

# **A cross-government outcomes strategy to save lives**

## **Consultation on Preventing Suicide in England**

### **Response to the National Suicide Prevention Strategy**

**from**

### **The Alliance of Suicide Prevention Charities (TASC)**

#### **1. TASC Background**

TASC is an alliance of suicide charities set up in November 2010 and its purpose is to encourage collaboration and prevent duplication of efforts and funding in the area of suicide research and prevention strategies. We represent a variety of organisations including:

The James Wentworth Stanley Memorial Fund  
The Charlie Waller Memorial Trust  
The Matthew Elvidge Trust  
The Judi Meadows Memorial Fund  
Papyrus  
CALM  
Maytree  
Head culture

We are also supported by MIND, Samaritans, SANE and Counsellors and Psychotherapists in Primary Care.

#### **2. Summary**

We are very encouraged that the Government has identified suicide as a major public health issue, which has a lasting impact on family, friends and colleagues both directly and indirectly.

The report provides a very comprehensive approach to the potential causes of suicide for all the affected groups and makes sensible recommendations for appropriate action to minimise deaths in the future. However, there appear to be a number of important areas, which need to be considered further in the report.

Our belief is that the Government's co-ordinated cross department strategy should set **clear targets**, which we consider should be to **halve the number of suicides over the next 10 years**. This is consistent with the Government's approach to reducing fatal road accidents since 1990 and its activities to deliver the target. There

needs to be an annual report presented to Parliament by the Minister with specific responsibility for suicide prevention.

There needs to be an **engaging Vision**, which paints a clear picture of the future and what life should look like in, say, 2021 relating to:

- building overall **public awareness** and understanding
- delivering **effective training** for all relevant people
- providing **effective risk assessment** at all stages of presentation
- delivering **effective follow-up services** and care pathways
- **learning from past suicides** and applying this data to prevent future suicides
- **measuring performance** against clear targets and having **clear accountability** at all levels

This strategy and vision should be supported by all relevant Government departments including Education (Schools and Children and Families); Business Innovation and Skills (Universities and Science, Business/Enterprise and Further Education); Health and Justice.

We consider that the strategy should be based on the principle that **prevention is as important as cure** and reducing suicide in the long term starts with increasing the resilience of our population, including young people at a time when the pressure to conform and perform is greater than ever, in an economic environment that is reducing employment opportunities to a historic low level.

This strategy should deal, amongst others, with the following areas:

### **3. Building Public awareness and understanding**

#### **3.1 Public Campaign**

**Suicide is a major public health issue** and it is vital that the general public in England understand that it results in c. 4,400 deaths each year and that men are three times more likely to take their own lives than women.

The general public also needs to understand that **suicide is preventable** and people who suffer from any form of mental illness, which may result in suicide, can be treated successfully with therapy and drugs.

It is vital that more people in the UK have a **greater level of understanding of suicide** and its impact on families and friends. They also need to have a greater understanding of mental illness and depression, how to spot the signs and how and where to seek the right professional help.

This campaign should target the general public as well as key groups including teachers, GPs, nurses, university staff, employers, parents and all those in contact with people, who may feel suicidal.

**The National Suicide Prevention Strategy should incorporate a new ‘Area for Action’ addressing the issue of suicide**, its impact on society and the fact that it is preventable. The campaign should aim to educate the general public and remove the taboo about suicide, such that people, particularly men, feel able to talk about their feelings.

This would tackle the challenge that HIV had 30 years ago and aim to increase the awareness of suicide and mental health, including anxiety and depression and its signs, as a medical problem that can be treated successfully

A large number of suicides will be the direct or indirect result of the individual being unable to talk about his or her feelings and mental health problems, particularly with young men.

The report seems to direct most of the proposed communication to those affected by mental health problems and related interest groups. We consider that this fundamentally misses the urgent need to create a step change in the way everyone views suicide and mental health in England and to de-stigmatise the issue by creating an atmosphere of openness in all schools, universities, workplaces and the general public. The current attitude towards suicide and mental health appears similar to those experienced by drink driving and the wearing of seatbelts decades ago.

Road deaths have fallen by 65% over the last forty years, largely due to a change in attitudes and yet, the government still invests heavily in further awareness campaigns.

The government should take a similar approach to mental health, until the number of suicides falls, perhaps, to the same levels, as it now kills more people than road deaths.

This would also help to make this subject top of mind for GPs, families, teachers, nurses, prison warders and all others, who are in regular contact with those at risk.

‘Time to Change’ has achieved a great deal, and we are pleased that the Government is supporting Phase 2 of this campaign. We consider that this support needs to be **long term and sustained (over, perhaps 10 years) to achieve a higher level of sustained public awareness.**

### **3.2 Schools**

We consider it vital to **improve and expand the PSHE curriculum to incorporate mental health and well-being as a statutory element**, with the explicit aim of **improving children’s’ resilience and ability** to cope with all the different situations that they experience, whether related to family, friends or the pressure of academic achievement.

This would require an enhancement to teacher training to cover the importance of mental health and well-being, how to spot signs of poor mental health and where to obtain the right help.

### **3.3 Universities and Colleges of Further education**

We need to ensure that all universities have **mental health and well being on their induction programmes/ fresher's' week agendas** as an explicit and mandatory topic, talking about its importance and where students can obtain support and help. They would also be required to ensure there is an **integrated approach to support** across the NUS, counselling services, student well-being, mental health advisers, local GPs, Hospital Emergency Departments, Night Line and other support services.

### **3.4 Employers**

There are many good examples of best practice schemes in the workplace supporting **initial and ongoing education in the understanding and importance of good mental health and well being** and providing all employees with advice on where to obtain help in the event of problems.

Every employer should be encouraged to implement similar schemes.

### **3.5 Media, internet and digital communications**

One of the questions asked in the consultation is whether additional measures and approaches could be considered for internet service providers to discourage internet sites/chat rooms giving detailed information on suicide methods?

This seems to be a very simple way of reducing the risk of suicide, in the same way that removing the availability of large pack pain killers had a significant, beneficial impact.

We have direct experience of these sites being used to research the most effective methods of suicide.

We would recommend that the talks held with all the ISPs should mandate that **all sites that in any way encourage people to take their own lives or inform them how to take their own lives should be removed from the internet.**

It would also be valuable for anyone, who searches "suicide" or "taking your own life" or similar to be directed to sites that provide help and support to those at risk (for example, the Samaritans and Maytree)

## **4. Delivering effective training for all relevant people**

There should be **mandatory training** tailored to all those in contact with people who feel suicidal including clinicians, ancillary health staff, teachers etc in how to identify and respond to suicidal thinking, feelings and behaviour, with a **mandatory 3 year update.**

A group should be formed comprising service users and providers, third sector and academics to **scope and review all training packages available** e.g. those funded by the EU, 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.

As part of **GP qualification training**, there should be a mandatory module on how to identify and respond to suicidal thinking, feelings and behaviour.

**Every aspect of professional and other health training** for consultants, GPs, nurses, care workers and all those in contact with patients should be enhanced to cover the importance of mental health and well-being, how to spot the signs and where to obtain the best professional help.

### **5. Providing effective risk assessment at all stages of presentation**

#### **5.1 The assessment process**

Our experience suggests that the psychosocial risk assessment process falls short of the standard required to minimise the number of suicides.

There are a wide variety of different frameworks used for the psychosocial assessment process and these need to be reviewed to identify a **best practice, evidence based set of risk assessment tools** that can be used by all those in the NHS and others required to carry out assessments. This best practice should reflect the increased risk of people planning a suicide attempt, as opposed to having suicidal ideation.

There also needs to be an **investment in training to support the best practice** to ensure that assessments are carried out in a non clinical, friendly environment where the service user feels at ease and there is total privacy. Health professionals should explain the whole assessment process to the service user and family/close friend. Assessments should be carried out with urgency and, wherever appropriate, a senior psychiatrist or relevant professional should be consulted. The style of the assessment should be therapeutic for the service user, so they feel better after the meeting. Care should be taken over the language used and the assessor should be empathetic to the service user and non-judgemental.

**Psychosocial assessments** carried out by the Crisis team, CMHT and other members of PHCT should always be **faxed to GPs on the day of the assessment** and marked for urgent attention.

#### **5.2 Involving families, friends and carers**

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

**New guidelines should 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.

Confidentiality often acts as an unnecessary barrier between clinicians, patients and families, particularly where the patient has an expressed wish to share information, which is then ignored. This is covered in detail in Section 5.2.

### **5.3 Young Men**

There is no mention of **young men aged 18 – 35**, where suicide is still the highest cause of death. National statistics focus on men aged 15 – 44 and we feel that more focus should be placed on the 18 - 35 group.

Bereaved parents and families feel shocked and betrayed to discover that suicide is the most likely cause of death for their son, and they had not been made aware of this. Every parent should have the right to know these facts. Currently there is no information available, which focuses on this major health risk for young men.

### **5.4 Psychological Assessment at ED**

The opportunity to reduce the risk of suicide and increase the chances of recovery and protection of service users would be greatly improved if all service users with injury or illness due to suicidal action or recent suicidal feelings were offered an assessment at the point of presentation at an Emergency Department.

All users entering an ED presenting with injury due to suicidal action or recent suicidal feelings should be offered a full psychosocial assessment by a suitably trained person and that records should be maintained to ensure that compliance can be monitored

### **5.5 Self assessment**

Over 75% of people suffering from mental health problems, including depression, don't seek professional help and we consider that there must be more action taken to encourage them to obtain help.

A group should be formed to review and/or develop **an appropriate self assessment tool**, which enables an individual to identify whether they may be suffering from some form of depression and how and where to obtain initial early help.

## **6. Delivering effective follow-up services and care pathways**

### **6.1 Named key workers**

There is very poor join up and follow up of people, who have attempted suicide or are seriously at risk, especially between EDs, mental health trusts and primary care. The chances of recovery would 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.

It is recommended that **service users should have an identified and named, high quality, 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.

## **6.2 Confidentiality**

Confidentiality can act as an unnecessary barrier between clinicians, patients and families, particularly where the patient has an expressed wish to share information which is then ignored.

The Department of Health 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 can be involved in their care and therefore be able to receive confidential information.

Awareness should be raised amongst carers, families and significant others and their related patient associations that confidentiality should not be a barrier to involvement.

Voluntary sector organisations should be involved in the development of a shared **advanced directive**, which could be widely disseminated and shared as best practice.

This should cover nurses, doctors, psychiatrists, police and all those people in contact with those, who may have suicidal feelings.

## **6.3 Support for families**

We believe that, following an **impact assessment at the time of suicide**, support is provided automatically to those who are likely to be impacted by a suicide. This may include family and friends and those who witnessed or found the suicide victim.

There should be a **nominated family liaison support person** (individual to be determined...GP?) who provides a constant and consistent link with the family, who would monitor, with the families' permission, how the family and friends are coping and any additional support required. This support should include providing access to the most helpful documents identifying support that is available (e.g. Help is at Hand).

There are examples of best practise in Derry, where all of the relevant local agencies are brought together following a suicide, co-ordinated by, we think, the local authority.

## **7. Learning from past suicides and applying this data to prevent future**

### **7.1 National Database**

There is a wealth of information and data on suicide, especially from coroners' inquests, with significant learning not yet understood and applied to reduce future risk. Implementation of a structured process at a local level for learning from individual cases of suicide or unexplained death and establishing a regular opportunity for making important improvements at both local and national level would reduce the risk of suicide and increase the chances of recovery and protection for service users.

**An impact assessment should be carried out** after every unexpected death, in order to capture this information, which would then be supplemented by the coroner's report and other sources.

**Every Health and Wellbeing Board should appoint a nominated individual with responsibility for ensuring that an impact assessment is carried out** for each case of suicide or unexplained death, to identify important improvements for implementation at a **local level**. These improvements should be recorded and collated at a national level, so that they can be incorporated into NICE Guidelines, where appropriate, to obtain the benefit at a **national level**.

There needs to be improved access to data relevant to suicides from various sources, e.g. Coroners, Police, National Confidential Inquiry into Suicide and Homicide. In particular, it is recommended that a coroners' information system should be created to capture the learning from all suicides. We are concerned about the huge increase in narrative verdicts and the impact this has on the accuracy of suicide statistics. We consider that this issue should be covered in all future reporting.

We feel that the National Confidential Inquiry needs to review its sources and quality of data to ensure that the statistics gathered are more accurate and useful.

Consideration should be given to a **National Database** available at a local level, which contains all the relevant learnings from suicides for improvement.

## **7.2 Research**

**A review of completed and ongoing research** should be carried out to identify the huge gaps in research and funding that would improve the care provided and lives of people with all types of mental health problem.

The report responds to the issues arising with a number of different protected groups, including those with untreated depression, drug users, BMEs, children and young people and many others. The report implies that the main driver of their mental health problems is purely a psychological disorder linked to their life experiences. There is no mention of the need for research into the common medical characteristics across all these groups, which may be causing these people to be susceptible to mental health problems. This might include aspects of DNA, genetic make-up or hereditary factors, which are likely to combine with life experience triggers to result in mental health problems, possibly leading to suicide. It seems vital that this aspect is recognised as an important area of research, resulting in early identification of potential problems and prevention.

We would therefore recommend that the report encourages **the government to fund both a review of existing medical papers around the world and a systematic piece of research to prove/disprove a linkage of a predisposition to suicide of people with either certain DNA markers or chemical imbalances.**

## **8. Measuring performance against clear targets and having clear accountability at all levels**

### **8.1 Governance**

The new suicide prevention strategy won't succeed unless there is **clear accountability both locally and nationally**.

There needs to be an annual report presented to Parliament by the Minister with specific responsibility for suicide prevention.

Health & Wellbeing Boards play key role at a local level and they should have a specific individual with responsibility for preparing and presenting an annual report on suicide prevention.

***This response has been prepared by and has the full support of the following individuals and organisations:***

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