Consultation on Preventing Suicide in England: A cross-government outcomes strategy to save lives

Consultation reply form

Please reply to as many of these questions as possible. We encourage responses from anyone interested in the issues raised in this document.

We would find it particularly helpful for you to refer to any research or evaluation evidence that supports your views. We would also like to hear more about proven measures in place in your local area which bring measurable benefits to your own community.

If you need more room to answer any of the following questions, please continue on a separate sheet, clearly marking the question number.

Area for action 1: Reduce the risk of suicide in key high-risk groups

1. In your view, are there any additional measures or approaches to reduce suicide in the high-risk groups that should be considered for inclusion? What evidence can you offer for their effectiveness?

There is an urgent need to review the efficacy of risk assessment tools and identify robust evidence-based tools. These should then be supported to ensure common adoption across primary and secondary care settings. We encourage the uptake of the GRIST model. GRiST is a web-based decision support system for assessing the risks of suicide, self-harm, harm to others, self-neglect and vulnerability. It is designed to reflect how mental health experts think about and assess risk, because it is based on the elicited expertise of multi-disciplinary mental health clinicians. The GRiST technology contains software simulations of how these experts assess low-level cues (e.g. lives alone), through higher level concepts (e.g. depression, anxiety, anger), to top-level risk categories such as suicide and harm to others. Based on psychological processes, GRiST can fully explain how a set of service user cues generates specific risk quantifications in a way that is intuitive, comprehensible, and resonates with clinicians' own understanding of risk. Further information is available at http://www.egrist.org/

Better outcomes are achievable if there is the opportunity for treatment, including preliminary assessments,to be provided in not clinical settings. This is particularly important for young men for whom clinical settings can represent a significant barrier.

We recommend a formal recognition of the value of the contribution of families such that they are genuinely involved, and at an earlier stage, in care plans and discharges. A clarification of confidentiality guidelines is required such that it is no longer used as a default barrier to family participation.

Any appropriate training needs to be made mandatory for all relevant professionals. Voluntary uptake is insufficient. It is also vital that mandatory training is extended to include ancillary staff (not just clinical professionals). Given staff turnover and the development of new evidence it is essential that regular mandatory updates are also provided.

2. In your view, are there any other specific occupational groups that should be included in this section? If so, what are the reasons for inclusion?

Area for action 2: Tailor approaches to improve mental health in specific groups

3. In your view, are the most appropriate groups considered, including any groups where there are issues relating to equality?

It is critical to acknowledge and plan for the challenge resulting from England's ageing population. The total number of over 75s is set to exponentially rise over the next twenty years. Whilst the total suicides amongst this group may currently represent a small, although meaningful, proportion of the total figure, we believe this group is likely to contributing an increasing, and possibly the greatest, number of suicides. There is therefore an urgent need to target preventative activity at this age group.

There is an alarming evidence gap into the impact of endocrine changes in women's mental well-being. In particular, the role of hormone levels in women's mood at menarche, pregnancy and birth, and menopause must be better understood. Greater empirical evidence is required to provide an empirical basis for greater suicide prevention targeting.

4. In your view, are there additional measures or approaches to reduce suicide in the identified groups that should be considered for inclusion? What evidence can you offer for their effectiveness?

More information, support and training is needed for professionals involved in the management of an individual with a physical and mental health problem. Any change in the experience of the physical health condition, particularly with chronic conditions, represents a potential pressure point for the individual's mental well-being. This needs to be acknowledged and managed by health professionals. Silo-working across physical and mental health needs to be urgently broken down such that an integrated care package can be delivered by knowledgeable and skilled multi-disclinary professionals.

We applaud the commitment in 'Talking Therapies' to provide access to talking therapies. It is imperative that the treatment length is not prescriptively set at e.g. six weeks and instead is tailored to the needs of the individual. As required, access to talking therapies should also be made available during periods of wellness for people with cyclical depression in order to provide coping strategies and reduce 'descent' towards suicidal tendencies.

Local interventions for prompt. effective and appropriate treatment for depression will not succeed unless this is set against a backdrop of supportive public attitudes. There are currently enduring issues with stigma and discrimination, often based on outdated perceptions about cause, treatment and risk. Public attitudes and behaviour must be targeted in a targeted, concerted and ongoing manner.

Area for action 3: Reduce access to the means of suicide

5. In your view, are there any additional means of suicide that should be considered?

-

6. What additional actions would you like to see taken to reduce people's access to the means of suicide? What evidence can you offer for their effectiveness?

-

Area for action 4: Provide better information and support to those bereaved or affected by a suicide

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

Any death is traumatic for the bereaved. However, suicide brings with it a particular set of challenges that can exacerbate that grief. Many people affected by suicide are affected by guilt. There is an important need to recognise that being bereaved by suicide is a different experience to when loved ones die by other means.

There continues to be high levels of public misunderstanding about death by suicide includes enduring opinions that it is a criminal offense and that it is un-Christian. Public attitudes need to challenged in order that those bereaved by suicide can be better supported.

Families bereaved by suicide have extensive, and valuable, knowledge, experiences and opinions that should be collected about the death of their loved one and potential contributing factors. This data is a valuable contribution to reviews of processes and systems such that lessons can be learned. A formal data collection process needs to be established to capture these experiences in a consistent and meaningful manner.

Families bereaved by suicide should have a greater opportunity to contribute to the coroner's process. Their role is currently undervalued and under-utilised. Family members often report to feeling as though they have been put 'on trial' during the process, with no emotional support provided and no consideration that they have been recently bereaved.

The Department of Health's 'Help is at Hand' resource is unknown amongst the bereaved families we are in touch with. This, or another similar resource, need to be urgently distributed through relevant and effective channels. The police, coroner's officers, funeral directors and GPs are priority contact points.

When loved ones are at risk of suicide family members should be involved in discussions about the individual's care and management and made aware of suicide ideation.

"My wife told her psychiatrist that she was thinking of suicide. He didn't discuss this with me. If he had I would have been more vigilant. I wouldn't have let her be alone. That could have saved her life as she wouldn't have been able to go out in the middle of the night and drown herself."

A clarification of confidentiality guidelines is required such that it is no longer used as a default barrier to discussions with family members. This is particularly the case when the person with suicide ideation gives their consent for their family member(s) involvement.

A national register of suicides is urgently required.

The data collated by the National Confidential Inquiry into Homicides and Suicides is fundamentally flawed because of the collection method (depending on health trusts and the recent involvement of mental health care services). There is an urgent need for a new process that enables robust, meaningful, comprehensive and timely collection of suicide data. This data must be collected locally but available nationally.

As noted in answer 7, there is a wealth of information from the inquests of families bereaved by suicide which is not currently being effectively collated.

There is a need for a comprehensive and robust empirical study into families bereaved by suicide.

8. What additional information or approaches would you like to see provided to support families, friends and colleagues who are concerned about someone who may be at risk of suicide? Please comment on how this help could be provided effectively and appropriately funded.

Robust bereavement information is urgently required that is consistently signposted by all key agencies at/soon after the time of death. This could be provided by a voluntary sector partner and funded. It is likely to be available from the suicide prevention charities if distribution can be secured through critical statutory channels (police, coroner's, GPs).

As noted in answer 7, there is a wealth of information in coroner's records from inquest proceedings.

Area for action 5: Support the media in delivering sensible and sensitive approaches to suicide and suicidal behaviour

9. In your view, are there any additional measures or approaches that could promote the responsible reporting and portrayal of suicide and suicidal behaviour in the media?

10. In your view, are there additional approaches that could be considered for the internet industry in England to maximise the positive potential of the internet to reach out to vulnerable individuals?

Content providers need to be encouraged to act more quickly to remove harmful or tasteless material. Industry-wide codes of conduct should be monitored and updated on a regular basis.

Content providers should be encouraged to develop screening packages that enable users to block access to particular sites (operating in the same way as parental controls for sex/violence). This would include searching for particular suicide-related terms.

Area for action 6: Support research, data collection and monitoring

11. Is there additional information available that could be collected at a national and local level to support the suicide prevention strategy?

A national register of suicides is urgently required.

The data collated by the National Confidential Inquiry into Homicides and Suicides is fundamentally flawed because of the collection method (depending on health trusts and the recent involvement of mental health care services). There is an urgent need for a new process that enables robust, meaningful, comprehensive and timely collection of suicide data. This data must be collected locally but availably nationally.

As noted in answer 7. there is a wealth of information amongst families bereaved by suicide which is not currently being effectively collated.

As noted in answer 7. there is a wealth of information in coroner's records from inquest proceedings.

More detailed data is required by the ONS in order to provide meaningful data that can genuinely contribute to the planning of suicide prevention activities.

Open access should be granted to locally and nationally collected data, such as a national register or the coroner's records such that it can be used by academics and other interested parties for non-commerical purposes.

12. In your view, where are the gaps in current knowledge of the most effective ways of preventing suicide?

There are significant gaps in understanding suicide risk factors. These can potentially be addressed by tools such as Grist. (See Answer 1).

A wealth of information is already being heard within coroner's courts. However, this is not being systematically collected or analysed. A comprehensive process is urgently required. This should include specific 'alerts' for local health boards on issues arising.

Making it happen locally and nationally

13. Are there examples of local good practice that could be disseminated to other areas?

-

14. What other local and national approaches could be developed to ensure the implementation of the strategy?

Joint Service Needs Assessments (JSNAs) must include suicide prevention in their locality.

Primary care is a critical setting for suicide prevention work. Multi-disciplinary and multitude settings approaches must put primary care at their heart.

Primary care is often the first, and only, port of call for people with suicide ideation. Primary care staff urgently require relevant and mandatory training in suicide.

There is an urgent need for current empirical evidence to support the often asserted fact that people with suicide ideation visit their GP in the month/week before taking their own life.

There is currently only one suicide respite centre - Maytree in North London.Anecdotal feedback shows that non-clinical settings and support can help people to overcome the immediate crisis. Research is required to determine the efficacy on establishing a larger network of centres.

15. What issues should the Department of Health be considering as we develop any potential indicators in the Public Health Outcomes Framework relevant to suicide prevention?

-

Impact assessment

The following questions relate to the consultation impact assessment published alongside the draft strategy.

16. What approaches would you suggest to measure progress against the objective to provide better support for those bereaved or affected by suicide?

All families affected by suicide should be surveyed about their experiences.

17. Do you have any comments and evidence on the costs and benefits of targeting suicide prevention training at groups other than GPs?

Efforts that focus solely on GPs will have limited impact. Training must be provided to ancillary staff such as Practice Managers and Receptionists and other related health professionals such as Pharmacists and Paramedics.

18. Are you able to offer any evidence on the number of public sites in England frequently used as locations for suicide?

Any other comments

19. Is there any other information or comment you wish to add?

A government department (and Minister) must be fully accountable for the delivery of the suicide prevention strategy.

There must be clear targets against which performance must be measured. Annual progress reports should be made publicly available.

You do not have to complete the sections about your personal background if you prefer not to. However the information is confidential and will only be used to assess whether the responses we receive represent a balanced cross-section of views from across society.

Name:

Amy Meadows

If you are responding on behalf of an organisation or interest group, please indicate the name of the organisation:

Judi Meadows Memorial Fund

Your role within the organisation or group:

Founder and Trustee

Gender

	Female	x	Male		Transgendered		Rather not say

How old are you?

	Under 18		18-24		25-34		35-54 x
	Over 55		Rather not say				

Ethnicity:

	White - British x		Asian/Asian British - Pakistani
	White – Irish		Asian/Asian British – Bangladeshi
	White – Other		Asian/Asian British – Other
	Mixed – White and Black Caribbean		Black/Black British – Caribbean
	Mixed – White and Black African		Black/Black British – African
	Mixed – White and Asian		Black/Black British – Other
	Mixed – Other		Chinese
	Asian/Asian British - Indian		Other

Other: please specify below

Do you consider yourself as a person with a disability?

	Yes		No x

If yes, please specify

Would you say that you have experienced mental health problems, either recently or in the past?

	Yes		No x