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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?

Question 1:1. Suggest Mental Health First Aid Training rolled out across wide range of groups: voluntary sector, inpatient, general adult and child care social work teams, and Carers support organisations. 2. Mainstreaming dual diagnosis teams / sub teams to cover whole spectrum of care, not just secondary care, or if that not possible ensuring that knowledge of dual diagnosis (and therefore raised levels of risk of suicide) reaches out to primary care.(Example of practice NHS South Tyne and Wear Commissioning Strategy for Dual Diagnosis covered whole patient pathway - training of 500 staff in MH first aid and alcohol and drug misuse.3. Ensure self referral to secondary / specialist MH teams as not everyone wants to / does come via primary care pathway. Local authorities have a long tradition of self referral and this is successful.4. A high risk group that not mentioned is those in poverty, particularly if combined with other high risk indicators. The impact of re assessments of benefits among high risk groups. (Also see comments in question 2)

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?

Question 2:1. There is an irony in using occupational categories as risk factors because much as they are important it does not include one of the highest risk groups - those not in an occupational group because of sickness, and or unemployment. DLA will cease to exist in 2013-14, replaced by the Personal Independence Payment (PIP). This is causing anxiety among groups of people with disabilities, including those with Mental Health Problems. October 2010 saw the introduction of a new work capability test for the 2.6m claimants of incapacity benefits. The new test is expected to cut significantly the claimant count. Significant numbers of people will be moved from Incapacity Benefit to the newer Employment and Support Allowance. The impact in terms of people's mental health of these changes is, as far as BASW are aware, is not being monitored, however anecdotal evidence from social workers is that the proposed and actual changes are having signficant affects on people's mental health, including some very basic ones such as inability to afford adequate food, or to afford bus fares to attend day support services. It is urged that thought is given to include non employed people as an occupational category.2. This section may also be the place to consider the impact of rurality (See MIND)

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

Question 3: Asylum seekers listed, but not refugees, it is suggested that they should be included as many (most) will have experienced trauma. Vulnerability due to social and economic circumstances is listed, but proposed that this category is unpicked in terms of awareness training and action plans. Could include those whose benefits have been cut, migrant and casual workers, those not eligibel for benefits who come from certanin accession countries, those in geographical areas of most deprivation.

4 In your view, are there any 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?

Question 4: Individual agencies doing excellent work on providing information to at risk groups, but this is often patchy. (The excellent leaflets for example on self harm created with service users and carers). It is hoped that the development of the responsibility for public health to local authorities and the re introduction of Directors of Public Health will help with co-ordination and distribution of information and access to help and advice.

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

Question 5:1. There is no reason that culinary knives have sharp pointed ends - this has been identified as a way of reducing violent crime, but (and not aware of research) may reduce the number of self harm and suicides using knives.2. The continued over prescribing of pharmaceuticals to people, particularly elderly people, creates ease of access to self harm. Pharmacecists are reluctant to take unwanted medicines any more, creating a problem of disposal of unwanted medicines.3. To re look at the death rates from car exhausts to see if anything more can be done to reduce this - engine cut when stationary after x minutes?

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?

Question 6: There isn't really a section for this, but consideration does need to be given to the subject of risk management, for example in psychiatric wards. There is a danger of creating a punitive environment that attempts to elliminate every risk. There needs to be consideration of debate about "positive risk taking". In a different way the issue of risk generally in society, particularly needs acknowledging. For example the impact of children being isolatad in their houses, not experiencing adventure, fun and risk in their environment. The over reduction of risk has resulted in increasing mental health problems in young people, lack of resilience. The reduction in youth work, outdoor play schemes etc. could have a negative impact on MH and ultimately suicide risk of young people.

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.

Question 7: Most MH trusts and MH teams offer follow up to bereaved families and do this well, it is often too soon after the event when families may not be ready to engage. Also for some families their feelings about MH services may preclude them from seeking help. There needs to be local consideration about Trusts and Social Care services working together (along with any voluntary agency that may be providing services) to consider how the needs of families and friends can best be met. Services need to be proactive, without being intrusive. A letter triggered after x number of weeks could be advantageous. There may be

an issue of funding, but it may be that funds are re directed, from some other services. Fundamentally this is a commissionning issue, which hopefully with improved commisisoning - moving money into more preventative services, money could be saved. (Relatives of peope who have committed suicide will themselves fall into a high risk category for mental and physical distress and therefore good intervention could save money on medication and other support functions).

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.

Question 8:1. Consistently good access to leaflets and information. However nothing is achieved by printing leaflets, or having information on a web site. Outcomes can only improve by people actually receiving information, knowing how to access it and people absorbing the information. Engaging users and carers in the development of information strategies is therefore essential, as is on-going monitoring of the the impact and improvement cycles. An outcome focus, not an output focus.2. A single contact point out of hours, with back up to respond3. Enabling relatives to refer people4. Access to crisis teams direct by carers and service users 5. Continued vigilence regarding sign - posting. Not having a blame culture if a sign posting system is not working (as with information posting) but by continued engagement with relevant stakeholders6. Include carers in service monitoring, both of the service to service users and to services in general7. Link suicide prevention services to carers strategy. For example the Carers Health Checks could / should include consideration to considering the perceived health / suicide risks of the cared for

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?

Question 9: There are two aspects and both need continued vigilence:a) Portrayal of suicide in dramas and soaps. This needs continued monitoring and continued work with film production companies to advise on the portrayal. b) Reporting of suicides. The Samaritans have produced a useful guide for the media on reporting of suicides. This needs wider recognition.http://www.samaritans.org/media_centre/media_guidelines.aspx

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?

Question 10: Certainly there there needs to be on going consideration of using new media to convey messages. If one googles "Help I am feeling suicidal" there are a large number of hits, but nothing that clearly offering reliable help and same on facebook. Consider sponsoring help lines that hit the top of the search engine lists

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

Question 11: There is the danger that data collection becomes an end in iteself and distracts from implementing local strategies. Suggest that the data is reviewed as part of the zero based review of social care and health data. Actual data on suicide will continue to be contentious and therefore should be treated with caution and the actual data qualtitatively analysed. For example there are communities where suicide continues to be a label that people would want to record at all costs and there are issues with recording of data with older people and people with severe disabilities / end of life. Consideration to be given to separating out data that relates to clear cut cases of suicide, against those where the verdict is less clear. The complexities of data collection need to be recognsed and therefore there needs to be careful consideration on how overall figures are presented to the media. There is a need to "old fashioned" quantitative data collection, that focuses on local intelligence in terms of what is being done and what is working at a local level.

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

Question 12: As in 11 suggest that needs to be the development of expertise on what really works, not only based on crude figures. This requires the re establishment of networks, such as NIMHE, the sharing of collective knowledge and strategies to get ownership of knowledge at local levels. That collective knowledge includes how inter agency and inter departmental strategies can help.IAPT has become the panacea for all psycghological problems, IAPT varies enormously in quality and deals very poorly with those who do not "fit" the criteria or "boxes". A more sophisticated psycho social model needs to be developed / re developed. Social work played and continues to play an important, but under recognised more sophisticated model of psycho social intervention. Social work however suffers from the lack of investment in research on effectiveness compared to the over simplisitic IAPT model.Health centres, with multi professional input, including social workers can provide a great service that helps with suicide prevention, but again has lacked the research base to demonstrate this. The impact of community groups is again poorly researched, as is the impact of the development of community capacity. The impact of funding cuts on community services is undoubtedly having an impact on community capacity.Community mental health teams that are intergrated, either formally or co - located appear to be reducing, this may have an affect on suicide prevention - the impact needs monitoring

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

Question 13:1. Examples of self harm liaison work developed by service users who have self harmed e.g. Northumberland and Tyne and Wear Mental Health Trust - examples of work include care plan layout and leaflets re self harm

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

Question 14: Urgent need to look at the impact of the reduction in integrated working between health and social care. There is enough evidence to show that integrated mental health teams that are also integrated into primary care make a positve impact. This does not have to be organisational merger, but process merger and cultural awareness of difference organisations.

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?

Question 15: Need to be very careful about indicators as they can so easily become ends in themselves, subject to manipulation and pressure to fit statistics into boxes. Outcomes are very laudable, but still can fall into the same trap as output and input recording

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

Question 16: Again need to be careful of imposing a simplistic measure. These things need local engagement as to what measures and how they are recorded and methods may well need to vary from community to community. The processes in a white middle class area my well need to differ from a rural area, a mutli ethnic community. These measures need to be referred to local public health boards

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

Question 17: There is virtually no training for groups such as home care and personal support workers, who work with some of the the most at risk people.The over specialisation of social workers and the introduction of more unqualified care assessors is leading to an increased ignorance of metal health and suicide. Children's social workers also group of workers who under trained on this subject. However these issues need tackling locally. There is evidence for example that many providers do not do the training that they are supposed to do under National Occupational Standards, National Mimumum Standards, so there needs to be local engagement with these issues.

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

Question 18:

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

Question 19: Social workers have had and continue to have an important role in suicide prevention. Social workers working in general medical, palliative care, maternity care come across many people who are at risk of suicide or have self harmed. There needs to be greater considertion of the role of social workers and social care workers in the strategy.

20 What is your name?

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21 What is your email address?

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22 What is your organisation?

Organisation: Professional Association of Social Workers

23 What is your role within the organisation?

Role within organisation: Professional Officer - adults lead

24 Gender

Male

25 How old are you?

Over 55

26 Ethnicity

White - British

Other - please specify:

27 Do you consider yourself as a person with a disability?

No

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

No