Health, Social Care and Sport Committee
Consultation on Suicide Prevention

Submission from Connecting with People: An Innovative Approach to Suicide Prevention

Executive Summary

This submission is made by Connecting with People (CwP) which develops and delivers best practice high quality training based on evidence and research-based principles to employees with healthcare and/or safeguarding responsibilities. We are motivated by the belief that self-harm and suicide prevention is better regarded from a 'whole community' perspective within organisations, and our approach has been adopted and delivered to a number of bodies including NHS Trusts and Health Boards, third sector and educational establishments throughout the UK, Jersey, Ireland and South Australia. In South Australia, and some settings in the UK, our training has been added into their suites of mandatory training. It has been the thinking of CwP that potential MH emergencies, such as associated with suicidal thoughts and self-harm, should receive training akin to cardiac resuscitation across the UK.

CwP's approach to suicide prevention combines compassion and governance with the aim of improving the assessment of people at risk of suicide through enhancing the quality, consistency and documentation of assessments and care, and Crisis and Safety Plans. Our aim is to ensure that every person experiencing suicidal thoughts or behaviours at any time and/or who self-harms is taken seriously and supported to co-produce a Safety Plan. This is regardless of the presence of a formal diagnosis at the time of contact. Our programmes build clinicians' knowledge and confidence to help them assess patients in emotional, or any form, of distress who may experience suicidal thoughts, and be able to respond appropriately in a compassionate, inclusive, and non-stigmatising manner.

CwP uses an assessment framework (SAFETool) which allows research to be linked with clinical practice. This is supported by training in suicide and self-harm awareness, mitigation, compassion in the workplace, emotional resilience, and resourcefulness. Other programmes are directed at specific responsible roles such as line management. These programmes support the development of a common language and approach, promoting consistent documentation of the assessment process, and a more integrated response across statutory services, third sector providers and communities as well as workplaces in other sectors.

A web-based app of the SAFETool is available in addition to a paper based version. The app can be fully integrated securely with NHS IT systems. The SAFETool Triage has been developed for use in the community, Primary Care, Secondary Care hospitals, and mental health services (both adult and young people) during the initial triage assessment by practitioners in a first point of contact role or by a first responder professional.

"Suicide is preventable, it is not inevitable. Suicidal people are in extreme emotional pain and are often ambivalent about dying. Their lives can be saved right up until the final moment. People take their own lives when the distress of living becomes too great, or personal circumstances seem intolerable. We need everyone to know that suicidal thoughts are a sign to change something in their life, not to end their life. It is possible to recover with the right support."

Dr Cole-King, Clinical Director of Connecting with People

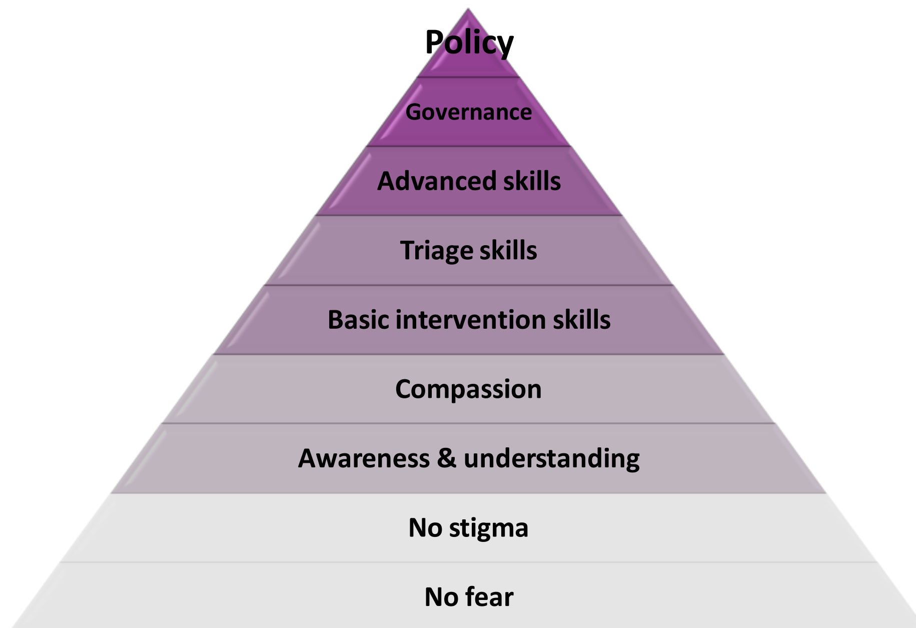
Connecting with People Training Programmes

CwP offers a suite of training programmes, with characteristics of a quality improvement initiative. The training is designed to break through and bypass unconscious barriers to the identification and intervention of people at risk of suicide such as fear, stigma, desensitization, personal experiences of suicidal distress or suicide loss, lack of time (real or perceived), lack of personal agency, and the erroneous sense that suicide is inevitable. CwP was designed to take participants on an emotional and experiential journey in addition to improving the knowledge, skills and confidence of people who come into contact with others in emotional distress, at risk of suicide and/or utilising self-harming behaviours.

CwP promotes the paradigm shift of suicide *mitigation,* which starts with suicidal thoughts being taken seriously and met with compassion and understanding on every occasion. The ethos of CwP is inviting people to consider 'What can I do to support this person to not want to end their life today… this week… this month?' In a Primary Care or frontline role, a compassionate tailored triage assessment should be done, leading to an appropriate and proportionate referral. The Classification of Suicidal Thoughts provides a common language to describe the nature and intensity of suicidal thoughts. Use of common language to describe suicidal thoughts can help to improve the consistency, accuracy and appropriate prioritisation of referrals (Waters & Cole-King 2017). In all cases, the principle is that those who have previously been deemed 'attention seeking' are in fact 'connection seeking' and this requires compassionate engagement every time.

Our training includes a suite of clinical frameworks, some of which have been adapted for non-mental health settings, including Primary Care, the third sector, education, and the police and criminal justice system. Starting from the premise that everyone in society has a role in suicide prevention, CwP offers different training modules designed for a range of different settings, but with the same core messages and a common language. Through this modular framework CwP enables people with very different levels of expertise, competence and confidence to receive training suited to their needs.

CwP training is delivered both on a Direct to Participant basis and also via in-house trainers in larger organisations by staff who have completed a Train-the-Trainer (TTT) programme. All CwP trainers must be licensed and undergo an annual reaccreditation. The material is updated annually which is shared with the trainers at the time of their reaccreditation. We also ensure the trainers have fidelity to the model for consistency, quality and safety. There are seven different 'bite sized' modules of between 2 and 2.5 hours' duration, designed for different sectors, including a module specifically designed for young people over the age of 13. A robust safety protocol for delegates is followed during the training, as delegates can often become distressed given the sensitivity of the subject matter. Live and real stories are used throughout the training, submitted by experts and those with lived experience, whilst at the same time carefully constructed case studies are used for interactive training, all of which is scrutinised and approved by a significant Expert Reference Group.



For the last decade, CwP training has been delivered in several different countries and to many different sectors including health and social care, third sector, education, universities, police, secure services, health and social care students, community members, and carers. It has also been adapted using co-production for different cultural groups.

Important Factors in Healthcare

Understanding which factors differentiate between those who will have thoughts of suicide and those who will act upon those thoughts and attempt suicide, is still elementary (Klonsky & May, 2014;). Demographic risk factors increase the suicide risk of a whole population across its lifetime, but do not predict the suicide of an individual at a single time-point. Furthermore, suicide risk assessment is itself a complex intervention, which means that it is not totally predictable and the process is influenced by practitioner, patient and organisational factors (Cole-King et al., 2013).

Absence of risk factors, however, does not mean the absence of the risk of suicide (Cole-King et al., 2013). Current suicide risk assessment tools are often weighted towards demographic risk factors (which may be as common in the general population) and have largely been developed without a solid empirical basis. This is the finding of a recent *BMJ* 'state of the art' review of suicide risk assessment and intervention in people with mental illness (Bolton, Gunnell & Turecki, 2015).

NICE guidelines (27) on the long-term management of self-harm state "do not use risk assessment tools and scales to predict future suicide or repetition of self-harm". Research has been unable to establish how thoughts of suicide progress from to planning to action. Nock's summary of variables examined in the World Health Organization (WHO) studies notes that they explain 62% of the variance in suicide ideation, but "only 7.1% of the variance predicting suicide attempts among ideators" (Glenn & Nock, 2014, p. S177).

Research has identified several strong predictors of having thoughts of suicide but nothing that strongly differentiates amongst those people who will progress to attempt suicide.

We need a new approach. People experiencing suicidal thoughts and feelings are extremely ambivalent and their life can be saved up until the final moment. Of note, CwP emphasises the fact that all patients need a co-produced Safety Plan and not just those judged to be at a higher risk. Compassionate communication with people at risk of suicide can save lives, is essential to the quality of the information underpinning an assessment, and can be the tipping point back to safety. Researchers call for a 'low level intervention' which can benefit everyone and not just focus efforts on those people judged to be at highest risk.

Even if a patient does not disclose, or has not yet developed suicidal thoughts, a practitioner is guided to co-produce, at the very least, an 'ultra-brief' Safety Plan with their patient to equip and prepare their patient should they ever became suicidal in the future. This in turn builds the patient's own resilience and resourcefulness. If patients do disclose suicidal thoughts, the practitioner can then undertake a triage or tailored assessment including the co-production of a comprehensive Safety Plan. The identification of reasons for living, and activities to support calm, relaxation and distraction whilst anticipating triggers is essential. This is backed up by social and emergency support mapping, whilst the whole process is embedded with building hope and aspiration.

Important Factors in Primary Care

The scale of need across consultations with a GP has been widely stated as 1 in 3 to 4 presentations have some mental health/psychological component, and that regardless of the acuity or complexity of the problems that arrives at the door of GP, they need to be equally capable of managing an appropriate response to these scenarios. We must also remember that the highest cause of death in men under 45 is suicide, hence this is a priority area as the vast majority will be registered with a GP. 91% of people with a mental health problem will be treated in Primary Care (National Survey of patients; 2003).

Only around one third of all suicides occurred in patients who had been in contact with mental health services in the year prior to their death. Of the 1,722 10-19 year olds who died by suicide only 14% were known to specialist services. In Wales during 2005-2015, 817 deaths (23% of general population suicides) were identified as having been in contact with mental health services in the 12 months prior to death (National Confidential Enquiry 2017)

Tension exists in general practice between the 'gold standard' of exploring every suicidal thought or action and the reality of a 10 min consultation (Cole-King & O'Neill 2017) . Clearly time is a factor in the Primary Care sector; time to learn, time to deliver consistent and high quality care, and time to manage one's own needs dealing with highly impactful consultations. However, this is solvable; Primary Care is almost universally already able to deliver excellent supportive care, although basic and emergency mental health skills are widely variable therefore additional skills would simply level the playing field. Primary Care could then manage risk, mitigate risk, and respond to risk far better to include enhanced approaches to congruent referral to Secondary Care. In doing this, it will also avoid the 'bounce' culture that is a regularly stated

criticism about Secondary Care from Primary Care as well as poor referral quality as a stated criticism conversely.

As above, whilst GPs possess the right platform of skills to manage many mental health problems, there is still a confidence and training gap around mental health and suicide. The tools that Primary Care has in place from identification, to assessment, from triage, to response, are significantly diverse, blunt, variable, or even non-existent. Any assessment framework should be comprehensive, easy to use, and consistent not only across Primary Care but recognisable at the interface with Secondary and Community Care.

Other factors that play into this are dependent upon the communities that Primary Care serves as there is great variation. We see practices that are located in areas of extreme affluence, others multi-varied, and others still that manage extreme deprivation day in and day out. Although the association with region is complex, there are nevertheless associations with deprivation and suicide both globally and in the UK. Suicide risk in England and Wales showed a two-fold increased risk from the least to the most deprived (Health Statistics Quarterly 31; Autumn 2006). Furthermore, culture, sexuality, faith and beliefs need to also be considered.

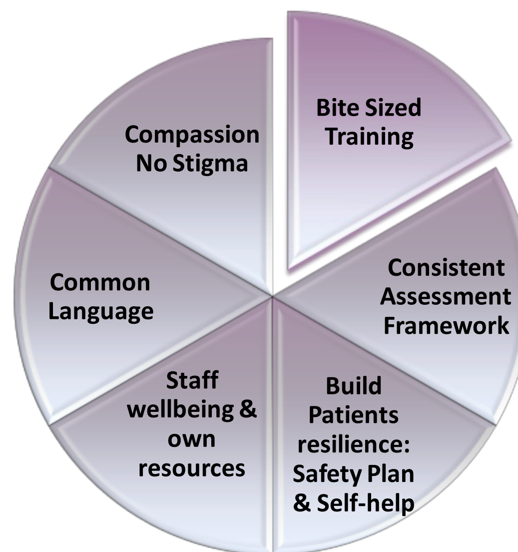
Summary of Barriers in Primary Care

- Suicide is seen as the preserve of specialist mental health services;
- It's difficult for busy GPs to access training;
- Training not on an equal footing with training regarding physical health – such as mandatory cardiac resuscitation. There is no MH or suicide/self-harm equivalent of the annual resuscitation training. This, despite the fact that GPs are likely to have more contact with patients in suicidal distress than those with an acute cardiac condition;
- Lack of consistency for a referral decision and no objective or evidence based referral approach;
- Over-reliance on risk assessment tools i.e. PHQ9 and demographic risk factors;
- Challenge of covering the issues that are affecting people when a GP only has ten minutes with a patient;
- Current assessment frameworks are neither GP nor patient 'friendly';
- Current assessment frameworks for patients in distress are often cumbersome, paper-based, or on standalone systems that are not linked to existing clinical systems such as SystmOne and EMIS – the leading Primary Care patient management systems. GPs need a tool that is effective and easy to use.

Suggestions on How to Overcome Barriers in Healthcare

The CwP SAFETool Triage (PHE & HEE, 2016) has been designed for settings where a lengthy assessment may not be required. It rapidly facilitates a low level intervention at the point people become distressed, potentially even *before* they develop suicidal thoughts. The SAFETool Triage includes the most important elements of such an assessment and has been shaped by the CwP Expert Reference Group, which includes international suicide prevention academics, practitioners, and people with lived experience.

Changing Working Practices



SAFETool

The CwP training provides a set of 'tools' to support people to intervene with someone at risk of suicide appropriate to that person's role and expertise. The Suicide Assessment Framework E-Tool (SAFETool) combines all the clinical tools and frameworks to ensure a consistent approach, and that the latest research and best practice are implemented.

SAFETool has been extensively peer reviewed and shaped by the CwP Expert Reference Group (ERG) and published in peer reviewed journals. The ERG includes international academics, practitioners and people with lived experience of suicidal distress, survivors of suicide, carers, and those bereaved by suicide. SAFETool is not intended to replace judgment, but to provide valuable guidance to a front line practitioner on key aspects of an assessment and co-producing a safety plan which helps the distressed person build their wellbeing, resilience and resourcefulness.

SAFETool forms part of the Suicide Response modules and together with the training, its use facilitates the development of a compassionate approach, a common language, consistent documentation and a more integrated response across statutory services, third sector providers and communities. The Suicide Response Part 1 module is designed for people in safeguarding and frontline roles such as emergency care, primary healthcare, secure services roles. It trains delegates in how to use the SAFEToolTriage to support their triage role: a triage assessment, referral and co-production of an immediate safety plan.

A web-based app version of the SAFETool is available and can be integrated securely with NHS IT systems in addition to a paper based version. A shorter version - The SAFETool Triage - was developed for Primary Care, the general hospital, triage assessments by a first point of contact or by a first responder professional (PHE & HEE, 2016). It facilities a low-level intervention at the point people become distressed, potentially even *before* they develop suicidal thoughts or plans.

CwP's SAFETool guides GPs through two very important processes: the assessment process provides a set of questions focused upon the patient's personal background, clinical history and current circumstances to assess their mood, aspects of their mental state and details of their thoughts and feelings of suicide. SAFETool is not intended to replace a doctor's clinical judgment, but to provide valuable guidance (supported by training) to a GP regarding the key aspects to cover whilst supporting practitioners to co-produce an appropriate Safety Plan with patients and helping them to build wellbeing, resilience and resourcefulness.

CwP collaborated with NHS Arden & GEM CSU's Clinical Systems Team to develop an electronic version of the SAFETool for SystmOne, with an EMIS (including EMIS Web) version soon to follow. SAFETool can be easily uploaded onto GPs' desktops and draws upon suicide prevention research. This enables GPs to undertake an appropriately tailored assessment of a patient at risk of suicide and provide an immediate treatment plan and a co-produced Safety Plan.

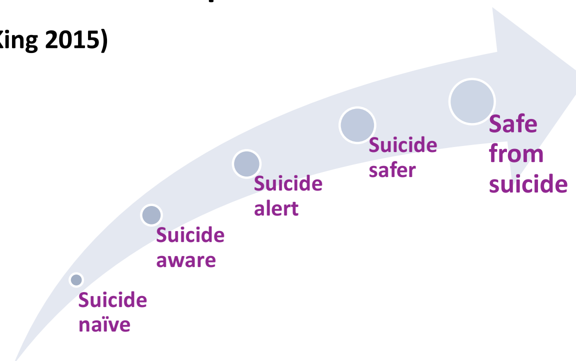
SystmOne is the IT system used by approximately 40% of Primary Care practices across England: EMIS systems are prolific across the UK. The SAFETool Triage guides practitioners to undertake a collaborative, evidenced-based assessment and culminates in the co-production of an appropriate Safety Plan, even if patients are unable to disclose suicidal thoughts (e.g. due to stigma, fear or embarrassment) or have not yet developed suicidal thoughts. In either case, they are invited to co-produce an 'ultra-brief' Safety Plan. Making such a plan develops a patient's own skills to deal with any potential future suicidal thoughts.

Warwickshire, Northamptonshire and Derbyshire have adopted a whole county-wide approach to training GPs

This involves offering training within Protected Learning Time sessions, as well as in convenient locations close to GP practices. The South Warwickshire CCG have also employed the Out Of Hours GP Service to provide cover at GP practices to enable all the GPs in their locality to attend the CwP training and still provide clinical care to patients. Additionally training was provided for school nurses.

Northamptonshire and Derbyshire have adopted a Train-the-Trainer approach and have in-house capability to deliver the training within both Primary and Secondary Care services.

Stages of learning for individuals, teams, organisations and communities



Suicide Naïve: You have little or no knowledge of suicide and do not think that suicide or suicide prevention has any relevance to you or your organisation. Due to this, you are highly likely to be fearful of encounters involving suicide, you may not be aware of the latest evidence, and may also have had negative experiences of this area in the past.

Suicide Aware: You are aware of suicide in general but your understanding is limited to what you see online or in the media; you are aware that you do not have the confidence, skills, or knowledge to know what to do to prevent suicide. This can be extremely anxiety provoking as you are aware of the issues but feel unable to respond safely. This can also cause 'organisational anxiety' and unconsciously cause either an excessive or inadequate response to identified risk.

Suicide Alert: You now have the attitudes, skills, knowledge, confidence and governance to identify and respond appropriately to someone at risk of suicide, although this may still not be across the whole organisation.

Suicide Safer: You have an excellent understanding of suicide with the attitudes, skills, knowledge, confidence and governance to identify and respond appropriately to someone at risk of suicide. You have personal experience of preventing suicide and effective interventions with patients at risk of suicide.

Safe from Suicide: This is an aspiration to describe a situation when patients will be **Safe from Suicide** when their family and friends, community and all their health and social care contacts reach the highest levels of understanding, compassion, skills and confidence to identify and respond to someone at risk of suicide according to their role and expected expertise. Your patients have the best possible care and every one they meet will have a high-level understanding of suicide and be able to play their part in an effective intervention and safety plan. Everyone at risk of suicide will have a co-produced safety plan with explicit reference to removal of access to means and will be strategically building their wellbeing, resilience and resourcefulness.

Evaluations and impact

Numerous in–house audits and evaluations of the CwP training programme have been undertaken.
Below is a summary of external evaluations.

Bangor University

An independent evaluation by Bangor University in an Emergency Department showed post training improvements in attitudes, self-reported knowledge in assessing patients, and documentation of compliance with NICE Guidelines. (Knipe M., *et* al 2010).

Feedback from ED staff post-training

(103 participants, 99% response rate):

- **100%** of respondents now believed they had a role in suicide prevention
- **97%** thought the training had increased their understanding of self-harm and suicidal thoughts.
- **85%** agreed they would now be able to show more empathy with patients attending ED following self harm and/or with suicidal thoughts.

STORM Skills CIC

An independent evaluation of CwP training by STORM Skills CIC showed post training improvements in attitudes, self-reported knowledge and confidence (Parker C., Green G. 2016) ***(details on request)***

University of Wolverhampton

The University of Wolverhampton (UOW) pioneered a whole-system approach to student self-harm and suicide, and won the *2017 Times Higher Educational Supplement Award* in recognition of their innovative student support across the university. Thus far, they have trained upwards of 750 people in the CwP programmes including students (nursing, social work, policing) and university staff, the Vice Chancellor, accommodation staff, security staff, student union representatives, conduct and appeals and finance, HR and academic staff. According to an internal audit by UOW:

- January 2015 (before CwP training) **25 students** were referred to the well-being coordinator for suicidal ideation
    - 2015 staff received CwP training (academics, counselors, security staff, catering, housekeeping, cleaners)
- January 2016 – 5 student referrals for suicide ideation
- January 2017 – 0 student referrals for suicide ideation

Police officers

Summary of feedback from a couple of Suicide Awareness modules delivered to Police officers (N= 40, 100% response rate)

- 90% 'know more about the myths associated with suicide and the barriers to seeking help'
- 90% 'have better understanding of the prevalence of suicide'
- 93% 'understand role of empathy and concept of mitigating suicide'
- 93% 'know how to talk to someone who is in emotional distress'
- 88% 'know where to seek help and how to get hold of compassionate leaflets e.g. 'Feeling on the Edge'

Nightline Student Association

The Nightline Student Association (student listening service) adopted CwP in 2013 and deliver the training to their volunteers. An evaluation of the first two years confirmed the of positive impact and cost-effectiveness of CwP with a module cost of £27 per head (Nightline 2014). In 2015, they won the coveted 'Helpline of the Year' award despite other large well known national helplines also being shortlisted.

Nightline feedback from the *Suicide Awareness modules*

N=198

- 96% 'understanding on the subject has increased'
- 97% 'know more about the myths associated with suicide and barriers to seeking help'
- 94% 'have better understanding of the prevalence of suicide'
- 98% 'understand role of empathy and concept of mitigating suicide'
- 97% 'know how to talk to someone who is in emotional distress'
- 83% 'know where to seek help and how to get hold of compassionate leaflets

Secondary Healthcare Trust (details on request)

Internal audit of consecutive attendees of the CwP training (n=800)

Suicide Awareness module: participant feedback form results

- 92% of attendees their “understanding on the subject has increased”
- 94% “know how to talk to someone who is in emotional distress”
- 87% “know more about the myths associated with suicide and the barriers to seeking help”
- 84% “know where to seek help and how to obtain the suite of compassionate leaflets (e.g. *Feeling on the Edge*)

Suicide Response Part 1 module: participant feedback form results

- 91% “feel able to put these learning outcomes into practice if required as a result of this training”
- 93% “understand the value and limitations of risk factor identification and the importance of red flag warning signs”
- 85% “can co-create an immediate safety plan with a patient”
- 82% “can co-create a long term mitigation plan which includes social support mapping and a contingency plan”
- 92% “understand the importance of supervision and self-care”

Testimonials and national recognition

2017 Included Local Government Association ‘Suicide prevention A guide for local authorities’

2016 Included in Public Health England/Health Education England ‘Mental health promotion and prevention training programmes: Emerging practice’

2016 Cited in Parliamentary Briefing, “On Board with Suicide Prevention”

Endorsed by the Royal College of Nursing

Supported by Royal College of General Practitioners Remote and Rural Forum

Participant Evaluation Forms: feedback results

I find Connecting with People truly inspiring. The experience has helped immeasurably with my confidence to support distressed callers.
(Helpline volunteer)

As a non-practitioner, I liked how the discussion and materials followed a systematic process that was clear, "simple," and comprehensive.. The resources resonate with broad audiences, not just with those in the mental health field. On a personal note, I was a mother of two suicide-risk daughters. Had I had the Suicide Assessment Framework as a resource, I would have been light years ahead of where I was in trying to help them, the family, their mental health providers, school staff, and myself.
(Healthcare Manager)

It was useful to learn that there aren't any risks in trying to reach out to a suicidal stranger and that you can't make them worse by broaching the topic.
(Nightline volunteer)

The best course/teaching sessions I have attended as a postgraduate. The course not only offered practical advice on how to discuss patient's suicidal thoughts, but more importantly how to reduce the patient's risk of suicide. I now feel able and confident to create and discuss a 'safety plan' for the patient. I feel empowered that by discussing a patient's suicidal thoughts I can assess them more accurately, will refer patients more appropriately to Secondary Care services, and by discussing simple practical solutions that I can actually reduce their risk of dying. This course should be compulsory for all GPs in training.
(General Practitioner)

*Inspiring (*full time carer for wife)

Excellent...the sooner the training gets rolled out across all sectors the better.
(Third sector development officer)

I used to think people who killed themselves were incredibly selfish now I can see how desperate they must have been.
*(*Consultant in a General Hospital***)***

I learnt a lot more about what 3rd sector services are out there, plus apps + websites to offer support or options rather than feeling trapped + helpless.
(Youth worker)

A new way of thinking about how to tackle suicide.
(Red Cross volunteer)

Resources for People at Risk of Suicide developed by Connecting with People

Staying safe if you're not sure life's worth living has practical, compassionate advice and links for people in distress http://www.connectingwithpeople.org/StayingSafe

The ***U Can Cope*** film (22 minutes long) inspirational stories of three people for whom life had become unbearable but who found a way through with support and three self-help resources http://www.connectingwithpeople.org/ucancope

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