Suicide Prevention Programme – Wave 4 Workshop 16

13 March 2024, 14:00-15:00

Details	Link/Resources
Welcome and introduction. Renata Souza *National Collaborating Centre for Mental Health* • The aim of these monthly workshops is to bring a learning community together to support each other, discuss issues and share some of our work around suicide prevention. They provide an opportunity to learn from the community, make connections and share resources. • Housekeeping was covered. • The funding for SPP Wave 4 comes to an end in March and we are currently looking into how we can continue to support the community.	Please get in touch with NCCMH at Suicide.Prevention@rcpsych.ac.uk if you would like to contact any workshop participants.

Topic 1:
Simon Kitchen
CEO, Bipolar UK
and
Ben
Expert by Experience
 	
Question/ topic: How understanding bipolar can save lives.
• Ben spoke at a Suicide Prevention Programme event last year to talk about his lived experience of having Bipolar. He was shocked by the huge risk of suicide for people with a Bipolar diagnosis and the horrendous journey some people have to go through to get a diagnosis.
• Bipolar used to be known as manic depression.
• Simon explained the Bipolar UK Mood Scale (found in slide). The worst day for people without a diagnosis may be a 4 and the high would be a 6 – in contrast, people with bipolar have huge variations. Bipolar UK tries to catch people on their way up and down the scale.
• Bipolar is very common however people experience it with differing severity. A study done in 2014 found that:
  ○ Approx 1 in 50 people have bipolar.
  ○ More than 1 million people in the UK alone.
  ○ 56% are still undiagnosed (this could be out of date).
  ○ Bipolar accounts for 17% of the total mental health burden. This is comparable to depression (23%) but twice the amount of schizophrenia, but it doesn't have its own care pathway like these two diagnosis do.
  ○ 50% of people get symptoms before the age of 21.
  ○ There is a 9.5-year delay to diagnosis in UK – a typical journey is for someone to experience a mild form of depression/ anxiety and display signs of perfectionism in their late teens then have their first manic episode in their early twenties, go to the doctor in their twenties then receive a diagnosis in their thirties.
	Simon Kitchen: skitchen@bipolaruk.org
	
	www.bipolaruk.org/diagnosing-bipolar

• The NHS is currently prioritising other conditions and not putting dedicated resources towards Bipolar. There should be a strategy for specialist treatment and support for people with Bipolar. Bipolar is too complex for IAPT but then access to psychological therapies is gate kept which is not transparent or fair. • There are strong links between bipolar and suicide. There have been 2 sets of studies (detailed in slides) that show having bipolar increases the risk of suicide 2-fold, 1 in 5 people with Bipolar will take their own life. • There are things that can be done (see the '5 ways' slide). The most cost-effective way is to implement a care pathway. Currently, using a GP to get to a psychiatrist is having a negative effect on services as more people are getting sectioned. Ben shared that he found out he had bipolar from antidepressants that triggered a multi episode. He highlighted clinicians should be aware of the risk of harm that prescribing can do. Ben also shared that it took 25 years to find peer support. • Bipolar UK recommend continuity of care, i.e. having someone to talk to quickly in order to stay well rather than the episodic care that is currently delivered by GPs. All Suicide Prevention Leads should have a line on bipolar. • *Could it be bipolar?* campaign reached 1.5mill people flagged symptoms, risk of antidepressants and resources such as a mood tracker app and e-learning package on www.bipolaruk.org/diagnosing-bipolar. • Everything has been coproduced with people with lived experience. **Questions and discussion:** • Medication – how do you prescribe for young women of child-bearing age considering the effect lithium can have on pregnancy? o Speak to a psychiatrist. Bipolar UK ran webinar programmes in which psychiatrists answered questions on issues such as that. Some women have taken medication during pregnancy – it should not be a barrier; they may just need to alter the dose/ type. • NCISH findings around self-harm and suicide – more than half of people who have completed suicide complete alone so peer support is crucial. o Bipolar UK would advocate for increasing frequency of access to a psychiatrist. There are pockets of community psychiatrists who still want that model of care. Provide universal peer support to get everyone to timely diagnosis, this shouldn't be a substitute to clinical expertise, it can be an additional benefit if people can have an informed discussion about it.	
Topic 2: **Philip Pirie** Suicide Prevention Campaigner **Question/ topic:** Risk Assessments. • Philip is a bereaved father and campaigner for reform of suicide risk assessment. His son Tom had a happy childhood; Tom believed the world was full of friends he hadn't met yet; he loved sport and spoke 3 languages fluently. He wanted to be a teacher to do good in the world. • In July 2020 Tom took his own life the day after he had been assessed as low risk for suicide by his counsellor. Philip thought he was an exception to the rule but was shocked to discover he was the rule. Of 17 people who take their own lives, 5 are in contact with Mental Health services and 4 of those 5 are assessed as low risk at their last contact with the service. They repeatedly use a 3-question checklist; Tom answered 'yes' to having suicidal thoughts but 'no' to having intentions to take his own life and 'no' to having any plans to take his own life. On the basis of these answers alone he was consistently assessed as low risk. • Philip speculated about what Tom may have been thinking during that counselling session. He surmised that it would have been a big deal for him to disclose suicide thoughts at all, and that he was testing the waters with counsellors to see how they'd respond. He may have been worried about being sectioned against his will. The counsellors in turn may have logged him as low risk and moved on to other topics so Tom may have felt dismissed. The checklist may have acted as a barrier rather than an enabler of necessary exploration. • This low-risk paradox has been known for about 25 years and nothing has been done about it. Philip speculated why the	• Philip Pirie: mail@philippirie.com Twitter/ X: @philippirie • Focus on Assessment on Suicide Risk - Chief Coroner to all coroners, summer 2022 • Philip Pirie: Why Change is Needed to Suicide Risk Assessment (youtube.com) • Lillian Morris: Lillian.Morris@cpft.nhs.uk

paradox still exists.
  ○ It must be terrifying to be with suicidal patients, everything you say or do may be a matter of life and death. An anchor needs to be connected to a stable seabed; the risk assessment seabed is nothing but stable.
  ○ Invalid checklists are being taught in colleges and universities. Universities and MH trusts and private organisations still require people to carry out invalid checklists, thus bad practice has become embedded.
• There is a contrast between medications and psychological interventions for Mental Health. For medical interventions there are phased research stages to validation, but it is a free-for-all with psychological interventions like risk assessments for suicide. Such interventions require the application of scientific methods.
• No doubt that individual practitioners think they're omitting liability by using risk assessments. Things are different now.
  ○ In August 2022 the chief coroner wrote to all coroners alerting them to risk assessment tools based on NICE guidelines in 2011 – they stated that suicide risk assessment tools were wrong over 90% of the time.
  ○ NICE issued further guidance – suicide risk should not be stratified as low, medium and high.
  ○ When coroners see tools, it places them under a legal obligation to issue a notification of future death report.
  ○ Insurance companies providing indemnity cover will soon refuse to pay out when they see this practice. Uninsured liability.
• It will take too much time for deeply embedded practices to change. Tom would be 30 years old by now. It is sometimes said we should prevent suicide because of the bereaved. Yes, we should care about the bereaved, but we should care about those like Tom who go about unendurable suffering and are no longer with us.
 	
Questions and discussion
 	
• Attendees would like to incorporate Philip's story as part of their teaching to advocate for the use of curious enquiry and individual narrative to assess risk.
• 2 areas of difficulty – understanding how we came to have the risk assessment tools and why it is we need to move away from them. It used to be based on personal or professional judgement – we then tried to become scientific, but this meant relying on population studies. Recently we found that doesn't work as it's not the patient's narrative.
  ○ It's a whole person approach - it's providing the environment where people feel safe to give their narrative – anything said or acted upon needs to be used as a trigger for something more.
  ○ Predicting is futile. The current desired practice is to have population studies that look at factors combined with person centered holistic assessment and should come together with risk formulation and with family and friends.
• Everyone needs to feel the power of lived experience. It's important for Trusts to embed good practice through lived experience stories.	

Topic 3: **Adele Owen** Greater Manchester Suicide Prevention & Bereavement Support Programme Manager, NHS Greater Manchester Integrated Care **Question/ topic:** Has anyone been asked to give suicide prevention training/inputs to local Police Force Call Handlers as Police and partners work to bring in the Right Care Right Person (RCRP) approach? • Adele has worked in the NHS for 5 years but before this worked for the Greater Manchester Police for 25 years – she found that a number of incidents call handlers were responding to day-to-day were ones where the police should not have been the first to call. Because of this, the call handlers have had to draw a line on what they could send a police vehicle out to. They were told that police will attend incidents where there is a near or immediate risk to life or serious harm, and if there has been a crime or potential crime. • Police's purpose is to preserve order but also to protect life. There's always going to be a place for police to respond to Mental Health issues, but how do they define what they respond to? • Adele spoke with local police to ask them what training call handlers will be having. She received no clear answer.	Adele Owen: adele.owen1@nhs.net • National Partnership Agreement: Right Care, Right Person (RCRP) - GOV.UK (www.gov.uk) • Core planning principles | College of Policing

- Adele kept in mind the wellbeing of the call handlers who deal with a lot of distress as well as the police. If they decide to send the police to an incident, they know help will be on its way – if they are now questioning whether police should attend or not, how will they be supported when making that decision?
- The RCRP approach has been designed so that all people will be responded to by 'right person at right time' etc. Police may be expecting another service will respond.

Questions and discussion

- Samaritans are involved with Sussex police.
- North Devon – had allocated liaison police officer working with most high frequency attenders. The funding for this has been withdrawn now – not sure how it is going to continue.
- Norfolk and Suffolk have been involved with the RCRP – they have devised a script with people with lived experience. The launch has been delayed – need to ensure script doesn't revert to risk assessment approach.
- What are the essentials call handlers need?

Shared by Adele Owen:

Please join us for the launch of a new Zero Suicide Alliance on-line training module focused on autism and suicide prevention 12-1pm 2nd April 2024 commissioned by NHS Greater Manchester Integrated Care Suicide Prevention Programme.

What the webinar will cover:

- more about why and how the training was developed.
- personal stories from steering group members.
- a preview of the training
- how to receive a communications toolkit.

Once the training is available online on the Zero Suicide Alliance website anyone can access it for free and it will take about 30 minutes to complete.

Registration link:
https://register.enthuse.com/ps/event/AutismandSuicideTrainingLaunchEvent