Prevention of Suicide in the Ambulance Service

What We Know

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Public Health England

ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

THE AMBULANCE STAFF CHARITY

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1. Introduction

This document presents the evidence for increased risk of suicide in the ambulance sector compared to the general population. It does not identify a single driver of suicide risk; rather the collective risk factors that negatively impact on overall mental health and wellbeing. These are the foundation for the national consensus statement for England and associated next steps for action.

2. Background

In England and Wales 33 deaths among paramedics and ambulance staff between 2005 and 2014 were classified as suicide or undetermined intent; 27 were men and six women.[1] Findings from an Australian study published in 2017[2] demonstrated that the age-adjusted suicide rate across all emergency and protective service workers was higher than for other occupations, with highest risk observed in those employed in the defence force, prison officers and ambulance staff.

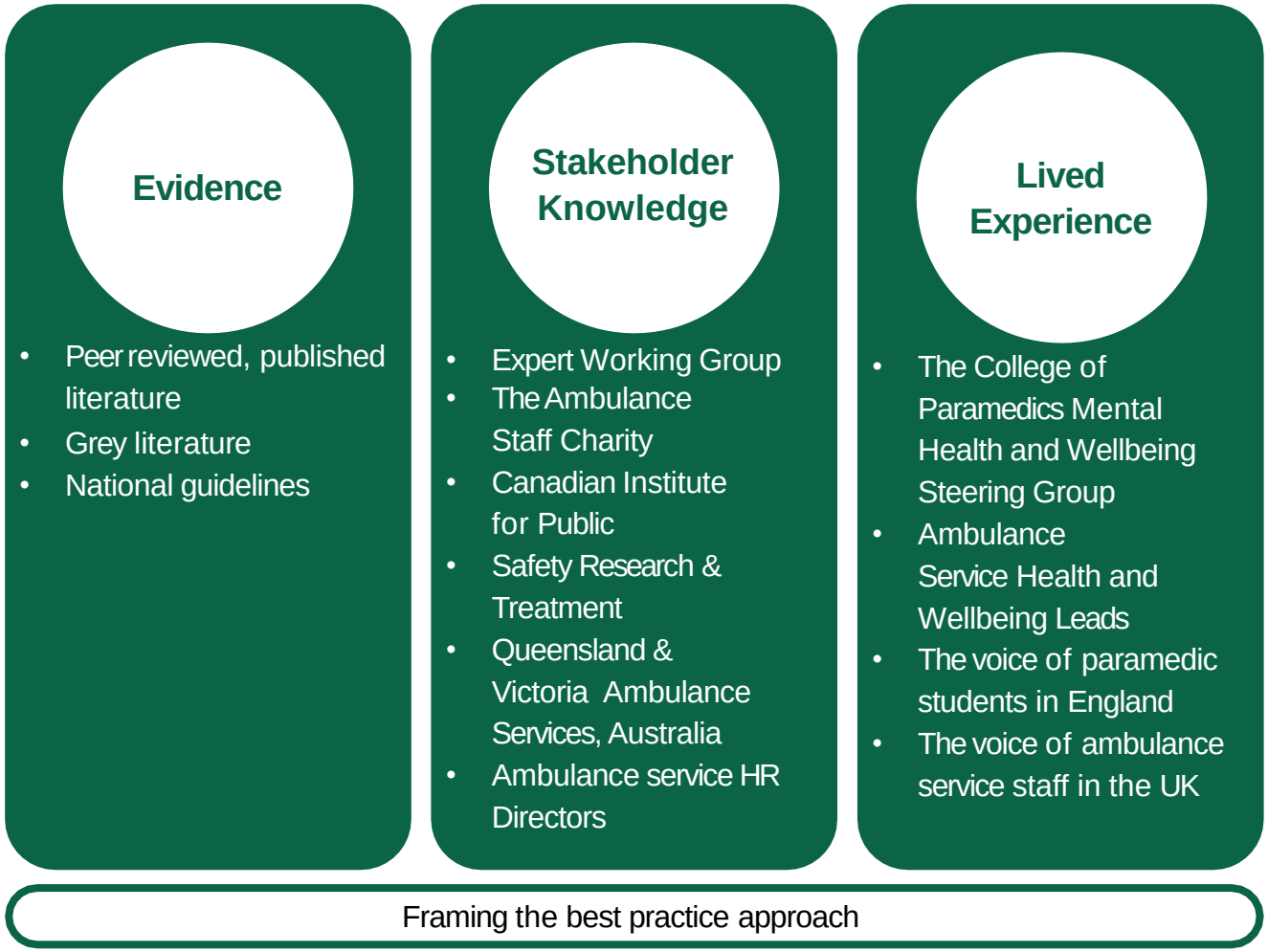
Research by Mind found that emergency services staff were twice as likely to identify problems at work as the main cause of their mental health problems, compared with the general workforce. Almost nine in 10 (88%) had experienced stress and poor mental health while working for blue light services. They were reluctant to disclose a mental health problem at work, perceived stigma associated with mental health and felt unsupported by employers to address mental wellbeing.[3]

A review of coroner findings for paramedic deaths by suicide between 2014 and 2015, commissioned by the Association of Ambulance Chief Executives (AACE), reported that five of the 11 cases had a history of contact with specialist psychiatric services, eight had depression or anxiety at the time of their death, and a third had previously harmed themselves. Six of the deaths by suicide occurred within one month of the individual returning to work following a period of sickness absence (four had returned to work in the previous week).[4,5]

3. Defining best practice for suicide prevention in the ambulance service

A multiagency approach is recognised as necessary to achieve further progress. In response to this need, the national consensus statement, signed by key partners, formalises a shared commitment to preventing suicide among ambulance staff.

This document supported the development of the statement by uniting the evidence base for best practice with expert experience and opinion and the valuable lived experience of ambulance staff. Each made a valid and equal contribution to defining what the best practice approach to suicide prevention should look like.



4. Understanding what the evidence tells us

The key themes relating to suicide among ambulance service staff are summarised here.

4.3

Current guidelines and recommendations

4.2

Effectiveness of interventions

4.1

Risk factors for poor mental well-being and suicide

4.1 Risk factors for poor mental wellbeing and suicide

While there is evidence that ambulance service staff may be at increased risk of suicide, very little research has been published identifying specific risk factors for suicide in this occupational group.

Identifiable risk factors Some common risk factors were identified in a eview[5] of coroner records for cases of ambulance staff suicide, including:

- recent return to work following a period of sickness absence
- poor mental health
- relationship and debt problems
- history of self-harm
- loss of a driving licence/change in job role.

Risk in those training to enter the paramedic profession must also be considered. In a study looking at this, a small but significant number of student paramedics reported emotional or psychological distress due to occupational risk factors while on clinical placement, highlighting the need to ensure their wellbeing is adequately supported while on placement.[6]

Attending a suicide: Paramedics who attend a suicide often do so without enough training or support. Training and postvention support could enable better coping strategies among staff, more effective support for bereaved individuals and reduce the risk of death by suicide in both those bereaved by suicide and in ambulance staff.[7]

Organisational factors: A comprehensive review of the mental health and wellbeing of emergency responder professionals published in 2020[8] found that organisational stressors, such as excessive workloads and lack of senior support, had a greater negative impact than those from operational incidents. The provision of wellbeing support varied by region, and the effectiveness of wellbeing interventions and programmes was inadequately evaluated. At an organisational level, limited funding, austerity and a mismatch between the corporate vision and individual needs hindered uptake of support. In contrast, a culture of openness and buy-in from management helped the implementation and uptake of support initiatives. Barriers to engagement with mental health support at an individual level included concerns about stigma, confidentiality and impact on career advancement.

Impact of the Sars-CoV2 pandemic: The pandemic is having a negative impact on population mental health which may worsen existing mental health conditions and increase suicide risk. Those with higher levels of exposure to the illness caused by COVID-19, such as frontline healthcare workers, are identified as being at particular risk [9]

4.2 Effectiveness of interventions

Evidence of effectiveness: There is a lack of evidence on which to ground occupational policy with respect to the prevention of suicide in this occupational group. This was the conclusion of a review of the limited studies of suicide prevention programmes for protective and emergency services employees.[10] Eligible studies were largely from the US of military personnel; none considered the prevention of suicide among ambulance staff and most focused on secondary and tertiary prevention. The multi-component nature of interventions also made it impossible to decipher evidence to support specific individual interventions.

In 2020 a systematic mapping of evidence of mental health and wellbeing interventions in the UK ambulance sector also found insufficient esearch, either published or in grey literature, to identify strategies for preventing or managing occupational stress at both an organisational and individual/social level, or to establish whether current staff wellbeing support is working.[11]

Access to services: A US study published in 2020 assessed how emergency and personal safety responders perceived their access to mental wellbeing support services, and how this influenced their mental health. Non-professionals such as spouses appear to play an important supportive role, often before professional support is accessed, and participation in mental health training may reduce some mental health conditions. The findings suggest that willingness to access professional support could be improved by revising training programmes, and that training and support for spouses/partners and sector leaders may also be beneficial [12]

4.3 Current guidelines and recommendations

Mind Blue Light Programme[13]: Between 2015 and 2019 Mind worked with partners to deliver an ambitious and comprehensive programme of activity to reduce stigma, promote wellbeing and improve mental health support for those working or volunteering in ambulance, fi e, police, and search and rescue services. While the programme did improve the perception that support is available, over the five years the number of people reporting to be in good mental health fell, excessive workload continued to be the key occupational driver of stress, and confidence that organisational culture was improving declined in those with lived experience of mental health. The key learning from the programme was the need to challenge stigma and shift organisational culture. It also highlighted the benefits of mental health champions, and the need for more accessible services and to strengthen the evidence for how to enhance staff resilience.

Mind Blue Light Programme recommendations for emergency services and those who work with them:
• Invest in and promote workplace wellbeing and mental health initiatives, tailored to the unique needs of blue light staff and volunteers.
• Enable strong policy frameworks that prioritise mental health and wellbeing, taking into account issues and pressures and how you intend to address them.
• Adopt and promote the Thriving at Work core and enhanced mental health standards, and regularly measure, review and act on feedback to ensure progress.
• Promote and invest in mental health training and make this mandatory – including for managers and new recruits.
• Create or strengthen networks of workplace mental health champions at all levels.
• Research bodies can help by further developing the strong evidence base we and others have developed to enhance our knowledge of how to support the mental health of 999 teams.
• Policy-makers can help ensure the mental health of our 999 teams is a national priority by continuing to make resources available to increase workplace wellbeing.

Cross-government suicide prevention workplan[14]: The first c oss-government suicide prevention plan, published in 2019 to support the Suicide Prevention Strategy,[15] gives specific attention to occupational groups known to be a greater risk of suicide, and commits to build on the achievements and recommendations of the Mind Blue Light Programme.

5. Stakeholder knowledge: What can we learn from others?

The absence of a robust evidence base on which to make recommendations for effective interventions for suicide prevention within ambulance services increases reliance on expert opinion and experience. We have sought this from several national and international sources, including:

- The Paramedic Mental Health and Wellbeing Working Group (England)
- The Queensland Ambulance Service (Australia)
- The Canadian Institute for Public Safety Research and Treatment (Canada)
- The Ambulance Staff Charity (TASC) (UK)
- Ambulance Victoria (Australia)
- Ambulance Trust HR Directors Network (England)
- Ambulance Service Health and Wellbeing Leads Network (England).

Key themes from stakeholder engagement are summarised here.

Shifting the culture

Focusing on primary prevention

Understanding and responding to need

Working practices

Supporting families and close personal contacts

Shifting the culture

Concerns around organisational culture need to be urgently addressed to improve staff mental wellbeing. Some ambulance staff believe that voicing concerns about mental health in the workplace will hinder career progression. Where occupational support services exist, in some cases there appears to be a disconnect between provision and access. Line managers/middle management may present a barrier to access and referral, possibly because they lack the training and support opportunities to develop the type of language and skills necessary to facilitate difficult discussions with the sta f they manage. Alongside this, the lack of robust clinical supervision for paramedic staff was highlighted.

Work to improve the mental health and wellbeing of ambulance service staff in Canada has gone hand in hand with efforts to shift organisational culture and reduce stigma. Senior sector leaders have enhanced an education campaign aimed at normalising mental health, by speaking out about mental health. They are working to reframe 'mental health injury' to sit alongside physical injury in terms of acceptability and importance, and have encouraged the concept of a mental wellbeing 'check-up' as a routine way of maintaining good mental wellbeing.

Australia has introduced a leadership programme focused on shifting from a hierarchical leadership structure to a person-centred one. This is supported by a mandatory training package for managers on staff mental health and wellbeing. The movement of new recruits up the structure is gradually shifting organisational culture: they appear to be more open to addressing mental health and wellbeing needs because of the access to mental and wellbeing services, and the normalisation of this, earlier in their careers.

Focusing on primary prevention

Stakeholder engagement highlighted the sector's responsibility to adequately equip staff with skills to build personal resilience and protect their mental wellbeing. Paramedics often have little time following a traumatic event to process the experience, and often can only speak to a single crew mate who experienced the same traumatic exposure. Building personal resilience is as important for emergency service call handlers who may be repeatedly exposed to traumatic scenarios.

In the UK, more paramedics now enter the profession through a graduate or apprentice route. They are likely to do so with limited background experience, having had less opportunity to develop their own emotional intelligence.

A large-scale intervention study in Canada is seeking to assess the impact of standardised resilience building for police trainees on future mental health and wellbeing. Its findings may have important implications for ambulance services.

The Finding the Silver Lining programme for all new staff at the Queensland Ambulance Service has shown the value of embedding resilience building at the start of an individual's career in the ambulance service. The programme involves a comprehensive resilience building package, aligned with mandatory interaction with a psychologist to normalise the process ahead of any acute need.

Understanding and responding to need

The Ambulance Staff Charity (TASC) continues to provide significant mental health and wellbeing support to staff across the ambulance service. It offers individualised support free at the point of contact, including counselling, suicide prevention intervention, and debt and financial management. Counselling is purchased on the open market, with significant attention paid to skill set in recognition of the unique needs of ambulance service staff. The charity reports that staff often prefer to contact it ahead of accessing occupational services, because it is separate from the employer and viewed as confidential and tailo ed to individual need.

Timely access to support services is key to effective management of mental ill health. Canada is demonstrating how technology can enhance the timely provision of support, with the national rollout of 24-hour online access to psychological support. A comprehensive programme of peer support, developed over 30 years, is provided to staff at Queensland Ambulance Service, with significant investment in training and supporting peer support workers to deliver care as well as to safeguard their own mental wellbeing.

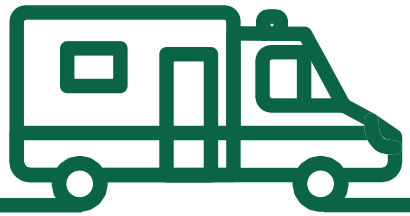
Working practices

Stakeholders believe that current working practices in the ambulance service may not promote good mental health and wellbeing. Issues associated with reactive, clinical shift work, such as the lack of control over shift finish times, can cause st ess and impact on life outside work. Shift patterns also impact on sleep and circadian rhythm, again potentially undermining mental wellbeing.

The unpredictable nature of ambulance service work is another potential stressor. As staff may attend more than one potentially traumatic or upsetting incident within a single shift, they must be as prepared and mentally resilient as possible and have access to effective supportive services.

Supporting families and close personal contacts

Families and loved ones are often a primary source of support to ambulance staff and they also need to be supported. Some ambulance trusts in England are trialling bespoke approaches such as providing family support guides/handbooks and holding family events to facilitate mixing and the development of informal support networks. Funding to deliver family events is a potential barrier, but some trusts are organising events such as walks and picnics at no cost.



6. What have ambulance service staff told us?

Mental health and wellbeing are not static

Suicide is complex and multifactoral

Preparing and supporting all staff is key

- **Mental health and wellbeing are not static**
- **Suicide is both complex and multifactorial**

The College of Paramedics Mental Health Group emphasised the importance of not making assumptions about the mental health and wellbeing of staff entering the service; and of recognising that mental health and wellbeing are fluid, and that exposu e to certain occupational triggers will not affect all staff uniformly. Accepting and responding to the variation in mental wellbeing across staff, from students and trainees through to those who have retired from service, is vital for progress across the sector.

AACE recently interviewed 34 staff in a variety of roles,[16] including paramedics, emergency technicians, call handlers, dispatchers, administrative staff and senior managers, to understand what contributes to poor mental health within the ambulance service. It highlighted the following factors:

- the combined influence of st ess outside and within work
- the cumulative impact of many stressful or traumatic jobs, over a short or longer timeframe
- the impact of responding to a particularly stressful job, or a job which activates specific personal mental health trigger
- the impact of occupational factors such as shift patterns, lone working and volume of workload.

Its work also suggests that a previous or existing mental health condition, a history of a traumatic personal event and previous suicidal ideation are all contributary risk factors to poor mental health and wellbeing. Attending repeated stressful 999 calls is potentially harmful, with repeated attendance at calls for suicides particularly traumatic.

Stakeholders emphasised the need for mental health and wellbeing support to cater for factors other than occupational ones, recognising that lifestyle challenges such as financial worries, family and marital issues, and problems with addiction can impact on ambulance service staff just as they do the wider population.

Working culture is viewed by some as a barrier to raising concerns about mental health and wellbeing and seeking help. Working practices that are not conducive to good mental wellbeing need to be addressed, such as poor shift patterns, a lack of breaks, failure to understand or offer staff an appropriate opportunity to emotionally process experiences between jobs.

Preparing and supporting all staff is key

The need for all ambulance staff to be able to access fast, confidential and e fective support is a priority. This support should begin the moment a concern is raised with a line manager, but this is reportedly often not the case. Access to postvention support following the death of a colleague regardless of cause was considered appropriate.

Researchers from University of Lincoln, University of East Anglia and Edge Hill University are exploring wellbeing provision in UK ambulance services, including during the Sars-Cov-2 pandemic (Bell F, personal communication, 2021). Early findings suggest that paramedic students rely heavily on contact with friends and family, and talking to colleagues and peers, as a means of looking after their own wellbeing. Few trainees access services for mental wellbeing, with many unaware of what their base trust provides. Internal services such as employee counselling and peer support, and external services provided by the charities TASC and MIND and by the NHS, are likely to be the most familiar to students. There appears to be a clear opportunity to both improve awareness of services and to support increased access to services among the student paramedic population.

7. Continuing the journey

Despite much work in the UK to reduce suicide among ambulance service staff, significant imp ovements in their mental health and wellbeing or in reducing the number of suicides have not been seen.

The development of a national consensus statement for the prevention of suicide in the ambulance service represents the next step towards achieving zero suicides, frames the multiagency commitment to driving change and recommends action to achieve sustainable changes within the sector. It builds on existing commitments and resources.

We have considered the following resources in directing the next steps:

AACE statement of commitment[17]	1. Promote a positive mental health culture in the workplace through leadership, communication, policy and procedure, environment and work/job design 2. Reduce stigma around mental health conditions and psychological stress in the workplace 3. Improve the mental health literacy of the workforce 4. Develop the capability of staff to interact with and help someone experiencing a mental health crisis, from identification through to return to work 5. Ensure that an integrated approach to mental health and wellbeing is woven through the workplace and that leaders at all levels model behaviours and practices that promote a mentally healthy workplace culture 6. Share examples of best practice and effective initiatives between services 7. Collaborate to ensure staff, during each phase of their career, have adequate self-awareness, knowledge and support in relation to managing their personal mental health and psychological stress triggers 8. Implement systems that provide the service with early notification of potential psychological harm- elated risk 9. Collect, monitor and respond to data that evaluates the mental health and wellbeing of the workforce and the possibility of psychological harm occurring 10. Seek internal/external specialist expertise when necessary to achieve improved mental health and wellbeing outcomes for the workforce

NHS Employers Ambulance Workforce[18] website	Includes resources and guidance on the following: • tackling bullying • how are you feeling toolkit • Head First • leading healthy workplaces • case studies and examples of best practice
The Mind Blue Light programme[13]	Provides a wealth of learning from the delivery of the four-year programme, plus a range of supportive tools and resources
Public Health England and Business in the Community[19]	Mental health toolkit for employers, which covers issues such as organisational culture, training and development, and provision of support
Public Health England and Business in the Community[19]	Employer toolkit for reducing the risk of suicide
AACE[20]	Guidance to support ambulance trusts to develop a mental health strategy
AACE (www.aace.org.uk)	Current AACE-led initiatives to support improvements in mental health and wellbeing, eg #ambulancekeeptalking

References

1 Office for National Statistics (2016) Number of deaths classified as suicide or undetermined intent among paramedics and ambulanc staff, deaths registered in England and Wales, 2005 to 2014. www.ons.gov.uk

2 Milner A, Witt K, Maheen H, LaMontagne AD (2017) Suicide among emergency and protective service workers: A retrospective mortality study in Australia, 2001 to 2012. *Work* 57(2): 281–7.

3 Mind (2019) *Wellbeing and mental health support in the emergency services: Our learning and key recommendations for the sector.* https://www.mind.org.uk/news-campaigns/campaigns/blue-light-support/

4 Association of Ambulance Chief Executives (AACE) (2018) *Employee mental health strategy guidance.* https://www.nhsemployers.org/-/media/Employers/Documents/Ambulance-workforce/AACE-Employee-Mental-Health-Strategy-Guidance.pdf

5 Mars B, Hird K, Bell F,James C, Gunnell D (2020) Suicide among ambulance service staff: a review of coroner and employment records. *British Paramedic Journal* 4(4): 10–15.

6 McManamny T, Boyd L, Sheen J(2013) Occupational risks in undergraduate student paramedic clinical placements. *Journal of Health, Safety and Environment* 29(1): 35–50.

7 Nelson PA, Cordingley L, Kapur N, Chew-Graham CA, Shaw J, Smith S, et al (2020) 'We're the first port of call' – perspectives of ambulance sta f on responding to deaths by suicide: A qualitative study. *Frontiers in Psychology* 11: 722.

8 King's College London, The Open University and The Royal Foundation (2020) *Assessing the mental health and wellbeing of the emergency responder community in the UK.* https://kcmhr.org/erreport2020-mentalhealth-wellbeing/

9 Gunnel D, Appleby L, Arensman E, Hawton K, John A, Kapur N, et al, and the COVID-19 Suicide Prevention Research Collaboration (2020) Suicide risk and prevention during the Covid-19 pandemic. *Lancet* 7: 468–71.

10 Witt K, Phil D, Milner A, Allisey A, Davenport L, LaMontagne AD (2017) Effectiveness of suicide prevention programs for emergency and protective services employees: a systematic review and meta-analysis. *American Journal of Industrial Medicine* 60: 394–407.

11 Clark L, Fida R, Skinner J, Murdoch J, Rees N, Williams J, et al (2021) Mental health, well-being and support interventions for UK ambulance services staff: an evidence map 2000 to 2020. *British Paramedic Journal* (in press).

12 Carleton RN, Afifi TO, urner T, Taillieu T, Vaughan AD, Anderson GS, et al (2020) Mental health training, attitudes toward support, and screening positive for mental disorders. *Cognitive Behaviour Therapy* 49(1): 55–73.

13 Mind (2019) *Wellbeing and mental health support in the emergency services: Our learning and key recommendations for the sector.* https://www.mind.org.uk/media-a/4524/20046_mind-blue-light-programme-legacy-report-v12_online.pdf

14 HM Government (2019) *Cross government suicide prevention workplan.* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/772210/national-suicide-p evention-strategy-workplan.pdf

15 HM Government (2012) *Preventing Suicide in England: A cross-government outcomes strategy to save lives.* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/P eventing-Suicide-.pdf

16 Association of Ambulance Chief Executives (AACE) (2020) *AACE mental health film: research findings.* https://aace.org.uk/mentalhealthandwellbeing/

17 Association of Ambulance Chief Executives (AACE) (2019) *CEO pledge to improve employee mental health and wellbeing.*

18 https://www.nhsemployers.org/retention-and-staff-experience/ambulance-workforce

19 Business in the Community and Public Health England (2017) *Mental health toolkit for employers* https://www.bitc.org.uk/wp-content/uploads/2019/10/bitc-wellbeing-toolkit-mentalhealthforemployers-may2016.pdf

20 Association of Ambulance Chief Executives (2018) *Employee mental health strategy guidance* https://www.nhsemployers.org/-/media/Employers/Documents/Ambulance-workforce/AACE-Employee-Mental-Health-Strategy-Guidance.pdf

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