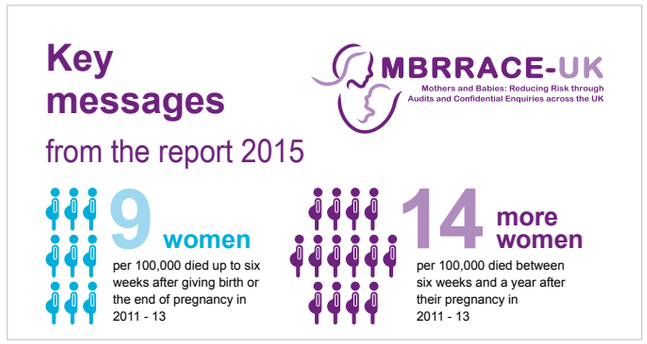
Alcohol Screening

This site has been designed to help you quickly and easily screen individuals for problematic alcohol use. You can provide personalised brief advice and facilitate referral to all the alcohol services provided by Sheffield Health and Social Care NHS Trust.

www.alcoholscreeningsheffield.co.uk

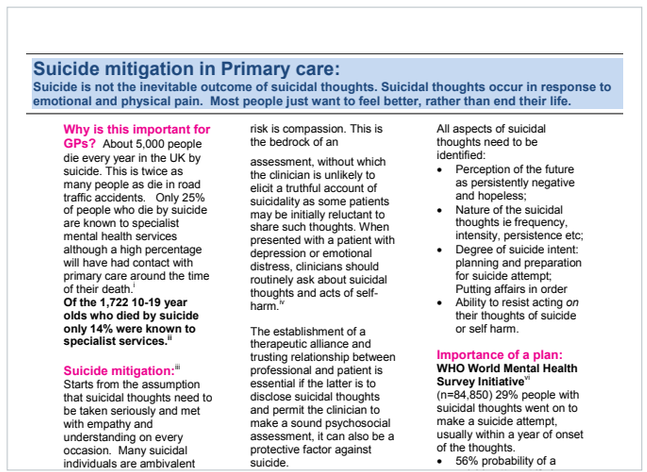
Maternal Mental Health Info

www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202015%20-%20Infographic.pdf



Suicide Mitigation in Primary Care:

www.connectingwithpeople.org/sites/default/files/SuicideMitigationInPrimaryCareFactsheet_0612.pdf



Suicide mitigation in Primary care:

Suicide is not the inevitable outcome of suicidal thoughts. Suicidal thoughts occur in response to emotional and physical pain. Most people just want to feel better, rather than end their life.

Why is this important for GPs? About 5,000 people die every year in the UK by suicide. This is twice as many people as die in road traffic accidents. Only 25% of people who die by suicide are known to specialist mental health services although a high percentage will have had contact with primary care around the time of their death.[i]
Of the 1,722 10-19 year olds who died by suicide only 14% were known to specialist services.[ii]

Suicide mitigation:[iii]
Starts from the assumption that suicidal thoughts need to be taken seriously and met with empathy and understanding on every occasion. Many suicidal individuals are ambivalent

risk is compassion. This is the bedrock of an

assessment, without which the clinician is unlikely to elicit a truthful account of suicidality as some patients may be initially reluctant to share such thoughts. When presented with a patient with depression or emotional distress, clinicians should routinely ask about suicidal thoughts and acts of self-harm.[iv]

The establishment of a therapeutic alliance and trusting relationship between professional and patient is essential if the latter is to disclose suicidal thoughts and permit the clinician to make a sound psychosocial assessment, it can also be a protective factor against suicide.

All aspects of suicidal thoughts need to be identified:

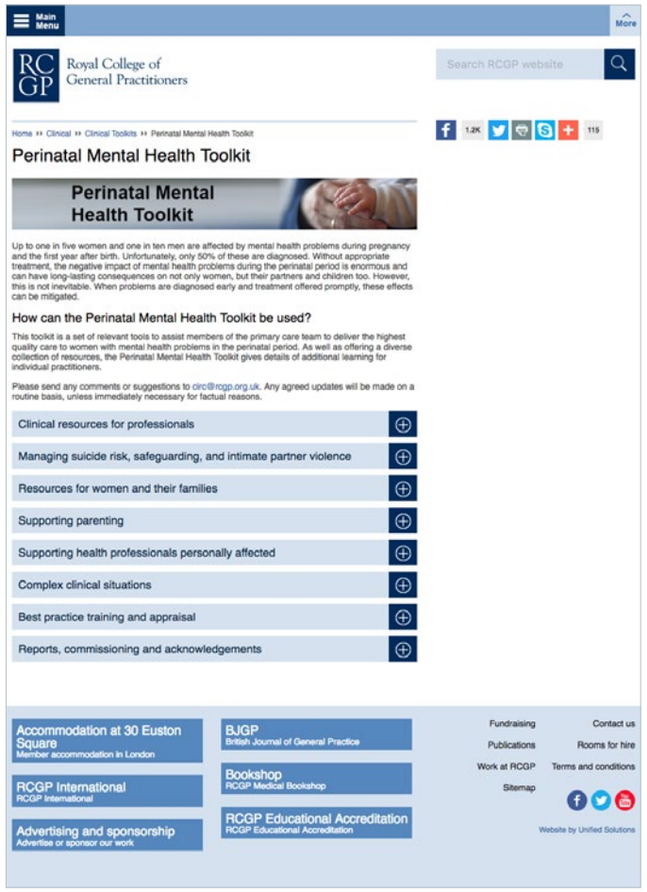
- Perception of the future as persistently negative and hopeless;
- Nature of the suicidal thoughts ie frequency, intensity, persistence etc;
- Degree of suicide intent: planning and preparation for suicide attempt; Putting affairs in order
- Ability to resist acting *on* their thoughts of suicide or self harm.

Importance of a plan:
WHO World Mental Health Survey Initiative[vi]
(n=84,850) 29% people with suicidal thoughts went on to make a suicide attempt, usually within a year of onset of the thoughts.

- 56% probability of a

The RCGP Perinatal Mental Health Toolkit:

www.rcgp.org.uk/clinical-and-research/toolkits/perinatal-mental-health-toolkit.aspx



Useful resources

Help is at Hand - support after someone may have died by suicide

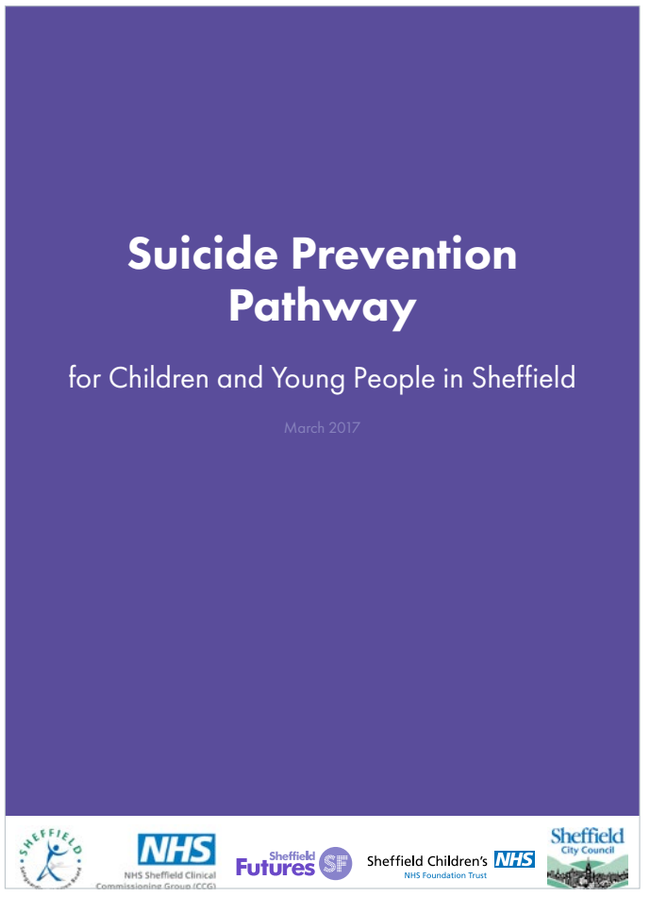
A guide for those grieving the death of someone they love.

www.nhs.uk/Livewell/Suicide/Documents/Help%20is%20at%20Hand.pdf

Suicide Prevention Pathway for Children and Young People in Sheffield

This document explores the risks of suicide and the impact on young people.

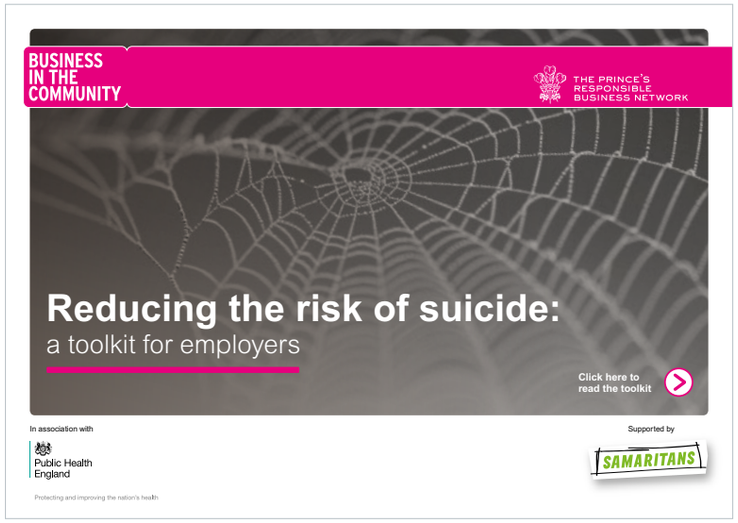
www.sheffieldfutures.org.uk/wp-content/uploads/2017/03/Suicide-Prevention-Pathway-SML.pdf



Mental Health in the workplace

Business in the Community / Public Health England Suicide Prevention Toolkit

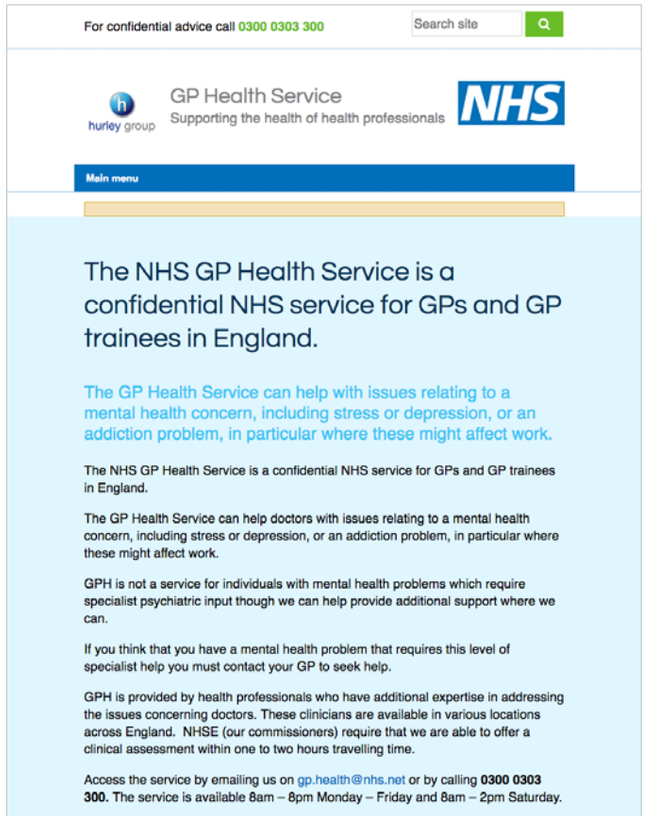
http://wellbeing.bitc.org.uk/sites/default/files/business_in_the_community_suicide_prevention_toolkit_0.pdf



The NHS GP Health Service is a confidential NHS service for GPs and GP trainees in England.

The GP Health Service can help with issues relating to a mental health concern, including stress or depression, or an addiction problem, in particular where these might affect work.

http://gphealth.nhs.uk/



THE NHS GP HEALTH SERVICE

- **can an offer support to any GP or GP trainee in who is registered on the National Performers List in England** or, who is looking to return to clinical practice after a period of absence and is has mental health or addiction concerns.

- **is not an Occupational Health service**, it is a treatment service. GPH clinicians may link with local OH services to support a GP patient's return to clinical practice. If OH support is what you need, please contact the NHS England regional team to identify your local OH provider.

- **is not a replacement for mainstream NHS services**, nor is it designed to offer a second opinion. GPs who are currently supported by NHS mental health services would be encouraged to remain with their local treatment team, but could seek guidance on particular aspects of care, or support for return to work.

- **can offer independent support to GPs who are undergoing performance proceedings,** but it can not be used to provide health reports to inform PAGs or PLDPs. Formal assessment of health issues should be commissioned from a separate organisation.

The service is **self-referral only**.

This service will not accept referrals from third parties.

The service may be able to provide advice to third parties to effectively signpost GPs to self-refer, but the service will not approach GPs direct to help them access the service.

CONTACT US

NHS
GP HEALTH SERVICE

Central Services:
Riverside Medical Centre
Hobart House
St George Wharf
Wandsworth Road
London SW8 2JB
plus
Locations across England

Telephone : 0300 0303 300
Monday to Friday 8am-8pm
Saturday 8am—2pm
Email: gp.health@nhs.net
Website: www.gphealth.nhs.uk

NHS
GP Health Service

NHS
GP Health Service

Self Referral

Web: www.gphealth.nhs.uk

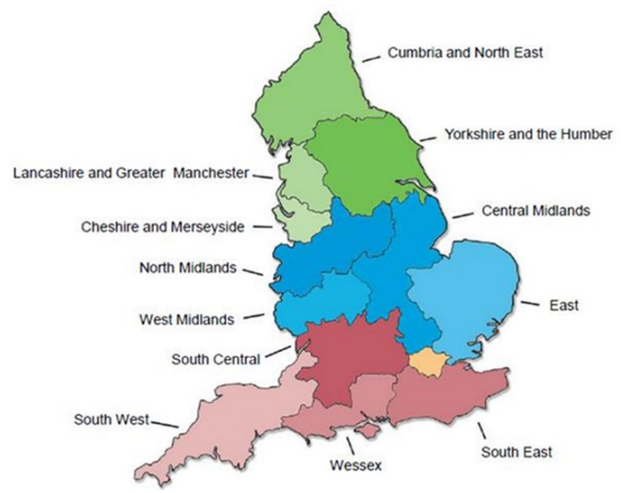
Tel: 0300 0303 300

Email: gp.health@nhs.net

How to access the NHS

GP Health Service

Access to confidential mental health and addiction support for GPs and GP trainees across England



Supporting the health of health professionals

What is GPH?

The NHS GP Health Service (GPH) is a service for GPs or GP trainees across England, with issues relating to mental health concerns or addiction problems, often where this might be affecting their work.

The central service is based in London, and is led by Dr Clare Gerada FRCGP FRCPsych, a general practitioner with extensive expertise in managing addiction and mental health problems and significant experience of treating health professionals. We have experienced clinicians and therapists working from locations across England able to offer assessment and ongoing treatment.

GPH is a confidential service, which seeks to protect doctor-patients from the stigma associated with mental ill health and addiction. GPH aims to get doctor-patients healthy and working, whilst safeguarding their patients, making sure the doctor is well enough to see patients safely. GPH recognises that -

- Doctors are more likely than the average person to suffer from problems with drugs, drink and depression.
- Up to 20% of UK doctors become depressed at some point in their career.
- Doctors have higher standardised mortality rates in respect of cirrhosis, accident and suicide.
- Suicide rates among female NHS doctors have been shown to be twice that of the general female population.
- Evidence shows that doctors are more likely to suffer from work-related mental ill health than other professions.

GPH is hosted by the NHS Practitioner Health Programme which has significant success rates for its practitioner-patients

- 88.1% remain in or returned to work during contact with PHP.
- 81% abstinent and attending PHP on a regular basis. (This compares to 10-20% of non-health professional population being abstinent).

What services do GPH provide?

The GPH team have extensive experience delivering care to doctors as patients and have seen more than 3000 patients since 2008. We are a highly confidential service and recognise that GPs and GP trainees may not feel able to, or do not want to, access their local NHS service where they may have to receive treatment from their own colleagues, be seen in their own place of work, or be treated by clinicians who are not experienced in providing care to other health care professionals. Unfortunately mental health and addictions remain stigmatised conditions, even within the NHS and doctor-patients are concerned that their professional credibility and their careers will be harmed by disclosure.

Patients can attend our service with confidence that their care will not be made known to friends/family/colleagues. They will be seen by a team of NHS professionals who are experienced in treating health professionals with mental health or addictions issues. We will only speak with employers, responsible officers and other bodies such as the GMC, with agreement and where it is necessary to protect the doctor patient and those they provide care for.

GPH protects its doctor-patients, and their patients, as well as the wider public, whilst improving the health of health practitioners.

GPH can provide:

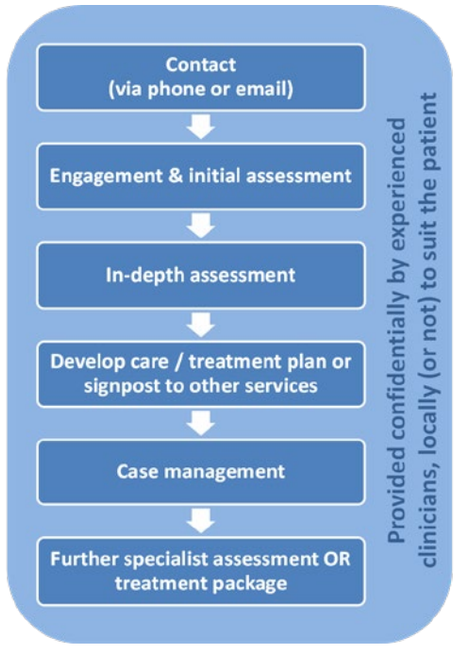
- Expert assessment usually within 48 hours
- Psychiatric assessment and treatment
- Medication
- Cognitive Behavioural Therapy
- Short term psychotherapeutic interventions
- Individual and group support
- Community detoxification
- Access to in-patient detoxification and residential rehabilitation
- Case management
- Support and advocacy in facilitating return to work
- Signposting to peer support and other sources
- Liaison with local health services as appropriate

GP Health Service NHS

How does the GPH service operate?

GPH operates via self-referral only. GPs or GP trainees can contact us via email or phone, or can complete the self-referral form on the website. They will then be offered a short telephone assessment, usually within 48 hours, and then be given access to our smartphone booking app. This enables doctor-patients to select a clinician and book their appointments at times and locations to meet their needs.

(If you don't have a smartphone or are unable to use the app the central office can arrange appointments for you).



Following assessment you and your lead clinician will discuss any treatment plans or next steps. You will be able to book future appointments with your lead clinician or suggested therapists/groups.

Your clinician and the central team will be available to support you via email, telephone and face to face throughout your treatment pathway, through to discharge from the service.

Links to guidance and training

Royal College of GP's: E-learning module: Suicide Prevention

Targeted at GP's, GP Trainees, GP Trainers or educators, Medical students, Nurses, First5

This hour long course consists of two modules. The first sets the scene on the problem of death by suicide. The interplay of numerous factors, culminating in suicidal behaviour, is discussed in order to highlight the various opportunities to intervene. The strategies of the home nations are explained, including some examples of projects which lead the way in suicide prevention.

The second module takes a case-based approach, focusing on the practical aspects of suicide prevention. The scenario is set in primary care, and includes useful strategies and resources for the mitigation of suicide.

www.rcgp.org.uk/learning/online-learning/ole/suicide-prevention.aspx

PABBS: Postvention, Assisting Those Bereaved by Suicide

PABBS is an interactive one day workshop targeted primarily at health professionals, GP's and mental health professionals

What competencies do attendees gain?

- recognise that supporting those bereaved by suicide is a key component of suicide prevention;
- enable health professionals to increase their knowledge, confidence, skills and provide a framework and service-response plan for immediate and ongoing support for parents bereaved by suicide;
- increase the need to ensure parents remain engaged with health professionals and services after their child's death; and
- encourage health professionals to consider and recognise their own emotional or self-care needs and develop a strategy or support structure that will be available to them if a patient dies by suicide.

www.suicidebereavementuk.com

Connecting with People

CwP suicide response parts 1 and 2

One day course suitable for health and social care professionals with an ongoing relationship with people experiencing suicidal thoughts.

www.connectingwithpeople.org

ASIST Applied Suicide Intervention Skills Training.

Model developed in Canada by Living Works

Teaches participants to carry out interventions for people at risk of suicide.

Suitable for people in non-clinical roles, but who are likely to be a 'caregiver' for people who are suicidal ; aim to operate as 'gatekeepers' within communities, building prevention networks. The course id delivered over 2 days.

www.livingworks.net

SafeTALK

A half day session, suitable for general public, community workforce, non-clinical staff

Teaches participants to identify people with thoughts of suicide and connect them with services and resources.

www.livingworks.net

Links to guidance and training

Suicide TALK

90 minute session suitable for the general public and community workers.

Helps participants reduce suicide stigma and become more aware of suicide prevention opportunities in their communities. Must be delivered by someone trained in ASIST or equivalent.

www.livingworks.net

Mental Health First Aid (MHFA)

International training model. Suicide awareness and intervention as part of wider mental health awareness and first aid response training. Topics covered include;

- Mental Health First Aid, mental health, and depression
- Depression (cont.) and suicidal crisis
- Anxiety, personality disorders, eating disorders and self harm
- Psychosis, schizophrenia and bipolar disorder

In each section you'll learn how to:

- Spot the early signs of a mental health issue
- Feel confident helping someone experiencing a mental health issue
- Provide help on a first aid basis
- Help prevent someone from hurting themselves or others
- Help stop a mental health issue from getting worse
- Help someone recover faster
- Guide someone towards the right support
- Reduce the stigma of mental health issues.

This is a 2 day course suitable for general public, community workforce, non-clinical staff.

http://mhfaengland.org

YOUTH Mental Health First Aid

Part of the MHFA England model Youth MHFA is a course designed specifically for those people that teach, work, live with or care for young people aged 8 to 18 years.

The Youth MHFA course is split into four topics. These are:

- What is mental health?
- Depression and anxiety
- Suicide and psychosis
- Self-harm and eating disorders.

Within each section there is clear focus on the issues faced by young people and attendees will learn to:

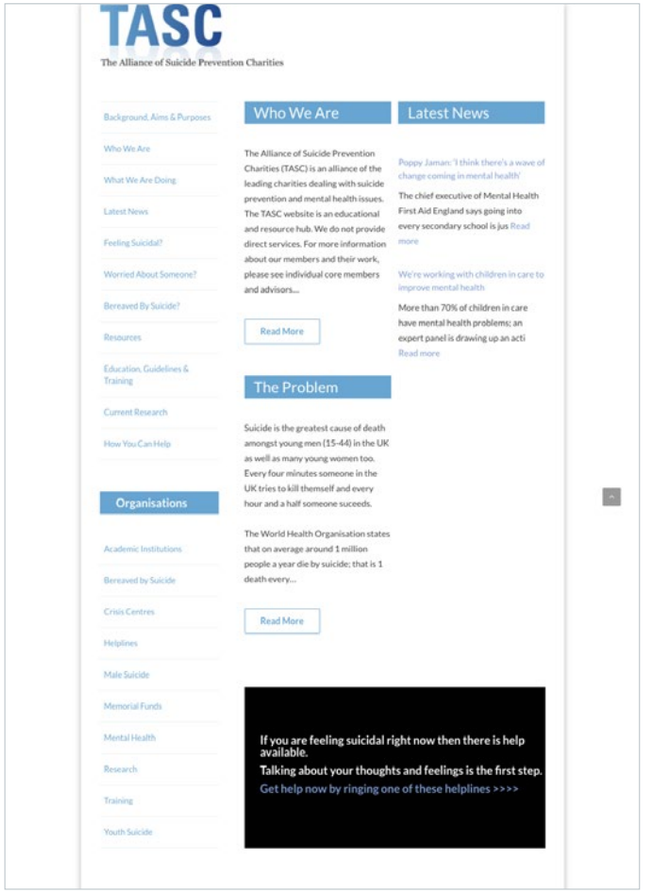
- Spot the early signs of a mental health issue in young people
- Feel confident helping a young person experiencing mental ill health
- Provide help on a first aid basis
- Help protect a young person who might be at risk of harm
- Help prevent a mental health issue from getting worse
- Help a young person recover faster
- Guide a young person towards the right support
- Reduce the stigma of mental health issues.

http://mhfaengland.org

Links to guidance and training

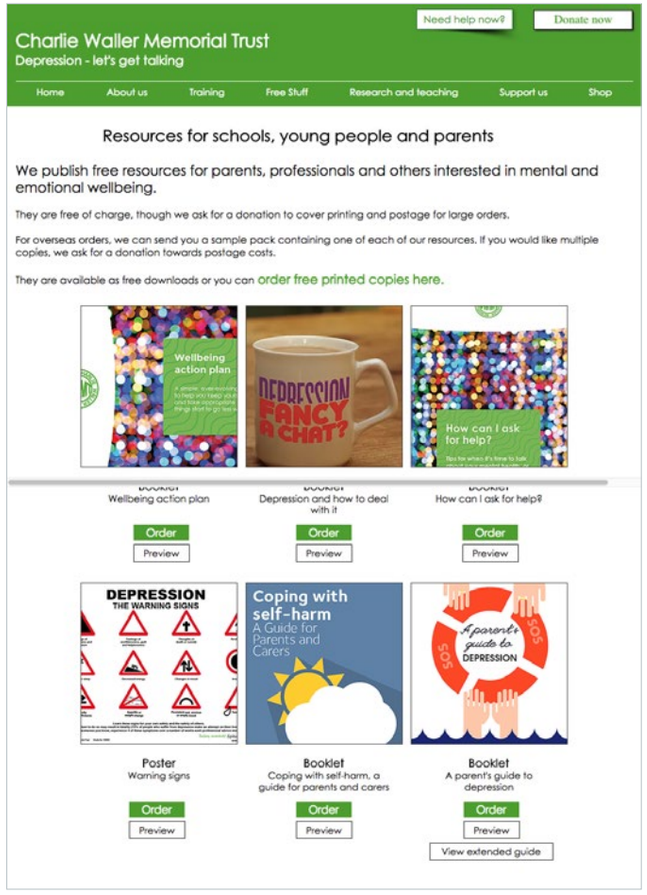
The Alliance of Suicide Prevention Charities

http://tasc-uk.org/



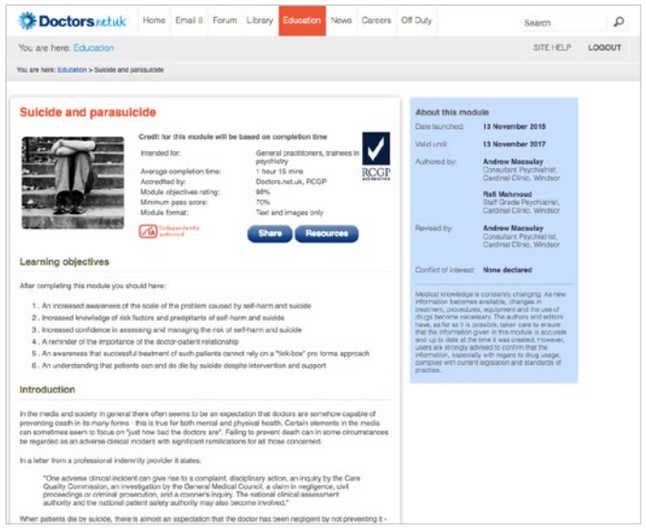
Charlie Waller Memorial Trust

www.cwmt.org.uk/resources



Doctors.net.uk

www.doctors.net.uk/ecme/wfrmNewIntro.aspx?moduleid=1675



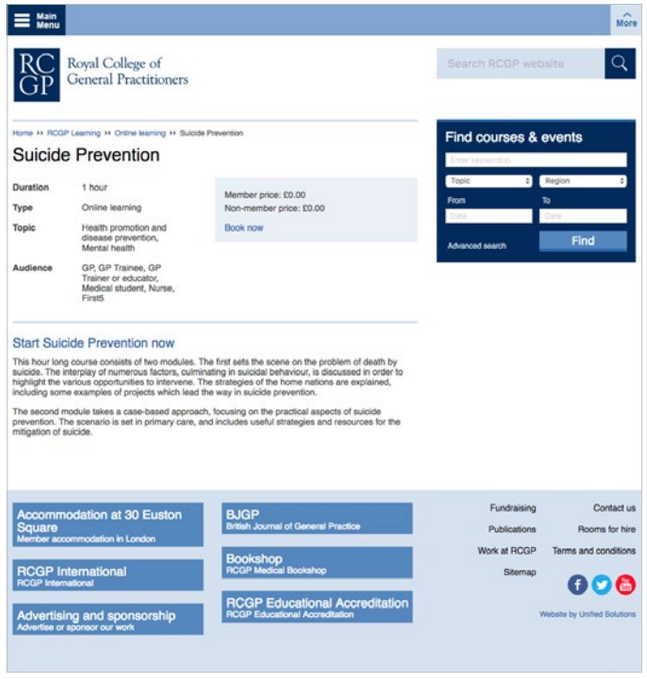
Links to guidance and training

GP Online

www.gponline.com/suicide-risk-assessment-management/neurology

Royal College of GPs

www.rcgp.org.uk/learning/online-learning/ole/suicide-prevention.aspx



Grass Roots Suicide Prevention

www.prevent-suicide.org.uk