

Royal College of Psychiatrists Consultation Response



DATE: 7 October 2011

RESPONSE OF: THE ROYAL COLLEGE OF PSYCHIATRISTS

RESPONSE TO: Consultation on preventing suicide in England: A cross-government outcomes strategy to save lives

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

We are pleased to respond to this consultation. The lead author for this consultation was Dr John F Morgan, with contributions from College faculties and divisions.

This consultation was approved by the Registrar, Dr Laurence Mynors-Wallis.

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Consultation response

Question 1:

In your view, are there any additional measures or approaches to reduce suicide in the high-risk groups that should be considered for inclusion? What evidence can you offer for their effectiveness? In your view, are there any other specific occupational groups which should be included in this section? If so, what are the reasons for inclusion?

We welcome the high risk groups specified and endorse the measures recommended. However, the strategy lacks sufficient detail on roles and responsibilities, and risks being marginalised without such detail;

People in the care of Mental Health Services, including inpatients

The suggestions are potentially useful, but require greater detail. For example, *"improving care pathways between emergency departments, primary and secondary care, inpatient and community care, and on discharge"* will add little without defining responsibilities within increasingly fragmented services.

People with a history of self harm

1.12 and 1.13 are both useful. However, 1.14 is very wide reaching and, without specific accountabilities, risks being seen as "somebody else's business".

While NICE guidelines on long term management of self harm will shortly be published, the draft of those guidelines makes clear that there are no effective tools to predict suicide in those people who self harm. Our members survey (*Self Harm, Suicide and Risk-Helping People Who Self Harm. College report CR158, Royal College of Psychiatrists*) noted inadequacy of risk assessment processes, and particularly reliance on locally developed, non-evidence based checklists. We continue to advocate risk assessment to be linked to an in-depth psychosocial assessment ('psychiatric assessment' for our members), rather than seen as a separate tick-box exercise.

People in contact with the Criminal Justice System

We would welcome more specific recommendations under “Effective Local Interventions”. There is insufficient reference to Prison Mental Health Inreach teams for earlier identification of mental illness and diversion from custody to a more appropriate environment, and this should be included.

People with untreated depression

The evidence base for early pharmacological treatment of depression with effective medication such as antidepressants should be emphasised under “Effective Local Interventions”.

People who are especially vulnerable due to social or economic circumstances

There are some useful suggestions in this section, especially around awareness training for non-health staff. However, accountability and resources for this are not sufficiently defined.

Question 2:

In your view, are the most appropriate groups considered, including any groups where there are issues relating to equality? In your view, are there any additional measures or approaches to reduce suicide in the identified groups that should be considered for inclusion? What evidence can you offer for their effectiveness?

We are broadly in agreement with the groups considered, but suggest the following additions;

People with physically disabling or painful illness

Whilst people with physically disabling or painful illness including chronic pain are mentioned in the Introduction and Executive summary, greater emphasis should be placed on chronic pain and disability as ‘Key High Risk Groups’, with recommended risk assessment processes required to reflect that emphasis.

People bereaved by suicide

Those bereaved by suicide should be considered as a high risk group, and greater consideration made of necessary support structures following bereavement.

Training needs

Our members survey (*Self Harm, Suicide and Risk-Helping People Who Self Harm. College report CR158, Royal College of Psychiatrists*) noted inadequacy of training. The 'suicide strategy' rightly emphasises improved care pathways and for provision of mandatory training for front line staff working with high risk groups. However, the draft falls short of making specific recommendations about nature and frequency of training, including responsibility and funding. Without such a requirement, we feel the well-considered recommendations will fail in the current financial climate. We believe that the Royal College of Psychiatrists should be tasked to identify in detail the training needs for clinical staff. This will of course be done in collaboration with other professional bodies. There must then be a requirement on those organisations which deliver mental health care to ensure staff meet the training standards set. This will be a responsibility of the Commissioning Board to set as a standard. We recommend that suicide/self harm assessment be essential to junior doctor induction and that evidence of embedding training in clinical practice be made a quality indicator for provider organisations.

Availability of treatment

We endorse the suggestion of better availability of evidence based psychological therapies, including problem solving therapy and cognitive behavioural therapy, in line with NICE Guidelines.

Question 3:

In your view, are there any additional means of suicide prevention that should be considered? What additional actions would you like to see taken to reduce people's access to the means of suicide? What evidence can you offer for their effectiveness?

We welcome the Strategy's emphasis on continuity of clinical care alongside good risk management. We recommend further clarity and detail, as development of various specialist teams within adult mental health care (inpatient, community, crisis, home treatment and other specialist teams) risks loss of such continuity. For example, we recommend that the Care Programme Approach (CPA) be accepted as fundamental to fulfilling recommendations of the draft strategy.

We commend emphasis on restricting access to harmful medication. We suggest the strategy make more prescriptive recommendations to all health professionals. For example, this might include placing restrictions on repeat prescribing for patients at risk of serious self harm or suicide, caution in prescription of regular paracetamol and assessment of access to harmful medication at consultations.

The suggestion of regularly checking potential ligatures in inpatient services is sensible. We recommend reference to the 'NPSA ward managers' checklist' to aid this.

Question 4:

What additional measures would you like to see to support those bereaved or affected by suicide? Please comment on how this help could be provided effectively and appropriately funded.

We regard the suggestions for support of the bereaved as sensible. We recommend greater clarity on roles and responsibilities in implementing these suggestions. We recommend closer working between voluntary and statutory

agencies in the support of those bereaved.

Question 5:

In your view, are there any additional measures or approaches that could promote the responsible reporting and portrayal of suicide and suicidal behaviours in the media? In your view, are there any additional approaches that could be considered for the internet industry in England to maximise the positive potential of the internet to reach out to vulnerable individuals?

We acknowledge the challenges of policing the media, and particularly the internet. We note the Press Complaints Commission leaflet entitled 'How the PCC Can Help You, Media Attention Following a Death'. We believe the Press Complaints Commission should be supported in a robust approach to sensitive representation. We commend the collaborative work completed by the Samaritans in conjunction with prominent search engines, in order to positively promote suicide prevention. We believe this positive approach is more likely to be fruitful than attempts to police the internet.

Question 6:

Is there additional information available that could be collected at a national and local level to support suicide prevention strategy? In your view, where are the gaps in current knowledge of the most effective ways of preventing suicide?

We continue to have concerns over accuracy of statistical data on suicide deriving from Coroner's Court, particularly with the increased use of narrative verdicts. We recommend that when narrative verdicts are used the coroner is requested to indicate whether the death was a result of suicide.

Question 7:

Are there examples of local good practice that could be disseminated to other areas? What other local and national approaches could be developed to ensure the implementation of the strategy? What issues should the Department of Health be considering as you develop any potential indicators in the Public Health Outcomes Framework that are relevant to suicide prevention?

The Strategy is heavily reliant on implementation of the national Mental Health Strategy for England, “No Health without Mental Health”, which does not currently have an Implementation Plan. Adding ‘meat to the bone’ of the latter is required for the current suicide prevention strategy to have value.

Extending choice in mental health services may see care pathways become more fragmented and delivered by different providers, with potential loss of the overall case management function. We suggest the Strategy includes evidence from other countries that demonstrates how increasing choice has resulted in reduced suicide rates, or else remove this endorsement.

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