



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

This evidence is submitted by Unite the Union - the UK's largest trade union. The union's members work in a range of industries including manufacturing, financial services, print, media, construction and not-for-profit sectors, local government, education and health services.

Unite represents approximately 250,000 members across the public sector. Approximately 100,000 of these are health sector workers, including members in seven professional associations – the Community Practitioners and Health Visitors' Association (CPHVA), Guild of Healthcare Pharmacists (GHP), Medical Practitioners Union (MPU), Society of Sexual Health Advisors (SSHA), Hospital Physicists Association (HPA), College of Health Care Chaplains (CHCC) and the Mental Health Nurses Association (MNHA) – and members in occupations such as allied health professions, healthcare science, applied psychology, counselling and psychotherapy, dental professions, audiology, optometry, building trades, estates, craft and maintenance, administration, ICT, support services and ambulance services. Unite also represents a large range of members working in social care for local authorities, housing associations, health, disability, elderly and children's charities as well as other community and not for profit organisations.

This response has been led by Unite/Mental Health Nurses Association.

1. Introduction

Unite the Union acknowledges the intention of the Department of Health in England to develop a new suicide prevention strategy for England with the aims of reducing the suicide rate and improving the support for those bereaved or affected by suicide. However, we believe that the coalition government's austerity measures will have an adverse effect on this intention.

It is already apparent that the rate of suicides is increasing in countries that are pursuing harsh austerity measures. In Greece there is evidence that between 2007 and 2009 suicides rose by 17%, and further unofficial 2010 data quoted in their parliament mentions a 25% rise compared with 2009. Even more worryingly, the health minister reported a 40% rise in the first half of 2011 compared with the same period in 2010¹.

A Greek charity, Klimaka, commenting on the almost doubling of suicides since the start of the financial crisis, stated that where they previously received approximately 10 calls per day, they now frequently get upwards of 100 calls per day. They stated that the majority of callers were "financially ruined males between the ages of 35 and 60"².

This comes, however, at a time when health organisations (both the NHS and charitable organisations) are facing large cuts to their funding and their ability to provide front line services. Earlier this year the False Economy group highlighted that over 53,000 confirmed, planned and potential job cuts in the NHS³. Channel 4 followed up on this story and found that some of the deepest cuts would hit the most vulnerable in mental health services. They quoted figures of 6,346 jobs at risk across

¹ SMITH, H. & BOSELEY, S (2011) **Greeks pay for economic crisis with their health**. The Guardian 10th October 2011. <http://www.guardian.co.uk/world/2011/oct/10/greece-economic-crisis-health>

² INDEPENDENT.IE (2011) **Suicides nearly double as financially ruined men take their lives in crisis-struck Greece**. Independent.ie 20th September 2011 <http://www.independent.ie/world-news/europe/suicides-nearly-double-as-financially-ruined-men-take-their-lives-in-crisisstruck-greece-2881575.html>

³ FALSE ECONOMY (2011) **50,000 NHS job losses uncovered by False Economy**. False Economy 23rd February 2011. <http://falseeconomy.org.uk/blog/more-than-50k-nhs-job-losses>

53 mental health trusts, with a high proportion of the jobs being on the clinical, rather than the management side⁴.

False Economy⁵ also carried out 265 freedom-of-information responses from local councils across England found that more than 2,000 charities are being forced to close services and sack staff as local authorities slash their funding, or in some cases completely withdraw it. The hardest hit included children's and young-people charities, with more than 380 organisations hit. Another 150 disability, 142 elderly and more than 110 adult care charities are also affected many dealing with mental health issues. These figures are supported by reports on cuts from all the major umbrella organisations in the not for profit sector (NCVO⁶, ACEVO⁷, SCVO and NIVCA⁸)

Unite members have come forward to report how the cuts are affecting the services that they provide and some of these are collected together on the website, Unite for our society (<http://uniteforoursociety.org>), for example Jan's story;

"I currently work for a charity working with young people aged 15 to 25 with severe mental health problems. We have recently lost our LA funding and are due to lose NHS funding. We work with some of the most vulnerable impoverished young people in the city of Manchester and there is a possibility we will shut in September".

And Timothy's story;

"I know "Face to Face youth counselling" in Oxfordshire has had to fold as the local council no longer funds paid counsellors, or supervisors which the volunteer counsellors require to continue. This is a great loss to youth in the community who originally could self-refer for counselling, so halting decline in their lives before the need for intervention at the point of offending or serious self harm. I understand that youth suicide has gone up considerably in recent months in Oxfordshire, and this may have contributed."

⁴ CHANNEL 4 (2011) 50,000 NHS job cuts hit mental health services. Channel 4. 23rd February 2011. <http://www.channel4.com/news/50-000-nhs-job-cuts-hit-mental-health-services>

⁵ <http://falseeconomy.org.uk/blog/exclusive-more-than-2000-charities-and-community-groups-face-cuts>

⁶ <http://www.ncvo-vol.org.uk/cuts-report>

⁷ <http://www.guardian.co.uk/society/2011/aug/02/charities-fight-survival-funds-slashed>

⁸ http://www.civilsociety.co.uk/finance/news/content/10198/ncvo_has_underestimated_cuts_to_devolved_nations

We have submitted this response early on World Mental Health day (Monday 10th October 2011) as it resonates strongly with the 2011 theme 'Investing in mental health'. We hope that the coalition government urgently changes its course and invests in our society and does not continue its attacks on our services which support our most disadvantaged.

2. Consultation Questions

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?*

- 'Front-line staff', particularly non-mental health specialists require more than training in risk assessment and management. Training is only the beginning in changing practice – staff need good role models, operating and managerial systems that are conducive to this kind of work (for example, district nurses have to meet targets re. contact numbers and 'physical' nursing tasks only) and on-going and high-quality clinical supervision. Who should provide and resource these interventions, particularly those for staff working within non-mental health services?
- The growing burden of paperwork for mental health practitioners (particularly care co-ordinators) mitigates their opportunities to work directly with service users. They cannot be out managing risk and working at a computer!
- More persistent follow up of those who have self harmed and presented in secondary care is required. Again, contact targets may have an unintended effect by discouraging this kind of persistence, particularly if there is little to show for it in the short-term.
- How confident can we be in the data relating to high-risk groups? Is the data that coroners collect fit for purpose?

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?*

- Given that access to, and knowledge about the means of completed suicide is

not amenable to change, perhaps we need new work to explore the dehumanising aspects of these occupations and, for health care professionals, mandatory clinical supervision.

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 not clear as to why these groups have been singled out for particular scrutiny other than for reasons of the quite abstract notion of ‘vulnerability’ and the social spotlight falling on them for broader social reasons.
- There may be further work needed to ensure that varying local demographics including those related to ethnicity and health inequalities are taken into consideration in local prevention strategies

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?*

- Political slogans that denigrate parts of the population (for example, anti-immigration policies and the ‘rioting underclass’) need to be carefully considered in relation to their powerful role in stigmatising vulnerable people and increasing suicide risks. On this and many other issues, ‘joined up’ government is required!
- A key issue in the isolated, vulnerable and those with mental illness and mental health problems is the role played by primary care – the recent decision to remove depression from ‘Quality and Outcomes Framework’ measurements and screening requirements will have a detrimental effect on identification efforts, diagnosis and optimal treatment to patients – this in turn is likely to have an impact on suicide prevalence and incidence.
- Consideration must be given to the elderly, especially those living alone
- A review of those with long term conditions, including chronic, intractable pain should also be included in developing comprehensive suicide prevention plans.

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?*

- An observation is that legislation on the selling of drugs such as paracetamol is commonly ignored. Members have reported as an example '2 for 1 offers' etc in local, corner shops.
- Firearm controls should be continually reviewed including systems to screen and scrutinise new applicants and all current licence and weapon holders – GPs have a key role in taking a holistic assessment of those with gun licences and reviewing risk in a structured and organised way.
- Young men are often seen as high risk and many will have been involved in alcohol and / or substance misuse or excesses prior to any act of self harm or para / real suicide – services to reach the hard to reach including young men should be a key part of the strategy.
- Commissioners should require all providers to address these issues in any agreed contracts and service specifications.

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?*

- Take action in relation to the issue raised above.
- An essential part of a successful prevention plan will be awareness raising and education programmes to reach the hard to reach and offer basic awareness to all re risk and signs and indications of risk

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.*

- When the suicide has involved a mental health service user there may be difficult tensions to manage if the person's family has made a complaint against the organisation. Perhaps local arrangements can put alternative means of support and advocacy in place?

- Access to IAPT (Improving Access to Psychological Therapies) services is essential however these primary care assessment and support teams are becoming more threatened in the cost constraints of the 'new' NHS.
- Again, costing systems need to be considered so that they do not act as a disincentive to supporting the bereaved.

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.*

- Getting access to expert mental health 'first aid' quickly is very problematic for people (including non-mental health professionals). First point of access services appear (to outsiders) to be designed to keep people out of services, not to welcome them in. They are experiencing service strategies designed to try and control work load. Placing this kind of work in Community Mental Health Trusts is at odds with all their other priorities. Crisis and access services need robust resourcing and could be available through a local emergency number. There needs to be efforts made to communicate between local services, for instance, between local MIND services and the Samaritans.
- Better access to help – free support via Samaritans and other open access support services.
- We are however concerned that with Government cuts to services, the third sector who provide important support are seeing their incomes dramatically reduced.

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?*

- Given the enormous importance of social media to young people could new 'Twitter' and 'Facebook' groups focus on supporting those who feel wretched and telling the stories of those who survived and grew stronger?

- Generally soaps and documentary coverage is responsible and proportionate however on occasions sensationalised and voyeuristic scenarios are seen. This must be addressed by the press and media scrutiny services including the press complaints commission and heavy fines imposed where breaches of responsible journalism take place – media projects and coverage should have a best practice code of conduct including working with experts from clinical areas of suicide prevention care.
- A positive media campaign to raise the profile of the issue.

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?

- As above.
- Better control of so called 'self help suicide assistance' websites must be devised and implemented.

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?

- Probably but we need to balance the benefits against the costs of turning health and social care workers into data collectors! All data collected should be easily accessible and reported back to those who collect it. Also, commissioning decisions should not be taken just because of an 'absence of data'.
- Collation of existing volumes of overdoses for examples seen in A&E depts. should be captured and reported leading to better follow up and repeat incidence with effective support.

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

- We seem to put lots of organisational energy into examining what went wrong when a person commits suicide but very little into examining cases of where things went well.
- How effective is early intervention and in what kind of cases?

- We need to drill down into different groups in order to better understand what is effective. For example, frequent A&E self-harming attendees are likely to have different needs from an older man who has lost his job and family and is suicidal for the first time.
- We need a more robust evaluation of education and training related to suicide prevention to ensure the best techniques and skills are developed for all those dealing with susceptible people.

Making it happen locally and nationally

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

- A DH follow up review should be developed to initiate a virtual and real special interest group – funded from combined partner funding including central Department of Health, pharmaceutical and independent resources – this can bring together a wide range of services and people with special interests and skills to share and exchange success and plans.

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

- We know that local commissioners lack know how and confidence about mental health promotion (there has been work done comparing organisations implementation of different National Service Frameworks and mental health was found to be particularly problematic). The people charged with putting arrangements in place need to be carefully chosen and supported.
- A set of guidelines and best practice advice should be constructed to support Clinical Commissioning Groups in addressing risk and management including the earlier point made about contracting and service specification advice – Unite/MHNA can assist in this exploration if required and asked to assist.

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?

- Whether or not the indicators are good enough measures. For example,

measuring rates of hospital admission for people who self-harm will only tell a very limited part of the story. Most people who self-harm are not admitted to hospital.

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?

- A comparative study of those experiencing a bespoke service with those experiencing 'treatment as usual'.
- A review of 'current state' re uptake of support should be considered, this might include some local consultation and exploration of patient / carer / service user experiences - 54% of all complaints about hospital care relate to end of life care⁹. Many of the complaints relate to the lack of support or follow up provided following their loss.

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

- See above (point 1, first bullet point). Ideally training etc should be multi-agency.

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

- This information may be gained from local police departments.
- Local high level structures such as Clifton Suspension Bridge in Bristol are locations for those with suicidal ideation, however better safety rails and observations and signage has reduced incidence in recent years.
- Local isolated spots and scenes of high profile suicides need regular reviews.

⁹ THE NATIONAL COUNCIL FOR PALLIATIVE CARE (2011) We all have a role to play to improve end of life care for vulnerable older people.
http://www.ncpc.org.uk/documents/NCPCDM_NHSOmbudsman_Report_Feb_11.pdf&sa=U&ei=bfySTuSSN9S68gPvkkpFA&ved=0CBIQFjAB&usg=AFQjCNEQ_Nimvj3Ez5d4tyDditse_C-CkQ

Any other comments

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

- This is timely given the national economic situation. We know that employment is good for mental health and unemployment bad for it. This is not a good time to be cutting mental health services either in the statutory or third sector. 'An inclusive society...' involves inclusion in employment and earning the means to live a decent life. The strategy proposed places heavy reliance on third sector services: what is the 'plan B' if these services disappear due to funding cuts?
- Whilst the document is informative and interesting there is quite a lot of repetition and far too much cross-referencing to other policy documents. This may put busy practitioners off reading it and they won't find all they need to know in one, accessible place.
- There seems to have been little attention paid to interventions used internationally: what lessons can we learn?
- The draft strategy contains lots of epidemiological data. This is useful but more of the same. Where is the work on therapeutic engagement? For example, the work of Dr E. Guthrie and her team in Manchester?
- Our major concern is that this strategy offers more of the same overall. A broader approach to understanding suicidal behaviour might enable a *broader intervention focused strategy*.

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