

## **'Improving Care for People who are at risk of suicide': The Guildford Consensus**

### **Background**

James Wentworth-Stanley took his own life on 15<sup>th</sup> December 2006. Since his death, his family, and those of others bereaved by suicide have been exploring how their lives could and should have been saved and how other people threatened by suicide can be appropriately helped. Their ambition complements the work of established academics, clinicians, policy makers and charity campaigners. In July 2011, the James Wentworth-Stanley Memorial Fund generously sponsored an invitation-only meeting to be attended by all stakeholders with an interest in suicide prevention to determine recommendations regarding priority actions.

### **Aim**

The aim of the one-day meeting was to produce consensus statements and recommendations regarding priorities for the implementation of optimal suicide prevention strategies. It is intended that these statements and recommendations are used as an adjunct to the Government's National Suicide Prevention Strategy.

### **Method**

The method for the development of the consensus statements was adapted from the method used for the National Depressive and Manic-Depressive Association Consensus Statement on the Under treatment of Depression (Hirschfield et al., JAMA, 1997; 277 (4): 333-40).

The meeting posed a series of key questions in order to determine the priority actions:

#### Key questions:

1. What is the gap between what is happening on the ground and optimal prevention strategies?
2. What can be done to bridge that gap in 4 areas?
  - a) Communication
  - b) Assessment
  - c) Organisational structure (including what can be learned from audit)
  - d) Training (including supervision, support and what can be learned from audit)

#### **Participants:**

Consensus panel members were drawn from psychiatry, psychology, mental health services, the Department of Health and the third sector. A full list of attendees can be found in Appendix 1.

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### **Evidence:**

There were five primary sources of evidence.

1. The personal stories of those affected by suicide with an emphasis on where they feel the health services did well and where they feel let down by the health services.
2. The personal experience of those working in the voluntary sector.
3. A consideration of research/reviews of patients and staff perspective on people who are vulnerable to suicide.
4. Policy and review documents produced by the Department of Health including those provided by the National Institute of Health and Clinical Excellence (NICE) and those produced by the voluntary sector.
5. Academic research on suicide prevention and the implementation of the NICE guidelines

### **Consensus Process:**

1. Panel members were involved in setting the scope of the meeting and responded to an outline plan in April 2011 to determine if there were any areas they felt were missing.
2. Panel members received copies of the presentations and relevant material/references at least 2 weeks prior to the meeting (6th July 2011). These documents are listed below:
  - Programme of the day
  - Aims of meeting
  - 'Attitudes towards and satisfaction with services among deliberate self-harm patients: a systematic review.' Article by Taylor and Hawton (2007)
  - Department of Health National Suicide Prevention Strategy for England
  - List of attendees
  - Map of meeting location
3. Panellists were asked which area most interested them and were divided into sub-groups to consider assessment, training, organisation or communication.
4. The panel members met on 20th July 2011. Four presentations were made addressing personal stories, staff/patient views, NICE guidelines and their implementation and the Government's new Suicide Prevention Strategy.
5. The main group was divided into the four sub-groups in accordance with their primary interest and each sub-group asked to produce consensus statements that would be practical to implement.
6. The Chair of the sub-group fed back the consensus statements produced to the larger group.

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7. The larger group commented on all the consensus statements produced.
8. A draft of 9 consensus statements was produced and circulated for comment. Panel members were asked to prioritise their three most important consensus statements and comment on how many consensus statements should be produced.
9. Four consensus statements were produced and drafted for circulation.
10. No further changes to the consensus statements were made.

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**The statements and recommendations below are the product of a whole day event attended by a high level group of people who work in the field of suicide prevention, including researchers, voluntary organisations, statutory providers, and families bereaved by suicide.**

**1. Confidentiality must not be a barrier to effective assessment and communication.**

**Statement:** Confidentiality can act as an unnecessary barrier between clinicians, patients and families. If the patient has an expressed wish to share information, such information should be shared without restrictions.

**Recommendations:**

- 1.1. That the Department of Health (or other) should urgently clarify limits of confidentiality especially if the suicidal person wishes others to be involved in their care. There should be a presumption that such nominated people should be involved in the care. Service users should automatically be asked, at each stage of presentation, who else they want to be involved in their care and therefore to receive confidential information.
- 1.2. That awareness should be raised amongst carers, families and significant others and their related patient associations that confidentiality should NOT be a barrier to their involvement.
- 1.3. That voluntary sector organisations lead the development of a shared advanced directive, which could be widely disseminated and shared as best practice.

**2. Assessment of service users who self harm needs urgent improvement**

**Statement:** The outcome for service users could be significantly improved if they and specific family members/close friends are closely involved in understanding the overall assessment process, the creation of the care pathway and subsequent care leading to recovery.

**Recommendations:**

- 2.1. That new NICE guidelines be issued to all clinical staff including GPs, Emergency Departments and secondary care workers, which set out how families/close friends and service users can be involved, where this protects the safety of the service user and increases their chances of recovery. NICE recommendations regarding offering a full psychosocial assessment by a suitably trained, empathic person in an appropriate environment should be followed (CG16; section 8.8) and

such assessments should be included in the Quality and Outcomes Framework where applicable.

- 2.2. As stated in the NICE Guidelines (CG16; section 4.4.1.5), all people who have self-harmed should be offered a psychosocial assessment. These psychosocial assessments should always be communicated to GPs on the day of the assessment and marked for urgent attention if there is high suicidal risk.

### **3. Training for all who come into contact with people who are suicidal needs improving**

**Statement:** There needs to be more training for clinicians (and others) in recognising suicidal ideation and acting appropriately.

**Recommendations:**

- 3.1. Related to NICE guidelines (CG16, section 4.12), there should be mandatory training tailored to all clinicians (and those who are most likely to work with people who are suicidal- e.g. A&E Nurses) in how to identify and respond to suicidal thinking, feelings and behaviour, with a mandatory 3 year update. Compliance with this recommendation will need to be assessed and reported in accordance with the NHS Compliance Framework.
- 3.2. The formation of a sub-group comprising service users and providers, third sector, and academics to scope and review all training packages available and advise on adoption and/or amendments and/or on gaps to be filled. As part of the above review the Group should advise on the ways and means of ensuring that the NICE guidelines on use of service users in dissemination are followed as service users are underused in the delivery of training.
- 3.3. As part of GP qualification training, there should be a mandatory module on how to identify and respond to suicidal thinking, feelings and behaviour. Such a module should be integrated into qualified GPs training to ensure on-going competence.

### **4. Effective pathways of care need to be created**

**Statement:** There can be very poor join up and follow up of people who have attempted suicide or are considered to be at serious risk, especially between A+E units, mental health trusts and primary care. *The chances of recovery might be significantly increased if service users didn't fall through gaps in care responsibility as they pass through the care pathway including emergency departments, GPs, PCTs and other service providers.*

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### **Recommendation:**

- 4.1. That all service users should have an identified and named key worker with responsibility for their care throughout each stage of the care pathway process. There should be a particular focus on patient follow up, which should include provision of appropriate personal action plans and self management tools.

### **Actions**

To help to generate positive change the panel members committed to individually and collectively working to ensure that the consensus statements are distributed widely amongst academics, policy-makers, services and voluntary sector organisations. Agreed actions include uploading the consensus statements onto websites, presenting them at conferences, sending them to every NHS Trust, and submitting them for publication in an academic journal.

A grant proposal has been written to pursue specific programmes of work that will contribute to the attainment of the recommendations and that best practice for suicide prevention will also become common practice in clinical services.

### **Appendix 1**

#### **Members of the Panel**

<b>Name</b>	<b>Organisation</b>
Ann Adams	Warwick Medical School
Ella Arensman	National Suicide Research Foundation
Simon Baron-Cohen	University of Cambridge
Outi Benson	SANE, UK mental health charity
Alexa Biesty	NICE, National Institute of Clinical Excellence
Christopher Buckingham	Aston University
Graham Durcan	Centre for Mental Health
Hamish Elvidge	The Matthew Elvidge Trust
Linda Elvidge	The Matthew Elvidge Trust
Paul Farmer	MIND
Seena Fazel	University of Oxford
Ged Flynn	Papyrus: prevention of young suicide
Naomi Garnett	The Charlie Waller Memorial Trust
Chris Gill	South Central Strategic Health Authority
Stephen Habgood	Papyrus: prevention of young suicide
Keith Hawton	University of Oxford, Centre for Suicide Research
Suzanne Hudson	MDF The Bipolar Organisation
Suzy Jackson	Counsellors and Psychotherapists in Primary Care
Catherine Johnstone	Samaritans
Sara Kelly	Western Sussex Hospitals NHS Trust
Julie Kerry	South Central Strategic Health Authority
Paula Lavis,	Young Minds
Simon Lawton-Smith	Mental Health Foundation
Rose McAfee	Volunteer for Maytree and The James

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	Wentworth-Stanley Memorial Fund
Amy Meadows	Judi Meadows Memorial Fund/McPin Foundation
Clare Milford Haven	James Wentworth Stanley Memorial Fund
Madeline Moon	Parliamentary Private Secretary to Lord Hunt and Member of Parliament (MP) for Bridgend
David Mosse	University of London
Linden Muirhead	MIND
Rory O'Connor	University of Stirling
Christabel Owens	Devon Partnership NHS Trust & Peninsula Medical School, University of Exeter
David Owens	University of Leeds
Steve Platt	The University of Edinburgh
Leanne Rivers	Samaritans
Roz Shafran	The Charlie Waller Institute, University of Reading
Helen Steele	Department of Health
Sir Mark Waller	The Charlie Waller Memorial Trust
Mark Williams	Department of Psychiatry, University of Oxford

**Acknowledgement:** Navneet Kapur, University of Manchester, for advice.

### Material distributed to Panel members

- Aims of the meeting
- Brief information about list of attendees
- Charlie Waller Institute brochures
- Charlie Waller Memorial Trust newsletter
- Department of Health (2002) National Suicide Prevention Strategy for England. Available at [www.doh.gov.uk/mentalhealth](http://www.doh.gov.uk/mentalhealth) .
- Department of Health (2007) Best Practice in Managing Risk. Available at <http://www.dh.gov.uk/health/category/publications/reports-publications/> .
- Francke A L, Smit, M C, de Veer A J E, Mistiaen P (2008) Factors influencing the implementation of clinical guidelines for health care professionals: A systematic meta-review. *BMC Medical Informatics and Decision Making*, 8, 38-49.
- Guide on how to write a consensus statement
- Hardcopy of four presentations
- HM Government & Department of Health (2011) Consultation of preventing suicide in England.
- Institute of Health Economics (2008) Consensus Statement on Depression in Adults. *Institute of Health Economics Consensus Statements*, 3.
- List of attendees
- Mann, J. J et al (2011) Suicide Prevention Strategies: A Systematic Review. *JAMA*, 294, 2064 – 2074.
- Mental Health Foundation (2006) Truth Hurts, Report of the National Inquiry into self-harm among young people, Fact or Fiction.
- National Institute of Clinical Excellence (2011) Draft for consultation, Self-harm: longer-term management in adults, children and young people.

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National Collaborating Centre for Mental Health. Available at <http://www.nice.org.uk/guidance/index.jsp?action=download&o=54071>.

- NHS National Institute of Clinical Excellence (2004) Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. Clinical Guideline 16. Developed by the National Collaborating Centre for Mental Health. Available at <http://www.nice.org.uk/CG016NICEguideline>.
- NHS National Institute of Clinical Excellence (2004) Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. Clinical Guideline 16. Developed by the National Collaborating Centre for Mental Health. Available at <http://www.nice.org.uk/nicemedia/live/10946/29424/29424.pdf>.
- NHS National Institute of Clinical Excellence (2008) Putting NICE guidance into practice. Available at: [http://www.nice.org.uk/usingguidance/niceimplementationprogramme/nice\\_implementation\\_programme.jsp?domedia=1&mid=79C96B25-19B9-E0B5-D4D383231B60E6C7](http://www.nice.org.uk/usingguidance/niceimplementationprogramme/nice_implementation_programme.jsp?domedia=1&mid=79C96B25-19B9-E0B5-D4D383231B60E6C7)
- NHS National Reporting and Learning Service, National Patient Safety Agency (2009) Preventing Suicide, A toolkit for mental health services. Reference 133 November 2009.
- NICE brochures on self-harm
- Programme of the day
- Samaritans (2011) Join the call to Action for Suicide Prevention in England (leaflet)
- Sheldon T, Cullum N, Dawson N, Lankshear A, Lowson K, Watt I, West P, Wright D, Wright J (2004) What's the evidence that NICE guidance has been implemented? Results from a national evaluation using time series analysis, audit of patients' notes, and interviews. *British Medical Journal*, 329, 1-8.
- Tansella M & Thornicroft G (2009) Implementation Science: understanding the translation of evidence into practice. *British Journal of Psychiatry*, 195, 283 – 285.
- The GRiST web-based decision support system for mental-health risk assessment and management document. Ann Adams & Christopher Buckingham, available at [www.egrist.org](http://www.egrist.org).