



The **Matthew Elvidge** Trust

Submission to the Health Select Committee Inquiry on Suicide Prevention

1. Source of evidence

This evidence is provided by Hamish Elvidge, Chair of the Matthew Elvidge Trust, which was established shortly after our son took his own life aged 23, after a short period of anxiety and depression.

The evidence is also informed by my role as Chair of the Support after Suicide Partnership (see separate submission), Member of the Government's National Suicide Prevention Advisory Group (NSPAG) (2012 - date), Co-Chair of the National Suicide Prevention Alliance (NSPA) (2013 - 2016) and Co-Chair of the Alliance of (Small) Suicide Prevention Charities (TASC) (2012 -date). I was Finance Director/Change Director, Sainsbury's Supermarkets (1996 – 2010).

Our submission is based on personal experience, supplemented by our learning over the last six years, which has provided us with a unique perspective on those actions that could be taken to improve suicide prevention work across England.

2. Executive Summary

This submission covers four areas:

- National Suicide Prevention Strategy (NSPS) – implementation and programme management (Section 3)
- patient confidentiality (Section 4)
- training of health professionals and others (Section 5)
- suicide prevention through emotional wellbeing and mental health education (Section 6)

We have set out:

- concerns about the gaps in governance between the NSPS strategy and effective implementation
- the need for a significant change in the approach to patient confidentiality to ensure that families are more involved
- the need for a greater level of understanding of suicide and suicide ideation amongst health professionals and others
- the need for a long term investment in our children's' understanding of the importance of good emotional wellbeing and mental health

3. National Suicide Prevention Strategy (NSPS) –Implementation and Programme Management

3.1 Background and Context

The NSPS (September 2012) provides a sound framework for the implementation of suicide prevention plans at a national and local level driven by Health and Wellbeing Boards (HWBBs) and Directors of Public Health (DoPH).



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On the day of the launch Norman Lamb asked for my views on the Strategy.

I raised one concern about the apparent lack of implementation resource and programme management capability to:

- drive the delivery of suicide prevention plans across the country and
- monitor and report on the quality and effectiveness of implementation

In January 2015, 27 months after the strategy was published, the All Party Parliamentary Group on Suicide Prevention (APPG) expressed concern about the lack of effective implementation of local suicide prevention plans, suicide audits and multi agency prevention groups with less than 50% of HWBBs having active plans.

There are currently many separate organisations involved in driving implementation activities, including the Department of Health (DoH), Public Health England (PHE), NHS England (NHSE), the National Suicide Prevention Alliance (NSPA), and the National Suicide Prevention Advisory Group (NSPAG), amongst others.

This is illustrated below:

Public Health England **National Suicide Prevention Alliance**

Suicide as a Public Health Issue

Strategy Sept 2012	2015 Plan	St'gy June 2015
NSPS 5. Media approach 1. High risk groups 2. Specific groups 3. Access to means 4. Support bereaved 6. Research and data 7. Implementation	Department of Health Time to Change Street Triage pilots x 9 Confidentiality St'mnt Helium Coroners' proof Suicide Data via ONS £1.5m research fund	Public Health England Cluster advice Public places Help is at Hand Real Time Surveill'ce MHIN G'dnce to Local Authorities/ Masterclasses
	NHS England Zero Suicide Amb'n Crisis Concordat	National Suicide Prevention Alliance 1. Awareness/Stigma - Public Conference 2. Help seeking behaviour - (Men) 3. Improving Support - G'dnce for Moderators 4. Access to Means 5. Bereavement Support - Framework/Pathway - SBSP Website 6. Data and Evidence 7. Collaboration

This slide shows some of the activities of the organisations involved in suicide prevention and illustrates the complexity that exists.



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However, there doesn't appear to be any governance or approach to producing one integrated change programme, which can be reviewed and updated on a regular basis.

It is unclear who has responsibility for implementation and delivery of the NSPS and this has a detrimental effect on the effectiveness of the strategy.

PHE have been having discussions about the possibility of more effective programme management and allocation of resources to achieve this; however, I don't believe that any actions have been agreed.

3.2 Recommendations

Set out below is a series of recommendations, which would provide a greater level of confidence that the strategy will be implemented effectively and that the number of suicides will start reducing:

3.2.1 Appoint a Programme Manager

- appoint a senior level programme manager, who would have responsibility for overseeing the effective implementation of the strategy
- ensure that the programme manager has adequate skilled resource to fulfil the role

3.2.2 Establish a senior level leadership group

- establish a senior level leadership group, comprising the DoH, PHE, NHSE, NSPA and others, which would review and approve the change programme, monitor the effectiveness of implementation, measure the outcomes and report annually
- this group would provide governance over changes at a national level (e.g. confidentiality, helium, zero suicide ambition, bereavement support), the support and guidance provided to Local Authorities and Health and Wellbeing Boards (e.g. local authority guidelines, masterclasses and cluster advice) as well as implementation of suicide prevention plans at a local level (e.g. local prevention plans, local audits and multi-agency prevention groups)
- this group would have an overall strategic picture of change across all areas of suicide prevention activity

All effective businesses that develop 3-5 year strategies to achieve significant change (in this case to save lives and reduce current levels of suicide from 6,122 (2014)) would not leave the effective implementation of the strategy to others, in the hope that it is implemented effectively... and have no visibility of performance and implementation success.

There is a significant gap between publishing the strategy in 2012 and its effective implementation, which is currently not being filled.

The slide below shows the essential stages for a successful change programme. We have a strategy provided by the DoH... and PHE are on the point of issuing guidelines to local authorities (albeit nearly four

Landline: 01252 842706 Mobile: 07836 252638

Email: info@thematthewelvidgetrust.com

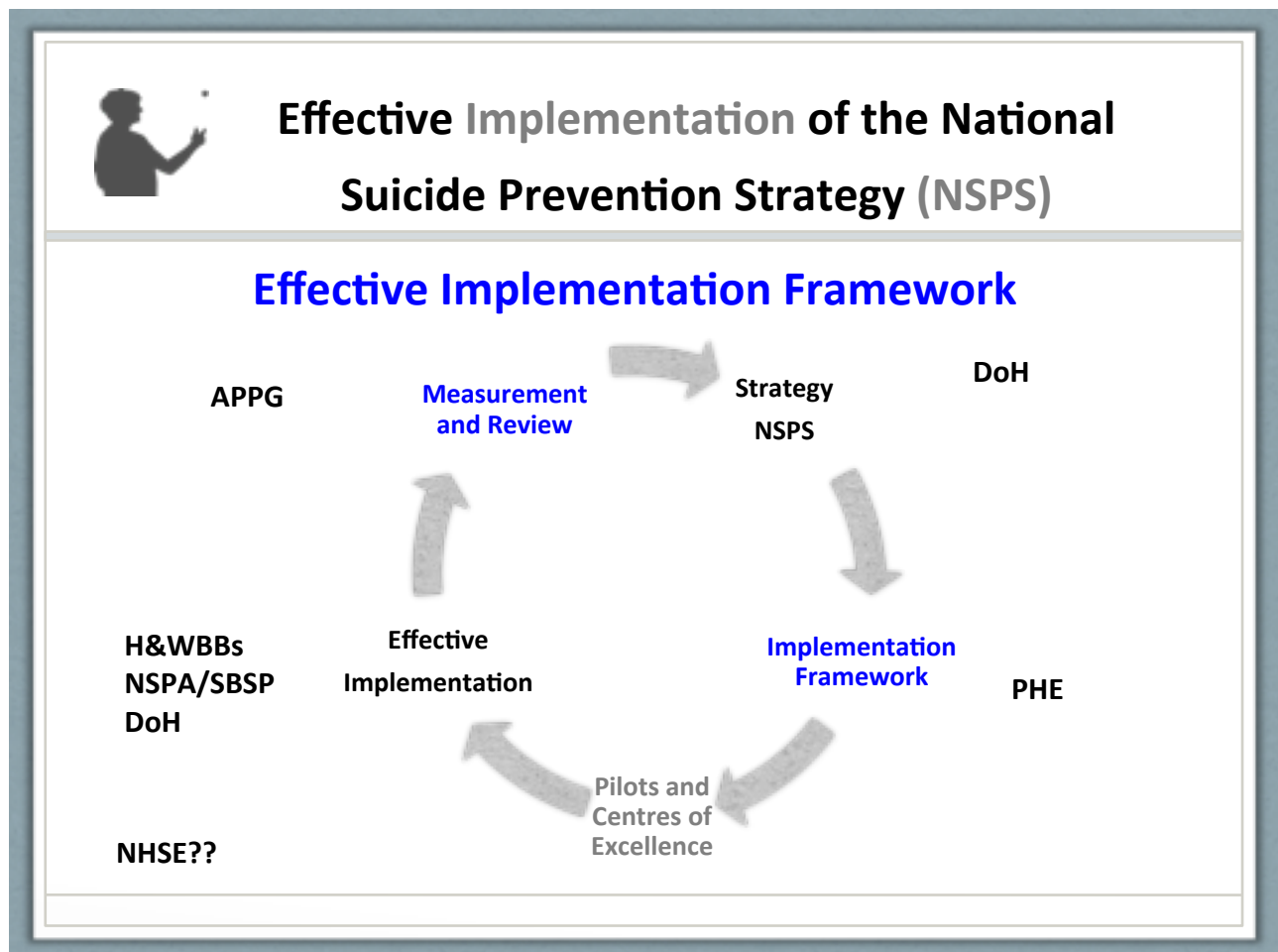


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years after the strategy was launched). However there is no visibility of pilots and centres of excellence or any structured monitoring of effective implementation, measurement and review other than that carried out by the APPG.

These gaps need to be filled urgently.





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4. Patient Confidentiality

4.1 Background and Context

Patient confidentiality is too frequently a barrier to effective assessment and the successful treatment and recovery of patients, who are feeling suicidal.

Confidentiality can act as an unnecessary barrier between clinicians, patients and families.

There are five members of the National Suicide Prevention Advisory Board, who have 'lived experience' of losing a family member to suicide. All five have direct experience of confidentiality acting as a barrier, including:

- no contact with the family prior to assessment
- permission being given to contact the family and this request being ignored
- no contact with the family after assessment to increase the chances of a successful recovery

This was recognised at the 'Guildford Consensus Meeting' in July 2011, which was attended by 38 people with wide experience of suicide prevention including academics, large and small charities, health professionals and NICE. The attendees included Prof Keith Hawton, Paul Farmer, Catherine Johnstone, Madeline Moon and Sir Mark Waller.

This Meeting made three recommendations 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 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 their involvement
- voluntary sector organisations lead the development of a shared advanced directive, which could be widely disseminated and shared as best practice.

The NSPAG, prompted and encouraged by the five members with lived experience, developed a Consensus Statement on Confidentiality, which was agreed by all parties in January 2014.

The Statement was approved by the Royal Colleges of Psychiatry, GPs and Nursing as well as the British Psychological Society, the British Association of Social Workers, the Mental Health Network NHS Confederation and others.

The agreed Consensus Statement is available [here](#).



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At the NSPAG meeting on September 6th 2016, we were updated with progress on the effectiveness of implementation of the statement and, sadly, very little progress has been made.

4.2 Recommendations

It seems that the Consensus statement can be viewed in three distinct, linked sections.

The recommendation to involve families in assessment, being listened to and receiving general information about services and risks seems uncontentious.

The section about asking permission for involvement of a trusted person is more challenging! The key issue is how professionals ask the question.

Is it simply: *“do we have your consent to share information with a family member or a friend/colleague?”*

Or is the question, for example, *“ in our experience, it’s always much better to involve a family member, friend or colleague (who you trust) in your treatment and recovery. This will result in you recovering much quicker. Would you like us to make contact with someone and would you like us to do this together?”*

I would recommend the following actions:

4.2.1 Introduce a training and culture change programme for professionals

All staff who are likely to be in contact with people experiencing suicidal feelings should be trained in suicide awareness and the Consensus Statement through the core curriculum and CPD within the next five years.

Each profession should introduce a culture change programme, which provides a clear understanding of the impact of language and the way questions are asked to ensure that more people are willing to involve a trusted third party in their care, as this, in most cases, increases the chances of recovery.

4.2.2 Appoint a senior team to drive change

A senior individual should be appointed to address this opportunity and work together with the Royal Colleges and others to agree a set of changes to their training, professional standards and culture.

4.2.3 Carry out research to inform the training and change

The DoH or others should fund research into the number of cases where confidentiality has acted as a barrier to successful assessment, treatment and recovery. This research should be widely disseminated and incorporated into the training and culture change programme.



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4.2.4 Involve people with lived experience to influence change

People with lived experience should be 'recruited' to influence the decision makers in the Royal Colleges and others to ensure that the necessary structural changes occur and that clear plans and timescales are agreed for implementation.

We cannot continue to see lives lost as a result of confidentiality acting as a barrier to effective recovery.



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5. Training of Health Professionals

5.1. Background and Context

A recent NSPAG meeting discussed the need for an improvement in suicide awareness and prevention (SAP) training across a wide range of people that are in contact with and provide support to individuals, who are, or maybe, experiencing suicidal feelings.

In July 2011, the 'Guildford Consensus Meeting' (referred to earlier) recommended the need for better training of professionals in suicide awareness and prevention (SAP) and mental health.

The recommendations were to:

- identify all the SAP training packages and materials that are currently available
- review the training that is currently carried out across all relevant roles
- identify the gaps in training resource and those being trained
- make recommendations for improved quality and volume of training

5.2. Current Situation

There doesn't appear to be a clear picture of the SAP training that is currently carried out covering:

- the qualification process for all professional staff
- the minimum level of training required for other staff
- CPD for all staff

We need to know what training is currently available, who delivers and receives it, how it is assessed and what further action is required to improve coverage for all relevant staff.

5.3 The Vision

We should aim to develop a Vision for the effective SAP training and how this could be achieved, in conjunction with all the Royal Colleges and other professional bodies that have responsibility for training the relevant people.

The Vision could be that: *"All staff engaging with people who may be experiencing suicidal feelings should be effectively trained in suicide awareness and how to keep people safe".*

5.4 The Gap



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We should then carry out a review of the Vision in relation to current provision, identify the gap and develop a plan to fill the gap within an agreed period of time....perhaps three years.

5.5 Recommendations

It is recommended that the following steps should be taken in the context of preparing an implementation plan, which would map out the next steps, which could include:

- the development of pilot projects to establish good practice and measure impacts
- securing support from all the professional bodies
- the establishment of Centres of Excellence across England
- the development of a website and web content, which sets out all the resource and training that is available
- the development of a training implementation plan across a wide range of Royal Colleges and other organisations



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6. Prevention through a whole school approach to Emotional Wellbeing and Mental Health Education

6.1. Background and Context

There is growing evidence that a whole school universal approach to children and young people's emotional wellbeing and mental health has a positive impact on academic performance, social and emotional skills and the ability to cope with life's ups and downs (see Professor Katherine Weare's paper – *What works in promoting social and emotional wellbeing and responding to mental health problems in schools?*)

The whole school approach involves governors, leadership teams, staff, parents and pupils understanding the importance of good emotional wellbeing and mental health and developing the skills to keep healthy. This is built on a preventive model, where more young people keep well, fewer need help and ultimately, through life, fewer taking their own lives.

The level of anxiety, depression and mental health problems in young people is increasing and well documented. 50% of mental health problems in adults start in childhood, which provides a clear link between young peoples' mental health and adult suicide.

6. 2 Current Situation

The Government is investing in anti-stigma 'campaigns' directed at young people and parents, but these will not result in all young people having a deep, personal understanding of emotional wellbeing and mental health.

The Government is investing £1.4bn in supporting young peoples' mental health over the next 5 years and this will focus on young people with 'problems' receiving the right support, which is good.

Future in Mind has made 10 recommendations to improve young peoples' mental health..... most of these talk about people with a 'problem' receiving the appropriate support.

The Department of Education points to:

- resource from the PHSE Association, which promotes lessons for pupils in all aspects of mental health as part of the PSHE curriculum. This is rarely based on a whole school universal approach.
- advice on mental health and behavior in relation to identification and referral (for people who have a problem)

All these initiatives are good and will result in more young people that need help receiving timely and appropriate support.



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6.3 The Opportunity

However, as the recent Education Minister said: *'the development of character, resilience and good mental health is vital alongside academic success in equipping young people with the skills to fulfil their potential'*.

There appears to be little activity to use the levers that might bring a truly *'whole school approach to wellbeing and mental health'* into the education of all our children.

We all have mental health and we should aspire to helping all young people keep well, move right on the continuum and avoid needing help.



A Whole School approach includes:

- proactively promoting positive social and emotional wellbeing for staff and students through a 'universal' approach; and
- identifying actions schools can take to prevent, identify and respond effectively to the mental health problems of their staff and students, through a 'targeted' approach

A whole school approach engages governors, leadership teams, staff, parents and pupils and should reach into all aspects of school life.

This would involve ensuring that all these groups:

- understand the importance of good emotional wellbeing and mental health. This would include how different individuals respond to different life situations and the latest research from neuroscience
- know how to keep emotionally and mentally healthy
- know how to spot the signs of anxiety and depression in themselves and others
- develop the resilience and skills to handle the ups and downs of life
- have the confidence to ask for help, when needed
- are confident they will receive the right support early



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This needs everyone to develop a shared understanding and use a common language.

The [Partnership for Wellbeing and Mental Health in Schools](#) is exploring a model to assist schools to undertake this change.

This approach would also include understanding all about the issues that young people face today including anxiety and depression, eating disorders, body image, suicidal feelings, bullying, exam pressure, transition challenges, self harm and so many more.

This would result in emotional wellbeing and mental health being embedded into the culture and ethos of our children's' education and being part of the language of the school.... of our children's' education.

This education and resulting understanding would significantly reduce the stigma and encourage young people to ask for help early.

This would develop a generation of young people (and to some extent their parents), who understand the importance of good emotional wellbeing and mental health and would be able to parent better. These young people would also secure key roles (NHS, GPs, nurses, carers, teachers, school staff and more) and, in the future, be able to support people with difficulties so much better.

6.4 Recommendations

A compelling case needs to be written, which would persuade the DoE, the DoH, the DWP, national education bodies, parents and others to invest in a 'Whole School Universal Approach', with the aim of having this implemented in all schools by 2025.

This would include a business case that spanned all three government departments.

This would involve making changes to all the appropriate levers, which might include:

- leadership team, teacher and staff initial training and CPD
- appropriate revisions to the inspection and assessment system
- changes to the curriculum
- perhaps, rebranding PSHE to Wellbeing (already done in some schools)
- influencing national bodies (DoH, DoE, NAHT, ASCL, ATL, Teach First, PSHE Association)
- influencing school groupings (Academies, Faith, Free, CTCs, State, Private (HMC and IAPS))

There is a real opportunity to make a difference for our 8 million students in 25,000 schools.

We shouldn't take the risk of withholding this opportunity from our children and should seek to influence government and others involved in education policy to implement a whole school approach at the earliest opportunity.

Hamish Elvidge September 9th 2016