



# The **Matthew Elvidge** Trust

## **Response to the Interim Report of the Health Select Committee Inquiry into Suicide Prevention and the Government's response through the Third Progress Report on the National Strategy**

### **Introduction and Source of Evidence**

This evidence is provided by Hamish Elvidge, Chair of the Matthew Elvidge Trust and is informed by my roles as Chair of the Support after Suicide Partnership; Member of the Government's National Suicide Prevention Advisory Group (NSPAG) (2012 - date); Founding 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).

The Trust welcomes the Select Committee's Interim Report, the Government's response and the 'third progress report of the cross government outcomes strategy to save lives'.

We are also pleased with the profile that suicide prevention and mental health has received over recent months and through the Prime Minister's speech on January 9th 2017.

However, we would like to see more of the aspirations supported by policy, well directed funding, clear implementation plans, improved accountability and programme management of change, to ensure there is effective delivery and successful outcomes over the next three to five years.

## **1. Implementation**

### **1.1 Background and Context**

The Select Committee's Interim Report recommends 'a clear implementation programme underpinned by external scrutiny'. It also suggests that the current 'suicide prevention strategy has been characterised by inadequate leadership, poor accountability and insufficient action... ..over the last four years there has been a failure to translate the strategy... into actual improvements..... implementation has been highly variable and subject to insufficient oversight.'

It therefore recommends that the refreshed strategy 'must be underpinned by a clear implementation strategy, with strong national leadership, clear accountability, and regular and transparent external scrutiny'.



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It also recommends 'that the Government's updated strategy should include a clear implementation programme, with strong external scrutiny of local authority plans and progress. Local areas also need a clear message from the top that suicide prevention plans are mandatory'

### **1.2 The Government's response**

The Government's third progress report says that 95% of local authorities have existing suicide prevention plans (113) or plans that are in development (30) with 6 having no plan at all. They describe this as a significant improvement from the figures reported by the APPG.

However, in the context of the Select Committee's recommendation for a 'clear implementation programme', we have no understanding of:

- the quality of those plans when compared to the local suicide prevention guidelines<sup>1</sup> and the seven areas of the National Strategy
- the actions that have been taken to deliver those plans
- the timetable for future actions
- the outcomes of the actions taken at a local level

We also have no perspective on whether all the local authority plans, if added together would make an effective impact on suicide prevention in England, towards the Task Force target reduction of 10% by 2020.

The Government has said that it will implement '**better and more consistent local planning and action** by ensuring that every local area has a multi-agency suicide prevention plan in 2017, with **agreed priorities and actions**'.

It has also said that 'it will put in place a **more robust implementation programme** to deliver the aims of the National Strategy as recommended by the HSC. To achieve this, we must **look at** ways to connect the national policy with local delivery to drive and monitor progress with our partners and stakeholders.

We will continue to work with the National Suicide Prevention Strategy Advisory Group and to provide financial support to the National Suicide Prevention Alliance (NSPA), which was formed after publication of the National Strategy in 2012 to support its delivery.

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<sup>1</sup> published by Public Health England in October 2016



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We will work with local authorities to support them in **assuring the quality of their plans** against Public Health England’s guidance. We will ensure that the status of local plans is updated annually to drive improvement and ensure that the newest information and best practice are incorporated’.

### 1.3 Recommendations

The statements above are encouraging; however it will be difficult to have a high level of confidence that programme management and implementation will be effective until there are clear proposals for integrated governance across the DoH, NHSE, NSPA, NHSI, CQC, HEE, Health Watch, NICE and others.

This might include appointing a senior programme manager with responsibility for developing an integrated implementation programme, which would have clear actions, timescales and accountabilities for delivery across all national and local aspects of the plan.

The following areas of action might be included:

2012 Strategy	2015 Plan	2016 Strategy
		
		
<b>5. Media approach</b>	<b>Time to Change</b>	<b>Awareness/Stigma</b> - Public Conference
1. High risk groups 2. Specific groups	Street Triage pilots x 9 Consensus Statement	Help seeking behaviour - (Men) Improving Support - G'dnce for Moderators
<b>3. Access to means</b>	<b>Helium</b>	<b>Access to Means</b>
4. Support bereaved	Coroners’ proof	Bereavement Support - Framework/Pathway - SASP Website
<b>6. Research and data</b>	Suicide Data via ONS £1.5m research fund	<b>Data and Evidence</b>
7. Reduce rates of self harm	<b>MHIN/Fingertips</b>	
<b>8. Implementation</b>	Guidance to LAs/ Masterclasses	Collaboration



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There may be two to four meetings a year when all the relevant heads come together to review progress at a national and local level.

The terms of reference may include the following:

- Develop a single view of the major activities involved in delivering and implementing the strategy (*'a clear implementation strategy'*). This might include the implementation of local suicide prevention plans, including bereavement support, as well as confidentiality; burden of proof; men; outcomes from research; media; training; data; helium and more
- Convene a biannual (or more regular) meeting of the key organisations, including DoH, NHSE, NSPA, NHSI, CQC, HEE, Health Watch, NICE and others, to review and update plans and gain commitment to deliverable dates to achieve agreed outcomes (e.g. 10% reduction in suicide.... and clear local authority plans by 2017) (*strong national leadership*)
- Ensure that there are clear accountabilities for each piece of work (*clear accountability*)
- Ensure there are clear project plans for implementation
- Set up a quality review of all LA suicide prevention plans and provide advice and guidance where required (*regular and transparent external scrutiny*) – through possible use of seconded National Audit Office, CQC or other more independent resource as required, including a potential appointment of an appropriate individual to deliver the requirements of sound external scrutiny.
- Establish centres of good practice in each PHE Region

## 2. Support for people bereaved or affected by suicide

### 2.1 Background and Context

The Select Committee's interim report recommends that *'all (local) suicide prevention plans should include **mandatory** provision of support for families, who have been bereaved by suicide'*.



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The report also highlights that:

- the cost of every life lost is estimated to be £1.67m, of which c.60% is attributed to the impact on the lives of those bereaved by suicide
- that a minimum of six people will experience a severe impact (although, based on personal experience, a more realistic estimate might be many more than 20)
- people bereaved by suicide are at 65% greater risk of suicide themselves
- bereaved people face onerous practical problems...inquests, serious incident reviews, loss of income, time away from work, relationship breakdown and more
- those bereaved by suicide are not entitled to any form of support. Victims of, even, minor crimes are provided with a liaison officer to provide support
- too many people are just given a leaflet.... or simply left to cope on their own

The Government's response highlights that, since this new area was introduced, for the first time, into the 2012 Suicide Prevention Strategy '*delivery.... has not been progressed enough to ensure that there are good quality and consistent suicide bereavement services in every area of the country*'.

### **2.2 Help is at Hand**

The Government's response highlights that Public Health England continues to provide funding for Help is at Hand (HiaH), which has enabled large numbers of people affected by suicide to receive this invaluable resource. However, we are a long way from having effective dissemination, which would ensure that everyone affected receives a copy, as part of a support service available across all parts of the country.

The Support after Suicide Partnership (SASP) is developing a dissemination plan, which is being reviewed at its Leadership team meeting in February 2017. We propose to include funeral directors, the police, GPs, nurses and other health professionals. We have already provided all coroners with 100 copies of the z-cards, that provide an introduction and access to HiaH.

The only way that dissemination will be effective is when all parts of the country have a support service, which requires the police/coroners/others to provide this resource to every family within a maximum of 48 hours, as part of a fully integrated, local support service.

### **2.3 Funding and the NSPA**

The Government third progress report says that the '*funding provided to the NSPA has enabled it to include suicide bereavement support as a clear work stream in its strategic framework*'.



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This work stream is run by the SASP, which is part of, and governed by the NSPA. It also receives substantial funding (80%) from other charities and trust funds. This has enabled the workstream to develop a new website, launch a survey, disseminate Help is at Hand and support the development of local postvention resource.

### **2.4 Framework and Pathway, Inquests and Serious Incident Reviews**

It is very encouraging that the NSPA, with funding from PHE and supported by the SASP has developed a framework and pathway for developing, delivering and evaluating local suicide bereavement support services<sup>2</sup>, which, as the Select Committee recommends should be a mandatory part of local suicide prevention plans.

This framework was built on the Vision that 'everyone bereaved or affected by suicide should be offered and received appropriate and timely support... (within 48 hours)'. It is vital that people affected by suicide are offered both practical and emotional support to meet their very individual needs.

An important part of this will be offering support with the Inquest and any NHS Serious Incident Review. These are both unfamiliar and complex processes, which make it very difficult for families to provide the very best opportunity for lessons to be learned to prevent future loss of life.

### **2.5 Local Suicide Bereavement Services**

The Government's third progress report says that 95% of local authorities have suicide prevention plans (113) or plans that are in development (30) with 6 having no plan at all. They describe this as a significant improvement from the figures reported by the APPG.

However, in the context of the Select Committee's recommendation for mandated bereavement support services, we have no understanding of:

- the quality of those plans when compared to the national strategy
- the actions that have been taken from those plans
- how many have plans to implement a local suicide bereavement support service, which is consistent with the vision and framework and pathway
- how many have implemented an effective local bereavement support service

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<sup>2</sup> Published by Public Health England January 2017



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It is very disappointing that, over four years after this new area of 'providing better information and support to those bereaved or affected by suicide', we have:

- no idea what is happening now across all 153 local authorities and
- no idea when a service will be made available to everyone affected by suicide
- who is accountable, at a national level, to ensure that the recommendations of the DoH and the Select Committee are implemented within an acceptable timescale
- when people bereaved or affected by suicide will be supported and protected as a high risk group

### **2.6 Recommendations**

I would therefore recommend that:

- people bereaved by suicide are considered a high risk group by the strategy
- one named individual from within the DoH or PHE is made responsible, with advice from the NSPA and SASP, for ensuring that this service (as set out in the vision and local postvention resources) is made available in all local authorities within three years
- all local authorities are asked whether they have a current service consistent with the framework and pathway and, if not, when they plan to implement such a service
- local authorities are incentivised to implement a service by providing appropriate funding, on the condition that they develop a service in line with the vision and local postvention resources linked to Improving Access to Psychological Therapies (IAPT). This funding should support a suicide bereavement liaison officer (SBLO), who could coordinate the development, implementation and evaluation of the support service with the Health and Wellbeing Board, the local CCGs, local third sector organisations and all supported by PHE. This investment may cost perhaps c.£12m and will be self-funding, since it represents the cost of just seven suicides
- local support services include assessment of cluster risk based on geography, chronology and social links and clear accountability for reviewing local audits for learning and improvement

**We can't continue to put more lives at risk, because we don't offer support to people bereaved or affected by suicide.**



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### **3. Services to support people who are vulnerable to suicide**

#### **3.1 Background and Context**

The Select Committee recommends that there should be wider support for public mental health and wellbeing alongside the identification and targeted support for at risk groups.

The Committee also expresses concern about the lack of strong, well co-ordinated national leadership to drive forward awareness of suicide risk and earlier identification of those at risk of suicide within local communities.

It also recommends a renewed focus on mental health training for staff in public facing roles, including GPs.

#### **3.2 Government's response**

The Government indicates that training of GPs and GP surgery staff in awareness of suicidality and safety planning can play a crucial role in suicide prevention.

#### **3.3 Recommendations**

##### **3.3.1 The Vision**

We should aim to develop a Vision for this effective training and how it 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'.

##### **3.3.2 The Gap**

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





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### **3.3.3 Implementation**

It is recommended that the following steps should be taken in the context of preparing an implementation plan, 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 good practice 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 with a requirement to complete the training within say three years

## **4. Consensus Statement for information sharing with families**

### **4.1 Background and Context**

The Select Committee recommended that 'professionals need better training to ensure that opportunities to involve families or friends in a patient's recovery are maximised, where appropriate.'

It also highlighted that 'the option to involve trusted family or friends can improve support and aid recovery' and 'professionals may err on the side of not involving families, rather than taking the time to explore fully with a patient, whether there would be benefit in contacting a trusted family member or friend.'

The Committee noted that a Consensus Statement had been drawn up by the National Suicide Advisory Board alongside most of the Royal Colleges; however, little has been done to implement the changes in approach set out in the statement.

### **4.2 Government Response**

The Government's response states that 'we should do more to promote the Consensus Statement, which was published in January 2014.'

The Consensus statement can be viewed in three distinct, linked sections.



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

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?'

The Select Committee was provided with a number of examples where patients have explicitly given permission for families to be made aware of their suicidal feelings, but sadly these requests were ignored.

The five members of the National Suicide Prevention Advisory Board, who have 'lived experience' of losing a family member to suicide 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

No details are provided on how this will be achieved and when the Statement might be embedded into practice across GPs, Nursing, Psychiatrists and other health professionals, other than working with the Royal Colleges to increase awareness with their members.

We are very pleased and appreciate being involved in these discussions in the hope that we can move further towards the recommendations set out below.

### **4.3 Recommendations**

The following recommendations are made to strengthen the Government's response:



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### **4.3.1 Secure agreement across the sector for implementation of the Consensus Statement**

Bring all the Royal Colleges, Government Health leaders and original signatories of the Statement together to agree a vision and long term implementation plan.

### **4.3.2 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 mental health, suicide awareness and the Consensus Statement through the core curriculum, initial training 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 assessment and care, as this, in most cases, increases the chances of recovery.

### **4.3.3 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.

### **4.3.4 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.

### **4.3.5 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. Data**

#### **5.1 Background and Context**

The Select Committee says that timely and appropriate data is needed to enable swift responses to suspected suicides, in order to save lives in the future. It suggests the need for more rapid provisional notification of suicide at the time of a suspected death by suicide. It suggests improved consistency across coroners, routine use of provisional notifications and moving to a civil, rather than criminal standard of proof.

#### **5.2 Government's response**

The Government highlights the good work that has been done by both ONS and PHE to improve the suicide data at a local and national level. However, there is little response to the specific points highlighted in the Interim Report.

#### **5.3 Recommendations**

It would be helpful to understand the specific steps that the Government is planning to take to improve timeliness of data, consistency of reporting across coroners and the move to a civil standard of proof.

### **6. Media**

#### **6.1 Background and Context**

The Select Committee stated that the media guidelines for reporting suicide are widely ignored and that greater attention must be paid to dealing with breaches.

It also recommends that consideration should be given to what changes can be made to restrict access to potentially harmful sites.

It recommended that a review should take place of accountability and responsibility for the adherence to media guidelines and that the refreshed strategy should include a commitment to work with internet providers and social media platforms to deliver changes which would restrict access to sites that encourage self harm or give advice on suicide methods.



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### **6.2 Government's response**

The Government's response talks about the excellent work that Samaritans are doing with Facebook and other online online and the work it plans to explore with UCCIS and the online sector; however no details are given on how to address harmful online content.

### **6.3 Recommendations**

It would be helpful to have a response from the Government on exactly how it plans to deal with media guideline breaches and what changes it considers can be made to restrict access to potentially harmful sites as well as how and when these will be implemented and who is accountable.

## **7. Children and Young People**

The Interim Report highlights the importance of building greater resilience and wellbeing in young people to tackle greater levels of distress and self harm.

The Government's third progress report talks about the important role that schools and colleges can play in promoting good mental health and the need to analyse suicide rates in universities.

Our evidence to the Health and Education Committee's Inquiry into 'the role of education in promoting emotional wellbeing in children and young people and preventing mental health problems' highlights the vital role that all education organisations can play in prevention, (which includes, suicide prevention) through long term investment in policy changes to position wellbeing and mental health at the centre of the culture and ethos of our children's education, based on an asset model and a whole organisation approach.

Please refer to our separate submission.

***HMAE January 24th 2017***