Suicide Risk Transcript.
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0.01 **Chair:** I would now like to introduce our speaker. Dr Ian Collins, who is a consultant psychiatrist and an Honorary Clinical Senior Lecturer at Swansea Bay University Health Board. He is going to talk to us now on suicide risk. Thank you, Ian.

0.22 **Speaker:** And in the interests of good learning theory, a good constructivist approach to learning, we are going to start with a question and a vote. It would be really good if I could get your views on which of the following three individuals is likely to carry the highest suicide risk? We've got three cases and I want you to have a think about which one is likely to carry the highest suicide risk.

Patient A is a 24-year-old man who took an overdose following an argument with his boyfriend. He was very drunk at the time he took the overdose. It was a very impulsive attempt with no pre-planning. In the cold light of day, he regrets it and feels mortified. And fortunately, he is back together with his boyfriend. So that's patient A.

Patient B is a 45-year-old man recently made unemployed and recently split from his wife. He's recently been diagnosed with depression by the GP and treated with SSRIs and he has been engaging in regular cutting since the breakdown of his relationship.

Patient C is a 25-year-old man with a diagnosis of schizophrenia. His condition is well treated with Clozapine. He has no history of self-harm or suicide attempts but has regularly been having thoughts that life is not worth living.

So, I'd like you to think of those three cases. Patient C - the 25-year-old man with schizophrenia, patient B the 45-year-old man who's recently made unemployed or patient A, the 24-year-old male who has taken an overdose after arguments with his boyfriend. I would like you to vote on which of those three patients you believe carries the highest suicide risk – A, B or C?

I can't see the answers to the poll on my screen. I'm presuming they will come up shortly.

3.16 **Chair:** We've got patient A with one response, patient B with 32 responses and patient C has seven responses.

3.30 **Speaker:** Okay that's wonderful. Thank you everyone. It doesn't sound like I need to do this webinar today, I'm very glad to say, because you're correct. The majority have gone with patient B. He carries the highest suicide risk. You notice that all patients were male and being male is a suicide risk in itself. Being unemployed, split from his wife are significant risk factors for completed suicide as is a diagnosis of depression, as is being treated with an SSRI potentially. Potentially in the early phases of treatment with an SSRI there is some evidence particularly with those SSRIs that perhaps have a short half-life, there is some evidence of increased risk of suicide with them and that's why it's always important to monitor very closely patients you are treating for depression with SSRIs. And of course, he is engaging in acts of self-harm which are in themselves the biggest risk factor for completed suicide. So well done and thank you for engaging with that pre-test if you like.

5.00 **Speaker:** Okay so what are we going to talk about in today's session. Firstly, we're going to talk about the demographics of suicide in the UK and I'm just going to update you regarding that and it would be remiss of me not to talk about the impact of the COVID 19 pandemic and whether that has had an impact on suicide rates. I'm going to speak about the main suicide risk factors that you need

to consider when assessing somebody for suicide risk, and we're going to think about those in terms of static risk factors and modifiable risk factors. We're going to talk about how you assess somebody who either engages in a suicide act and you're seeing them following that or somebody who is presenting with suicidal thoughts. We're going to talk about an approach to assessment and I'm also going to speak about an approach to assessment during these times, if you like, because I'm cognizant that many of us and many of our clinical workers switched over to using various forms of technology to do our assessment be that sort of video technology or telephone consultation. So we're going to speak about how do we assess patients' risk of suicide during these times. I'm going to briefly touch on the use of suicide rating scales. Really just to say that they're not very effective and we really shouldn't be using them. I'm going to talk about management of suicide risk, and I'm going to end and talk a bit about suicide prevention.

6.57 **Speaker:** So, what about the suicide demographics in the UK? In 2019 the suicide rate in England and Wales (we don't yet have the figures for Northern Ireland and Scotland) was about 11 per 100,000 head of population and that is increased quite significantly from 2017. The suicide rate in the UK has been increasing since the year 2000 but there was a significant jump as you can see between 2017 and 2019. The suicide rate across the whole of the UK for 2018 was about 11.2 per 100,000 and in 2019 in England and Wales there were approximately 5,691 suicides. And as you are aware, the suicide rate in males is significantly higher than the suicide rate in females. About three quarters are of completed suicides occur in males, and in 2018 the suicide rate was 17.2 per 100,000 and in 2019 16.9.

8.27 **Speaker:** And here you have a breakdown again using the 2018 figures of where in the four nations suicide rates are most common. Highest rates in Scotland and lowest in Northern Ireland and as you probably are aware, the highest rates per age group are in males between the ages of 45 and 49. That's where you get the highest suicide rates. And interestingly in recent years, the highest suicide rates in females have moved from the age range 45 to 49 to now being the ages between 50 and 54. So the highest suicide rates in females occur now in that age group. Of note and of importance to consider, is that in the age group of 10 to 24 age females there has been a significant increase in suicide rate since 2012. Something you might want to be cognizant about in your practice. But of course, the rates in this age group in females are still significantly lower than in males of all ages. The most common method of suicide remains hanging both in males and females.

10.00 **Speaker:** What about COVID - has that impacted the rates of suicide? Well so far, not. A recent study conducted by Lewis Appleby in the National Confidential Enquiry into Suicides and Homicides based at Manchester University, concluded that there has not been a significant increase in suicide during the coronavirus pandemic. There have been slightly higher rates, but I think you can understand that in terms of the general trajectory we have seen in suicide rates since 2000, as I've already mentioned. Now there is a caveat to this data. As you know there's probably a lot of delays with regards to inquests because of the coronavirus pandemic, so we don't yet have all of the figures and importantly we are yet to ascertain what the full impact on the economy and the subsequent impact on mental health and suicide will have following the coronavirus pandemic. So, headline figures, is that there doesn't appear to be any significant increase in suicide rates following on from the coronavirus pandemic, but it's too early to say.

11.42 **Speaker:** So, let us move on and to talk about suicide risk factors and I've here listed some of the principal static suicide risk factors and this is by no means an exhaustive list, but they're the most important ones if you like, that you would need to consider when assessing suicide ideation and suicide acts in the round. Clearly suicide risks are more common in males as is suicide risk more common in the LGTBQ plus community particularly in transgender individuals. Clearly in those

individuals there's a lot of gender dysphoria associated and that can increase the likelihood of suicide risk. In addition, of course there's a lot of stigma and a lot of social and societal adversity often associated with those who are transgender.

As you've already seen age is a risk factor. Certain ages have an increased likelihood of suicide.

Previous history of self-harm or suicide attempts is a risk factor. In fact, it is the most important risk factor for completed suicide. Depending on which study you look at, because obviously different studies give different estimates of the increased risk of suicide, having a previous history of deliberate self-harm can increase your risk of suicide by anywhere between 30 and 100 times in the following year following that act of self-harm.

Family history of suicide and is also an important risk factor you need to consider, as is marital status as we saw in that previous question. Being in a confiding relationship, being in a long-term relationship, being married, being in a civil partnership, is protective to suicide. However, being single, being divorced, is potentially a risk factor for complete suicide, as is having a criminal record and a history of violence. Studies have shown that both these are static risk factors for completed suicide.

And trauma is a risk factor for suicide. Experience of disaster or conflict is an important risk factor that you need to consider in particular groups. For example, refugees. So, these are all static risk factors for completed suicide. So, little option to mitigate any of these risk factors but important to consider in the round when you are assessing somebody's suicide risk.

15.05 **Speaker:** Moving on to those risk factors that perhaps are more modifiable in terms of you can do something to ameliorate these risk factors. Well obviously, a big risk factor for suicide is the presence of mental disorder, particularly untreated mental disorder. All the mental disorders have an increased risk of suicide. Some more than others. Obviously, the depressive disorders have an increased risk of suicide more than other mental disorders. Schizophrenia has an increased risk of suicide perhaps more than other mental disorders particularly after acute episodes of schizophrenia. The suicide risk can increase by upwards of 10% maybe even 15% in younger males, following an acute episode. And personality disorder as well is associated with an increased risk of suicide, particularly what we refer to as the Cluster B personality disorders - I'm talking about the antisocial personality disorders, I'm talking about the emotionally unstable or borderline personality disorders. They have an increased risk of suicide. And all of these mental disorders potentially are manageable or treatable and in that you can reduce the risk of suicide with good management of those mental disorders. Other modifiable risk factors – well, thinking patterns. Obviously, as you know, when we think about the cognitive behavioural theory of mental disorders, we will know that in the majority of people with mental disorders they will have altered patterns of thinking which can increase risk of those mental disorders and increase risk of suicide. This is why we do CBT therapy to alter those maladaptive thinking patterns, to treat the mental disorder or ameliorate the risk of suicide.

Substance misuse is a modifiable risk factor to those of your patients who are engaged in a range of substance misuse activities be it alcohol/illegal drugs. Increased risk of suicide there. Having easy access to the means by which you can commit suicide is a modifiable risk factor that is really important to consider when trying to plan the management of those patients. Safety planning, if you like, for those patients who are presenting with suicide acts or suicide thoughts. One of the biggest things I learned as a as a registrar working in the North Pembrokeshire Crisis Team was understanding the very unique sets of circumstances that rural communities have in terms of suicide means. I would frequently go to see farmers and families of farmers and of course you know having access to guns, having access to chemicals in sort of industrial quantities is really important to

consider, that perhaps may not be something you would consider in a more of a city population. So, having access to means is something new to think about, as is unemployment and socio-economic status. So being unemployed, being in the lower ends I guess of socio-economic status increases your risk of suicide. As does level of social support. So social support is both a modifiable risk factor but also a potential protective factor that you may want to consider when you're assessing somebody with suicide risk. As are medical conditions. So, studies have demonstrated that those with a history of ischemic heart disease and stroke, chronic obstructive airways disease, osteoporosis, chronic pain - all of these medical conditions have an increased risk of suicide that you need to consider. And of course, potentially can be ameliorated perhaps as a risk factor.

19.59 **Speaker:** So, we spoke about the static risk factors and we've spoken about the modifiable risk factors, now perhaps thinking about your approach to assessment of someone that is presenting following a suicide attempt or your approach to assessment of someone that is presenting perhaps with, you know, suicidal thoughts.

So, what about your approach to assessment following a suicide attempt in a patient. What kinds of things do you need to consider? Well, you need to be satisfied when you're seeing a patient following a suicide attempt, you need to be satisfied as to the level of suicidal intent there was during that attempt. And these are the kinds of things that I guess would be perhaps red flags in terms for the level of suicide attempt. So, if there was a suicide note that would increase your awareness if you like of high suicidal attempt; if there was a level of understanding of the lethality of the act so you know important question to ask someone who has recently presented with a suicide attempt is how lethal did you think the means that you used to attempt suicide was? How much did you believe it would kill you? And this is important often in assessing people particularly perhaps older populations who may have a less of an understanding in terms of perhaps the amount of medication they would need to take to kill themselves. And if the person who you're assessing believes that their means was a sure-fire way of ending their life then that is quite concerning. And if that person, for example, is an 80-year-old female who thought taking four paracetamols was absolutely going to cause her death, then that's actually very concerning. As opposed to perhaps a 23-year-old female who took 10 paracetamols but didn't think it would kill them. So that level of understanding of the lethality of act is really important.

Acts in preparation for death. So, this is the person who writes a will. This is the person who you know settles their affairs, sorts out insurance policies, leaves a note for the milkman, make sure their pets are looked after. These are all sort of warning signs that someone was very serious in terms of their suicide attempt. As is the level of planning. Clearly someone who attempts suicide impulsively is of a lower risk perhaps than someone who has been planning this attempt for days or weeks. Getting together the means. Trying things out. So, you know, for example, you know making sure that the rope for example if they're considering hanging themselves, is tight enough and tied to a suitably strong ligature point. These are all important things you need to consider.

Acts to avoid discovery. Clearly someone who is taking an overdose in front of a loved one is of a lower suicide intent than someone who books to go away on their own to a cottage in the middle of nowhere. They clearly have a higher level of suicide attempt. And behaviours following the suicide attempt is also important to ascertain. So, someone who immediately phones the ambulance or tries to make themselves sick if they fake in an overdose, has a lower level of suicide intent than someone who perhaps goes to sleep.

And also, important to ascertain the thoughts and feelings following the attempt. If someone like in our very first patient (Patient A) is mortified by the attempt, no longer feels suicidal, then that gives

you a level of reassurance as compared to somebody who is mortified and feels dreadful that they are still alive and continues to have those suicidal thoughts. So, all of these factors are important to consider when assessing someone following a suicide attempt.

24.47 **Speaker:** A quick mention about suicide rating scales. Don't use them. They don't work. In fact, they could be quite dangerous to use. They have a low positive predictive value and they're very bad at missing suicide deaths in low-risk groups. So false negatives particularly. I mentioned one suicide risk assessment there - SADPERSONS - that's a mnemonic: sex, age, depression, previous attempts, excessive alcohol/drug use, rational thinking loss, separated/divorced/widowed, organised, or serious attempt, no suicidal support, stated future intent. It's a mnemonic for all of those things. SADPERSONS has actually been demonstrated as being potentially quite harmful in terms of assessing suicide. And the reason suicide rating scales are not helpful, is they're very static in their approach. You know hopefully I'm demonstrating, or I will be demonstrating to you in my presentation today, that assessment of suicide risk has to be individualised and it has to be a dynamic. There needs to be a dynamic approach. And using fixed suicide rating scales isn't particularly dynamic because it doesn't really address the person that's in front of you. So, I would absolutely encourage you to steer clear of suicide rating scales.

26.37 **Speaker:** Okay so we've sort of talked about how you might want to approach somebody who's already engaged in a suicide attempt and what kinds of things you need to consider.

What about somebody who is presenting with suicidal thoughts?

So, these are the things you need to consider when you're assessing somebody with suicidal thoughts. Clearly the risk factors and we've gone through a longlist of both those static and modifiable risk factors, so you need to consider those. You need to think about the level of intent and the level of planning, and we already spoke about that in terms of:

How easy is it to come by the means that they are thinking about using?
How much planning have they done?
What have they done in anticipation potentially of their death?
What have they done in terms of avoiding discovery following that?

So, all of those things need to be considered. You need to consider the individual needs of the patient and this is very much thinking about the patients in a sort of biopsychosocial perspective. So, there may well be mental health needs, there may be physical health needs, but there may be social determinants as well that you need to consider that perhaps you could ameliorate, that could reduce the suicide risk. And you need to consider that individual's protective factors which may be protecting them against completed suicide. So, this is why assessment of suicide risk is a dynamic process and not a static process that some suicide rating scales perhaps will lead you into a false sense of security if you to use them.

23.33 **Speaker:** So, in terms of the level of ideation - if someone presents to you with suicidal thoughts it is important that you satisfy yourself as to the level of those suicidal thoughts. Because there can be a range of suicidal thoughts in a patient from wanting to go to sleep and not wake up (very passive) to quite active suicidal thoughts, actively wanting to end their own lives. It's a spectrum. Perhaps somebody with very passive suicide (like wanting to go to sleep and not wake up) they may not ever get to the point where they would actively want to take their own lives and that in itself potentially is a protective factor, if they're very passive.

What about the level of planning? I've already talked about this to a great degree. The person who does things impulsively has a much lower level of planning that the person who's been thinking about doing it for weeks and weeks. The lethality, the perspective of the patient regarding the lethality of their chosen attempt. Remember the older lady perhaps who thinks that four paracetamol tablets will be sufficient to kill her versus somebody who thinks that a large quantity will only make them go to sleep for a few days. Think about how accessible that person’s chosen method of suicide is. You know if someone is talking to me about shooting themselves but live in an urban population with no access to any forms of guns, then actually their access is limited to that means compared to that rural population perhaps, that have an increased access. And if that person has gone out and bought a rope or stockpiled tablets for weeks on end by going to different pharmacies and buying16 paracetamol in each pharmacy, then obviously they’re that the things that would need to concern you.

And the level of intent okay in terms of what do they want to accomplish by engaging in this particular act? Are they rather vague about it? Do they just want to go to sleep or actually do they have a strong desire to die? And if you're thinking about all of these factors, you can almost rank each of these factors in a sort of low/moderate/high type way which can feed into that sort of dynamic risk assessment that you're going to take when you’re thinking about assessing the risk in that person.

31.30 **Speaker:** Other things, and again thinking about suicide risk in the round, other things that you might want to be aware of is individual social determinants. You know unemployment, housing problems, relationship issues, untreated disorders, untreated mental disorders because obviously significant risk is associated with untreated mental disorder and you would want to treat those mental disorders in your own setting in primary care or escalating it to secondary care if necessary. We spoke about physical symptoms. Thinking about psychosocial and occupational functioning because if someone has got good levels of psychosocial and occupational function this can potentially be a protective factor against suicide. Any ongoing personal or financial difficulties. It's easy to signpost people with those kinds of issues particularly if that is the main reason that they are having suicidal thoughts.

And also, the needs of dependents. It’s almost doing that family assessment. Are there any particular needs of dependents, some mental health needs in children, challenging behaviour needs, autistic spectrum disorder etc that could be addressed to ameliorate the suicide risk in that individual?

33.04 **Speaker:** And what about protective factors. This is why it's so important to think about suicide assessment as a dynamic process not as a static process, because all of these things need to be considered. We spoke about social support being a modifiable risk factor before. Yes, it is. Because somebody who has good social support around them – a supportive family, supportive parents, supportive spouse - then obviously they're going to be protective factors. They're going to reduce the likelihood of suicide risk. As is future plans, you know. It's important and I often find it important in my assessments to try and get the person to talk about what their future plans might be away from thinking about suicide because if they sort of have lots of plans for the future, unrelated to suicide, then that reduces the risk of suicide. As does employment as we've already mentioned. As do children. All protective factors. How good is that person’s problem solving or coping skills? And this is sometimes where support from a practice counsellor or third sector organisation can be helpful. And faith. Remember having a strong faith is a protective factor against suicide and needs to be considered when you're assessing suicide risk.

34.29 **Speaker:** And I thought I'd just bring in somethings to consider during coronavirus pandemic, particularly as we're all maybe doing more assessments using other means of technology - telephone assessments/video assessments. So, I thought it'd be helpful just to list some questions here that it might be helpful for you to ask an individual who you may have some concerns about suicide risk. I commend these questions to you. You may certainly want to adapt these questions to your own individualised approach. These are kinds of things you might want to ask:

Asking questions about how the pandemic has affected their well-being. Asking questions about perhaps in the last two weeks have they felt low, fatigued, or lacking in enjoyment - the three cardinal symptoms of depression. Ask generally about views or plans of the future. Ask - do you ever feel if life is not worth living or do you go to bed wishing you wouldn't wake up? So, we're talking now about increasingly escalating questions around suicide. Have you had thoughts about harming yourself and others? What methods have you thought about? How are you planning to act on these methods? Have you made any plans in anticipation for your death? Are there any reasons, including loved ones, that may make you think twice about these plans? And, what kind of help do they think they need to support them? It's always a really important question to ask patient - what do you think would help/support you? And these questions might help you in your assessments using various forms of technology that we're all using at the moment.

36.19 **Speaker:** Moving on now perhaps for the last few minutes to talk about managing suicide risk. And again, there has to be an individualised approach and a dynamic approach to managing suicide risk because no two individuals are the same and you know no two individuals maybe have the same needs or the same risk factors or the same protective factors. And this is why it's important to think about it in a dynamic way. So, think about individualised risk reduction in all patients. What is it about that individual's risk factors that you can potentially mitigate? How could you potentially ameliorate some of those risk factors to increase the sort of sense of well-being and reduce the chances of suicide? So, this is where sort of individualised safety plans come into place (and I will be talking about self-harm in the New Year, on the 15th of February) particularly about people maybe that recurrently self-harm. What can be done to reduce the dangers of that self-harm or that suicidal behaviour that can increase the safety of that patient? You know, reducing access to means, for example.

Clearly evidence-based treatments are a way we manage suicide risk, so this is about treating any underlying mental or physical disorder that may be having an impact on the suicide risk. Having that therapeutic relationship. Absolutely crucial. Don't ever underestimate the importance and the positivity a strong therapeutic relationship can have. Because it's with that strong therapeutic relationship and that good relationship, that you can get that individual to disclose some of the things that they may be thinking.

And I understand the next one would need to be considered in the bounds of patient confidentiality, but if possible, involve family and others. Obviously, the patient might need to agree to this though obviously there are some considerations that you can breach patient confidentiality if you think there's immediate risk to that patient and it's in their interest.

Reducing access to means. You know, reducing access to stockpiled medications in some situations, reducing access to sharp implements, that kind of thing. And having clear and communicated plans so that's clear and communicated plans with the individual the patient, their family, and others if they're agreeing to have them involved in those plans. But also, other agencies, if other agencies are involved. So secondary mental health services, the local authority etc. You know one of the things that always comes up in the review following a suicide is that breakdown in communication between

professionals and between agencies. One of the one of those key factors that always seems to come up in those root cause analysis following suicides.

39.49 **Speaker:** Consider a stepped approach to care to managing suicides. What do I mean when I talk about stepped approach to care? Well depending on the severity perhaps of their mental disorder, depending on the level of risk, you may want to involve secondary mental health services. Okay, so if someone is very severely depressed, new onset psychosis, has high levels of risk, then of course you would want to get in secondary mental health services involved. And depending on the immediacy of that involvement that you require, you would want to involve different teams. If there's not an immediate need for input, you might want to refer to Community Mental Health Teams. But if there's more immediate needs you want to think about the Home Treatment Team, Crisis Team or Accident and Emergency of course, if they've engaged in an act that needs dealing with and Substance Misuse Services.

Importantly you must consider those who have recently been bereaved by suicide because there's increasing evidence that in those individuals there is an increased risk of suicide as well. So, it's important to consider them. And you also need to think about where third sector can support you in your work and support people who are having suicidal ideation. Particularly if that suicidal ideation is not associated with mental disorder or physical health. So, you know, finance issues, relationship issues, bereavements as I've said.

41.40 **Speaker:** Just finishing off now with thinking about suicide prevention in the round and almost our responsibility as society to reduce suicide. Well clearly, it's important to identify high-risk groups for suicide and reduce the risk in those groups. So again, I'm thinking about you know those are mental disorders, refugees, LGBTQ plus. Identifying and supporting those with higher risk of suicide, improving mental health for all, using evidence-based practice, reducing access to the means of suicide. So obviously you know the reduction in size of paracetamol packets was an important way of reducing access to means of suicide. Obviously reducing the amount, I think, of coal gas in natural gas reduced the likelihood of being able to kill yourself by gassing yourself in an oven. So, these are all sort of societal things that have been done to reduce access to means. Providing better information and support for those affected by bereavement and supporting the media in delivering sensitive approaches to suicide. So, this is this whole issue around destigmatizing suicide and suicidal behaviour. Making it something that can be talked about more openly. All of these things should be considered in sort of wider suicide prevention.

43.17 **Speaker:** Okay I'm going to finish off with a question and I'm going to defer to Nicola as to whether we want to think about answering this question or if there's lots of questions come in, I can answer those questions. But here's a typical presentation that you may well find in primary care: How would you assess this and manage this person?

35-year-old man with a history of emotionally unstable personality disorder. Discharged from the community mental health team because of non-engagement, which is often a common feature. History of overdose and superficial cutting but nothing for two years. Recent history relationship breakdown and has started to cut superficially again. No evidence of effective or psychotic symptoms. However recently been drinking alcohol heavily and smoking cannabis. Had benefits stopped last week because of failure to attend DWP appointments. All very common features our patient groups. So very happy if you want to jot some suggestions down in the text box. I'm also very happy to answer some questions as well before I end with perhaps a summary of my talk today. Thank you.

44.36 **Chair:** Hi Ian. Yes, there's been a few questions. I think probably we'll go to those first and then if you've got time comeback to that patient question that you've set there.

44.45 **Speaker:** Sure absolutely.

44.46 **Chair:** The first question is - Is there any advice on when patients with substance misuse engaging with substance misuse services should also be accepted for treatment with secondary mental health services?

45.00 **Speaker:** This is a this is a hot issue, I think. It's the issue of dual diagnosis and the roles and responsibilities of services to manage both issues if you like if you've got someone with a substance misused issue and an ongoing mental health presentation. It's difficult. Again, it's individualised. It's based on the individual need of that patient. It's often really important to deal with any acute substance misuse issues really before you can engage the patient with meaningful mental health support. It depends on the level of acuity and it depends on I suppose, this old chicken and egg issue - what's caused which? If you've got someone with an acute presentation, for example, a psychotic presentation, who we may well be using substances at the same time, then clearly the issue there is about treating the acute psychosis and perhaps dealing with the substance misuse problem secondarily. Or, in another patient you could have someone who's using a lot of substances, using a lot of alcohol, who may be depressed or anxious as a consequence that you would clearly want to try and address the substance misuse issue first. So, I'm sorry it's not a very clear answer. It is important to consider these groups of patients in the round in terms of dual diagnosis but it's often important also to have an individualised approach to those people.

46.45 **Chair:** Okay thank you very much. The second question is do you think that we can safely assess suicide risk by phone? Would it be wise to always see individuals who are high or medium risk face to face?

45.00 **Speaker:** That's a really difficult question to answer. And I can't really base this on any evidence base because probably there hasn't been lots of evidence done because we've been obviously all been forced to use different means of technology over the last eight months to assess our patients. I've been doing it as well. And you know I would never underestimate you know the power of your gut, in terms of assessing risk. I mean you know it's not just a feeling it's a feeling based on a high level of expertise and experience and it's a feeling based on an understanding of the unique sets of needs that our patients have. And I think if through a phone conversation or through a video conversation you're getting some red flags regarding suicide risk, then I'd absolutely try and do a face-to-face assessment of that individual. If you've got long-standing patients who perhaps have long-standing mental health problems and there's evidence of relapse indicators then there's some red flags going up there, then I absolutely encourage you to try and do that face to face. But I think there's a good proportion of assessments you could likely do over the phone or using video consultation and you could reassuringly do them to ahigh level and manage that risk in those individuals. But if there are lots of red flags and of course then I would clearly encourage you to see that patient.

48.44 **Chair:** Thank you. The third question. The GP is writing that in her practice serving a population of 6,500 they've tragically had four suicides this year. Prior to this she can only recall one suicide in the last 10 year. Three out of the four were male and all were from hanging. Only one was under the mental health team and had regular contact with the GP. So, the question is, as GPs, what can we do to identify these high-risk individuals who do not self-present. It seems an impossible task.

49.20 **Speaker:** Well, it is an impossible task of course. And remember that the vast majority of completed suicides in the UK occur in people who've had no contact with either primary or secondary mental health services. So, you know, there's not much we can do about things we don't know about. It's those unknown unknowns, you know. I think we can only do stuff about what we know about and we can only support those patients that were aware of as being perhaps a suicide risk. And we can only do that suicide prevention stuff that I mentioned about identifying perhaps those high-risk groups - those asylum seekers, those people who have recently been bereaved by suicide. You know, I've had a suicide myself in the last eight months which I believe probably was also related in a way to the COVID pandemic. This was a patient who had been through our rehabilitation service and left hospital eight months ago and was a real success story of ours in terms of the impact we had on him and the and all of the hard work he'd done himself in terms of relapse prevention. And you know unfortunately he completed suicide in August in a very bizarre way, a very strange set of circumstances which I won't go into now. I think I would just encourage. You can only do what you can. You only know about those patients who are increased suicide rates risk. Those unknown unknown patients - there's very little you can do apart from that societal approach about identifying those high-risk groups and making suicide and suicidal thoughts destigmatizing. Talking about theme.

51.30 **Chair:** After starting an SSRI how frequently should we be reviewing the patient initially to check for increase in suicidal ideation?

51.40 **Speaker:** Thank you that's a great question. So, as I said in my presentation there is ***some*** evidence (and I say some evidence and I really emphasise some) to suggest that there may be an increased risk of suicidal ideation and attempts following starting an SSRI. Particularly, I mean you I'm sure you'll remember the Panorama programme a few years ago homing in on Paroxetine Seroxat as a potential cause and some criticism there of the drug companies for hiding some of that data. It's complicated why an SSRI may increase suicide. It could be that actually the person is getting better and one of the first things that improves in depression is motivation so they're more inclined to act. It could be that we know SSRIs can tend to increase anxiety and agitation when you start them and the important thing there is make sure you tell your patient that. Or it could be actually a real effect of the SSRI initially, I guess. But I would look to monitor everyone to two weeks following commencing an SSRI to assess response, because there is increasing evidence that if you don't see a response in the first two weeks to an SSRI, even the flicker of a response, you're unlikely to see a response in six weeks.

53.02 **Chair:** Thank you. What is the best way to help someone who doesn't have underlying mental health issues, is not depressed etc but for example has lost his job and has calculated his family will financially be better off without him around due to the insurance payoff?

49.20 **Speaker:** Well as I've experienced in my own personal life that is not always a foregone conclusion that an insurance company/life insurance company will pay out following suicide. This is a real example I believe of stigma in the insurance system actually, that a lot of insurance policies do not pay out following suicide or will pay out a significantly reduced amount. I think the only thing I would say there is consider those social determinants of suicide in that individua, l and you know, use the support that the third sector can perhaps offer in supporting this individual. And look at how you can support that individual to improve their coping strategy. So, this is where I guess referral to third sector CAB, referral to your in-house counsellor perhaps could be really really beneficial.

54.19 **Chair:** Thank you. We've got the last two questions. Is there any evidence that patients who are discharged by the crisis team on diazepam and zopiclone will benefit from a continued script of the above? It's a common issue that we face, where patients are asked to see their GP for them.

54.20 **Speaker:** Well yes, I would hope that those scripts that the patient is discharged from the crisis team with are just short-term scripts and they should only be used as short-term interventions. So just to emphasise that the use of benzodiazepines, the use of those Z drugs, the zopiclones, should only really be used to ameliorate symptoms in the short term. They shouldn't really be prescribed long term because of the significant risk of dependence in those drugs and increasingly I would say the same about gabapentin as well. I think gabapentin is going to be our 21st century equivalent of Valium was in the 20th century and we're going to have lots of issues with it potentially in the future. So, my encouragement there would be they should only be prescribed for short term unless under specialist direction, I guess, if there's a clear rationale. But generally, the headline would be short-term use only.

55.48 **Chair:** Thanks. It's particularly helpful for us all, I think. And the final question: We've identified a patient with tragic past history but frequently declines to engage, though has full capacity. The only protective factor is her father who is a terminal care patient. And the question is how can we best support her once he dies? She's seen regularly but refuses to engage at all.

56.15 **Speaker:** I think this is difficult, this is really difficult. I think without knowing the full details of the history it would be hard for me to give you a really reasoned approach to this. But clearly you know we talked about supporting bereaved families, bereaved individuals so that might be something you would need to consider when she does lose her father. You know referral to Cruse, for example. And you know I think it sounds like you're doing exactly the right thing. You're seeing that person regularly, you're trying to develop that therapeutic relationship, that supportive relationship with the individual which will hopefully go a long way in terms of them disclosing things to you. You need to keep thinking about that sort of dynamic risk assessment, asking those questions and you know, and if you have those concerns/if those concerns ramp up or if you have any acute red flags that appear, then you need to consider about escalating to mental health services.

57.15 **Chair:** Lovely Ian. That's the final question so I think probably if you'd like to round up your talk that would be great.

57.22 **Speaker:** Oh, thank you very much Nicola. It's been absolutely wonderful to speak to you all today even though it's been sort of you know fairly one way and you don't get the feedback you do perhaps that you do when you're in a room full of people. But it has been great speaking to you, and I hope you have found that session helpful.

Just really summarise. As I've already said, suicide has been increasing since 2000 in the UK particularly that big increase between 2017 and 2018. As you know it's highest in that age group of males 45 to 49. There isn't an increased risk of suicide post-COVID yet, though of course we all know of examples of very tragic situations that we've all dealt with perhaps of suicides in this time. When you are assessing an individual with suicide risk you need to consider risk and protective factors. And you have you absolutely have to have dynamic approach to both assessment and management. Risk assessment scales aren't effective in predicting risk because they are very static. And management should be focused on those modifiable risk factors and access to appropriate services.

So, thank you very much and it's been wonderful speaking to you as I've already said and the final two slides really are just some contact details, some links for services in your local areas and should

you need to access those services in the future. So great to speak to you. Thank you very much indeed.

58.57 **Chair:** Thank you very much Ian for a fabulous talk. I'm sure that we've all found something very helpful and useful for our everyday practice for it. Thank you to everybody who attended and for taking the time out of your busy days to come and listen to Ian. Can I ask again that when the questionnaire comes through to you if you could take a few more minutes of your time and fill it in to feedback to us because it definitely informs future meetings. And just to remind you that Ian is talking again on self-harm and a similar webinar on the 15th of February next year.