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Agenda Supplement - Health, Social Care and Sport Committee

Meeting Venue:

Committee Room 4 - Tŷ Hywel

Meeting date: 21 March 2018

Meeting time: 09.15

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- Suicide Prevention: Consultation Responses

Please note the documents below are in addition to those published in the main Agenda and Reports pack for this Meeting

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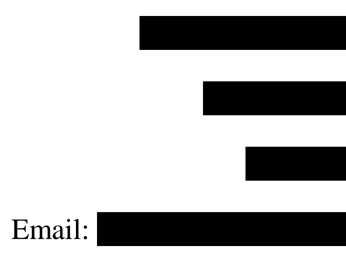
S 01

Inquiry into Suicide Prevention

Ymchwiliad i Atal Hunanladdiad

Ymateb gan Unigolyn

Response from an Individual



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17/10/2017

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Evidence for the Suicide Prevention Consultation

To whom it may concern,

I will give you my opinion on the things that I think need to improve in order to reduce suicide and self harm in Wales, then I will give you a little background about myself.

The first thing is to remove the stigma surrounding mental health. This is being tackled by organisations such as Time to Change Wales, but still has a long way to go. Their new schools programme is an example of the work that needs to be done. If young people are happy to talk about their mental health things will improve.

For me, the next most important thing is easy, face to face, access to a health care professional. The new triage system in most health centres is a nightmare for anyone seeking urgent help. You cannot walk into a surgery and make an appointment, you have to telephone and wait for a call back. By the time you receive that call it may be too late.

Then, there is the lack of access to counselling services. If you can't pay privately the waiting list is endless.

Those last two points are vital, even if we tackle the first. Once someone has admitted that there is a problem they need access to help.

Another point is that the current benefit systems are horrendous, with people being left in debt for weeks even if their application id successful.

My Background:

To spread some light on my experiences I'll now tell you a bit about myself. I am a 55 year old female IT professional, a wife and mother of two, a town councillor, committed Christian and Food bank organiser and Time to Change Wales mental health champion.

I don't remember when I started self harming, but it was before secondary school. I am an introvert and had very low self esteem, and used self harm as a way of managing my emotions. I never discussed it with anyone. At 33, with a small baby and having been through a stressful time at work, everything on the surface looked fine, but I tried to kill myself by throwing myself under a bus. I was lucky that I knew the bus driver and he smiled at me, so I stepped back instead of forward. I was able to go straight from the roadside to my local surgery and see a doctor within minutes. I think that the smile and the quick treatment saved my life.

I am pretty well now, but I do have a great worry that if I go downhill I won't have the strength to go through the rigmarole that is now needed in order to get help.

I'm also aware, from my work in the food bank and with TTCW of the huge number of people who are not currently receiving any help at all. This really needs to be addressed.

Thank you for giving me the chance to contribute. If I can be of any further help, please let me know.

Yours,

S 02

Inquiry into Suicide Prevention

Ymchwiliad i Atal Hunanladdiad

Ymateb gan David Hitt

Response from David Hitt

Hi,

I'm not entirely certain how this works. I just wanted to include the WHO review of suicide prevention, as clearly this should be used as a benchmark if considering a document pertinent to Wales.

http://iris.wpro.who.int/bitstream/handle/10665.1/5497/9789290614623_eng.pdf

As for adding to the debate, then as a CBT therapist, it would be useful to refer to page 23 of this document which looks at the impact of CBT on suicide prevention (via numerous trials worldwide). I can vouch in my own practice that I have seen individuals who have been let down by generic mental health services who I have then seen and treated effectively, moving them further away from the risk of suicide. There is a paucity of CBT offered within Wales with too few people trained and access limited. We have some specialist services, but usually people with depression who may be at risk are not seen by such specialist services, as individuals with depression are not seen as an interest for clinicians in the same way as say, PTSD or eating disorders. This may be controversial, but across the country you will see very few services in existence. As such, maybe it is time for depression to be offered such a service, or if not then for individuals to be assured that they are offered evidence based treatment at a time of crisis or to prevent it from reaching this point. With more strain on CMHT's, individuals aren't receiving the support they need, and have to be acutely suicidal often before this support is on the table. Offering these individuals the right treatment at source is one way by which we can ultimately reduce the suicide rate in Wales.

Thank you.

S 03

Inquiry into Suicide Prevention

Ymchwiliad i Atal Hunanladdiad

Ymateb gan Millie Griffiths

Response from Millie Griffiths

To whom it may concern,

I am currently a Support Worker within a complex needs facility, this means that I am regularly in contact with individuals who more often than not present with a dual diagnosis. The types of dual diagnosis that I am regularly in contact with are anxiety and depression, which in my experience is usually the wrong diagnosis, and substance misuse, both of which make the individual susceptible to homelessness.

Although I have worked in this industry for numerous years I have only really come in to contact with one client who has actively attempted suicide on several occasions. However, this being said, the vast majority have all expressed suicidal tendencies. It could be argued that their high risk taking behaviour is a direct manifestation of a form of self harm, which at times can result in attempted suicide through misadventure.

I believe that there needs to be clearer guidelines on how to manage someone who is making serious attempts on their life, for those working within the third sector. For example, I recently had a client who in the space of a week attempted to asphyxiate themselves three times. On the second threat of suicide I contacted the crisis team in the Royal Glamorgan Hospital. I was informed by them that it was not there duty to attend the project, instead I should contact the police. I contacted 101 and explained how I had been sign posted to the police in order to deal with this individual. The police officer who handled the call was excellent and very thorough. He explained to me that he did not feel that it was the police's responsibility to attend the project from a threat alone because there was no actual law being broken. However, should the person have left the project with a rope or some other form of paraphernalia that could be used in an attempted suicide, then they could act. He then went to double check with his superior that he was giving me the correct information and from that conversation he was able to establish that organisations like mine were in the habit of making internal policies on how to handle situations like this. However, they are being massively misguided because they are not taking into consideration the policies which are being made by the emergency services themselves.

Therefore, my proposal is that there is a significant need for a blanket policy that should be applicable to all organisations within the third sector with a clearer more enriched pathway towards getting the individual the help that they need. This blanket policy should be informed by those of the emergency services and should be in place in order to provide clarity, reassurance and better working links between organisations and emergency services about their duty of care and to provide the individual with more effective care at the point of need.

Things that should be considered:

1. lone working members of staff who may not have the ability to leave the project of an evening (a time when most suicide attempts are prevalent) because they may have several other individuals under their care.
2. ASSIST training should be incorporated into mandatory training.
3. Individuals who are under the influence of substances are more likely to attempt suicide because of impaired and disinhibited judgement. Therefore, despite the fact that they can not be subject to a proper mental health assessment, there should still be a service available to them to assess the severity of their threats.
4. More accessible counselling services, with shorter waiting times to deal with the underlying issues.
5. Children accessing social services should be offered play therapy, music therapy or talking therapies as a way of coping with traumatic life events and to build resilience for their future, making them stronger better rounded adults.
6. Prison leavers who are susceptible to homelessness, through a lack of family support, should be offered a continuation of care upon leaving prison.
7. More accurate mental health diagnosis, which accounts for testimonies and considerations from those working within the third sector who may spend a significant amount of time with those individuals accessing mental health services.

Although I am aware that the problem is that much more complicated and complex than my suggestions alone, but I am hoping that they will highlight some of the barriers that we in the third sector find with regards to the prevention of suicide.

Kind regards

S 04

Inquiry into Suicide Prevention

Ymchwiliad i Atal Hunanladdiad

Ymateb gan Unigolyn

Response from An Individual

Suicide Prevention Submission

1. This submission is in response to the call for evidence by the Health, Social Care, and Sports Committee on the topic of Suicide Prevention. It is a personal account of my own experience with depression, anxiety, and suicidal thoughts. Although my experiences will likely differ in terms of cause and effect from others, I still feel this could be helpful in the committees work.
2. I am a 33 year old male, who lives in [redacted]. I dropped out of college, but later went on to achieve my BA and MA. I have worked several minimum wage jobs, but also held public office in local government between 2012-2017. I now work as a research support worker in [redacted] University.
3. My conclusion in this submission is that, while I agree that support services that focus considerably on talking therapies need to be invested in and maintained, more needs to be done to recognise the potential for social capital building work in communities to improve individual and community mental health. Also, work needs to be done to ensure that early warning signs are identified – with support offered and taken up as early as possible – and that opportunities for meaningful employment or volunteering are widened.

Home and School

4. This section is about my school life, and while the bullying I mentioned started as early as primary school – much of what follows arose during secondary and further education.
5. I suffered from bullying throughout much of my statutory education, and towards the end of this period my parents' marriage was breaking down. School became a refuge from home, and home became a refuge from school. Neither allowed me to feel fully relaxed, and as a result I began to find my own ways of escape. During some lessons in school I would go to the library and, if asked, say I had permission to do work there. In other lessons where the teacher was more lenient, I would spend much of my time just chatting to friends and not doing much work.
6. This resulted in me having to drop a GCSE as I was continually missing classes, and it also led to me getting a far lower grade than I could have received in another subject. In another subject, though I did eventually walk out with a good grade, I was reluctant to speak to my teacher about the fact I was struggling at times because I feared being moved down a set and away from those I felt somewhat comfortable with.
7. I should say that relevant teachers did try to discuss with me what was going on, but I would deliberately refuse to give them more information than I needed to. In hindsight I feel that perhaps I should have spoken to someone at this point, but at the time I feared the outcome

– especially as the school would've been unlikely to stop the bullying, and they had no power to fix my parents' marriage (or speed up their divorce!).

8. After leaving school I went to college, electing to go to a nearby college rather than my nearest college. It wasn't long after I started that I regretted this decision, as I felt isolated and my confidence made it very difficult for me to make new friends. I did not make friends in the subjects I had taken and, similar to my behaviour in school, I started to miss lessons in order to spend more time with the few friends I did manage to make. However, missing lessons had its consequences and eventually I was basically told that due to my attendance I would need to drop the subject. This led to me dropping out of college altogether.
9. Before all this happened, one teacher did suggest I speak to someone about the problems I was having although I did not take up this opportunity. Also during this time, my older sister moved away for university which left me with my parents and their failing marriage at home.

Education to Employment

10. After leaving college I tried to find work, although by this point my confidence had plummeted further and I found it difficult to do. I didn't engage with the Jobcentre at first, because of my increasing anxiety that was becoming overpowering and stopped me from either walking through their doors or phoning. This anxiety also stopped me from getting driving lessons, which didn't help my job prospects.
11. I think it was during this time that I had some thoughts about suicide, but it wasn't serious or lingering. At the time I put it down to just having a bad day and overthinking my situation. My parents also divorced during this time, which led to a complete breakdown in the relationship between myself and my father – we wouldn't talk for years afterwards.
12. Eventually, I managed to get job working at a local bar and restaurant. Overall my time was challenging but I didn't many problems, aside from several incidents where I would feel anxious about making sure I was doing everything right when it was busy. Later on however, hours became infrequent and as I worried about my finances more I felt myself becoming more withdrawn, anxious, and depressed. This led to me leaving the job.

Depression

13. After leaving that job, my mental state deteriorated at an increased pace. My sleeping patterns changed as I started to stay awake later at night (into the early hours of the morning) and spent more time sleeping during the day. I started speaking to people online more, especially women, and avoided many social encounters day to day.
14. My eating habits also changed, for a while I hardly ate but then afterwards I just ate junk food rather than anything healthy. Coupled with lower activity levels, I quickly put on weight – which further hit my confidence.
15. I did begin to engage more with the Jobcentre, as since the divorce my mother was in a weakened financial position which made me feel that I should be helping her out more and contributing. However, despite some good people working at the Jobcentre, my anxiety was so bad that I would constantly feel as though they were looking down at me, judging me, and looking at me as though I was purposely unemployed. The money helped, but I did not find going to the Jobcentre regularly as being helpful – and in fact felt as though it harmed more.

16. It was during this time that I started to think more about where my life was heading, whether I had failed completely, if there was any chance of being able to do something again, and the burden I was becoming to those around me. I started asking myself these questions every day, especially during the night, and would often come to the conclusion that I was a failure and a burden, and that those around me would be better off without me around.
17. The longer this went on, the more serious I got about thinking about suicide and considered how I would actually do it. I did not go through with any of my thoughts, something I attribute to the reassurance by some of those close around me – including my mother, sister, and friends – but these thoughts did not go away.
18. I started to escape more from reality by concentrating on writing short stories, attempting writing a novel, all of which took place in a completely fictional location or in a historical setting. In some of the characters I was able to address some of the issues I was facing, or imagine some of the qualities I would have loved to possess.

Getting Better

19. Things started to change for me when my sister suggested that I consider applying to go to university, using some of the knowledge I had gained during researching for my creative endeavours. Although I didn't expect anything to come out of it, I reached out to a nearby university and had a discussion with a lecturer there.
20. Later that year I formally applied to university and was successful. Over the next three years, I gained my BA, but then the recession hit and I couldn't find work when I left. This hit the confidence I had developed over the years in university, but I got involved with local politics due to a developing interest in some of the issues that I had experienced.
21. My mother then suggested that I go back to university to undertake postgraduate study, which she would fund. I decided to do this, and a year later I received my MA and was volunteering in the community. This gave me opportunities to frequently speak to people, do something I had an interest in, feel as though I was contributing, and that I wasn't useless or pathetic.
22. This volunteering work also helped me get some direction in my life overall, and I decided that I wanted to seek election to public office – which I achieved in 2012. During my time in office I spoke and wrote publicly about my battles with depression, feeling safe to do so due to others being open about the challenges they had faced. I hoped that by speaking about these things (as a relatively young man in a high profile position), I could help encourage others to speak about what they're going through as well. In fact, for several days after the article was published I had individuals speaking to me on the bus, in work, and even in a few shops about it.
23. Although I would later lose out narrowly in the 2017 elections, I managed to find work again within a few months and am also working with my partner to develop a project based on our mutual interests. At times, I did once again have some dark thoughts at times – with the main triggers being; when my bank balance was low and bills were due, something broke unexpectedly in the house, or after receiving several job rejection letters. These wouldn't last long and are easier to cope with.
24. Getting into a serious relationship, after various failed relationships or associations, has also helped considerably – especially as she challenged me to face some of my problems and

helped me become a healthier person overall. We are now expecting our first child, so there's plenty to be positive about, look forward to, and be proud about.

Conclusions

25. Writing all of this has been easier than I thought it would, but is only a rough outline of my experiences and not the full extent of everything that contributed to my depression, suicidal thoughts, and recovery.
26. However I feel that there was a clear pattern emerging long before I had suicidal thoughts, one that – in my opinion – shows that while early identification and engagement is crucial, not everyone is going to feel confident enough to seek professional or semi-professional help. Creating a culture where people feel at ease talking about concerns or pressures is vital.
27. Throughout, family, friends and most recently my partner, have all played an enormous role in keeping me positive and giving me something to live for. Even though I have felt like a burden to them, just knowing how my death could affect them pulled me back from the brink several times.
28. Unemployment and the grinding sense of failure is deadly, especially for men who are still believe they are expected to be providers or that success is linked heavily with attraction. Working or otherwise contributing through volunteering was very helpful in my case, although bad employment (insecure, unappreciated, low valued) can be almost as bad as unemployment.
29. I have no knowledge of support in place for those suffering from depression and having suicidal thoughts, but I think that if someone does take the step in actually reaching out for them – they need it to be appropriate, considerate, and delivered in a timely manner. Attention also needs to take into account the wider network of support that can exist within the community and how community development (through social capital building) can help to improve community mental health while reducing demand on more formal structures.
30. I think that building more opportunities to volunteer in communities, more community based activities and participatory organisations, as well as opening up the public sector to increased volunteerism (carefully managed so that public bodies don't see volunteers as a cheaper alternative to properly employed staff) would be helpful.
31. If there is anything that you want to ask me about in connection with any of the above, please feel free to do so.

S 05
Inquiry into Suicide Prevention
Ymchwiliad i Atal Hunanladdiad
Ymateb gan Autistica
Response from Autistica

Written evidence from Autistica to the Health, Social Care and Sport Committee: Suicide in autism

Autistica is the UK's autism research charity. We exist to ensure everyone affected by autism has the chance of a long, happy, healthy life.
Autistica funds ground-breaking research into the issues which matter most to autistic people and their families, including mental health in autism, ageing and autism, and early intervention. In March 2016, we published *Personal tragedies, public crisis,* a policy report bringing together evidence on premature death in autism from multiple studies, reviewed by scientists, clinicians and autistic adults. The full report can be found online here.

Executive Summary

- Ongoing research, funded by Autistica, is increasing finding that the autism community many account for a *significant* proportion of total suicides in the UK**. The preliminary results of our psychological autopsies study suggests that 11% of people who die by suicide in the UK may be autistic** (please note that this exact figure is provisional). In contrast, only 1% of the population are autistic.
- After heart disease, suicide is now the leading cause of early death in autistic adults with no learning disability: this group are over nine times more likely to take their own lives than the general population. 14% of children with autism and 66% of autistic adults report having experienced suicidal thoughts.
- Autistic women are more likely to take their own lives than autistic men – a very unusual finding in the context of suicide.
- There is evidence that autistic people are more likely to choose violent methods of suicide, increasing their likelihood of taking their own life.
- Autistic people may not be diagnosed with depression prior to suicidal ideation, presenting major challenges in preventing suicide in this group.
- Because most autistic adults are undiagnosed and awareness of the links between autism and suicide is low, data on autistic suicides remains very limited.
- The Welsh Government's *Talk to me 2* strategy currently makes no mention of autism. We strongly urge the Government to establish a priority work-stream to identify and implement short- and medium-term actions to begin supporting this particular at risk group. Unless specific measures are introduced to address the needs of the autistic community, a significant number of suicides in Wales will not be prevented.
- The *Together for Mental Health* strategy includes provisions (Goal 8.1) to improve the assessment and post-diagnostic support available to people with neurodevelopmental conditions like autism. It's essential that this work addresses the distinct nature of mental health in the autism community.
- NHS Wales, the Local Health Boards, GPs and mental health services should consider autistic people with no learning disability as a high risk group for deaths from suicide. Health professionals should also be aware that often unsuspected groups (such as women and children) may be at significantly increased risk of suicide within the autistic community.
- NHS Wales should consider implementing NICE's recommendation to the NHS in England: that GP practices should establish and maintain confidential local registers of their autistic patients. Similar registers have commonly been used to improve care for people with learning disabilities and also provide the basis for targeted health promotion programmes, like annual health checks which Autistica will pilot to support the physical and mental health of autistic people.
- Suicide prevention and other mental health services should ensure their staff are trained in autism-appropriate communication techniques and building resilience in autistic people. Services should ensure frontline workers are aware of the high and distinctive lifetime risk of suicidal ideation and suicide plans or attempts, especially in individuals receiving a late diagnosis of autism.

- There are currently no evidence-based autism-appropriate suicide prevention tools or treatment programmes. Prevention and treatment methods such as helplines or talking therapies may not be suitable for autistic people who often have challenges with communication, group situations and awareness of their own and others' emotions. Research piloting these tools is essential.

Suicide in autism

1. From the very start in childhood and through to adulthood, mental health in autism is an enormous issue: 70% of children and 79% of adults meet clinical criteria for a mental health disorder, such as bipolar disorder, depression, anxiety, obsessive compulsive disorder and schizophrenia (Simonoff et al. 2008; Lever and Geurts. 2016). Research suggests a genetic link between autism and mental health problems, but mental health problems may also be triggered or influenced by environmental factors, such as social exclusion, bullying, and experiencing stigma.

2. Emerging UK research also indicates very high rates of suicidality in autistic people. 66% of newly diagnosed adults with Asperger Syndrome have considered suicide, significantly higher than the UK general population (17%) and patients with psychosis (59%); 35% have planned or attempted suicide (Cassidy et al. 2014).

3. In children with autism, suicidal thoughts are much more common than in the typical population, with 14% talking about or attempting suicide compared to 0.5% of non-autistic children (Mayes et al, 2013).

4. The largest global study of premature mortality in autism highlights suicide as a leading cause of early death in people with autism and no learning disability who make up approximately two third of autistic people (Hirvikoski et al. 2015).

5. This study also found that women with autism and no co-morbid learning disability were most at risk of death from suicide. In contrast, 87% of suicides in the UK were by males (ONS, 2015). The reasons for this increased risk in women are unclear but it may be a combination of two factors: women are typically more likely than men to attempt suicide but less likely to be successful; however autistic people may be more likely to choose more lethal methods of attempting suicide, increasing the likelihood of successfully taking their own life (Takara & Kondo, 2014)

6. The characteristics of suicide in autism may be very different to the general population, and thus require tailored prevention strategies. For example, research showed that more adults with Asperger Syndrome experienced suicidal ideation (66%) than were depressed (32%) (Cassidy et al. 2014), suggesting a different route to suicidal ideation than found in the general population.

7. There are no suicide prevention tools or treatments which have been tested in autistic populations. Given that many autistic people have challenges with communication, group situations and awareness of their own emotions, it is likely that traditional services such as telephone helplines or group cognitive behavioural therapy may not be effective in autism.

8. Despite widespread use of anti-depressants and anti-psychotics to treat mental health problems in autistic children and adults, there is very limited evidence of efficacy or safety. A diagnosis of autism is generally an exclusion factor in pharmaceutical trials, meaning that most mental health medications have never been clinically tested in autistic people.

Data on suicide in autism

9. Data on suicide in autism remains frustratingly limited for several reasons including: most autistic adults are undiagnosed; even following a diagnosis, autism is poorly recorded in health records; and coroners are unaware of the links between autism and suicide so are unlikely to include autism in a coroner's report.

10. Better data at national and local level, including local case reviews, would be a significant step forwards. Researchers at Nottingham University are creating a Suicide in Autism Research Database (SIARD) and working with Autistica and others to explore how best to understand risk factors leading to suicide in autism and how to prevent and treat suicidality.

Recommendations for action

11. **Autistic people should be considered a priority group in suicide prevention policy**. There is increasing evidence that autistic people account for a significant and disproportionate portion of total deaths by suicide. Furthermore the characteristics of suicide – along with the measures that will be best suited for prevention – appear different within the autism community than amongst the rest of the population. Unless specific measures are introduced to address the needs of the autistic community, a significant number of suicides in Wales will not be prevented.

12. **Health professionals in mental health, crisis and other NHS services must be informed about the unique risk of suicide amongst previously unsuspected groups.** The groups at risk within the autism community may not be those that health professionals expect; for example suicidal thoughts and attempts are much more common amongst autistic women and children than in the rest of the population. Similarly, autistic people at risk of taking their own lives may not present in the way that health professionals may be used to seeing. Processes such as masking – which is a common practice amongst autistic people without a learning disability (who are at highest risk) – may mean that an individual does not appear to be struggling when they are in crisis. Many autistic people report not being believed or understood by health professionals when they disclose feeling suicidal. Services should ensure frontline workers are aware of the high and distinctive lifetime risk of suicidal ideation and suicide plans or attempts, especially in individuals receiving a late diagnosis of autism.

13. **Crisis interventions need to be made accessible for autistic people.** Autistic people are unlikely to call a helpline to talk to a stranger about their feelings at the best of times, let alone when they are in crisis. Alternative methods, such as instant messaging services, should be trialled amongst this community.

14. **Mental health pathways need to be designed for autistic people's needs.** Autistic people are usually among those having the worst time within the mental health system. Mental health problems can present differently for autistic people and so are often missed or misdiagnosed. Even though a third and a half of autistic adults report having had depression, a surprisingly low number of autistic people who die by suicide have a recorded clinical history of depression. Furthermore some mental health interventions do not work for autistic people in the same way that they do for neurotypical individuals. Group therapies, for example, are less likely to be appropriate whilst common interventions – like CBT, DBT or anti-depressants – may need adjustments to work for autistic people.

15. **The Assembly should ensure that the NICE-recommended indicator on autism GP registers is included in the Quality and Outcomes Framework (QOF)** and any successor programme(s). GP registers are a tried and tested measure for addressing health inequalities – they are already used to support people with conditions like asthma, diabetes and learning disabilities. Whilst many of the general population approach their GP as a first port of call for mental health problems, the environment in a GP practices may make that difficult for an autistic person. Locally, the registers would enable GPs to make tailored reasonable adjustments (for example by offering a double appointment at a quieter time of day) based on each individual's needs. Nationally, the registers would help to begin addressing the lack of data available on autism, within the NHS.

Contact us

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S 06
Inquiry into Suicide Prevention
Ymchwiliad i Atal Hunanladdiad
Ymateb gan Network Rail
Response from Network Rail

<u>Health, Social Care and Sport Committee's inquiry into Suicide Prevention</u>

Written evidence submitted on behalf of Network Rail and the rail industry

1. Introduction

1.1 Network Rail runs, maintains and develops Britain's railway infrastructure. We also manage 18 stations and there are 22,000 miles of track with 32,000 bridges and tunnels. We have circa 4.5 million people who travel on the rail network each day.

1.2 There are 28 different Train Operating Companies (TOC's) who run trains on the railway system of Great Britain, 23 of them are passenger and 5 are freight.

1.3 The award winning and publicly acknowledged work of Network Rail and the rail industry has made us world leaders in the area of suicide prevention on railway networks. We contribute significant amounts of time to support Government initiatives work with other industries and sectors to more broadly spread the suicide prevention message and lecture around the world to other railway administrations in an effort to not only reduce the number of suicides on the railway, but in the community at large.

1.4 We feel this inquiry provides us with the opportunity to highlight the award winning and ground breaking work we do in relation to Suicide Prevention.

2. Key facts and figures

2.1 80% of people who die by suicide on the rail network are men

2.2 Men are three and a half times more likely to take their own lives than women

2.3 Those from the most deprived areas are ten times more likely to take their own lives than those from the most affluent areas. Men from deprived social groups are at the highest risk of all

2.4 In 2016-17 85 people or one in four who attempted to take their live survived. Most were left with life changing injuries.

3. Impact of suicide

3.1 Each suicide on the network causes on average 2,200 minutes of delay and costs £230,000. The annual cost of suicide to the rail industry in 2016-17 was circa £54 million.

3.2 The trauma experienced by staff involved in or witness a suicide may mean that they never return to work. On average most who are involved in such events take 29 days off work. For every suicide that occurs on the railway around 10 staff/support colleagues will get directly involved.

3.3 On average there are 262 suicides on the network per year. In 2015/16 there were 253, a 12% reduction in suicides on 2014/15 (287 incidents) and in 2016/17 a further 6% reduction in suicides on 2015/16 (237 incidents)

3.4 Each suicide is a tragic event for the individual, their friends and family, but also for a wider group of people; notably our staff, the emergency services and passengers.

3.5 The Rail Industry's objectives relative to suicide prevention are:

I. To reduce the risk of suicide on the railway
II. Reduce trauma to staff
III. Improve the passenger journey experience.

3.6 The safety impact of these incidents can be wider than just the immediate incident location. Our customers may be detained on trains until the network can be returned to full operation.

3.7 One of our challenges is the operational/safety difficulties encountered when people come onto the running lines to hold vigils or place memorials. This may take the form of 'symbols of mourning' left near to where an individual took their life. We look to remove memorials as quickly and as sympathetically as possible. Whilst they may appear not to be causing harm they are in fact:

I. Acting as a constant reminder to rail staff of where a tragic event took place
II. Potentially presenting a safety risk to the operational railway as mourners for example congregate around them on the infrastructure.
III. Identifying a particular location as one from which a suicide can be completed. This may in turn encourage others to do likewise

4. Network Rail and the industry role in suicide prevention

4.1 Suicide is a complex societal issue and whilst the rail industry has a responsibility to prevent deaths on the railway, there is only so much it can do in relation to a problem it has no direct control over. If the number of suicides is to be significantly reduced on the network, then support must come from those external to it such as local authorities and the health sector. They must play their part in reducing the risk of suicide just as the rail industry does.

4.2 The rail industry has made significant progress in suicide prevention over the last seven years, but the problem is a truly 'wicked' one which is beyond the industry's gift to solve. Whilst we recognise, acknowledge and discharge our responsibilities in this area; we make the following 'calls to action' to drive down the suicide rate not only on the railway but in society as a whole:

I. Mental and physical health should be treated equally, and vulnerable people should be encouraged to seek help;
II. There should be compulsory suicide prevention training for all those in the health sector;
III. All local authorities/health boards should engage with the British Transport Police and Network Rail when creating Suicide Prevention Action Plans to ensure that they have the fullest picture of local trends;

IV. More should be done in schools, colleges and universities to make our young people aware of mental health issues to allow them to look after themselves and others at any point through life's journey;

V. We should not have to rely on our police force supporting vulnerable people until appropriate medical facilities become available for them. A situation brought about by the lack of adequate health care provision for those most at risk in our society;

VI. The standard of proof required in Coroner's Inquests should be changed. Despite suicide being decriminalized in 1961, Coroners are still required to use the criminal standard of proof (beyond reasonable doubt) before making suicide findings. All other available findings (except unlawful killing) require the civil standard to be met (on the balance of probabilities). This extremely high standard of proof may mask the true extent of suicide and hinder research into it.

VII. Consideration on the impact to the Railway when Care Homes and Mental Health Hospitals are built or relocated near the railway.

VIII. The need for real time data capture to identify where focus work needs to be completed and to assist local authorities with their decision making and completion of suicide audits.

IX. The need to share information between health services, local authorities and the rail industry on individuals who have disclosed that they are considering taking their life on the network.

X. The sharing of information held by public bodies with the British Transport Police should be a positive requirement, rather than the current cautious approach based around data protection requirements.

5. Suicide Prevention Strategy

Our strategy consists of measures that seek to prevent the incidents occurring whilst ensuring we respond to each event in a dignified, respectful and supportive way.

Prevention measures

5.1 Physical and technological measures

For the rail industry's part, a significant and increasing amount of intervention measures are being installed or implemented across the network. These are measures related to engineering or technology such as fencing, landscaping, detection systems and lighting devices. They seek to influence the behaviour of a suicidal individual prior to them accessing the infrastructure or once they are on it, providing some form of warning to rail staff or other industry partners which can then be acted upon.

The prevention methods that the industry deploys across the network can be classified into 'hard' and 'soft' measures. Hard measures are defined as those that present a physical barrier or require some form of mechanical process to introduce them, whilst soft measures are those which rely on people or some form of social interaction to deliver them.

5.2 'Hard' prevention measures

These are deployed on the network and may also be referred to as 'engineering' or 'target hardening' solutions.

I. Restricting access to the running lines - It is important to make access to the running lines as difficult as possible to reduce accessibility to the lethal means.

II. Securing Platform Ends - Platform end barriers and trespass guards, provide an effective counter measure to prevent individuals easily accessing the running lines from platforms.

III. Lineside Fencing - Locations on high speed lines that are particularly prone to suicide events are best fenced using industry standard palisade fencing.

IV. Mid Platform Fencing - Such fencing is deployed to divide platforms where one is served by stopping services and an adjacent one is served by high speed non-stopping services. The introduction of the fence restricts the ability of individuals gaining access to the high speed line just by walking across the platform. Note: The installation of mid platform fencing requires a high level of stakeholder consultation, reference to a number of standards and may not be viable for all appropriate locations due to issues such as pedestrian flows.

V. Restricting access to unused platforms - Unused platforms with adjacent running lines open to traffic should not be accessible to the public. They offer an unrestricted point of entry to the network.

VI. Securing small and unique access points - Surveys of high risk sites may identify unique vulnerable points of access to the network. These will require bespoke mitigation measures to ensure their security.

VII. Securing large and unique access points - Surveys of locations at risk of suicide may identify unique vulnerable points of access to the network. These will require bespoke mitigation measures to be employed and in some cases the requirements of third parties to be taken into account when doing so.

VIII. CCTV Cameras - There are a considerable number of CCTV cameras on the network and these can be employed to monitor key locations. A camera is trained to capture images of an area that is otherwise invisible to station staff and where it is known those contemplating taking their lives emerge from. Linking cameras with the means of communicating with or making announcements to individuals who may be loitering in strategic locations, provides a means of immediate access to them where staff or security personnel may not be on hand to approach them.

IX. Platform hatching/yellow box markings - yellow cross hatching on platforms is a psychological measure. Many grow up knowing that a yellow box painted on the road indicates the need to keep the

carriageway clear. Their use on platforms is to promote this thinking. Vulnerable people subsequently have to deal with the dilemma of stepping into this area to gain access to the running line, whilst at the same time potentially exposing themselves to increased surveillance from rail staff and passengers amongst others.

5.3 'Soft' prevention measures

These are employed across the industry and rely on people or some form of social interaction to deliver them and involve the following activities:

5.4 Third party cooperation

Where there are known high risk locations and our mitigation measures are not reducing the number of suicides at them, we find ourselves working increasingly with or seeking the cooperation of others to reach out and identify those in the wider community that are at risk of suicide by:

i. Organisational and procedural measures - These are strategic, collaborative, enforcement and process related measures which seek to define the suicide problem in particular areas and develop strategies with third parties to help address them. The benefit of these measures is that they have the potential to influence the attitude and/or activities of a vulnerable individual who may be considering taking their life prior to them accessing the railway or even thinking about it as a means of lethality. Collaborating with third parties is critical to the success of these measures not only to prevent suicides on the railway but in the wider community as a whole.

ii. Public awareness and educational measures - Such measures seek to improve the knowledge or skills of various groups of people who have the potential to influence those at risk of suicide. They comprise of communications campaigns, signage, education, media guidelines and work with third parties.

5.5 Training

As an industry, we recognise the importance of suicide prevention training and Samaritans our partners, deliver a Managing Suicidal Contacts Course to all rail industry staff and to date we have trained over 15,000 people. A positive output of this training is the number of lifesaving interventions made and last year we saw over 1500 completed. This year there have already been 1048. The aim of the training is to:

I. Increase the number of people who use the network to identify, approach and support a potentially suicidal person

II. Provide basic guidance on talking to a vulnerable person; how and where to seek support and safely resolve the situation

III. Increase awareness of trauma, how it can affect people and the warning signs

IV. Provide basic guidance on talking to someone who may be suffering from trauma and how and where to seek further support

We have created a highly acclaimed suicide prevention video package known as the Learning Tool which has been designed to allow everyone in the industry to play their part in our suicide prevention programme. It provides insight into how to prevent a suicide through to understanding the trauma such events can have and how to manage it.

The tool has been developed at the request of the industry to make the details and materials of the programme more accessible to its entire workforce through video content that can form part of a briefing, training or personal awareness package.

5.6 Intervening in suicide attempts

Intervening in suicides is one of the most effective methods the industry has of preventing them. Interventions rely on rail staff and others being on hand to personally interrupt an individual in the act of taking their own life - this usually means by approaching them, providing ‘emotional’ support, taking them to a place of safety and handing them on to the emergency services for treatment or further support.

We are aware that interventions are successful and as an industry have recently launched our Small Talk Saves Lives Campaign. The objective is to further increase the number of successful suicide interventions on the rail network by targeting potential bystanders amongst the general public and encouraging action for people to intervene safely through highlighting that a simple question can be all takes and emphasises that suicides can be prevented.

5.7 Trauma support

Ensuring our people are appropriately cared for following a traumatic event forms a key part of our programme. A trauma support code of practice has been developed which provides guidance to help support colleagues involved in, or who witness a potentially traumatic incident. The implementation of this code of practice contributes to the mitigation of the risk of poor health and well-being. It helps employees to:

I. identify work colleagues potentially at risk immediately after a traumatic event and in the weeks following;
II. confirm that work colleagues are offered effective support from the point of incident onwards;
III. assess and refer colleagues to appropriate clinical support services if required;
IV. specific collateral has been developed to supplement the code of practice which is distributed to all at risk staff.

Bespoke trauma support training delivered by Samaritans is offered to key groups that may be at risk of experiencing traumatic events.

5.8 Partnership Approach

i. As an industry we have made contributions to many Government documentation

ii. We have been in partnership with Samaritans since 2010; we renewed our contractual arrangements with them for another five years in 2015. We work closely and part-fund a dedicated BTP Mental Health and Suicide Prevention Unit.
iii. We have developed an escalation process which targets specific additional activity at locations where three suicides or injurious attempts have occurred in a rolling 12 month period, to mitigate against the risk of further incidents. This involves forging links with Local Authorities and relevant stakeholders. This process has enabled us to prompt some Local Authorities to develop Suicide Prevention Plans and establish steering groups.

5.9 Innovative measures

As an industry we continually strive to find new ways of learning to improve our knowledge and understanding of this complex area and how to manage it. Some examples include:

i. Middlesex University was commissioned to carry out research that would increase the industry's understanding of why people take their lives on the railways and what factors might influence their decision.
ii. Rail505 a pilot project that has tested the concept of using passengers to report people who they suspect may be at risk of taking their own lives. The success of the system has prompted the industry to consider rolling it out more widely across the network.
iii. Commissioning an Anthropologist to support the industry to identify why clusters of people take their lives at specific locations particularly where existing mitigation measures should, it is believed, act as a significant deterrent.

6 Conclusions

Since 2010, the rail industry has invested millions of pounds in preventing suicides on Great Britain's railways and in the communities it is very much a part of.

Roughly 4.5% of those that take their lives each year do so on the railway. This percentage we acknowledge as being far too high and as an industry look to those with responsibility to address the causes of suicide in society, to do so more robustly and effectively.

However, we recognise the part we have to play in reducing not only suicides on the railway, but in the communities we are part of as a whole and the stigma that surrounds them. To conclude, as well as discharging our legal responsibilities in this area as an industry of 'Duty Holders' (be it of franchises or railway operations); we seek to work with any organisation and share our knowledge and materials with those that can help achieve that end for the greater good of society.

S 07

Inquiry into Suicide Prevention

Ymchwiliad i Atal Hunanladdiad

Ymateb gan Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Response from Cardiff and Vale University Health Board

HEALTH, SOCIAL CARE AND SPORT COMMITTEE CONSULTATION: INQUIRY INTO SUICIDE PREVENTION

EVIDENCE FROM CARDIFF AND VALE UHB

1. Cardiff and Vale University Health Board is one of the largest NHS organisations in Europe. We employ approximately 14,500 staff, and spend around £1.4 billion every year on providing health and wellbeing services to a population of around 0.5 million people living in Cardiff and the Vale of Glamorgan. We also serve a wider population across South and Mid Wales for a range of specialties.

The extent of the problem of suicide in Wales and evidence of its causes

2. Current data from 35 OECD countries, based on the WHO mortality database, ranks the UK average suicide rate (7.5/100,000) as tenth lowest and below the OECD average of 12.1/100,000[1]. More up to date data from the Office of National Statistics shows that in Great Britain, Wales has the second highest suicide rate at 11.8/100,000 in 2016[2]. In comparison, England has the lowest at 9.5/100,000 in 2016. Males in Wales have over 4 times the suicide rate of females[3]. The incidence of suicide in middle age (age 45-64 years) is also highest for Welsh persons across the age groups. Compared to other Health Boards in Wales, Cardiff and Vale UHB has the fourth highest suicide rate at 12.9/100,000 (2011-2015). The highest rate is in Cwm Taf (15.3/100,000), and the lowest is in Betsi Cadwaladr (10.7/100,000). The total number of suicides in Wales between 2011 and 2015 was 1,665. Therefore, as Cardiff and Vale UHB had 257 suicides during this period, this contributed to 15.4 per cent of the total in Wales.

[1] OECD (2017), *Health at a Glance 2017: OECD Indicators*, OECD Publishing, Paris. http://dx.doi.org/10.1787/health_glance-2017-en [accessed 29 November 2017].

[2] ONS (2017), Suicides in Great Britain: 2016 registrations, https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2016registration#great-britain [accessed 6 November 2017].

[3] PHWO (2017), Public Health Outcomes Framework, https://public.tableau.com/profile/publichealthwalesobservatory#!/vizhome/PHOF2017Characteristics-Individual/Individual?:iid&:tabs=no , [accessed 6 November 2017].

3. Suicides are highest in middle aged men in Wales and the causal factors for this are complex, but certainly material disadvantage has a role to play. The report researched and written by the Samaritans: *Men, Suicide and Society*, explains the key causes for suicides in this population[4]. Explanations include: personality traits, masculinity, relationship breakdowns, challenges of mid-life, emotional illiteracy and socio-economic factors. The Welsh Government Strategy, *Talk to me 2,* also highlights the high risk groups for suicide, which include: male sex, low socio-economic status, low educational attainment, previous suicide attempts, mental disorder, chronic illness and alcohol/substance misuse amongst others[5].

The social and economic impact of suicide

4. Suicide is a tragedy for all concerned and has both social and economic impacts. The social impact of suicide is outlined in the relatively recently published guide to suicide bereavement: 'Help is at Hand' [6]. The guide highlights that not only will the grief reaction be present, but more in-depth feelings of guilt; questioning as to why it happened; and whether it could have been prevented. Particular mention goes to close family and friends of the deceased plus health and social care professionals who may have been supporting the individual concerned.

5. *Talk to Me 2* highlights the economic impact of suicide in that it most often occurs in the productive ages of the population: it is in the top three causes of death in the 15-44 year old age group within Wales [5]. Studies suggest that the cost per completed suicide is around £1.5 million [7].

The effectiveness of the Welsh Government's approach to suicide prevention

6. Welsh Government launched their suicide and self-harm prevention strategy *Talk to Me 2* in 2015. Locally this has provided a useful framework by which to prioritise suicide prevention activities across Cardiff and the Vale of Glamorgan. Across Cardiff and the Vale of Glamorgan we have formed a Suicide and Self-harm Prevention Steering Group, with a multi-agency membership. Based on audit findings of where the partnership was against the action plan of *Talk to Me 2*, we created a local Suicide and Self-harm Prevention Strategy and action plan. There are three priority workstreams falling out from this work: training and development (focusing on the development of a local database and sharing of good practice); prisons (learning from other areas as to how best to prevent suicide a

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[4] Samaritans (2012), Men, Suicide and Society, https://www.samaritans.org/sites/default/files/kcfinder/files/press/Men%20Suicide%20and%20Society%20Research%20Report%20151112.pdf [accessed 6 November 2017].
[5] WG (2015), Talk to me 2, https://www.samaritans.org/sites/default/files/kcfinder/files/press/Men%20Suicide%20and%20Society%20Research%20Report%20151112.pdf [accessed 6 November 2017].
[6] PHW (2016), *Help is at hand*, http://www.wales.nhs.uk/sitesplus/documents/888/HelpIsAtHand%20English%20web.pdf [accessed 29 November 2017].
[7] Centre for Mental Health (2015), *Aiming for 'zero suicides'*, https://www.centreformentalhealth.org.uk/Handlers/Download.ashx?IDMF=e423419a-f86b-48c7-9c83-7e3d33df4fc9 [accessed 29 November 2017].

7. nd self-harm in prisons); and geographical suicide hotspots (collecting data to inform us where hotspots might be, and to prevent any future suicides at these sites). Therefore, the national strategy has provided structure and function to suicide prevention on a local level. There was also a regional network for South East Wales, comprising of Cardiff and Vale, Cwm Taf and Aneurin Bevan Health Boards which progressed some shared learning; however, this has not met for a while.

8. More Welsh Government support could be realised through targeted resources being made available for suicide prevention training for frontline multi-agency staff. This would include the cost of the training and for the respective backfill of staff. Additionally, mental health services for both children and young people and for adults are currently at capacity. Whilst service redesign is one way of responding to this issue, enhancing capacity of mental health teams through additional capacity and resource could help to alleviate current pinch points and waiting times.

The contribution of the range of public services to suicide prevention, and mental health services in particular

9. Across Cardiff and the Vale of Glamorgan a range of public services prevent and provide support to people at risk of suicide. Within Cardiff and Vale UHB, mental health services in particular provide support to people at risk of suicide across the life course. All ages are managed by workers from within the Primary Mental Health Support Service – this is part of the service delivery of Part 1 of the Mental Health Measure (Wales) Act.

10. Under 18s with a more severe presentation are managed by Child and Adolescent Mental Health Services (CAMHS) in the community, or in the inpatient setting if required. Within CAMHS, based at St David's hospital in Cardiff, there is a Community Intensive Therapy Team (CITT) which provides support to young people and families who are at high risk and they provide support and therapeutic interventions, such as Dialectical Behavioural Therapy, and young people and families can access Tier 4 Services (Ty Llidiard inpatient unit). The majority of crisis / intervention / prevention work is managed by the Crisis Liaison Team which provides a service from 9.00 am to 9.30 pm Monday to Friday but will be covering 7 days a week in the New Year. They assess young people who present in Crisis in a number of settings, including Emergency Department, Paediatric Ward and Police Custody Suite. They also interface with several third sector agencies including the Early Psychosis Team. All assessments that are carried out have a Wales Applied Risk Research Network (WARRN) Risk Assessment completed and generally follow-ups are offered and on occasion can be referred into generic CAMHS for further ongoing support. Cardiff and Vale UHB also commissions a young person's Emotional Wellbeing Service through Change, Grow, Live.

11. People aged 18 and over are managed by appropriately trained specialists in Community Mental Health Teams for Adults and for Older People. Other options include Crisis Resolution Home Treatment teams and the inpatient setting. Mental Health workers are trained in WARRN risk assessment. Mental health workers also

provide a limited level of training for school teachers, third sector and other agencies.

12. Other public sector services support children and young people through: youth services; educational psychology; school anti-bullying campaigns; and school counselling services. These services also help to contribute to the wellbeing of children and young people and help to prevent suicide.

The contribution of local communities and civil society to suicide prevention

13. Local communities and civil society make a significant contribution to suicide prevention both nationally and locally. The Samaritans have made some headway regarding signage/phone lines at known local hotspot areas in order to encourage help-seeking. They also provide support to people in distress through a variety of communication methods. Children and young people are supported by: Barnado's; Change, Grow, Live; Head above the Waves; and the Amber project to name but a few local third sector agencies.

Other relevant Welsh Government strategies and initiatives

14. The Welsh Government Strategy: 'Together for Mental Health' is currently overseen by the Cardiff and Vale Mental Health Partnership Board. This strategy initially kick-started the audit locally as to where we were with the 'Talk to Me' national and local actions. It also provided a framework for action on many issues which affect the potential for suicide risk in our population.

Innovative approaches to suicide prevention

15. In terms of innovative approaches being undertaken within Cardiff and Vale UHB, there are several projects which are showing promise. There is an in-patient project using a manualised Cognitive Behavioural Therapy (CBT) approach for hospital in-patients, whereby mental health staff are trained to have difficult conversations with patients who are expressing suicidal and self-harming ideas. There is also a project in planning phase currently, amongst the Advanced Nurse Practitioners in Mental Health with a focus on community services. It is looking at developing clinical assessment in order to predict more accurately when individuals are building capability to commit suicide, based on recognised behaviours.

16. As part of the planning process for future developments within Cardiff, developers will need to consider suicide prevention. This is because this is noted as a part of the Health Supplementary Planning Guidance of the Local Development Plan. This will ensure that future housing developments have considered suicide risk and therefore suicide prevention strategies such as barriers and nets.

S 08

Inquiry into Suicide Prevention

Ymchwiliad i Atal Hunanladdiad

Ymateb gan Y Samariaid Cymru

Response from Samaritans Cymru

Suicide Prevention

Samaritans Cymru response

Samaritans is a registered charity aimed at providing emotional support to anyone in emotional distress. In Wales, Samaritans work locally and nationally to raise awareness of their service and reach out into local communities to support people who are struggling to cope. They seek to use their expertise and experience to improve policy and practice and are active contributors to the development and implementation of Wales Suicide and Self Harm Prevention Action Plan 'Talk to Me 2'.

1. **The extent of the problem of suicide in Wales and evidence for its causes**

1.1 Globally, over 800,000 people die by suicide each year.[1] In the United Kingdom and Ireland, more than 6000 people take their own lives each year and in Wales, between 300 and 350 people die by suicide each year. This is about 3 times the number killed in road accidents. In both England and Wales, suicide is the most common cause of death for men aged 20-49. Of the 322 suicides in Wales in 2016, 265 (82%) of these were by men.[2] In 2015, the age groups with the highest suicide rate per 100,000 in Wales were: 30-34 years, for all persons and 30-34 years for males. In reviewing trends over time, there has been a general increase in male suicide in Wales over the last 30 years, with a specific trend of increase since around 2008. Female suicide in Wales has decreased over same period, however, in line with the male trend, there has been a period of general increase since 2008.[3]

1.2 Whilst there is no single reason why people take their own lives, there are a wide range of risk factors and subsequent high-risk groups who are more likely to experience suicidal feelings or completed suicide. These groups include; young and middle-aged men; people in contact with mental health services, people living in areas of socio-economic deprivation; people with a history of self-harm; people experiencing loneliness and isolation, people in contact with the criminal justice system, including prisoners; people with a history of alcohol and substance misuse, asylum seekers and refugees, the Gypsy, Roma and Traveller community, specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers; friends and family bereaved by suicide, and lesbian, gay, bisexual, transgender and questioning (LGBTQ).

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[1] World Health Organization (WHO). (2014). *Preventing suicide: A global imperative*. Retrieved from: http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/

[2] ONS. (2016). *Suicides in the United Kingdom, 2015 registrations*. United Kingdom: Office for National Statistics

[3] Scowcroft, E. (2016). *Suicide statistics report 2016: Including data for 2013-2014*. Surrey: Samaritans.

1.3 There must be a concerted and targeted effort from both public and voluntary bodies to identify and reduce the risk of suicide in high-risk groups. Whilst we must maintain an overall population approach to suicide prevention in Wales, it is important that there is cross-governmental and cross-sectoral knowledge of the risk factors for such a prevalent public health problem.

2. The social and economic impact of suicide.

2.1 Every suicide is a tragedy which has a devastating effect on families, friends, colleagues and the wider community. For each of the deaths by suicide in Wales each year, it has been suggested that an average of 6 people are deeply affected and family and friends who have been bereaved by suicide are 1.7 times more likely to attempt suicide.[4] The average cost of a suicide in the general population has been estimated as £1.67m per completed suicide.[5] This includes intangible costs (loss of life to the individual and the pain and suffering of relatives), as well as lost output (both waged and unwaged), police time and funerals.

2.2 We must provide better information and support to those bereaved or affected by suicide. Waiting lists for bereavement support are a major barrier to follow-up care in Wales. Resources such as 'Help is at Hand Cymru' must be more widely disseminated. The stigma around death by suicide can be isolating for the friends and families left behind with survivors of suicide loss experiencing very distinctive bereavement issues surrounding guilt, shame and rejection. We must promote talking as a form of help seeking and early intervention to reduce the stigma of bereavement by suicide.

3. The effectiveness of the Welsh Government's approach to suicide prevention

3.1 As members of the National Advisory Group to Welsh Government on Suicide and Self-harm, we have contributed to the development and implementation of Talk to Me 2. We welcome the 3 C's approach outlined in Talk to Me 2 (Cross-governmental, cross-sectoral and collaborative in design and delivery) and the identification of priority care providers, priority places and priority people. In terms of progress, we believe implementation is still an issue. In the Public Health Wales Midpoint review of the implementation of Talk to Me (2012), it was noted that implementation was difficult due to the *'difficulty in setting up Regional Groups and a lack of high level support in many health boards and local authorities'* We believe the existence of such plans is vital for efforts to reduce suicide and self harm in Wales but this action plan needs a clear

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[4] Pitman, A. L., Osborn, D. P., Rantell, K., & King, M. B. (2016). *Bereavement by suicide as a risk factor for suicide attempt: A cross-sectional national UK-wide study of 3432 young bereaved adults.*

[5] McDaid, D., Park, A., & Bonin, E. (2011). *Population level suicide awareness training and intervention. In M. Knapp, D. McDaid & M. Parsonage (Eds.), Mental Health Promotion and Prevention: The Economic Case* (26-28). London: Department of Health.

framework for implementation; one which recognizes the importance of acting locally.

3.2 Many of the top-level objectives in Talk to Me 2 are reliant on effective local partnership working through a cross-collaborative approach. For example, one of the main objectives is to improve awareness, knowledge and understanding of suicide and self harm amongst individuals who frequently come in to contact with people at risk of suicide and self harm and professionals in Wales. This objective is facilitated by frontline training in suicide awareness for public services. However, to achieve this, it is vital that local services, agencies and organisations work in a joined up and collaborative way to effectively manage and target their resources.

3.3 The most effective means of achieving this local and collaborative approach, is the creation and implementation of local suicide prevention plans and ensuring the engagement of Local Health Boards and local authorities in Regional Multi-Agency Suicide Prevention Fora. Local suicide prevention plans are developed and implemented by multi-agency groups and are critical to implementing the national suicide prevention strategies published by Welsh Government.

3.4 We are aware that there is inconsistency surrounding local forums and regional fora in Wales. Whilst there are some groups which champion the strategy and engage in multi-agency working, there are local authority areas in Wales who are not sufficiently engaged. Without a local suicide prevention plan, suicide prevention work is much less effective than it could be.

Through our own collaborative working, there are examples of good practice from public services in reducing access to the means of suicide. We provide a range of public services with Samaritans signs which they install in locations where they have identified a risk or have seen an increase in suicidal behaviour or suicide. We witness good partnership working between public services (such as Police and Fire and Rescue) but this does not necessarily mean they are linked up with local suicide prevention fora. This is for a range of reasons ranging from lack of awareness through to some groups being less focused on operational action.

Reducing Access to Means

3.5 There is evidence to suggest that lives can be saved by the use of a variety of measures including: the installation of Samaritans signs; physical barriers; nets and telephone lines at high risk locations for suicide; and improved surveillance, such as CCTV, at possible, or known, high risk locations.[6] High risk locations could include: bridges, viaducts, high-rise buildings, multi-story car

[6] *Interventions to reduce suicides at suicide hotspots: a systematic review and meta-analysis Pirkis, Jane et al. The Lancet Psychiatry, Volume 2, Issue 11, 994 - 1001*

parks, cliffs and level crossings. Some services we work with identify the benefits of a preventative approach to reducing access to means at locations which are either known to be high-risk or have the potential to become so. In terms of fulfilling this trajectory, the main barrier is often budget and a lack of shared understanding throughout the sector. Whilst we work with many champions for mental health and suicide prevention, the placement of signs in particular can be a lengthy procedure in terms of budget and approval.

Suicide Prevention Training

3.6 Alongside this, suicide prevention training should form a major part of local suicide prevention. There needs to be greater awareness surrounding the benefits of a preventative approach to suicide, including training of this kind. Training should be provided to frontline workers both in the public sector but also key frontline sectors who are more likely to meet vulnerable groups. Increased awareness of specialist training provided by organisations, including Samaritans and Mind, should also be highlighted. Suicide Prevention Training is particularly important for those identified as 'Priority Care Providers' in Talk to Me 2, such as Job Centre Staff, Emergency Health Staff and teachers.

3.7 A good example of the benefits of suicide prevention training for workplaces and public services is our work with the rail industry in Wales. In 2010, Samaritans began working with Network Rail with the aim of preventing rail suicides and supporting those affected by them. The Rail Industry Suicide Prevention Programme (RISPP) is now a joint partnership between Samaritans, Network Rail and British Transport Police and the wider rail industry.

In Wales, our partnership with Network Rail and work with the wider rail industry focusses on seven key areas: Suicide prevention training, engaging the rail industry in suicide prevention and support activities, reaching out to those most at risk, supporting people affected by a traumatic incident, support at stations following a suicide, working with the media to encourage responsible reporting of rail suicides and working with police and health services. In Wales, the Network Rail suicide prevention team have developed a 12-point plan to push forward the agenda of suicide prevention. Its inclusion in the Wales Route joint suicide prevention plan, as well as adopting recommendations from Talk to me 2, ensures that they are making a difference for Wales and the Route. 1,400 frontline Arriva trains staff members in Wales have now completed a basic level of suicide prevention training, allowing them to act as a preventative force alongside their training for post-incident action.

4. Mental Health Services

4.1 1 in 3 people who die by suicide have been in contact with mental health services in the year before their death.[7] We believe that swift and timely access to psychological therapies can enable and improve recovery, and act as a form of early intervention which can reduce the need for secondary services. Despite the cross-party support and focus on access to psychological therapies in the Together for Children and Young People Programme (T4CYP), Together for Mental Health and the Mental Health (Wales) Measure, access to psychological therapies is still a problematic issue in Wales.

4.2 People's mental health can deteriorate significantly during lengthy waiting times for psychological therapies, which can lead to suicidal feelings or suicide. As members of the Wales Alliance for Mental Health, we believe that an introduction of waiting time measures for psychological therapies across primary and secondary care is crucial. This data should be recorded and published to reduce waiting time

Post-hospital support

4.3 It is also crucial that health boards in Wales collect and publish data for post-hospital support for patients following admissions for self-harm or a mental health crisis. As of April 2017, there is only one health board in Wales that records how many people get timely follow up contact after they've been discharged. The lack of data for post-hospital support in Wales is a major concern. A survey of over 850 people with mental health problems about their experiences after leaving hospital in Wales showed those who weren't followed up appropriately (after seven days or not at all) were twice as likely to attempt suicide and a third more likely to harm themselves compared to respondents who said they were followed up within seven days of being discharged.[8]

4.4 Research by the NSPCC found that 1,193 young people were admitted to A&E departments in Wales because of self-harm in 2015. That number has increased by 41 per cent in the past three years.[9] National suicide prevention strategies recognise that Accident & Emergency services have an important role in treating people who have self-harmed or have made a suicide attempt. At least half of people who die by suicide have a history of self-harm and one in four have attended hospital for self-harm in the preceding year.[10]Given the particularly high suicide risk of people who attend hospital and A&E after harming themselves it is essential that rapid follow-up care is always available. It's

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[7] National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). (2016). *Making mental health care safer: Annual report and 20-year review*. University of Manchester.

[8] *Thousands left to cope alone after leaving mental health hospital - putting their lives at risk* Mind Cymru (April 2017)

[9] *Child self-harm figures 'frightening' in Wales, NSPCC says*, BBC Wales (December 2016)

[10] *How local authorities can prevent suicide*, Samaritans (2017)

essential that anyone having self-harmed is treated with respect, given a proper assessment and follow-up care.

Improvements to the accuracy and availability of suicide data.

4.5 We welcome some recent improvements to the availability of suicide data from agencies in the UK such as Office for National Statistics (ONS). Suicide data is now available more quickly and in more useful formats. However, there are still many challenges with suicide data across the UK and Republic of Ireland, which will hinder our understanding of suicide unless they are addressed.

4.6 Ascertaining and recording numbers of attempted and completed suicides, and monitoring them, is an integral component in the development of suicide prevention. Local suicide audits are an effective way for public sector bodies to identify and respond to high risk groups in their areas, as well as reveal sites of concern. It is best practice for public sector organisations, including Health Boards, Local Authorities and the coroner, work to develop and undertake a suicide audit. Learning lessons from the response to a suicide to reduce the number of future suicides and better support bereaved families.

5. Innovative approaches to suicide prevention

Education – Investment in Prevention and Early Intervention

5.1 Many aspects of modern society impact negatively on the mental health and wellbeing of children and young people. The specialist Child and Adolescent Mental Health Services in Wales (CAMHS) is under more pressure than ever before. The last 4 years has seen a 100% increase in demand.[11]

5.2 We must embed a public health approach to mental health and suicide prevention by placing a primary focus on prevention rather than cure alone. Investment in prevention and early intervention can reduce human, social and economic costs. Emotional health programmes in schools should be viewed as a form of promotion, prevention and early intervention which could reduce pressure on CAMHS, reduce specific mental health problems and increase academic achievement.

5.3 To successfully implement and fulfil the potential of the new curriculum, we must provide emotional and mental health awareness training to teaching staff across all schools in Wales to increase confidence in teaching the subject. We must increase confidence in new teaching staff and ensure basic mental health literacy by embedding emotional and mental health awareness in Initial Teacher

[11] National Assembly for Wales, Children, Young People and Education Committee. (2014). *Inquiry into Child and Adolescent Mental Health Services (CAMHS)*

Training (ITT) and make sure the potential of the 'Health and Wellbeing' area of learning is fulfilled; The inclusion of emotional health and wellbeing on the curriculum should be mandatory and not optional.

5.4 We have recently welcomed the announcement of a two-year Welsh Government trial which will allow pupils with mental health problems at more than 200 schools in Wales to access early help from onsite CAMHS practitioners. Whilst this kind of linking up between education and health services is essential, we would like to emphasise that our call for action continues to be placed further downstream and in the primary context of early intervention through building resilience; a skill that can mitigate suicide in the future. It is vital that we realise the potential of the new curriculum.

The Power of Community

5.5 Loneliness and isolation increases the likelihood of suicide and social connection is therefore a protective factor for suicide risk. One intervention which addresses loneliness and isolation is community and outreach group participation. In terms of achieving the protective factor of social connection, the theme or nature of community and outreach groups can be extensive and wide-ranging.

5.6 Organisations such as Men's Sheds Cymru, which cite 'social exclusion as a hidden but persistent problem in many communities', aim to address the problem by creating community groups for men to pursue their interests, develop new ones, belong to a unique group, feel useful, fulfilled and a sense of belonging. Men's Sheds is now established and growing in the United Kingdom but these type of organisations are supported and funded by the Third Sector and their sustainability needs to be safeguarded to protect those who are most vulnerable.

"It gives me a reason to get up in the morning and for two days a week I feel I'm gainfully employed. I feel good working with and helping chaps who often feel isolated in the community. I would need a very good reason not to come." Bill, 67

5.7 It is vital that these types of community or social outreach groups are recognised for their health benefits; social connectedness tackles loneliness and isolation, and can work to reach those who are at the highest risk of being socially excluded and suicidal. This is particularly significant within the current Wales context, following the closure of Communities First and with the lack of a central strategy. Community groups should be given more focus as a form of prevention and early intervention for loneliness and isolation in Wales and policy solutions should be worked up to increase community participation.

Minimising the risk of the internet

5.8 The internet is often used by people who self-harm and/or attempt suicide to explore possible methods and read others' personal accounts of suicidal feelings and behaviour. In a population survey of 21 year olds, of the 248 participants who had made suicide attempts (6% of the overall sample), almost three quarters reported suicide-related internet use at some point in their lives. One in five had accessed sites giving information on how to hurt or kill yourself, though most of these had also visited help-sites.[12]

5.9 This research which was undertaken by Samaritans and University of Bristol identified the internet may pose a particular threat to young people. A policy report launched in 2016 set out a range of implications and recommendations for the industry and providers of online help, both of which we believe should be circulated appropriately.

[12] University of Bristol / Samaritans Policy Report (7/2016) *Priorities for suicide prevention: balancing the risks and opportunities of internet use*

7 December 2017

Response from the Royal College of Nursing Wales to the Health, Social Care & Sport Committee's consultation on suicide prevention

The Royal College of Nursing Wales is grateful for the opportunity to respond to the consultation on suicide prevention in Wales. We would like to raise a number of points in relation to the terms of reference:

Overview

I. The quality, availability and accessibility of mental health services plays a key role in suicide prevention. It is vital therefore that anyone who may be at risk of considering or attempting suicide is able to access the right type of service, delivered by appropriately skilled professionals, in the right place, and at the right time.

II. Mental health care is a specialist and skilled area of nursing and mental health nurses are specifically trained to work in mental health care settings and to treat and care for people with a wide range of illnesses and complex needs. The Royal College of Nursing calls for a clear workforce development and education strategy for mental health nursing in Wales that will help to meet the current and future mental health needs of the population, including those who are in crisis.

III. Unscheduled care services (such as drop-in centres, or A&E departments) should all be designed to have the facilities and expertise to engage with people in a mental health crisis. All Health Boards should have well developed multi agency crisis plans and protocols to enable people to access services 24/7. Assertive outreach and crisis resolution teams should be developed, adequately resourced and be accessible across Wales.

Extent of the problem and evidence for its causes

IV. As stated in the Welsh Government's 'Talk to Me' strategy, suicide rates are higher in more deprived communities, and this highlights that suicide prevention should address inequalities that exist in society. It is also known that some groups in society are more 'at risk' than others including veterans, members of the trans community, prisoners and those suffering from chronic illnesses. It is important therefore that suicide prevention strategies are able to reach all groups in society, including those who are hard to reach.

Effectiveness of Welsh Government's approach

V. It is understood from our members, that whilst suicide prevention strategies such as 'Talk to me 2' are, in principle, meant to be embedded within health boards and community services, this is not consistently the case across Wales. Mental health services have a key part to play in implementing and delivering these strategies and yet teams and resources already experience a level of demand which outstrips capacity. The Committee may therefore want to consider whether additional resource and investment is required in order for strategies such as 'Talk to me 2' to be truly embedded within and across services.

Contribution of public services/local communities to suicide prevention

VI. RCN Wales believes that health and social services (alongside all other public services) need to promote good mental health and wellbeing. As part of this promotion RCN Wales believes the pre-16 education curriculum should include the teaching of strategies to develop emotional resilience and promote emotional well-being. This can help equip children and young people with skills which can help later on in life.

VII. The RCN has partnered with MindEd which is a free educational resource aimed at upskilling the workforce, as well as parents, carers and other professionals. The resources offer free online learning and information to help educate the workforce, plus advice and information for families and carers, and an example of how technology can be utilised to communicate vital information. There are two resources:

- MindEd for Families – online advice and information to help families understand and identify early issues and how best to support children. Specific pathways have been developed to signpost school nurses and others to key modules to complete.
- MindEd for Professionals and Volunteers – provides adults who care or work with young people the knowledge to support their wellbeing, the understanding to identify a child at risk of a mental health condition, and the confidence to act on their concern and, if needed, signpost to services that can help.

Mental Health Crisis Care Concordat

VIII. The Mental Health Crisis Care Concordat, of which the Royal College of Nursing Wales is a joint signatory along with Welsh Government and other

partners, outlines a number of Core Principles. The Committee may want to consider the extent to which these principles are embedded into practice:

- Access to support before crisis point
  Early intervention is universally recognised as the best form of prevention. People with mental health problems or their families, friends or partners are often aware that a crisis is fast approaching and may know how it might be averted.

- Urgent and emergency access to crisis care
  People in mental distress should be kept safe and find the support they need from whatever source. As a key requirement, local services need to be available out of hours – 24/7. Responses to people in crisis are best undertaken wherever possible locally and close to home. Local plans should aim to ensure that no one is turned away and a least restrictive treatment option, most appropriate to the individuals needs should be applied

- Quality of treatment and therapeutic care when in crisis
  Local mental health services should meet the needs of people in crisis, appropriately at all times. Responses should have parity with emergency physical health need, and these services will be inspected and regulated.

- Recovery and staying well
  Care planning is a key element of prevention and should focus on recovery. An emphasis should be placed on care and treatment planning, accessing services within agreed time-frames and the duties placed on those services to deliver appropriate care.

About the Royal College of Nursing

The RCN is the world's largest professional union of nurses, representing over 430,000 nurses, midwives, health visitors and nursing students, including over 25,000 members in Wales. The majority of RCN members work in the NHS with around a quarter working in the independent sector. The RCN works locally, nationally and internationally to promote standards of care and the interests of patients and nurses, and of nursing as a profession. The RCN is a UK-wide organisation, with its own National Boards for Wales, Scotland and Northern Ireland. The RCN is a major contributor to nursing practice, standards of care, and public policy as it affects health and nursing. The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies.

S 10

Inquiry into Suicide Prevention

Ymchwiliad i Atal Hunanladdiad

Ymateb gan Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg

Response from Abertawe Bro Morgannwg University Health Board

Welsh Government Inquiry into Suicide Prevention
Call for Evidence December 2017
Submission by ABMU Health Board

Sentinel Incident Review Group

The Mental Health and Learning Disabilities Delivery Unit has a monthly Sentinel Incident Group (SIG) meeting chaired by the Medical Director of the service. The aim of the group, which is drawn from across the Delivery Unit together with the Health Board's Serious Incident and Patient Feedback Teams, is to review critical incident reports and ensure that appropriate actions are taken if any failings are identified. Critical incident reviews are commissioned following the unexpected death of a patient who has had contact with secondary care mental health services in the previous 12 months. The reviews are chaired by a Consultant Psychiatrist unconnected with the patient's care and follow a root cause analysis process.

In addition to reviewing individual clinical incident review reports, the group also produces an annual report summarising lessons which have been learnt through the year which are categorised into themes. This report also considers the work generated from the National Confidential Inquiry hosted by Manchester University into confirmed deaths by suicide.

Following the publication of the National Confidential Inquiry report in October 2017 and drawing on themes from the work of SIG, areas for development have been identified, including:

- Audit programmes including an audit on all adult acute admission units against the NICE guideline (NG53) Transition of Inpatients to Community, together with the ongoing audit of care and treatment planning
- Redesign of the current three places of safety and renewal of the Section 136 policy, particularly in relation to the implications of the new Policing and Crime Act 2017 which places further restrictions on the use of police cells as a place of safety.
- Implementation of the MAZARS report following the Southern Healthcare Inquiry which includes the rollout of a pilot project in the Neath Port Talbot locality relating to the completion of mortality reviews and the involvement of families in the review process.
- Participation in the Welsh Government's Fatal Drug Poisoning Consensus Seminar programme which highlights the recent increasing number of suspected drug related deaths in Wales. This programme also includes a key message from the National Confidential Inquiry in relation to the need to effectively manage opiate prescribing.

Single Point of Access

A single point of access for all referrals was adopted in Old Age Psychiatry in Bridgend in 2003. The

model was published in 2007 (Colgate R and Jones S). Further collaboration with academic nursing colleagues from Melbourne Australia led to the United Kingdom mental health triage scale in 2015 which was quickly adopted by General Adult Psychiatry services in Bridgend and more recently in Swansea.

The triage scale allows a modern mental health service to achieve reconfiguration to identify those patients who need urgent assessment accurately and consistently both in the working week and out of hours. Suicidal ideas and intent are accorded priority usually within four hours (category B) or where clinically appropriate within 24 hours (category C). (Also published as Sands N et al 2016.)

The triage process concentrates upon patient need rather than requiring a diagnosis. Governance and reliability are especially strong where services have been able to identify a dedicated referral coordinator who is able to allocate a priority based on individual patient need, separate from (the term dislocated is used) the immediate availability of staff or service pressures.

Mental Health Crisis Services

Each of the 3 localities within the Mental Health and Learning Disabilities Delivery Unit of the Health Board has a mental health crisis service comprising acute inpatient admission crisis resolution and home treatment, together with recovery unit services. The recent reduction in suicides among people leaving hospital may suggest that the crisis resolution and home treatment teams are now better able to support people to prepare for discharge and when they return home. The demand however for crisis team assessments has been substantially increased each year since their inception in Wales in 2006. Each of the 3 crisis teams within the ABMU Health Board has the challenge of balancing the provision of patient assessments with the need to provide home treatment and discharge planning services.

As part of the Health Board's response to the Mental Health Crisis Concordat, frontline police officers have been asked to contact local crisis teams at the point when they are considering applying a Section 136 detention. Work is currently ongoing to closely monitor these requests for advice to help ensure the most appropriate use of this power.

Early and Effective Intervention within the Inpatient setting

Recent funding from the Welsh Government has enabled the establishment of psychology input into the inpatient wards to enable holistic care and treatment planning for individuals under the Mental Health Measure. This has ensured that inpatients who have attempted suicide or engaged in self harm have access to qualified psychological risk assessment and specialist psychological intervention according to their needs in addition to input provided by other multidisciplinary team members. As a consequence to the establishment of psychology, regular CBT and mindfulness groups have also been set up on wards to help individuals develop problem solving and coping mechanisms to mitigate risk and prevent future episodes.

The establishment of a psychosocial care pathway on the community for older individuals experiencing mental health issues and carers of people with dementia has also enabled a rolling programme of CBT, mindfulness, carers CBT and positive psychology groups on the community to help individuals develop coping mechanisms, problem solving strategies and social connections to hopefully mitigate the risk of suicide and self-harm for attendees.

Initiatives around Psychiatric Liaison

The Morriston Hospital Psychiatric Liaison team provides a service to the Emergency Department. Referrals to the Liaison service are made by the triage nurse so that waiting times in ED for patients with mental health issues are reduced.

The Liaison service in Morriston Hospital is planning to start a follow up clinic in the new year for those individuals who have been seen and assessed by Liaison in the Emergency Department following self harm and where the person does not require a referral to either primary or secondary mental health services. It would be offered to those individuals who Liaison feel would benefit from brief solution focused interventions, coping skills type interventions and would be offered for a maximum of 3 sessions with either the psychologist or a mental health nurse. Psychiatrist input would be offered to commence medication if appropriate.

Management of young people (16-17) presenting following self-harm to the A&E departments at Morriston Hospital, Swansea and Princess of Wales Hospital, Bridgend

When young people present to Accident and Emergency departments within the ABMU Health Board, they receive the necessary medical treatment for any physical health which may involve admission to the hospital. When they are determined to be medically fit, there is sometimes a considerable delay in securing the necessary CAMHS assessment. Those under the age of 16 can be admitted to a paediatric ward on each of the general hospital sites to facilitate the mental health assessment in an appropriate environment. For those between the ages of 16 and 17, there is just a single bed identified on the adult acute assessment mental health Ward F, Neath Port Talbot Hospital. Patients are only normally transferred into this single bed once the CAMHS assessment has been completed within the Accident and Emergency Department. Accident and Emergency departments report the challenge of having to safeguard the young person within their department whilst the assessment process is completed and arrangements are made for admission to a mental health unit if necessary. This can take many hours and often requires special 1:1 observations for which the departments are not staffed.

Morriston Hospital bereavement group

A bereavement service was established in the A&E department at Morriston Hospital which aimed to provide help and support to the family, carers and friends of individuals who had deceased within the department. This involved the offer of a meeting with a nurse representative from the department and a clinical psychologist from the psychiatric liaison service 6 weeks after the death. These meetings have provided helpful support in providing answers to questions and signposting to bereavement counselling. This scheme has recently been rolled out throughout the hospital.

Self-harm prevention initiatives in the regional Burns and Plastic Surgery service, Morriston Hospital

The regional burns and plastic surgery service based at Morriston Hospital provides care to many patients who have sustained injury as a result of deliberate self harm. The regional burns unit has been working proactively with the prison service over prevention and early intervention initiatives. The plastic surgery unit would also like to develop this work in addition to the existing arrangements which are in place for the safeguarding of individual prolific self harmers.

Dechrau Newydd

Dechrau Newydd is a community-based complex needs team providing specialist therapy to secondary care clients, with a presentation indicative of a personality disorder. The team offer

Dialectical Behaviour Therapy (DBT) to clients who have a recent history (last six months) of self-harm and/or suicidal behaviour. DBT consists of a weekly group in which clients learn skills in four domains: mindfulness, distress tolerance, emotional regulation and interpersonal effectiveness. Clients also attend a weekly one to one session with a therapist, and have access to a coaching line Monday- Friday 9-5pm.

All DBT clients have a formulation and agreed targets to address suicidal behaviour and self-harm. When clients have learned sufficient skills, they devise a crisis plan with their therapist which highlights the skills they find the most useful in crisis, and this is shared with the Community Mental Health Teams. Clients are encouraged to use the coaching telephone line when they have urges to self-harm, so that therapists can offer support and encouragement to utilise skills to cope 'in the moment'. Outside office hours, clients are encouraged to contact the Community Crisis Teams for this support.

Initiatives around Primary Care

The 3 locality based Local Primary Mental Health Support Services (LPMHSS) within the Health Board were set up under Part 1 of the Mental Health Measure to work with clients with mild to moderate common mental health problems. The teams however also have contact with clients who have variable levels of suicidal/self-harm ideation and intent. In order to help manage such risks, the teams provide education and advice, receive appropriate training (for example STORM), use scoring tools such as Corenet to measure levels of risk when providing mental health assessments and interventions, work closely with GP surgeries, constantly review risk through the therapeutic process and signpost to third sector services, as appropriate.

Preventing Suicide in Public Places

The Health Board helped coordinate the regional collaborative Suicide and Self Harm Prevention Workshop which was held with partners on 22nd November 2017. The aim of the workshop was to help pull together the regional collaborative prevention plan which is required by the Welsh Government as part of the Talk to Me 2 strategy by February 2018. During the event, there was discussion on the need for a more strategic approach to preventing suicide in public places. As a result, the Health Board will be aiming to develop a group with partners to help address environmental risks within the community. This will involve representation from such organisations as Network Rail, the police and Local Authority.

Improving Community Resilience and Social Connectedness

Talk to Me 2 (2015) indicates that a major protective factor in the case of suicidal behaviour is for an individual to have a strong sense of community connection and the ability to harness social and cultural and spiritual beliefs to support the self. The locality is planning the resurrection of an ABM-wide Mental Health and Spirituality Special Interest group (MHSSIG). The remit of the group will be to explore and facilitate the relationship between statutory services and faith communities to help raise mental health and suicide awareness in those 'harder to reach' communities including asylum seekers, refugees and the Muslim community. The plan is to hold a NPT conference on Mental Health and Spirituality entitled 'Breaking down the Barriers' to enable service providers, faith communities and individuals to come together to consider how to address the issue of mental health and suicide going forward at this time of austerity and to also consider how best to target socially deprived areas of the patch.

S 11

Inquiry into Suicide Prevention

Ymchwiliad i Atal Hunanladdiad

Ymateb gan Goleg Brenhinol y Therapyddion Galwedigaethol

Response from the Royal College of Occupational Therapists

Date: 8th December 2017. Health, Social Care and Sports Committee Inquiry into Suicide Prevention, Wales

This submission is made on behalf of the Royal College of Occupational Therapists (RCOT), the professional body for occupational therapists across the UK which supports 1880 occupational therapists in Wales, 300 of whom work in mental health services. The submission is made in response to the Inquiry into Suicide Prevention in Wales. Further information on any aspect of this response can be gained by contacting the RCOT.

Executive Summary

Key points to note from this submission include:

- Occupational therapists can lead innovative approaches to suicide prevention by focusing on the roots of emotional distress
- Occupational therapist believe more focus is needed on survivor legacy as they experience higher rates of suicide
- The value of meaningful occupation as a form of suicide prevention needs better recognition.

Submission

1. Innovative approaches to suicide prevention

An innovative and progressive approach to suicide prevention, with the potential to transform mental health services and generate significant social and economic impact, would be for the Welsh Government to support the introduction of a capacity test for suicidality.

For decades mental health services have been attempting a paradigm shift from the paternalistic medical model to a more holistic user-focussed recovery model – with only partial success. The impact of austerity has been a dramatic increase in poverty, homelessness and hopelessness, whilst at the same time funding for public services has been endlessly cut back.

This combination of undersupply and over demand has led to the tacit rationing of services, with criteria for access being set ever higher. Add into the mix spiralling public expectation and a culture of risk-aversion, and it is small wonder that the medical model has maintained its dominance.

The culturally-encoded concept of illness is so deeply embedded in society that in times of harsh austerity, to be labelled as sick becomes tolerable or even desirable if it means being cared for in an uncaring world.

Services have responded by fixating on risk rather than need to such a degree that the era when mental health services were focussed on severe and enduring mental illness (SMI) is long gone. Services have become a battleground for entitlement, a merry-go-round of assessment, and to a lesser extent management of risk, with precious little to offer in the way of rehabilitation or recovery.

In this socioeconomic context, suicidality has become a unit of currency, tradable for access to services. As the height of the bar rises so do the risks some people feel compelled to take, and so the focus of mental health services has become critically and unsustainably distorted.

Our members suggested solution is to stop treating suicidal ideation as *necessarily* a sign of illness, but rather a metaphor for emotional distress. By doing so we would free up services to address the root causes on an individual, needs-led basis – be it lack of meaningful occupation such as employment, accommodation, coping skills, social networks, all of which are the focus for occupational therapists. That is not to say that an individual's cognition can never be impaired by SMI that they can see no alternative to ending their life. Indeed these are the very cases towards which services should in future, be orientated. The capacity test tells us if this is the case. Occupational therapists leading this type of approach would enable people to learn to deal with emotional distress and use meaningful occupation as an effective coping strategy.

2. Survivor legacy

A strong theme for our members is survivor legacy. Partners, parents and children present to mental health services with trauma symptoms such as guilt, anger, emotional volatility, alcohol and substance misuse that can be attributed to a critical trigger event such as suicide of a loved one.

Many of these survivors will manage with time but never fully recover. In many of these stories our members see pre-morbid behaviours of high expressed emotion, substance / alcohol misuse, dysfunctional relationships and abuse histories in both those who take their own life and survivors – in summary, vulnerable people with poor coping skills and little support. Our members feel that this group needs more policy focus and support. Occupational therapists can effectively support the survivors of suicide by focusing on how to use hope and goal setting to move forward positively with their lives.

3. Value of occupation.

Occupational therapists delivering occupation focused interventions can lessen suicidality. Participation in meaningful occupations or activities will have a positive impact on mental health and wellbeing and is often neglected as an effective intervention. A short film about Matt who tried to end his life and worked with an occupational therapist to regain meaning and motivation can be found here: **https://www.youtube.com/watch?v=lVX_h-OroF0**

Case study – Adult Community Mental Health Services - Hywel Dda University Health Board.

A 25 year old man had been suffering from severe depression with suicidal thoughts and self-harm. He had been in hospital for about 6 weeks and was discharged back into the community where he started working with the occupational therapist. There was little improvement in his mental health, he had not responded to CBT and had been off work sick. When the occupational therapist met him, he did not want to get out of bed and was voicing suicidal ideation. He lived in a rural location and was worried about losing contact with his two young sons because they were distressed at seeing their father so depressed.

By working with the occupational therapist he was able to identify that he hated his job and was constantly worried about making target sales. He was worried about paying his mortgage and providing security for his sons. He felt hopeless about the future. By working in collaboration with the man, the occupational therapist developed a care plan focused less on medication or talking therapies and more about re-engaging with everyday tasks such as self-care, work and leisure.

The man demonstrated that he had been a creative person who enjoyed making things out of wood and metal and was extremely good at DIY. His activity levels improved with activity scheduling and he began walking his dog on the beach every day, collecting driftwood and beginning to make things in his workshop. With the support of the occupational therapist, he began to sell his work on EBay and it sold quickly which improved his confidence and self-esteem. As his mood and sleep improved he made the decision not to return to the job he hated but to set his own business up as a handyman. After seeing the occupational therapist over a six month period he was discharged saying he felt like a different person with a vision and hope for the future.

Three months after his discharge he wrote the occupational therapist a thank you letter saying he had regained his driving license, had an improved relationship with his sons, was enjoying being self-employed and still sold his creative sculptures on the internet. The total cost of the occupational therapy intervention was approximately £1251 but the value to this man and his family is priceless.

About the College

The Royal College of Occupational Therapists (RCOT) is pleased to provide a response to this inquiry. RCOT is the professional body for occupational therapists and represents over 31,000 occupational therapists, support workers and students from across the United Kingdom. In Wales there are approximately 1880 occupational therapists, 300 of whom work in mental health services. Occupational therapy enables people of all ages to participate in daily life to improve health and wellbeing. The philosophy of occupational therapy is founded on the concept that occupation (participating in activities) is essential to human existence and good health and wellbeing.

Occupational therapists are regulated by the Health and Care Professions Council (HCPC), and work with people of all ages with a wide range of occupational problems resulting from physical, mental, social or developmental difficulties. Occupational therapists work in the NHS, Local Authority social care services, housing, schools, prisons, care homes, voluntary and independent sectors, and vocational and employment rehabilitation services.

Contact

For further information on this submission, please contact:

Genevieve Smyth
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Royal College of Occupational Therapists

EVIDENCE TO HEALTH, SOCIAL CARE AND SPORT COMMITTEE - EXTENT OF THE PROBLEM OF SUICIDE IN WALES

1. Introduction

This paper is submitted by Stephanie Hoffman, Head of Social Action at ProMo-Cymru, on behalf of ProMo-Cymru, referencing information from the Meic service. ProMo-Cymru is happy for its submission and evidence to be shared and made public.

Please see Appendix 1 for ProMo-Cymru, and Meic information and contact details.

2. How big a problem is it

2.1 At Meic, we deal with up to 6000 contacts a year via phone, text and instant message

2.2 Recently, we have seen an increase in the number of young people contacting us about suicide - from having suicidal thoughts through to carrying out a plan to commit suicide

2.3 In the period April – September 2017, Meic received 2500+ contacts, of whom more than 10% presented with mental health issues, of whom 65+ presented with self harm issues, and 100+ with suicide, of whom 10+% resulted in action requiring police intervention

2.4 There was a significant increase of between 55% and 62% in the contacts presenting in respect of self harm and suicide respectively, between the periods April – June 2017, and July – September 2017

2.5 These figures represent a doubling on the same period in the previous year (2016)

3. Why is it happening (/ increasing)

4.1 Meic does not have the sophistication necessary to establish indisputable and robust correlations, however anecdotal evidence based on feedback elicited from children and young people contacting the service suggests the following contributory factors:

4.2 Transition of adolescence to adulthood

4.3 Social / environmental pressures: education, employment, housing, finance

4.4 Personal experience especially unhealthy experiences / expectations of relationships eg: bullying, exposure to pornography, confusion about sex and sexuality, controlling / coercive behaviour, historic abuse

4. How does Meic help

Young people who contact Meic who are feeling suicidal, experiencing suicidal thoughts, harming themselves, are offered help and support in the following ways:

- Giving young people the space to discuss their situation without judgment.
- Supporting the young people to retain as much control as possible over their situation and the information they give us, even when we need to contact emergency services.
- Training all our staff in the use of the ASIST model and Youth Mental Health First Aid course as tools to help keep young people safe.
- Where young people can identify a specific cause for their suicidal thoughts (e.g. homelessness, substance misuse, abusive relationship etc.) we support the young person to tackle these issues.
- Advocating on behalf of young people to access mental health support services that they are entitled to
- Helping young people resolve issues that can be contributing to suicidal thoughts and feelings
- Helping young people to identify on-going support through existing support networks and via outside agencies such as GPs, the Samaritans, specialist suicide support services such as

Papyrus' Hope Line or local services that deal with mental health issues such as Mind.
- Directing young people to on line information and resources for their own self efficacy
- Contacting the police when a young person is in immediate danger or at risk of significant harm when a safety plan cannot be formulated, and a young person discloses that they intend to carry out a plan and die by suicide

5. Some examples

5.1 Suicidal thoughts, self harm, past intervention, range of pressures, actions going forward:
A young person (YP) contacted Meic by phone to discuss his suicidal feelings. He confirmed he had no immediate plans to kill himself. He explained that his relationship had broken down, school was stressful and the relationship between him and his mum had broken down, following his parents' split, resulting in him moving to live with his dad after his mum's repeated late night abusive behaviour towards his dad. He also explained that he had self-harmed in the past by cutting and bruising himself and had recently stopped eating properly. Further details about his history revealed various interventions including a mental health assessment resulting in no further follow up, and counselling which was felt to be of little help. The YP confirmed he did not really want to die in spite of the suicidal thoughts, he just wanted to feel better. The YP confirmed he had a good support network and that he could talk to his dad; he didn't feel he could go to his friends who had their own issues. The HAA clarified that the YP did not intend to kill himself, and signposted the YP to Papyrus for more specialist support as well as The Mix, and Meic Calming Sites for further information and resources on mental health issues and how to deal with them. The YP thanked the HAA for talking to him and said he felt a lot better.

5.2 Plan for suicide, acute distress, history, holding intervention, police intervention:
24 year old male very upset crying on the phone, said he was suicidal and needed help. HAA asked if he had a plan, he said he wanted to kill himself and said he could do it a few ways, then hung up. YP called back in a few mins and same HAA took call. YP gave name and local town, said he needed help, had tried to stab himself earlier on today but knife was

too blunt. Asked if he had another plan YP said he had taken cocaine and drunk 24 cans. HAA explained concern for his safety and requested further contact / identifier information, which he refused. YP acknowledged need for help, had been on medication years ago but hadn't been to see his GP and no mental health support at the moment; he had found his Mum dead a few months ago, he had been in prison when he was younger. He had tried to kill himself several times before, overdosed and jumped out of window. YP broke down in tears again, talking about finding his dead mother. He said he wanted to talk about her, YP was crying and unable to talk at the point. Then YP said he had rope in his room and he had tied it around his neck; voices were telling him to do it. HAA instructed YP to listen to her voice not the voices in his head and that he needed to take the rope from his neck and to take 5 steps away – HAA reassured him she was there to help him to keep him safe. YP said he couldn't and was sobbing, HAA repeated reassurance and instructions. YP silent, prompting HAA to ask if still there and YP confirmed had taken rope from neck and stepped away. HAA praised YP, told him that he needed to make sure to listen to her voice now. YP said he had lost his cocaine, spent time looking for it, HAA engaged in this conversation with him to distracted him from the rope, YP then said he needed to throw up and went to the toilet to be sick. YP said he had tied the rope around his neck again, HAA repeated instructions as before and YP complied for which he was praised and reassured. HAA explained to YP that help was on the way and could get to him sooner if provided his details, which he did and which were forwarded to the police. HAA kept him on the phone while waiting for the police to arrive, instructing him to stay on the phone until their arrival and then hand over the phone to them police which he did – his safety ensured.

6. What would help

6.1 Young people need young person led, young person friendly services that are relevant to them and available when they need them - especially at the point when they ask for help or are in distress

6.2 Adolescence and young adulthood - which it is acknowledged now spans a considerable length of time - (early teens to mid/late 20’s), is a time of significant transition physically, emotionally, neurologically, and services need to be sufficiently agile and flexible in recognition of this and in order to be relevant and helpful

6.3 These services need to be available face to face as well as online / helpline - many young people find talking about these things very difficult, and especially face to face and sometimes voice

6.4 These services need to include brief / early intervention as well as on-going support and treatment

6.5 There needs to be an easy and smooth pathway for young people to (re-)enter into, move between and exit services, as well as be held by services where waiting is unavoidable

7. ProMo-Cymru would welcome

7.1 Any request for its support in respect of CYP co-produced and co-designed on line / digital information and support services more generally

7.2 Any request for its support in respect of data collection, information gathering, evaluation to better understand the nature and extent of suicide and self harm

7.3 Any request for its support and participation in any national / regional face to face or on line networks for sharing of information and best practice, including helpline specific services

7.4 Any extension / rolling out of training the trainer initiatives to enable a wider pool of (lived experience and other) trainers of ASIST and YMHFA

Appendix 1 – INFORMATION ABOUT PROMO-CYMRU AND MEIC

INFORMATION ABOUT MEIC (managed by ProMo-Cymru)

Meic is the national information advice and advocacy helpline service for children and young people in Wales up to the age of 25

Confidential and bilingual, it is available 16 hours per day, 7 days per week, 365 days per year between 8am and midnight

It is accessible by phone (landline and mobile), text, instant message, email and website:
https://www.meiccymru.org/?gclid=EAIaIQobChMInbO0tZLz1wIVyb3tCh3fLwQXEAAYASAAEgILpfD_BwE

Since 2011, Meic has dealt with nearly 40000 contacts presenting nearly 50000 issues, the main ones being:

- family relationships 11%
- other relationships 11%
- mental health 10%
- rights and citizenship 8%
- physical health 7%

INFORMATION ABOUT PROMO-CYMRU

Vision: To empower people and communities to create positive change

Mission: To listen, break down barriers and build bridges in order to bring positive change and lasting relationships between individuals, families and communities. It provides innovative and creative solutions through meaningful conversations, digital technology and by working together

Address: 17 West Bute Street, Cardiff bay, CF10 5EP
Tel. No:
Website: http://www.promo.cymru/
Company Limited by Guarantee: 1816889
Registered Charity: 1094652

S 13
Inquiry into Suicide Prevention
Ymchwiliad i Atal Hunanladdiad
Ymateb gan Goleg Brenhinol y Bydwragedd
Response from the Royal College of Midwives

Response to National Assembly for Wales consultation on Suicide Prevention

December 2017

Promoting · Supporting · Influencing

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The Royal College of Midwives
8th Floor, Eastgate House, 35-43 Newport Road, Cardiff, CF24 0AB

The Royal College of Midwives' response to the National Assembly for Wales consultation on Suicide Prevention

The Royal College of Midwives (RCM) is the trade union and professional organisation that represents the vast majority of practising midwives in the UK. It is the only such organisation run by midwives for midwives. The RCM is the voice of midwifery, providing excellence in representation, professional leadership, education and influence for and on behalf of midwives. We actively support and campaign for improvements to maternity services and provide professional leadership for one of the most established clinical disciplines.

The RCM welcomes the opportunity to respond to this consultation and our views are set out below.

Our response will be mainly but not entirely focussed on those aspects of the consultation relating to maternity care.

Overall we support the Talk to me 2, Suicide and Self Harm Prevention Strategy for Wales and the accompanying Action Plan. We recognise that significant progress has been made in relation to perinatal health services in Wales, including additional funding and significant recommendations from the Children, Young People and Education Committee. However we are extremely disappointed to note that there is no reference in the Suicide and Self Harm Prevention Strategy or the Action Plan to perinatal mental health, maternity services or the significant role that midwives play in the diagnosis, treatment and prevention of perinatal mental illness in Wales. Perinatal mental health has been recognised as a major public health issue that must be taken seriously. If untreated, perinatal mental illnesses can have a devastating impact on women and their families. They are one of the leading causes of death for mothers during pregnancy and the year after birth.

We note the purpose and aims of the strategy and the action plan; however we would wish to see the scope extended to include women at risk of suffering from perinatal ill-health.

Society's perception of childbirth as a happy event is true, yet what we do not see are the struggles of women behind closed doors whose mental well-being are affected as a direct result of pregnancy and birth. Suicide remains a leading cause of maternal deaths, particularly in the postnatal period. Almost a quarter of women who died between six weeks and one year after pregnancy died from mental-health related causes (MBRRACE-UK, 2015). Over the last five years in the UK, 101 maternal deaths were the result of suicide, representing 2.3 deaths per 100,000 maternities in pregnancy and up to one year post birth.

It is estimated that up to 50% of women may suffer from some form of mental health problems relating to pregnancy and birth, 15% - 20% suffer from postnatal depression (anxiety is at least as common and often co-exists with depression), and 3% have severe mental illness. 1 in every 500 women will suffer from postnatal psychosis and although instances of psychosis are rare, they can occur suddenly and result in significant harm to mother and baby. We must end the disparity of service provision between physical and mental health for women receiving maternity care.

Whilst it is clear in the Strategy that there is a gendered aspect to suicide in Wales, with men three times more likely to die than women, we would wish to see here some acknowledgement of the specific issues for women suffering from perinatal illnesses.

The Children, Young People and Education Committee has, as already stated, made a number of recommendations in relation to perinatal mental health and we would wish to see these being put in place as a matter of urgency. However we would also wish to see synergy between these and any other strategies to prevent suicide in Wales.

We recognise that there is a link between suicide and social depravation and this will impact on women who live in areas of residence based deprivation where rates are higher in more deprived communities. When developing strategies for prevention it is imperative that pregnant and post natal women are recognised as being in a high risk group.

It is noted that the age and pattern of self harm shows that young women aged 15 to 19 have the highest prevalence of self harm in Wales. Therefore there must be a specific focus on prevention efforts and ongoing support for this group of young women.

The key role that the midwife plays in the recognition and treatment of women with mental health issues is not recognised within the strategy. Currently midwives in Wales will ask women about their mental health when they first make contact and during subsequent contacts. With this in mind the vital role that the midwife plays needs to be recognised when addressing issues around suicide prevention.

However, midwives do need the skills, training and the ability to refer to appropriate services as necessary. This means that they will need to be considered when training, development and communication packages are being designed and implemented.

The social impact of suicide cannot be overestimated. Any strategy must take into account the additional needs of families where a mother has committed suicide leaving a new born baby behind or where she has also killed the new born infant or other children in addition to taking her own life. There are specific issues around supporting families where there has been infanticide and a failed suicide.

The Royal College of Midwives
December 2017

S 14

Inquiry into Suicide Prevention

Ymchwiliad i Atal Hunanladdiad

Ymateb gan NSPCC Cymru

Response from NSPCC Wales

Diane Engelhardt House, (Unit 2) Treglown Court, Dowlais Road, Cardiff, CF24 5LQ
Tŷ Diane Engelhardt, (Uned 2) Cwrt Treglown, Ffordd Dowlais, Caerdydd, CF24 5LQ
| nspcc.org.uk

8th December 2017

Health, Social Care and Sport Committee
National Assembly for Wales
Pierhead Street
Cardiff
CF99 1NA

Dear Chair

NSPCC Cymru/ Wales would like to submit some evidence to the Committee as part of the consultation on Suicide Prevention. There are specific factors and circumstances that mean some people are more at risk of suicide, such as children and young people who have suffered sexual abuse and/ or neglect. Research suggests up to 9 in 10 children abused at an early age go on to develop a mental illness by the time they're 18[1], which can lead to self-harm and suicidal thoughts.

Against the following element of the terms of reference we have two sources of evidence we would like to bring to the Committee's attention: evidence from our How Safe are our Children Report 2017 and Childline.

The extent of the problem of suicide in Wales and evidence for its causes - including numbers of people dying by suicide, trends and patterns in the incidence of suicide; vulnerability of particular groups; risk factors influencing suicidal behaviour.

1. NSPCC's How Safe Are our Children report

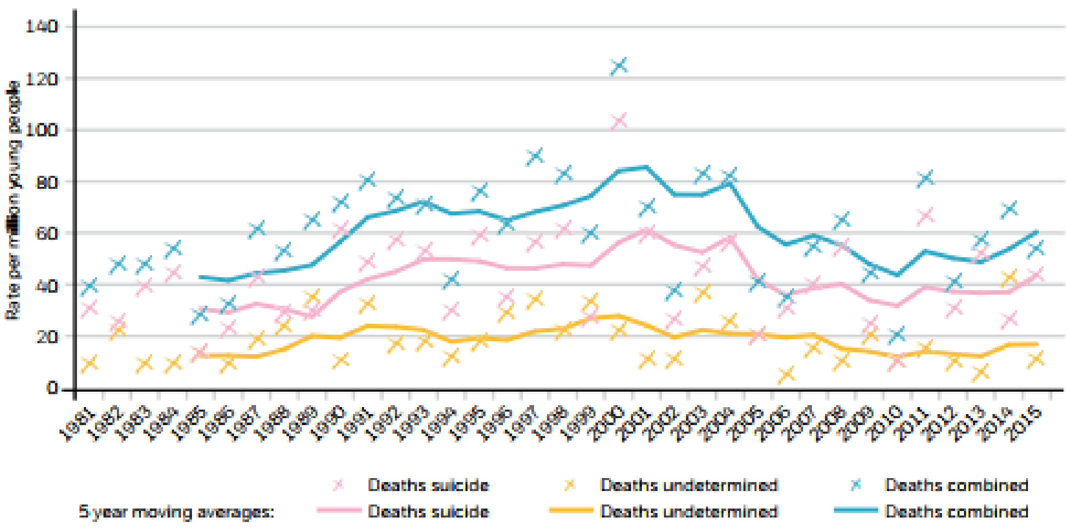
The NSPCC's How Safe Are our Children report, is one of the most comprehensive overviews of child protection in the UK. In this, data is reported on the suicide rates for young people. The most recent report, published in 2017, shows how, after decline in recent years, suicide rates for 15 to 19 year olds have started to rise in England and Wales.[2]

[1] Sroufe, L.A. et al. (2005) The development of the person: the Minnesota study of risk and adaptation from birth to adulthood

[2] Bentley, H. et al (2017) How safe are our children? The most comprehensive overview of child protection in the UK 2017. London: NSPCC.

Wales

Suicide rate per million 15 to 19 year olds



In Wales, there were eight suicides where death was recorded as by intentional self-harm, and a further two deaths by undetermined intent of 15 to 19 year olds in 2015, a five-year average combined rate of 60.4 per million 15 to 19 year olds. The five-year combined average rate among 15 to 19 year olds peaked in 2001 at 85.5 per million, and since then has been on a downward trend, reaching a low of 43.7 suicides per million in 2010. However since then there has been an increase, up 38 per cent to 60.4 per million 15 to 19 year olds. It should be noted that the numbers involved for Wales are small, meaning that a small change in the number of deaths has a significant impact.

2. Data from Childline

For 30 years Childline has provided a safe confidential space where children and young people can talk, be listened to and receive support, advice and information about the issues they are worrying about. In 2016/17, Childline delivered 295,202 counselling sessions across the UK. The most common reason for children and young people contacting Childline in 2016/7 was mental and emotional health with 22% of counselling sessions and the fourth most common reason was suicidal thoughts and feelings with 8% of counselling sessions in the UK. That 8% equated to 22,456 counselling sessions where the main concern was suicidal thoughts and feelings. This is a 15% increase from 2015/16, and averages 62 suicide counselling sessions a day.[3]

Suicide is the third most common reason for girls to contact Childline, and the fifth most common reason for boys. This is an important figure, due to the fact that men are around three times more likely to die by suicide than females, and that the suicide rate for boys aged 10-19 was more than double that for girls in 2015.[4] Childline's campaign 'Tough To Talk' launched in early 2017 encourages boys to seek help for the issues and problems that they may be facing, but it is key to continue findings ways to ensure males feel able to speak up about the way they are feeling.

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[3] NSPCC (2017): Childline annual review 2016/17: Not Alone Anymore.

[4] Office for National Statistics (2016) Suicides in the UK: 2015 registrations

MAE POB PLENTYNDOD WERTH BRWYDRO DROSTO

EVERY CHILDHOOD IS WORTH FIGHTING FOR

National Society for the Prevention of Cruelty to Children (NSPCC). Noddwr Brenhinol: Ei Mawrhydi'r Frenhines. Llywydd: Ei Uchelder Brenhinol Iarlless Wessex. Sefydlwyd yn 1884. Ymgorfforwyd gan Siartr Frenhinol RC000374. Rhif elusen gofrestredig 216401 (Cymru a Lloegr) a SC037717 (Yr Alban).
National Society for the Prevention of Cruelty to Children (NSPCC). Royal Patron: Her Majesty The Queen. President: HRH The Countess of Wessex. Founded in 1884. Incorporated by Royal Charter RC000374. Registered charity number 216401 (England and Wales) and SC037717 (Scotland).

"I'm feeling really low and suicidal. I'm being bullied at school and have a bad family life. The kids at school call me names and throw things at me so I've stopped going to school and now I'm getting into trouble. I don't eat, I just stay in bed and sometimes self-harm. I just don't think my life is worth it." (Girl, 15, Wales).

Due to Childline being a confidential service, children and young people do not always reveal where they live. In 2016/17, 4% of counselling sessions where the child's country is known were from Wales, which equates to 8,626 children. Of these, there were 2,163 Childline counselling sessions for mental and emotional health and 769 where the main concern was suicidal thoughts and feelings. Similar to the UK as a whole, in Wales, mental / emotional health was the most common reason for children contacting with 25% of counselling sessions, but in Wales suicidal thoughts and feelings was the third most common reason for children and young people to contact Childline with 9% of all counselling sessions.[5]

This is a worrying figure, and one that has increased over recent years. Children and young people who discussed suicide as their main concern, also talked about mental/emotional health, self-harm and family relationships. These were the top three additional concerns for children and young people in Wales who contacted Childline about suicide.

Young people who talked about having poor mental/emotional health spoke about feeling low, depressed, anxious and having low self-esteem. Those who discussed suicide with Childline counsellors also spoke about self-harm being an issue they were battling with or using it as a coping mechanism. Young people discussed self-harming for a period of time and felt urges to do more, or that it was getting worse. Young people discussed severe self-harm leading to suicide attempts, such as strangulation or cutting themselves badly.

As stated in 'Talk to me 2: Suicide and self-harm prevention strategy for Wales 2015-2020', suicide is complex and there is often not one single reason why someone may choose to end their life. Young people who spoke to Childline about what was affecting their emotions mentioned a range of issues including bullying; exam stress; relationship issues; family problems; body image issues and abuse. Childline's confidentiality policy means that young people can talk to trained counsellors about suicidal thoughts in private, however, when there is serious intent and means to act on these thoughts, help is sought for those who need it.

Children and young people who contact Childline about suicide or mental/emotional health, often mention CAMHS when they are already receiving support, however when young people were struggling to access services they told Childline they were worried about CAMHS being understaffed, they were still waiting for an appointment, they had not found their experience with them useful or they found it difficult to trust people and so did not want to access help. Young people facing barriers to accessing services discussed feeling anxious speaking to people face-to-face about their feelings as they had low self-esteem, feeling as though they didn't want to use up someone's time or not thinking their feelings were important enough. Other young people worried that they wouldn't be taken seriously, or that they would be seen as attention-seeking.

Young people who had accessed support had told friends, parents, school or their doctor, who had in turn helped them to access specialised support. Young people mentioned that seeing their school counsellor or other therapists helped to take a "weight off of their shoulders" but young people weren't getting as many counselling sessions as they would

[5] ibid

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like, or they were not able to access the school counsellor during half-terms or the school holidays.

Some young people who were accessing services because of suicidal feelings did not feel that the support they received was helpful and did not know what to do or who to turn to next. Some young people were unsure how to book a GP appointment or if an adult had to be present, and some young people discussed building up the courage to go to their doctor for an initial conversation about how they were feeling. Some young people had seen their doctor and were unhappy with their treatment. Some were waiting for their referral appointments but were unsure how to cope and what to do in the meantime.

I hope that evidence is helpful and should you want to discuss any element further please don’t hesitate to contact our Policy and Public Affairs Manager, Vivienne Laing on .

Yours sincerely

Des Mannion
NSPCC National Head of Service Cymru / Wales
Children’s Services Development and Delivery

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S 01

Inquiry into Suicide Prevention

Ymchwiliad i Atal Hunanladdiad

Ymateb gan Partneriaeth Cynllunio a Datblygu Iechyd Meddwl Powys a Phartneriaeth Plant a Phobl Ifanc Powys

Response from Powys Mental Health Planning and Development and Children and Young People Partnership

Mental Health Department, Bronllys Hospital, Bronllys
Brecon, Powys LD3 0LU
Direct Line/Llinell Uniongyrchol
Email/e bost

Dear Sir/Madam

Joint response of the Powys Mental Health Planning and Development and Children and Young People's Partnership to the Health, Social Care and Sport Committee consultation on suicide prevention.

<u>Powys Position statement</u>

In Powys, suicide and self harm prevention planning is mainly informed by ONS data, learning from SUI, Suicide, and fatal and non fatal poisonings case review processes, referral data and information from specific pieces of work such as 'A desk based review of probable suicides amongst children and young adults in Mid and West Wales – Concise Report' by Dr. Tom Slater at Cardiff University.

The rural nature of Powys can lead to isolation for many people particularly older age groups. Farming communities are still a vulnerable group that the Partnerships consistently seek to engage with, more recently working with 'The Farming Community, an organisation providing peer/volunteer led targeted support for this at risk group.

A recent study (summer 2017) of three months of referrals to CAMHs in Powys showed that self harm, suicidal intent, thoughts or overdose represented the highest percentage of referrals to the CAMHS service (38.3%), whilst depression, low mood and sadness represented the next highest figure (19%).

Work is ongoing under the auspices of the National mortality review to bring together serious and untoward incident processes to ensure membership is correct and that learning is captured effectively, shared with the right networks and improvement activity is monitored.

The Welsh Government's approach to suicide prevention, most specifically the suicide prevention strategy Talk to Me 2 has focussed local activity in terms of multi-agency approaches to suicide prevention; public awareness campaigns; reducing access to the means of suicide is delivered locally

Pencadlys y Bwrdd Iechyd
Bronllys, Aberhonddu, Powys LD3 0LS
Ffôn: Ffacs:

Health Board Headquarters
Bronllys, Brecon, Powys LD3 0LS
Tel: Fax:

Rydym yn croesawu gohebiaeth Gymraeg
Bwrdd Iechyd Addysgu Powys yw enw gweithredd Bwrdd Iechyd Lleol Addysgu Powys

We welcome correspondence in Welsh
Powys Teaching Health Board is the operational name of Powys Teaching Local Health Board

through the Powys Hearts and Minds: Together for Mental Health Delivery Plan ensuring a cross sector approach. Guidance associated with the strategy became available in October 2017 which has supported development of a local plan which is due for submission to the Regional fora in Wales in February 2018. The Mental Health Planning and Development Partnership will be monitoring the effectiveness of this important work stream at a local level.

One of the local priorities for suicide and self harm prevention is to tackle stigma and to encourage innovation in early intervention enabling individuals and their families or carers to access the right support at the right time and at the right level. Partnerships will be working with communities to encourage a similar approach to that taken by Dementia Friends.

To this end, a resource support list has been produced to share with primary care, third sector, 'blue light' services and other partners to ensure the pathway for accessing support is clear. However, whilst help lines and internet based offerings are numerous, work needs to be undertaken to develop local support groups for those bereaved by suicide.

Emotional Health and Wellbeing services, activity and support are numerous in Powys and the Families First programme and commissioning of Xenzone to provide school based and online counselling for children and young people has yielded much benefit but as part of a current CAMHs review this agenda is being revisited to identify any gaps in localities and areas where more focussed work can be undertaken which will include suicide and self harm prevention.

A powerpoint presentation is appended to this response to provide further information on key issues and activity in Powys.

Yours faithfully

Louisa Kerr
Mental Health Partnership Manager

S 16
Inquiry into Suicide Prevention
Ymchwiliad i Atal Hunanladdiad
Ymateb gan Cymdeithas Seicolegol Prydain
Response from the British Psychological Society

British Psychological Society response to the National Assembly for Wales Health Committee

Suicide Prevention

About the Society
The British Psychological Society, incorporated by Royal Charter, is the learned and professional body for psychologists in the United Kingdom. We are a registered charity with a total membership of just over 50,000.

Under its Royal Charter, the objective of the British Psychological Society is "to promote the advancement and diffusion of the knowledge of psychology pure and applied and especially to promote the efficiency and usefulness of members by setting up a high standard of professional education and knowledge". We are committed to providing and disseminating evidence-based expertise and advice, engaging with policy and decision makers, and promoting the highest standards in learning and teaching, professional practice and research.

The British Psychological Society is an examining body granting certificates and diplomas in specialist areas of professional applied psychology.

Publication and Queries
We are content for our response, as well as our name and address, to be made public. We are also content for NAW to contact us in the future in relation to this inquiry.

Please direct all queries to:-
Joe Liardet, Policy Advice Administrator (Consultations)
The British Psychological Society, 48 Princess Road East, Leicester, LE1 7DR
Email: [redacted] Tel: [redacted]

About this Response

The response was jointly led on behalf of the Society by:
Nigel Atter, British Psychological Society Policy Advisor

We hope you find our comments useful.

Alison Clarke
Chair, BPS Professional Practice Board

Dr Paul Hutchings CPsychol AFBPsS
Chair, Welsh Branch

British Psychological Society response to the National Assembly for Wales Health Committee

Suicide Prevention

	The extent of the problem of suicide in Wales and evidence for its causes - including numbers of people dying by suicide, trends and patterns in the incidence of suicide; vulnerability of particular groups; risk factors influencing suicidal behaviour.
1.	Comments: **Numbers of People Dying / Trends and Patterns** Statistical data on the number of people dying by suicide is found in the Office of National Statistics, Suicides in Great Britain: 2016 registrations. For example, 'The rate in Wales has fallen from 13.0 in 2015 to 11.8 per 100,000 people in 2016. The suicide rate in Wales is generally more erratic than in England, due mainly to having a smaller population, making any long- and short-term trends difficult to identify. Welsh males saw their lowest rate in 2008 at 15.1 and their highest in 2013 at 24.3 suicides per 100,000 males. Similarly to females in England, a large improvement was seen during the 1980s but there has been little change since'. (ONS, 2016 registrations). **Vulnerable groups** Bruffaerts et al. (2011) found that roughly 60% of people with suicidal thoughts and behaviour do not receive treatment. For those who do, there are very few evidence-based treatments (such as prevention programmes, pharmacological interventions and psychological treatments) that are available. Thus it is important that there are tailored services to target specific groups, including: men, pregnant women and new mothers, people in the criminal justice system, children and young people, LGBT, people leaving the care of mental health services, and people who self-harm. Another challenge is that despite 75% of the world's suicides occurring in low and middle income countries (Vijayakumar & Phillips, 2016), the vast majority of research and evidence is gathered in high income countries. **Self-harm** Some recent encouraging evidence suggests that a very brief intervention based on implementation intentions (a volitional help sheet) may reduce repeated self-harm in patients admitted to hospital via emergency departments) (O'Connor et al 2017), however this was only helpful for those with a history of repeated self-harm. Results suggested that the help sheet might actually increase self-harm in those who had not previously been hospitalised for self-harm (i.e., it was their first ever hospital-treated episode), though this increase was not statistically significant. These findings now require replication. **The Psychological Risk and Protective Factors** In addition to the established role of psychiatric disorders/mental health conditions in suicide risk (Turecki & Brent, 2015; Hawton, Saunders & O'Connor, 2012), personality and individual differences, cognitive factors, social factors and negative life events are all associated with suicide risk. The key psychological risk/protective factors for suicidal ideation and suicidal behaviour are indicated in the table below and the

evidence for these factors is summarised in O'Connor & Nock, 2014.

Psychological Risk and Protective Factors for Suicidal ideation and Behaviour	
Personality and Individual Differences Hopelessness Impulsivity Perfectionism Neuroticism and extroversion Optimism Resilience	**Cognitive factors** Cognitive rigidity Rumination Thought suppression Autobiographical memory biases Belongingness and burdensomeness Fearlessness about injury and death Pain insensitivity Problem solving and coping Agitation Implicit associations Attentional biases Future thinking Goal adjustment Reasons for living Defeat and entrapment
Social factors Social transmission Modelling Contagion Assortative homophily Exposure to deaths by suicide of others Social Insolation	**Negative life events** Childhood adversities Traumatic life events during adulthood Physical illness Other interpersonal stressors Psychophysiological stress response
Adapted from O'Connor & Nock (2014)	

In recent decades a number of theoretical models have been developed to describe the pathways to suicide (Joiner, 2005; Johnson et al., 2008; O'Connor, 2011; Klonsky & May, 2014). A commonalty across most of these models is that they are grounded within the ideation to action framework (Klonsky, 2014), namely that the factors leading to suicidal thinking are distinct from those that govern the transition from thinking about suicide to attempting suicide (O'Connor, 2011; O'Connor & Nock, 2014). One of these models, *the integrated motivational-volitional (IMV) model of suicidal behaviou*r (IMV; O'Connor, 2011), maps the final common pathway to suicidal behaviour. In brief, the IMV model suggests that suicidal ideation emerges from feelings of defeat or humiliation from where there is no escape (O'Connor, 2011; O'Connor et al., 2013). Whether someone acts on their thoughts of suicide is governed by a range of factors, labelled *volitional moderators* (e.g., impulsivity, exposure to suicide, acquired capability, planning, access to the means of suicide), the presence of which increases the likelihood that suicide attempts/death by suicide will occur. For example, if someone has thoughts of suicide and is impulsive or knows someone close to them who has died by suicide, they are more likely to act on their thoughts of suicide. Theories such as the IMV model are important not only to advance our understanding of suicide risk but also because they form the basis for intervention development. However, the complexity of suicide risk should not be under-estimated.

The complexity of suicide risk

Biopsychosocial models attempt to integrate the understanding of biological,

	psychological and sociocultural factors associated with an increased risk of suicidal behaviour and death by suicide. They recognise that these behaviours cannot be understood from any one perspective alone. Instead suicidality is best explained as a complex interplay between risk factors across domains. As an illustration, consider the association between unemployment and suicide. Exposure to high rates of unemployment can affect an individual's feelings of hopelessness or entrapment – to increase risk of suicidality. However, not everyone who is unemployed will feel suicidal. Risk factors are likely to interact with one another in complex ways to determine vulnerability. It is valuable to consider the contribution of biological, psychological and social factors at every point in the suicidal process. Psychological processes can be described as the biological and social factors which act to increase the risk that a person will end their life. However, even at this point, environmental factors such as the availability of means of suicide, and psychological factors, such as an individual's propensity to select between these means, will influence the likelihood of death. Thus understanding the complex interplay between the various biological, psychological and social risk factors that contribute to risk of suicidality is critical to the development of comprehensive and effective suicide prevention and treatment approaches. **Risk assessment** Although risk factors that increase the propensity to engage in suicidal behaviour have been identified, suicide remains a rare event and most risk factors have little positive predictive value in determining likelihood of eventual death by suicide (Turecki & Brent, 2015; Hawton, Saunders & O'Connor, 2012; Franklin et al., 2017). Likewise, as reviewed by Bolton, Gunnell & Turecki (2015) although a number of risk assessment scales for suicide exist none to date provide enough robust evidence to justify their routine use in clinical settings and the vast majority are limited by their reliance on patient self-report (Quinlivan et al., 2017; Chan et al., 2016). Novel, evidence based, methods of suicide risk assessment are being developed, but these are still at an early stage. The National Institute for Health and Care Excellence supports the importance of conducting an assessment of patient risk and needs, but does not support the use of specific risk assessment tools (https://www.nice.org.uk/donotdo/do-not-use-risk-assessment-tools-and-scales-to-predict-future-suicide-or-repetition-of-selfharm). All individuals who present to hospital following self-harm should receive a caring assessment, which takes into account individual, social, and behavioural influences. Such an assessment should address an individual's clinical history and current condition, their previous suicidal behaviour as well as their current suicidal thoughts and plans. It should also address their social context, help them to keep themselves safe when in crisis and support them in obtaining ongoing clinical treatment, as required. A compassionate psychosocial assessment plays an important role in establishing a positive therapeutic relationship between a clinician and patient in distress. It is important to ask about suicide in a direct but sensitive manner. Although clinicians can be concerned about exploring suicidal thoughts, there is no evidence to suggest that talking about suicidal thoughts and plans increases risk of suicidal ideation or self-harm, and some evidence that it is beneficial for those at higher risk (Dazzi et al., 2014).
	The social and economic impact of suicide.
2.	Comments: **Postvention: Providing support after suicide** There has been increased recognition of the importance of supporting vulnerable

populations, such as bereaved families and friends, following suicides (WHO, 2014). The research demonstrates that people who are exposed to suicide deaths are at increased risk of complicated grief, traumatic grief and PTSD (Melhelm et al., 2004). Furthermore, the relatives and friends of the deceased may be particularly vulnerable to suicidal thoughts and behaviour (Joiner, 2005). Psychologists have a key role in providing support and interventions to those affected by the death and psychological models may be applied to understand how individuals manage grief and adjustment following a death by suicide.

There is emerging evidence supporting beneficial effects of a number of interventions, including counselling postvention for survivors and outreach at the scene of suicide (Szumilas & Kutcher, 2011). In addition, evidence-based guidelines for responding to suicide in a secondary school setting have been published recently (Cox et al, 2016). However, further research is required into the effectiveness of postvention services and interventions on reducing suicide and attempted suicide/self-harm.
Suicide deaths are often incredibly traumatic, the method of death is frequently violent and survivors are often plagued with the "re-experiencing" symptoms of trauma, such as flashbacks, nightmares and intrusive thoughts. These can occur even if the survivor did not witness the death scene. Re-experiencing, when accompanied with avoidance and hypervigilance symptoms, is characteristic of PTSD, and therefore counsellors need to be equipped to recognise and manage these symptoms or refer the person for trauma-focused cognitive therapy or another recognised PTSD treatment (NICE, 2005).

Suicide survivors may also be at risk of comorbid alcohol and other substance disorders, which may require treatment. Suicide has a huge impact on social relationships, there can be feelings of rejection and abandonment in addition to the burden of the loss. The death can also have a detrimental impact on social relationships and isolation due to the stigma surrounding the death and others' beliefs about causes and blame. Individuals who are bereaved by suicide can feel unable to accept support and those close to suicide survivors often have difficulty responding appropriately and may even withdraw from the survivor (Grad, 2011). Therapeutic interventions should include helping the survivor manage and navigate social interactions, harness support networks and foster connectedness. Group support from other suicide survivors, or programmes which link survivors to others who have had a similar loss may be particularly useful for this reason (Jordan, 2011).

Organisational Postvention

The planned interventions with individuals and groups affected by a suicide death in a school or workplace are known as *organisational postvention*. Organisational postvention is a significant challenge and it is recommended that plans and protocols are put in place prior to a death. The goal of this type of postvention is in providing support to the bereaved, respecting their wish to honour the life of the deceased, without glamourising the death in a way that increases the risk of further suicidal acts. It is also important to do this in a way that respects the community's cultural and religious beliefs, does not further contribute to the stigma of suicide or leave the bereaved feeling that the deceased has been demonised or punished (Berkowitz et al., 2011).

Response plans

Postvention response plans typically include the coordination of resources, dissemination of information and the provision of support for those most affected by the death, or at risk of contagion. Psychoeducation regarding grief, depression and PTSD is an important component of postvention for those affected by the death.

	Organisational postvention should also include screening and case finding to detect people who are at higher risk of suicide, who may not come forward. Several screening and case finding tools are available for use in educational settings, however the identification of suicide risk based on screening tools is fraught with difficulties and many high risk individuals do not screen positive using such instruments (O'Connor et al., 2013). It is therefore important to foster an ethos of help seeking and compassionate peer support so that people can identify when others may be at risk and help them to seek support through clear support and referral structures. In the longer term, postvention should include the provision of opportunities for safe commemoration. It is advised that whilst commemoration should be no different for individuals who have died by any cause, permanent memorials, or events/awards in the memory of the deceased should be avoided, again to prevent contagion (Berkowitz et al., 2011). Broader mental health and resilience programmes may also be helpful in group settings such as schools, however these need to be selected carefully and implemented alongside effective referral pathways (Hawton, et al., 2015; Wasserman et al., 2012).
	The effectiveness of the Welsh Government's approach to suicide prevention - including the suicide prevention strategy *Talk to me 2* and its impact at the local, regional and national levels; the effectiveness of multi-agency approaches to suicide prevention; public awareness campaigns; reducing access to the means of suicide.
3.	Comments: The Society has no comment to make.
	The contribution of the range of public services to suicide prevention, and mental health services in particular.
4.	Comments: **Public Information Campaigns** There is emerging evidence for increasing awareness via public information campaigns to improve the care for people diagnosed with depression and simultaneously address awareness and skills in early identification of suicide risk among healthcare and community-based professionals (Szekely et al, 2013; Hegerl et al, 2013), with proven synergistic effects of simultaneously implementing evidence-based interventions (Harris et al, 2016).
	The contribution of local communities and civil society to suicide prevention.
5.	Comments: **Prevention** "Early identification and effective management are key to ensuring that people receive the care they need." (WHO, 2014 p.9) There are two important aspects to prevention: as noted above: (i) understanding the factors associated with suicidal thinking/ideation with a view to reducing distress and (ii) reducing the likelihood that an individual makes a suicide attempt or dies by suicide. It is important to understand the psychological processes underlying each aspect as interventions must be tailored to

each; for example, intervention at the suicide ideation stage would be specifically targeted at preventing progression to suicidal attempt.
National suicide prevention strategies tend to adopt a dual track approach of implementing large-scale public health interventions, such as restricting access to lethal means of suicide as well as intervening with those at high risk (see WHO, 2014). High risk groups may include those who have self-harmed in the past; they are important group to target given the established relationship between self-harm and future death by suicide.

Restricting access to means
Restricting access to means involves implementation of measures to reduce availability of and access to frequently used means of suicide, e.g. drugs, fire arms, enhancing safety of bridges etc. Internationally, there is consistent evidence that restricting access to lethal means is associated with a decrease in suicide and that substitution to other methods is limited (Zalsman et al, 2016).

Education
Educating health care and community-based professionals to recognise depression and early signs of suicidal behaviour is important for determining level of care and referral for treatment, and subsequent prevention of suicidal behaviour (Wasserman et al, 2012; Coppens et al, 2014). Sustainability and capacity building of trainers and benefits in terms of knowledge, attitudes and confidence can be achieved via a Train-The-Trainer model *(*Coppens et al, 2014; Isaac et al, 2009). There are some indications for a link between improvements in intermediate outcomes (e.g. improved knowledge, attitudes and confidence) among health care and community-based professionals and primary outcomes, e.g. reduced suicide and self-harm rates (Mann et al, 2005; Hegerl et al, 2011; Zalsman et al, 2016).

Responsible Media Reporting
The importance of responsible media reporting of suicide in print, broadcast, internet, and social media is underlined by Niederkrotenthaler et al. (2014). The role of mass media has been shown to be effective in reducing stigma and increasing help seeking behaviour. There are also indications of promising results based on multi-level suicide prevention programmes (Niederkrotenthaler et al., 2014). A systematic review covering 30 studies on social media sites for suicide prevention (Robinson et al, 2016) showed that social media platforms can reach large numbers of individuals and may allow others to intervene following expression of suicidal behaviour. However, reported challenges include lack of control over user behaviour, possibility of suicide contagion, limitations in accurately assessing suicide risk, and issues relating to privacy and confidentiality.

Intervention - How effective are psychosocial interventions?
Preventing repeat self-harm is a crucial part of suicide prevention efforts since, as noted earlier, many who die by suicide have previously engaged in such behaviour (NCIS, 2016). The gold-standard method for assessing the effectiveness of interventions is a randomised controlled trial (RCT).

Adults
Recently, two systematic reviews have synthesized the worldwide RCT evidence on the effectiveness of interventions for self-harm (Hawton et al 2015, Hawton et al 2016a). These reviews demonstrate that there is now strong evidence that psychological therapies such as problem solving behaviour, dialectical behaviour therapy (DBT) and cognitive behavioural therapy (CBT) (so called ‘talking therapies’) can effectively prevent the repetition of self-harm in adults (people aged 18 years old

	and over) (Hawton et al, 2016a, 2016b). They have also been shown to reduce the psychological distress associated with such behaviours (Townsend et al 2001, Hawton et al 2016a, 2016b). **Under 18s** For younger people (those aged under 18 years old) the evidence is very limited – with only eleven trials uncovered that have tested an intervention to prevent repeated self-harm in young people (Hawton et al 2015). Moreover, the evidence is more equivocal for psychological interventions in this age group (Townsend 2014; Hawton et al., 2015). So, for DBT (2 RCTs) and group-based psychotherapy (3 RCTS) meta-analysis revealed no significant effect in terms of reducing the number of people repeating self-harm (group therapy) or the frequency of self-harm (DBT). However, there is some evidence (from one trial) that mentalisation-based therapy, an integrative form of psychotherapy, may be helpful in preventing repeated self-harm (Rossouw et al 2012).
	Other relevant Welsh Government strategies and initiatives - for example *Together for Mental Health*, data collection, policies relating to community resilience and safety.
6.	Comments: The Society has no comment to make.
	Innovative approaches to suicide prevention.
	Comments: **Electronic mental health interventions** Electronic mental health (e-mental health) interventions represent a promising means of increasing the capacity for patients' self-management of depression (Arensman et al., 2015). Using the Internet to deliver treatment for affective disorders has been shown to be an effective option for reaching patients who were not able to receive face-to-face treatment due to geographical or other situational barriers (Vallury et al, 2015) or to augment face-to-face therapy (Hoifodt et al, 2013). Electronic mental health interventions for mental health problems and mood disorders in particular have increased rapidly over the past decade. In recent years, an increasing number of e-mental health interventions have been delivered in the form of apps that are delivered via smartphones (Dogan et al, 2017). Available research underlines the value of smartphone-based approaches for gathering long-term objective data to predict changes in clinical states. However, the current evidence base does not provide conclusive information on the effectiveness and the risks of these approaches. Methodological limitations in this area include small sample sizes, variations in the number of observations or monitoring duration, lack of RCTs, and heterogeneity of methods (Dogan et al, 2017).
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End.

Health, Social Care and Sports Committee's inquiry into suicide prevention.

The Royal College of General Practitioners Wales (RCGPW) welcomes the opportunity to respond to the Health, Social Care and Sports Committee's inquiry into suicide prevention.

RCGPW is grateful for contributions to this response to Dr Nigel Mathers, Dr Clare Gerada, Dr Steve Mowle, Dr David Paynton and Dr Liz England who have previously responded on behalf of RCGP to an enquiry to the Westminster Select Committee enquiry into the same subject last year as well as to local members from Wales.

The RCGPW is part of the RCGP, which is the largest membership organisation in the United Kingdom solely for GPs and GPs in training Founded in 1952, it has over 50,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with expertise in patient-centred generalist clinical care.

Our response focuses on the role of general practice in preventing suicide. Although self harm may be related to suicide as described in Talk to Me 2 some of those presenting with self harm have a different disease protectory. This needs to be taken seriously and those who self harm should always be assessed for suicide risk.

Summary

1. Talk to Me and Talk to Me 2 were published to link with the Mental Health Plan and help the strategy for preventing suicide in Wales preventing suicide. There is clearly a role for general practice and GPs to play in reducing suicide. However, there are many issues which mean that general practice is currently constrained in its ability to prevent suicide. We are aware that the implementation of the strategies set out in Talk to Me 2 are patchy particularly the improvements in school counselling services. Some counselling services to universities and higher education services have been reduced. We are not aware of improvements in occupational health services in relation to mental health and wellbeing. In some areas it was reported to us, where there have been several suicides within a school, counselling services may be stretched and young people and children traumatised by multiple bereavement issues needing additional skills that may not be easy to access.

2. There are many challenges which mean it is difficult to ensure that all patients at risk of suicide are identified and that all risks are acted upon, such as a lack of opportunities for assessment, the interface between primary and secondary care, and the current crisis in general practice. Universal screening for suicide risk is not practicable, though there are some factors which could provide the basis for increased opportunistic assessment, such as the presence of long term physical health conditions or drug and alcohol misuse.

3. Even when a patient has been assessed as being at high risk of suicide, there are many barriers to referral which mean that GPs are often left unable to act when they assess a patient as being at high risk, most often a lack of capacity within secondary care services. The interface between primary care and secondary care often prevents GPs from referring suicidal patients to treatment and must be improved, for example by mandating secondary care services to respond to the referring GP within a certain time frame, especially in urgent cases. The location of mental health services within clusters or general practice would also allow more suicidal patients to be seen by a specialist.

4. There is a role for increased training for GPs and all health professionals to improve suicide risk assessment and treatment. However, this must be manageable and provide multiple options for health professionals. Funding should be provided to extend training for GPs to four years to allow trainees more exposure to patients who are at risk of self-harm, suicide, or who have mental health problems.

5. Ultimately, GPs will be limited in their ability to prevent suicide as long as the service continues to be under-resourced and under-staffed.

6. There is potentially scope for adopting a zero-suicide strategy which has been shown to be effective in preventing suicide, and is explored later in this submission.

Suicide risk assessment in primary care

7. There is some evidence to suggest that many individuals who commit suicide consult with their GP close to the time of their death. The 2014 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness states that 45% of people who commit suicide consult with their GP in the preceding month[i]. This has led to concerns about low levels of risk assessment.

8. However, a Nuffield Trust study, also in 2014, found that two-thirds of patients see their GP at least once during the last three months of life[ii]. This suggests that it is not only people who commit suicide who are likely to consult their GP close to the end of their life, but that it is in fact all people who are likely to do so. It is therefore difficult to conclude that the correlation between prevalence of GP consultations in the month prior to death for people who commit suicide is due to poor risk assessment of suicide in general practice.

9. The National Confidential Inquiry also found that 37% of people who died by suicide had not seen their GP in the previous year. Among the 37% who had not seen their GP, suicide risk was increased by 67%[iii]. Therefore, even if suicide risk assessment in general practice were significantly improved, a significant

proportion of those who commit suicide would still not be helped due their non-attendance at their GP.

Maximising the effectiveness of suicide risk assessment in primary care

10. There is certainly a role for general practice and wider primary care to play in identifying and reacting to suicide risk, and there are some factors which can be used to more reliably identify a need for suicide risk assessment.

11. As well as finding that GP non-attendance increased suicide risk, the National Confidential Inquiry also found that risk of suicide increased as the number of GP consultations with the patient grew, with a 12-fold increase in suicide risk in patients that attended their GP more than 24 times in the final year of their life[iv]. This correlation between very high rates of GP attendance and suicide risk tallies with known risk factors for suicide, for example long-term physical health problems, drug and alcohol misuse, a diagnosis of a personality disorder, and current and past mental health problems. Each of these risk factors for suicide may also cause a patient to attend their GP more often.

12. There is insufficient evidence to recommend general screening for suicide prevention in primary care, but factors such as those listed above can be used to form the basis of a more targeted assessment approach. Risk markers and areas of concern such as those mentioned above could be flagged in patient records, or an electronic alert could be added to highlight patients, for example, with increasingly frequent attendance or patients prescribed more than one psychotropic drug, or specific combinations such as benzodiazepines with antidepressants.

13. The RCGP Perinatal Mental Health toolkit has a section on managing suicide risk for those at risk with perinatal mental health issues but also those at risk of domestic violence: http://www.rcgp.org.uk/clinical-and-research/toolkits/perinatal-mental-health-toolkit.aspx

14. Doctors are a high-risk group and there needs to be an emphasis on ensuring that all doctors particularly GPs are registered with a GP and that they have access to good occupation health services with counselling and wellbeing support. For those patients who are not attending general practice, opportunistic screening could be trialled, for example during new patient health checks when they register with a GP. This would help to establish a patient's suicide risk when they register with their GP so that the GP could proactively reach out to high risk patients even if they are not attending general practice regularly.

Difficulty referring patients

15. Even when suicide risk is accurately identified, many GPs report problems referring patients to specialist services. For example, one study found that in two cases out of 27 where GPs made referrals, these referrals were not acted upon by the service as a matter of urgency and the two patients in question died within two weeks of their final GP consultation[v]. Though these are not large numbers they are not insignificant, and they certainly corroborate anecdotal evidence the College has received in answering this inquiry, namely that GPs are consistently having difficulty having their referrals accepted when referring patients to specialist mental health services. This has been reported in Wales from individual GPs during the preparation of this report. Teenagers can compound problems as referral to CMHS is restricted especially in some parts of Wales.

16. In some areas GPs reported that referral in hours for assessment by Mental Health worked well for patients presenting to general practice services. Patients who presented outside of the 9am-5pm hours Monday to Friday and often earlier on a Friday found the services less good. This was compounded if there were additional transportation issues causing undue additional distress for patients. There were particular problems reported by a GP from Blaenau Gwent area. Sometimes arranging referral takes up a considerable amount of GP time. The GP may need to track down and speak to different mental health care professionals.

17. In one case, a College member reported being unable to get a patient accepted into secondary mental health services due to a divergent assessment of risk. This meant that the GP was left with no other option but to advise the patient to attend A&E if suffering from a crisis. This is clearly unacceptable and speaks to the relative unavailability of specialist mental health services as well as the problem of the primary/secondary care interface in suicide risk assessment. There are also problems when patients have mental health as well as substance or alcohol abuse issues. There can also be problems if patients are older and do not fit the criteria for the Primary Care Mental Health Team or the Crisis unit.

18. The suicide prevention requires communication between secondary and primary care as being vital to ensuring high levels of care for patients who are identified as being at risk of suicide. We have not found evidence to suggest that communication has improved since the implementation of Talk to me or Talk to me 2.

19. At the least, progress must be made on simplifying the interface between primary and secondary care. GPs will always be limited in their ability to prevent suicide

when secondary mental health services disagree with the GP's assessment of risk or simply do not have the capacity to accept referrals from GP services.

20. In Wales Community Mental Health has been moved essentially out of secondary care but it is not part of primary care and not linked to general practice. It has meant that services are closely zoned into localities, and patients who move find that they often must wait re-referral and it has separated it further from secondary and tertiary care mental health. The increased location of mental health services in primary care should also be considered. 90% of all initial patient contact occurs within general practice, including for mental ill health. To render more efficient, the process by which patients receive treatment for mental ill health, the movement of mental health services closer to the community should be supported. Funding and staff resources for this should be relocated from other parts of mental health.

21. Most Gps have access to counsellors in their own practices as well as to assessments by the primary care mental health support services (PCMHSS). The waiting time for therapy via these services may be long i.e. 3-6 months. These healthcare workers should be trained in assessment of suicide risk and be able to refer patients onward for management in mental health. Currently counsellors are unable to see children and young people under 18 years and there are limited services via PCMHSS for this group.

22. For those in education or work there is a great importance in being able to get contact health support and counselling including occupation health and wellbeing services. We are concerned that although Talk to Me 2 advocated these being increased, cut backs relating to austerity have occurred.

Training

23. Many GPs have reported that they have not received formal training in preventing self-harm and suicidal ideation – clearly it is important to ensure that this is addressed. Current suicide prevention training models have been successful, for example the STORM programme which improved skills and was well-received by GPs and staff.

24. There is also evidence to suggest that final consultations with patients who commit suicide have been liable to be of limited utility in terms of suicide prevention. In one study, interviews with 159 GPs whose patients committed suicide found that in only 15% of cases did the patient express suicidal thoughts or intentions during their final consultation, only 26% of GPs reported being concerned for their patient's safety during the final consultation, and only 16% felt that the suicide could have been prevented[vi]. The risk that regular attenders at GPs surgeries are not regularly reassessed for suicidal risk remains a possibility

and enhanced education for GPs focussing on targeted risk assessment would help to improve this.

25. However, training programmes must be flexible in order that all GPs and primary care staff are able to benefit. Current models may present a barrier to engagement as they can be quite intensive, lengthy, and inflexible: given the current unsustainable workload of GPs and their staff, due to persistent underinvestment and a chronic shortage of GPs, these training models may be inappropriate for many GPs and their staff. Future training programmes should focus on developing a broader package of training to deliver benefit for those who are unable to attend courses, for example by making greater use of online resources. There is also a need for better monitoring of outcomes from educational approaches to measure their impact on suicide prevention in primary care.

26. The College has collaborated with the Royal College of Psychiatrists to produce many resources on approaches to suicide prevention. The RCGP has developed a mental health toolkit with a specific suicide and crisis care section, a suicide assessment toolkit, and information sharing guidance: http://www.rcgp.org.uk/clinical-and-research/toolkits/mental-health-toolkit.aspx Healthcare professionals are also able to access an RCGP eLearning module on suicide prevention free of charge. The College continues to work in this area and is a signatory to the Crisis Care Concordat.

27. The RCGP has had its case for four-year GP training accepted in principle. However, this has not been delivered and the funding has not been made available. Four-year GP training, with an extension of the minimum time spent in general practice placements to 24 months, and an increase in the proportion of trainees undertaking psychiatry placements, will better prepare new GPs with the skills to be able to provide high quality care for people at risk of self-harm and suicide, along with numerous other complex and multiple health problems. The Government must now act to deliver four-year GP training.

Zero suicide strategy

28. There is evidence that a zero-suicide approach could be successful in reducing suicide. In Detroit, Michigan, a programme was launched by Henry Ford Health System whereby zero suicides was adopted as a target and actions were taken such as the establishment of a protocol to assign patients into one of three levels of risk for suicide, each requiring a specific intervention; the provision of training for all psychotherapists to develop competency in Cognitive Behavioural Therapy; and the establishment of three means of access for patients – drop-in group medication appointments, same-day access to care or support, and email updates. This led to a reduction in the suicide rate in Henry Ford Health System's

patient population by 75% from 89 suicides per 100,000 patients to 22 per 100,000 from 2001 to 2005. By 2008, the group had achieved a zero-suicide rate[vii].

29. Research should be conducted to explore how such a strategy could be adopted in the UK to deliver a whole system approach to suicide reduction.

Resourcing

30. Ultimately, while there are many means by which the ability of GPs to improve suicide reduction could potentially be improved – such as improved training, an improved interface between primary and secondary care, and the increased location of mental health services within general practice or clusters – the ability of GPs to prevent suicide will be necessarily constrained by the conditions in which GPs are working and the sustainability of general practice.

31. Since 2005 the level of investment in general practice has significantly declined as a proportion of the NHS budget, and the number of GPs has failed to keep pace with rising demand, with the number and complexity of consultations increasing due to an ageing and growing population. This has left general practice overburdened, with GPs themselves facing unsustainable workloads. In this context, the ability of GPs to make any meaningful contribution to suicide prevention is reduced.

32. Therefore, as well as the actions above, we request that the Welsh Government ensure that funding is transferred into general practice and the issues addressed in the RCGP Transform Document are implemented to improve access for patients, and give GPs the time they need to make the fullest possible impact on suicide reduction. http://www.rcgp.org.uk/news/2016/october/rcgp-wales-calls-for-297m-extra-investment-by-2021-to-save-general-practice.aspx

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i Suicide in primary care in England: 2002-2011. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). Manchester: University of Manchester, 2014. p.3

ii Exploring the cost of care at the end of life. Nuffield Trust, 2014. p.2

iii NCISH, p.3

iv NCISH, p.3

v

Pearson, 2009.

vi

Primary care contact prior to suicide in individuals with mental illness. Pearson, Anna, et. al. *British Journal of General Practice*, November 2009, 59 (568). pp. 825-832

vii

Depression Care Program Eliminates Suicide. Detroit, Michigan: Henry Ford Health System, 2010. Available at: http://www.henryford.com/body.cfm?id=46335&action=detail&ref=1104

Betsi Cadwaladr University Health Board Response to Welsh Assembly Committee call for evidence on Suicide Prevention

1/ The extent of the problem of suicide in Wales and evidence for its causes - including numbers of people dying by suicide, trends and patterns in the incidence of suicide; vulnerability of particular groups; risk factors influencing suicidal behaviour

In 2015, 64 people died by suicide in North Wales. Suicide is one of the leading causes of preventable death and is the biggest killer of men under 50 years in Wales and England (ONS, 2015).

In the background to the suicide and self-harm prevention strategic plan for North Wales, we present a range of suicide data in order to quantify the burden of suicide in the region.

Figure 1 shows how rates of suicide in Betsi Cadwaladr University Health Board (BCUHB) compare to Wales rates over time. Suicide rates are presented as number of deaths per 100,000 people of all ages, and are given as five-year averages to 'smooth out' variations in the data given the relatively small number of deaths each year. It can be seen that the suicide rate in BCUHB was higher than the Welsh average between 2002-2006 and 2008-2012, but in 2009-2013, it crossed over and became lower than the Welsh average.

Figure 1: BCUHB and Wales

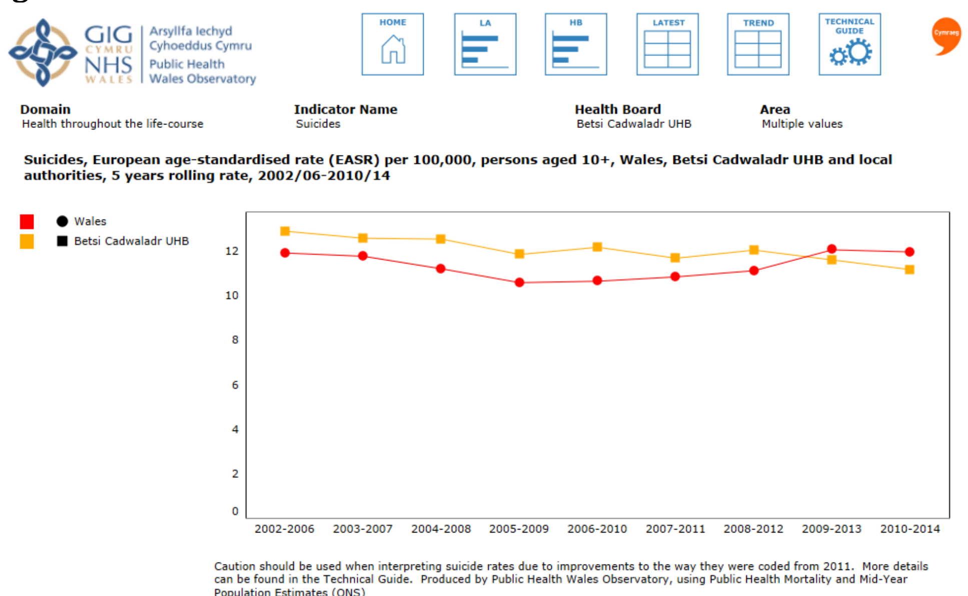


Figure 2 shows the rate of suicide in BCUHB in recent years (the five calendar years 2010-14) is not statistically significantly different from the Wales rate as a whole. In terms of the individual Unitary Authorities (UAs), Figure 3 shows that none of the North Wales UAs are statistically significantly different from the Welsh average.

Figure 2:

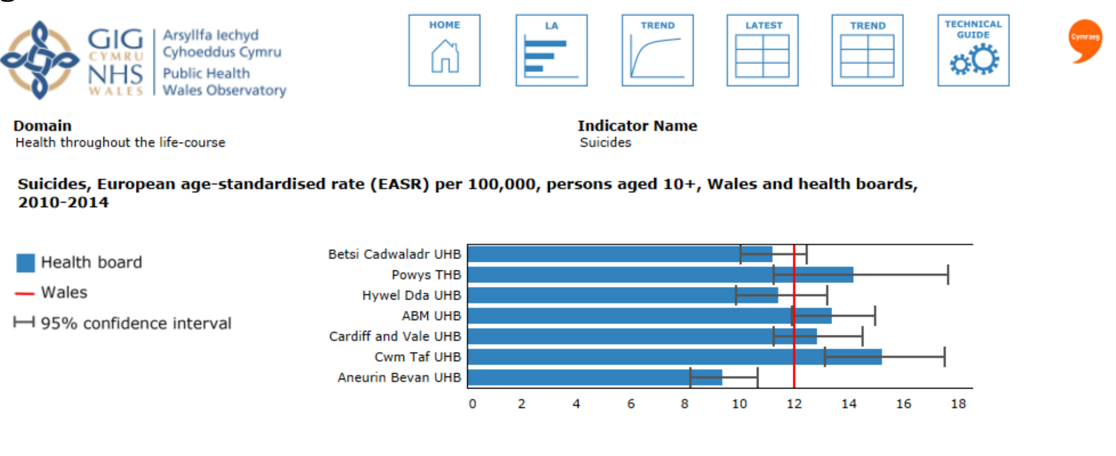
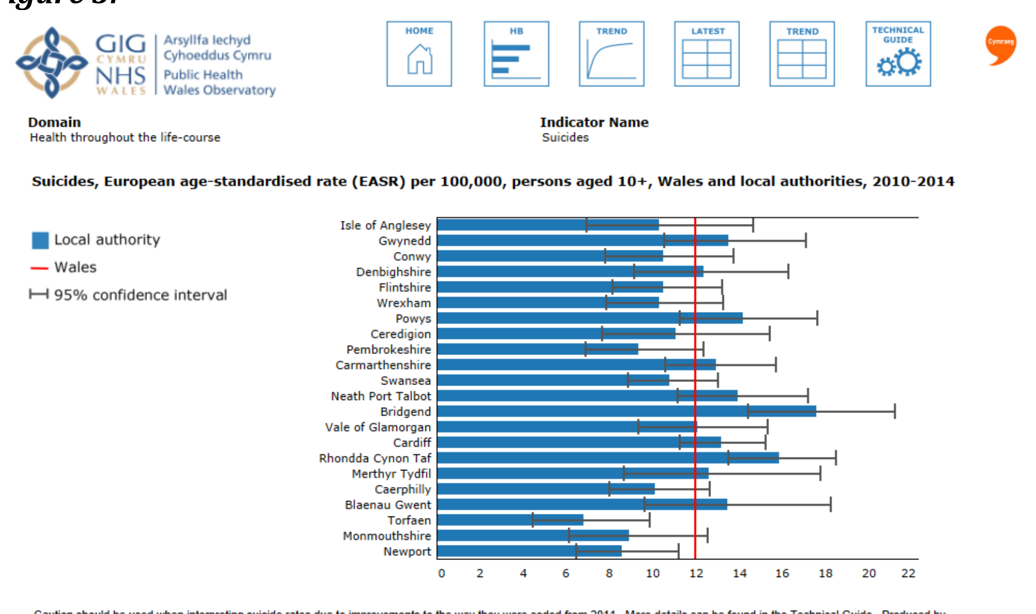


Figure 3:



The overall rate of suicide for all persons hides considerable differences between the rates for men and women in Wales. Male suicide rates are nearly three times higher than female rates, and this has been a consistent pattern. The latest data for 2014 gives a rate of 11.1 deaths by suicide per 100,000 men, and for women the rate is 4.4 per 100,000 in Wales (Appleby et al, 2016). The gender differences in suicide are important and need to be considered. There have been suggestions that this is due in part to the changing nature of society but records suggest that across England male suicides have

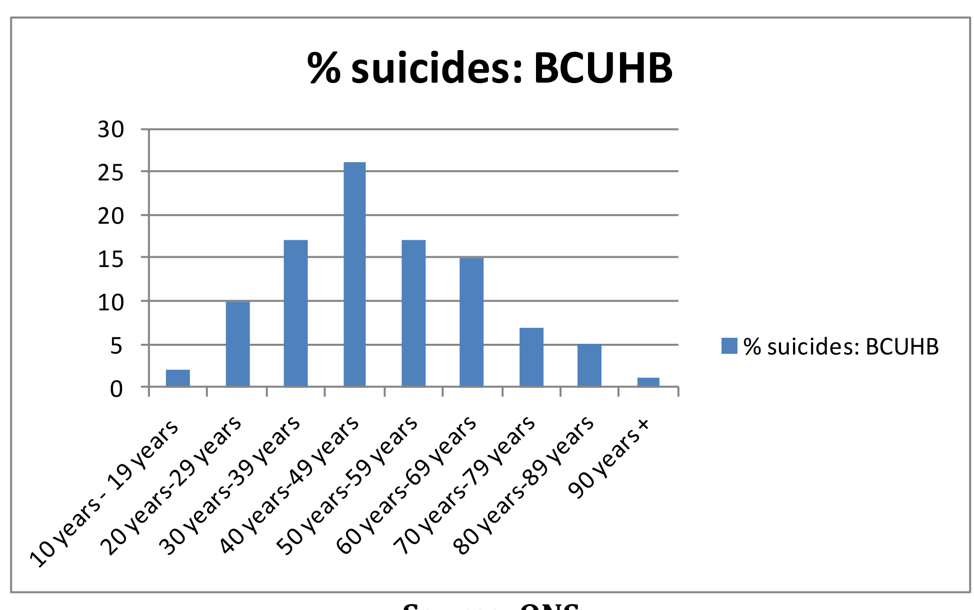
been considerably higher than female suicides since the 1860s, with the male to female ratio fluctuating from 4:1 in the 1880s to 1.5:1 in the 1960s (Thomas & Gunnell, 2010).

As part of the preparation in writing this strategic action plan, the BCUHB Public Health Directorate carried out a 'suicide audit' which reviewed ONS data on 741 suicides that were registered between 2006 and 2015 (calendar years) and occurred in BCUHB or were by BCUHB residents elsewhere in the UK. This was compiled using the strict ONS classification for suicide.

In North Wales over the registration period 2006 and 2015 (calendar years), 580 recorded suicides out of 741 (78%) were in males and 162 in females (22%) (Source: ONS).

Suicide also varies with age. Figure 4 shows the age distribution of the 741 suicides (Source: ONS). It can be seen that the greatest proportion is in those aged 40-49 years.

Figure 4:



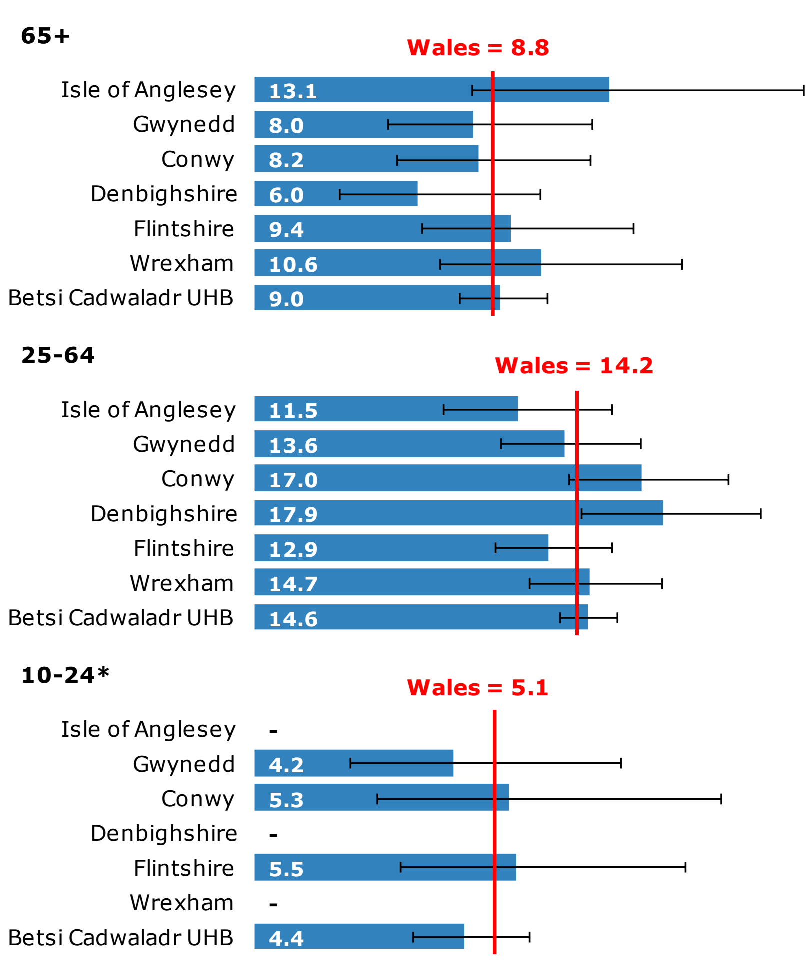
Source: ONS

Rates of suicide also vary with age in BCUHB and across Wales. Figure 5 shows that the rate of death by suicide climbs from a relatively low rate of deaths in young people aged 10-24 and peaks in the age band 25-64. There are no statistical differences between the UAs in North Wales.

Figure 5

Suicides, age-specific rate per 100,000, persons aged 10 & over, Betsi Cadwaladr UHB and Wales, 2005-14

Produced by Public Health Wales Observatory, using PHM & MYE (ONS)



* Following a definition change in 2016, deaths in children aged 10-14 are considered suicides if the ICD-10 code was X60-X84 intentional self-harm. Rates have been suppressed where there were counts of less than 10.

Risk factors for suicide include male gender, those aged 35 – 49 years, a recent history of self-harm, people in the care of mental health services, being transgender, those with one or more long term physical health conditions, a family history of suicide, a history of childhood abuse and trauma, redundancy and living with material deprivation, those with relationship problems and people in contact with the criminal justice system. However, this list is not exhaustive.

There is a regular review of suicide by people known to mental health services - the *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*. The Inquiry report refers to 'patient suicides' as those that occur within 12 months of mental health service contact. The most recent report (Appleby et al, 2016) covers the period 2004-2014. This reported that across Wales, 23% of all suicides were identified as patient suicides; in total there were 63 in-patient deaths by suicide in Wales in 2004-2014, an average of 6 per year. There was an increase in the number of patient suicides between 2004 and 2013 with a large rise in 2012 and 2013. The most common methods

of suicide by patients were hanging (47%), self-poisoning (24%) and jumping (10%). The most common primary diagnoses were affective disorders (42%), schizophrenia (16%) and alcohol dependence/misuse (10%).

At least half of people who die by suicide have a history of self-harm, and one in four have been treated for self-harm in hospital in the past year (Department of Health, 2012). The risk of suicide is highest in people who repeatedly self-harm and who have used violent or dangerous methods.

Research has shown that nurses, doctors, farmers/agricultural workers and veterinary workers are all at higher risk of suicide which may be related to their ready access to the means of suicide and knowledge of how to use them (Department of Health, 2012). In the UK, the suicide rate between 2011 and 2015 for all female health care professionals was higher than national average (ONS, 2017). Suicide rates for female doctors have been historically higher than the national average for females. In contrast the rates of suicide for male doctors were 37% lower than the male average (ONS, 2017).

North Wales has a significant population of seasonal workers due to the tourist industry and males working in the lowest-skilled occupations have a 44% higher risk of suicide than the male national average; the risk among males in skilled trades is 35% higher. Additionally, the risk of suicide among low-skilled male labourers, particularly those working in construction roles, is 3 times higher than the male national average (ONS, 2017).

Military veterans are another occupational group at risk. Kapur et al (2009) analysed the demographic data of 224 veterans who had died by suicide between 1996 and 2005. The risk of suicide was greatest for males, those who had served in the army, those with a short length of service, and those of lower rank. Although the overall rate of suicide was no greater than in the general population, the risk of suicide in male veterans aged 24 years and younger was about two to three times higher than the risk for the same age group in the general population. Importantly, the rate of contact with specialist mental health was lowest in the age groups at greatest risk of suicide, suggesting that needs are not being met. The reasons behind this population's vulnerability to suicide are not clear, but the researchers suggested that this might include:

- Finding the transition back to civilian life more difficult
- Being adversely affected by service-related experiences
- Having a pre-service vulnerability which has not been addressed

With males in this age group known to be particularly reluctant to seek help, as well as the fact that they may not even identify themselves as veterans, this sub-group may be particularly vulnerable. Fear et al (2010) backed up these findings by reporting that the overall suicide rate is no higher in UK ex-service personnel than it is in the UK general population; ex-service men aged 24 years or younger are, however, at an increased risk relative to those in the general population of the same age.

People in contact with the criminal justice system also have a higher risk of suicide than the general population (Suffolk CC, 2016). People are at highest risk in their first week

of imprisonment. North Wales has one new prison (HMP Berwyn) and fortunately there have not been any deaths by suicide since it opened. No data was available for suicide in other forms of custody in North Wales. Prison health, including mental health, is the responsibility of BCUHB.

It is widely recognised that other factors and life experiences may place individuals at higher risk of suicide. These can include: chronic pain or disability; job loss and unemployment leading to socio-economic disadvantage; family breakdown and relationship conflict, financial difficulties, and social isolation (Suffolk CC, 2016).

Living with a long term physical health condition, including cancer, heart failure, HIV/Aids, Traumatic Brain Injury, COPD, chronic pain, renal disease, diabetes, and sleep disorders, is associated with higher risk of suicide (Ahmed et al, 2017).

Alcohol or drug abuse is strongly associated with suicide risk, particularly in individuals who also experience poor mental health (known as dual diagnosis).

Other groups of people who may have higher rates of mental ill-health (although detailed data on suicide rates is lacking) include survivors of abuse or violence, members of minority ethnic groups, and children who are especially vulnerable such as looked after children, care leavers, and children in the youth justice system. It is also recognised that members of the LGBT+ community are at increased risk of suicide (Department of Health, 2012).

Perinatal mental health refers to a woman's mental health during pregnancy and the first year after birth. This includes mental illness existing before pregnancy, as well as illnesses that develop for the first time, or are greatly exacerbated in the perinatal period. Suicide is a leading cause of death for women during pregnancy and in the year after giving birth (MBRRACE-UK, 2015).

Adverse childhood experiences (ACEs), including exposure to child abuse and neglect, are well documented risk factors for suicidality (Ports et al, 2017). Cymru Well Wales has committed to addressing ACEs and their impact in Wales by making all public services in Wales able to respond effectively to prevent and mitigate the harms from ACEs, and by building protective factors and resilience in the population to cope with ACEs that cannot be prevented.

2/ The social and economic impact of suicide.

The family and friends of someone who dies by suicide are at increased risk of poor mental health and emotional distress. Partners bereaved by suicide are at an increased risk of suicide themselves, as are mothers who lose an adult child to suicide. Children bereaved by a parent's suicide are at increased risk of depression, alcohol or drug misuse, Post Traumatic Stress Disorder, and their own risk of suicide is increased (Penny and Stubbs, 2015; Pitman et al 2014). These risks are additional to the risks associated with bereavement from non-suicide deaths. The evidence suggests that specialist bereavement counselling and support can be helpful for people, although the efficacy has not been well demonstrated to date (Department of Health, 2012).

Furthermore, every death has a ripple effect within families and communities, resulting in the lives of at least ten others being seriously affected to the extent that they are likely to find it difficult to work, to form relationships and live life to their full potential.

Suicide is a significant equality issue as there are marked differences in the suicide rates according to people's socio-economic backgrounds (John, Glendenning & Price, 2017). *Talk to Me 2* highlights that improving the mental health of people who are vulnerable due to these circumstances supports suicide prevention.

The economic cost of each death by suicide for those of working age is estimated to be £1.67 million at 2009 prices (John, Glendenning & Price, 2017). This covers the direct costs of care, indirect costs relating to loss of productivity and earnings, and the intangible costs associated with pain, grief and suffering. It is estimated that at least ten people are ultimately affected by every suicide.

If we assume that 85% of the 64 suicides (=54) that occurred in BCUHB in 2015 are of working age, this means a potential cost to North Wales of about £90m per annum. If an area-wide suicide prevention intervention were to achieve only a modest 1% reduction rate in the number of suicides, there would be a saving of almost £1m per annum.

3/ The effectiveness of the Welsh Government's approach to suicide prevention - including the suicide prevention strategy *Talk to me 2* and its impact at the local, regional and national levels; the effectiveness of multi-agency approaches to suicide prevention; public awareness campaigns; reducing access to the means of suicide

The Welsh Government Strategy *Talk to Me 2*, sets out the strategic aims and objectives to reduce suicide and self-harm in Wales over the period 2015-2020. It identifies priority care providers to deliver action in priority locations to the benefit of key priority groups, and confirms the national and local action required. The six main objectives of *Talk to Me 2* are:

- Improve awareness, knowledge and understanding of suicide and self-harm amongst the public, individuals who frequently come into contact with people at risk of suicide and self-harm and professionals in Wales
- To deliver appropriate responses to personal crises, early intervention and management of suicide and self-harm
- Information and support for those bereaved or affected by suicide and self-harm
- Support the media in responsible reporting and portrayal of suicide and suicidal behaviour
- Reduce access to the means of suicide
- Continue to promote and support learning, information and monitoring systems and research to improve our understanding of suicide and self-harm in Wales and guide action

Some of the priority groups that the strategy targets include: men in mid-life; older people over 75 years with depression and co-morbid physical illness; children and

young people with a background of vulnerability; people in mental health services; people with a history of self-harm; priority care providers; police; firemen; Welsh Ambulance staff; primary care workers; emergency department staff.

Some of the priority places and settings that the strategy targets include: hospitals, prisons, police custody suites; workplaces, schools, further and higher education establishments, primary care facilities, emergency departments, rural areas and deprived areas.

We believe that *Talk to Me 2* has proven effective on the ground, with the aims and objectives of the North Wales Suicide and Self-harm prevention strategic plan mirroring the aims and objectives of the Welsh Government Strategy.

The North Wales Suicide and Self-Harm Prevention Group has an active multi-sector and multidisciplinary membership who collaborate very effectively. Recently they led a number of local North Wales public awareness campaigns in collaboration with the Health Board. They worked with the Mental Health Head of Communications on a campaign targeted at educating the public about the Netfix series "13 Reasons Why." In July 2017 the Health Board published a 1 min YouTube clip to help educate the public about the '13 Reasons Why' and how concerned adults should safely respond and how young people seek help if needed. The video and information was also shared on the BCUHB and CALL Helpline websites and Facebook pages, via their Twitter feed and was featured in the main North Wales online news outlets and news papers including: Wales online, Daily Post, Cambrian News (Dwyfor and Meirionnydd weekly paper) and North Wales Chronicle, Rhyl Prestatyn and Abergele journal, News North Wales. In addition to covering the issues around '13 Reasons Why', the articles also included public awareness messages around suicide prevention. The features also promoted the importance of help seeking, the basics of making a safety plan and included a link to an online resource written for people in distress which included guidance on how to get through tough times, who to contact and how to make a simple safety plan.

The North Wales Suicide and Self-harm prevention group has also been working hard to reduce access to the means of suicide, especially regarding the Menai Bridge, which is a high frequency location for suicide. A number of Samaritans signs have now been erected on the bridge, as well as work to install 4 phones connected directly to the Samaritans on both sides of carriageway and at each end of bridge. There have also been early discussions around the installation of thermal imaging cameras. An alert could be sent to police control centre or other organisation if someone lingers for too long, especially at dusk/dark. There is a feasibility study underway regarding installation of higher barriers on the bridge, an evidence based intervention. There have also been initial discussions with the operators of the Pontcysyllte Aqueduct, another high frequency location for suicide.

4/ The contribution of the range of public services to suicide prevention, and mental health services in particular.

Suicide and self-harm prevention requires a multi-sectoral approach to ensure joint working across a range of settings. A wide range of public services need to be involved

including: NHS, Local Authorities, Fire Service, Coroner and Police. All these agencies are around the table as part of the North Wales Suicide and Self-harm Prevention Group. Mental health services also play a key role in the North Wales Suicide and Self-harm prevention group and feature strongly in the implementation of the new strategic plan in North Wales.

People take their own lives because the distress of living becomes too great or illness or other personal circumstances seem intolerable**.** Suicide is preventable, but a significant culture change is needed. To this end the Health Board recently ran a Suicide Awareness and Suicide Response training day for 100 cross-sector, multidisciplinary professionals which was extremely well received. The training programme supports the development of a common language and approach, promoting a consistent assessment and documentation of the process, and a more integrated response across statutory services, third sector providers and communities. The training included a suite of clinical frameworks, some of which have been adapted for non mental health settings, including primary care, third sector, education, and the police.

5/ The contribution of local communities and civil society to suicide prevention.

The Third Sector, as well as local communities, need to be involved in the design of suicide prevention interventions through the principle of co-production. In the development of the North Wales Suicide and Self-harm Prevention Strategic Plan, we cooperated very closely with organisations such as Caniad, who are the combined voice for mental health and substance misuse involvement in North Wales.

Responsibility for people with suicidal thoughts has traditionally been seen to lie with specialist mental health services and many people feel ill equipped to respond. However early intervention from a relative, friend, colleague or compassionate care giver could make a real difference to saving lives. Suicidal people are often ambivalent about dying, and their lives can be saved right up until the final moment.

We need to move away from a pre-occupation with a 'risk assessment' process of characterising, quantifying and managing suicide risk, towards a greater focus on intervention based on compassion, safeguarding and safety planning.

Everyone in society has a role to play in the prevention of suicide and self-harm. Every person experiencing suicidal thoughts and/or self-harming, should be taken seriously and supported to co-produce a safety plan, with strategies, contacts for support and explicit reference to the removal or mitigation of access to lethal means.

Equipping people to respond safely and effectively to someone at risk of suicide, is itself an emotional journey, as well as a process of developing the right attitudes, knowledge, skills and confidence.

The BCUHB Self-Care Team has been delivering Emotional Resilience training across North Wales to members of the community, patients, carers and staff.

Third Sector services are available when statutory services are not available such as out of office hours and at weekends. Samaritans branches in Bangor, Rhyl, Aberystwyth, Llandrindod Wells, Newport, Bridgend, Cardiff, Swansea, Haverford West (Chester branch plays an active role in North East Wales and Wrexham) provide 24-hour phone, text and email help line service for those in despair and who have suicidal thoughts. Many branches also offer people the opportunity to talk face to face. Bridgend branch pioneered "Feet on the Streets" to provide support for those on Friday and Saturday evenings in town, when the night is not working out very well.

Two specific projects that Samaritans have been involved in include: Network Rail project – Samaritans have trained network rail staff to enter into conversation with those who do not catch a train or look distressed along the rail network; Small talk Saves Lives campaign – encouraging general public to talk to people who appear upset on rail network.

We believe that Third Sector "Drop Ins" and other services that are provided across North Wales are invaluable as they provide an informal & safe place for people to get the support (often peer support) that they need to prevent their suicidal thoughts escalating. This support could come from a mental health specific organisation e.g. Mind, or from a community group such as a church group. Lots of this informal support happens on a daily basis, but it is not necessarily known about by the wider community. Many organisations also get calls for help from people and although this is probably recorded internally, this is not necessarily recorded or collated elsewhere. Certain counties across North Wales have local suicide prevention groups in which third sector organisations play an active part.

6/ Other relevant Welsh Government strategies and initiatives - for example *Together for Mental Health*, data collection, policies relating to community resilience and safety.

The Welsh Government strategy, *Together for Mental Health,* shows the importance of ownership of mental wellbeing as a multi-sectoral issue.

There are issues which have been highlighted around having the data to understand where we can have an impact in terms of suicide and self-harm and how this translates to regional and local improvement and implementation. We would therefore call for increased resource to improve data in this area.

From a Child and Adolescent Mental Health Service (CAMHS) perspective, we have seen the number of cases admitted to paediatric wards increase dramatically over the past 5 years, to the point where in North Wales we have a dedicated team of CAMHS clinicians based on the paediatric ward in order to deal with the work of assessing these young people. We tend to see an increase in admissions due to self-harm around the time of exams, and there seems to be a correlation between stress experienced at school and acts of self-harm.

CAMHS also feels that bullying is an important factor in mental ill health amongst young people, be it online bullying or face to face. Bullying appears to be a factor in many presentations (anxiety, depression, OCD), not just self-harming and para-suicidal behaviour.

We would welcome the government's continued support in putting more emotional health workers into schools, so that young people can access help to regulate their emotions before they consider engaging in self harming and suicidal behaviour. A national anti-bullying programme (such as Kiva) in all schools would help to decrease the number of referrals made into specialist services such as CAMHS.

We have welcomed the Adverse Childhood Experiences educational programme, and agree that it is so important for the public and for health professionals to be aware of the effects of ACE's on a person's life. As a team of professionals we feel that it is highly important for school children to be educated about the importance of stability in the first 1000 days of life and how instability at this time can be a very important factor in the development of severe mental health problems later on in life. We also recognise that during this period (first 1000 days of life) the foundation for emotion empathy and good social skills is formed: skills which increase resilience to adverse life experiences, and thus resilience to developing mental health problems.

Lack of bereavement counselling has been identified as a concern locally and whether there are links to self-harming.

7/ Innovative approaches to suicide prevention.

In the WHO 2014 report 'Preventing suicide: A global imperative' Dr Margaret Chan, Director-General World Health Organization encourages the view that suicide is preventable (WHO 2014). Encouraging help-seeking behaviour, rapid access to effective

treatments, hopefulness, identifying reasons for living, and removal of access to means can contribute to suicide prevention. Suicide is also rare event and we must keep this in perspective.

There are a number of innovative approaches to suicide prevention – but these need to be based on evidence of what works. The Public Health Wales Observatory Evidence Service has produced an evidence map to inform the development of local suicide and self-harm prevention plans in Wales (Public Health Wales Observatory, 2017). It summarises research evidence that addresses the question: "What interventions might be effective in reducing rates of suicide, self-harm and suicide ideation in Wales"? Included sources were limited to NICE and NICE accredited guidelines and systematic reviews produced using a robust methodology adhering to systematic review principles. Sources have not been critically appraised by the evidence service. Where evidence included in NICE guidance was duplicated in retrieved systematic reviews only the NICE guidance has been included. Some additional sources that may be useful in informing the development of local suicide prevention plans have also been included. These include high level sources such as published systematic reviews or evidence syntheses/statements/guidelines from recognised (e.g. expert body) sources.

The evidence map covers:

- Primary prevention
- Screening and assessment tools
- Management of self-harm and suicide
- Mental healthcare
- Specific populations
- Others

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December 7th 2017

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S 19
Inquiry into Suicide Prevention
Ymchwiliad i Atal Hunanladdiad
Ymateb gan Gwasanaeth Carchardai a Phrawf EM yng Nghymru
Response from HM Prison & Probation Service in Wales

Gwasanaeth Carchardai a
Phrawf EM yng Nghymru

HM Prison & Probation
Service in Wales

To: SeneddHealth@assembly.wales
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Business manager: Kate Duran
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Date: 8th December 2017

Annwyl / Dear Dai,

Re: Suicide Prevention

Her Majesty's Prison and Probation Service (HMPPS) in Wales is responsible for Public Sector Prisons (PSPs), the National Probation Service (NPS) in Wales and has contract management responsibilities for the privately contracted prison HMP Parc and the Wales Community Rehabilitation Company (CRC). The focus of these services is to protect the public, support the rehabilitation of offenders and reduce their risk of re-offending. HMPPS in Wales supervise approximately 16,000 offenders in custody and in the community at any one time[1]. We welcome the opportunity to contribute to your inquiry into Suicide across Wales and to provide information on the contribution we are making to suicide and self-harm prevention in Wales.

HMPPS has clear policy and practice to manage and mitigate risks around suicide and self-harm. We work closely with Welsh Government officials in the development and delivery of the Talk to me 2 strategy and related delivery plans. Those we work with are often among the most vulnerable group of people at risk of suicide and self-harm. The latest Ministry of Justice Safer Custody Statistics[2] for England and Wales reflect that there were 77 self-inflicted deaths in prison custody in the 12 months to September 2017. Self-harm reached a record high of 41,103 incidents in the 12 months to June

[1] https://www.gov.uk/government/collections/offender-management-statistics-quarterly

[2] https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-june-2017

2017. There were 233 self-inflicted deaths in the community during 2016/17[3]. It is, therefore, a critical priority for HMPPS to make sure that offenders who are at risk of suicide and/or self-harm are identified, managed and supported at the earliest opportunity.

Essential to this is the early identification of those at risk to provide them with the necessary integrated care and intervention needed; through collaborative staff awareness training and the routes to appropriate counselling or mental health support in custody and in the community. HMPPS in Wales is working closely with health boards, social services and other partners to look at how support services can be further aligned and expanded to improve provision, for example, through increasing opportunities to access counselling that gives individuals hope that can be lifesaving.

HMPPS in Wales staff are suicide and self-harm aware. Our case recording systems will alert staff to an individual's potential risks and to consider contingency plans at the earliest point of entry to our service. The Wales CRC and the NPS in Wales have jointly developed key documents in relation to suicide to support offender managers. This includes a resource pack, a guide for managing crisis situations and a risk assessment guide. These are designed to help offender managers best support individuals who present a suicide risk and to help individuals in a crisis situation. They also contain guidance on detailed risk assessment around suicide and how to record this appropriately. We work closely with external stakeholders to collectively manage a range of risks in the community. Welfare checks can be made by the police where there are safety concerns. We also report and make referrals to social services for POVAs (protection of vulnerable adults) and other safeguarding issues.

In custody, HMPPS has an integrated and evidence-based prisoner suicide prevention strategy that seeks to reduce the distress of all those in prison, staff, prisoners and visitors. Any prisoner identified as at risk of suicide or self-harm must be managed using the Assessment, Care in Custody and Teamwork (ACCT) procedures. ACCT is a prisoner-centred, multi-agency care-planning system which reduces an individual's risk. We are rolling out Suicide and Self-Harm (SASH) Prevention Training across all prisons, with the aim of having everyone who works in the prison, with HMPPS and staff, trained by April 2019. The training covers risks and triggers, conversing with vulnerable people, ACCT documents, referral processes, resilience and mental health.

Prisons also have peer support workers, such as Insiders, to support induction to the prison and the custodial journey. The Samaritans has been working in partnership with HMPPS for over 25 years to reduce suicide in prisons. Samaritans selects, trains and supports prisoners to become 'Listeners' who provide confidential, emotional support to their fellow prisoners. In 2016-17, the Listener scheme was operating in 113 prisons in England and Wales. Prisoners can also phone the Samaritans helpline at any time or write to them.

There are further projects and initiatives HMPPS in Wales are delivering that you may be interested in knowing more about. These include:

- Delivering training to staff on trauma informed approaches and adverse childhood experiences (ACEs). ACEs increase the likelihood of suicide and self-harm issues across an individual's life-course and those we manage are likely to have four or more adverse experiences in their lives[4].

[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/654856/deaths-of-offenders-in-the-community-2016-17.pdf

[4] http://www.wales.nhs.uk/sitesplus/888/page/88504

- The #StayAlive mobile application for offenders in the community so they can access a safety plan, coping strategies and links with wider support networks such as the Samaritans.
- The Suicide Prevention Learning Tool which is a series of six short films to support learning from previous staff experience. These films will be published on the Justice Academy website.
- HMP Parc will be rolling out a revised mental health referral pathway to allow staff and offender self-referral and an integrated case management approach to those prisoners who may require enhanced case management through joint operational and health structures.
- Improving the use of and access to Mental Health Treatment Requirements to support supervision of offenders with complex mental health needs in the community.

We recognise there is always more to be done to support offenders in our care and to help them value their lives and improve their mental health and wellbeing. This is an ongoing and clear priority for HMPPS.

I hope the outline of this important work has been helpful and we look forward to seeing the full report of the Inquiry. If you require anything further please do not hesitate to get in touch.

Yn gywir / Yours sincerely

A. Rees

Amy Rees

Cyfarwyddwr Gweithredol, Gwasanaeth Carchardai a Phrawf EM yng Nghymru
Executive Director, HM Prison and Probation Service in Wales

S 20
Inquiry into Suicide Prevention
Ymchwiliad i Atal Hunanladdiad
Ymateb gan Unigolyn
Response from An Individual

Summary of key points

1) The best information about the causes of suicide, comes from talking to people who have attempted suicide and survived. This needs to happen more often to help us to understand:-

    If people ask for help, do they get it?

    If they didn't get help, were they told why not?

    What are the characteristics of people who do not get help?

    Is the help offered useful? If so what was helpful? What was unhelpful?

    If they saw their GP before the attempt, did they discuss suicide and if not, why not?

    Did anything happen when they asked for help which made things worse, and/or discouraged them to ever ask for help again?

    Does the clinical record and the person's intention agree. Ie is a suicide attempt recorded as a suicide attempt or is it recorded as self-harm?

    What were the reasons for the attempt? Were they caused by voices? Where they related to a diagnosed mental health problem? Were they related to an un-diagnosed mental health problem? Did the person belong to the group who have mental health problems too severe for Primary care mental health support services and not severe enough for secondary mental health services?

    What are the protected characteristics of people who attempt suicide, those who do not get help, and those who do?

2) The best information on what helps to prevent suicide when people feel suicidal, comes from those who have felt suicidal and not gone on to make an attempt. We need to be talking to people in this group more to find out what works

3) When evaluating interventions to see if they are having an impact on suicide rates, the data that best indicates change due to higher numbers with a clear correlation with suicide rates, is:

Self-harm seen by GPs

Self-harm which requires hospital treatment

Suicide attempts

Escalating self harm and suicide attempts

It would be extremely helpful to make suicide ideation and self-harm notifiable conditions to ensure a) we know what resources are currently being spent on this group, and b) we have excellent quality data through which to monitor and evaluate suicide prevention measures.

4) We need to investigate all suicides because we need to know:

what contact people have with health or social care services immediately before the event? (including GP,999 and A&E).

Are they ex users of secondary care services, and hence were they ready for discharge?

Had they re-referred themselves under the measure and not had an assessment? Or had an assessment and not been taken back on for a service?

Were they referred to and not taken on by secondary services?

Were they under the care of the mental health crisis service, and hence was everything done that could have been done?

Had a family member or other member of the public raised concern with services? If so did this lead to an offer of help or not?

If they saw a GP in the week before death, did they raise the issue of feeling suicidal? If so was help offered or denied?

If they were not considered to have a mental health problem, what help would have been available to them in their area? How easy is it for people to find out about this help?

What are the protected characteristics of people who die by suicide?

5) We need to look more closely at coroners decisions on the deaths of women with a diagnosis of Personality Disorder, as there is evidence that these deaths are more likely to be recorded as accidental, when they are actually suicides, because staff feel that these people are wanting attention and hence the death is not intended. There is a risk that female suicides are therefore being under-reported.

6) We need better self-harm and suicide risk assessment processes, based on the research into causes of suicide, rather than research based on demographic groups. Focusing on demographic groups causes inequity of service, and values some lives more than others, some suffering more than other suffering. This is not compliant with the Public Equality Duty.

7) We need a wider range of innovative interventions and trainings, preferably co-productively designed with self-harmers and people who have survived suicide attempts, to create differences in different areas, in order to build practice based evidence on what makes a difference.

8) We need standards for the delivery of training, and the teaching/training qualifications and supervision of trainers, so that it meets the evidence base for training effectiveness in improving knowledge in action.

9) We need an assessment of current staff attitudes to self-harm and suicide, and to their knowledge and practice, to underpin a plan to improve attitudes, knowledge in action and high quality supervision of staff.

10) We need to consider mandatory training for frontline staff in suicide and self-harm prevention options, on the same basis as first aid (including in the work-place), and CPR. (GPs have said that they would use suicide and self-harm prevention far more than CPR in their day to day practice).

11) We need to look at the impact of interventions not directly aimed at reducing suicide and self-harm, which none the less have an effect on the incidence of it. Eg school health curriculum, communication skills, picking up vulnerabilities such as ASD/ADHD early, including in high academically achieving children, and in adults in touch with mental health services.

12) We need to do more about the causes of suicide, such as domestic abuse, bullying in any context, harassment of any kind in any context, sudden change in financial circumstances, debt, poverty, homelessness, unsuitable housing, rates of violent crime, accident prevention, not coping with serious health changes, access to work, access to services, quality of life, work based stress, not coping with grief, - both in terms of prevention and in terms of support.

13) We need to be increasing conversations about suicide and self-harm, which challenge assumptions, increase compassion and understanding, increase tolerance, and reduce anger.

14) No progress can be made without financial investment. There is not enough slack in the system to release the money and time required on the frontline at present. There are significant gaps in the knowledge of a large proportion of health, social care and mental health workers and professionals, and significant problems with attitudes, which require investment in training, supervision and staffing levels sufficient to ensure staff can be released to do the training; much data and research needs to be done to help us assess the costs of doing nothing compared to the costs of intervention and to underpin the development of effective training and interventions; and new services need to be developed for currently unserved groups. None of this can be done without additional investment. However, it is likely that any up front investment will lead to savings elsewhere when services become more effective. At the end of the day this is about the value of life and the cost of loss of life, even if money were not saved a willingness to invest shows that the Government cares. Not investing suggests they don’t.

The Committee is calling for evidence about:

- The extent of the problem of suicide in Wales and evidence for its causes - including numbers of people dying by suicide, trends and patterns in the incidence of suicide; vulnerability of particular groups; risk factors influencing suicidal behaviour.

I am responding to this as a person who has attempted suicide on several occasions and faced negative attitudes and extremely distressing reactions both from people in the community including members of my own family and from health service staff, especially those working within mental health services. The latter particularly increased my vulnerability and ultimately had the greatest impact on my actions.

I belong to the occupation with the highest risk of suicide, consistently, with rates 4-5X that of the general population. [redacted]. I know a number of people in that profession who have committed suicide, and have been concerned about this issue for many years, before I was affected myself.

The suicide rate for women in the profession is 5 time the average, which brings it roughly level with the suicide rate for the most at risk age group for men.

However, even though 1 in 4 deaths by suicide are women, they are not taken seriously. Instead they are often labelled with Personality Disorder and face attitudes which make the situation for them far worse.

As the [redacted] I have seen existing information on this issue, which shows that women who commit suicide generally are dealing with more of the issues found to be affecting people who die by suicide than men, suggesting that they work harder to survive and suffer more before they take the decision. The focus on men fails to acknowledge women's heroic bravery and struggle, denies an adequate response to this suffering and minimises and neglects it in an unjust way. As a representative of service users I have discussed shocking situations with independent advocates. The story which sticks in my memory is the woman who attempted suicide 5 times, requiring intensive physical hospital care on each occasion, whilst 'under the care' of the crisis team, who discharged her after 6 weeks, because that is the maximum time of their intervention, without her having made any progress, without referring her to other services, and without any admission to protect her. This story whilst extreme, reflects many stories I have heard, and my own, which is that mental health

services, and sometimes emergency services, do not take suicidal ideation in women seriously, and rarely admit women at risk. I remember one story of a woman who had cut her wrists and was bleeding in the park by the bandstand, who phoned 999 and was told that no-one would be responding. She was just left there at night in the cold, alone. Fortunately she survived to tell the tale. The ultimate message women go away with, is that female lives are not as valuable as male lives, and that their suffering and well-being do not matter to mental health staff or policy makers.

The issue that perplexes me the most is the lack of investigation of attempted suicides, as this seems to be the best possible resource for understanding and responding to the questions you are asking. After people are dead you will at best be guessing, when the survivors can be absolutely accurate about the complex issues involved.

The other lost opportunity is in not keeping figures on presentations linked to suicidal feelings, because we don't get any understanding of what helps people to survive, and eventually be free from this struggle. Too often staff assume that those who come forward for help can't really be suicidal, or they wouldn't be looking for help, rather than seeing the survival of suicidal people as a success for intervention.

There is an assumption that people from disadvantaged urban communities are the worst affected. However, the other professions consistently in the top 5 affected occupations include farmers, and the other 4 are professionals with relatively high incomes – vets, Dr's, Dentists, and pharmacists. All these groups have access to the means in the form of anaesthetics/guns.

The suicide figures given for Wales are all based on local authority areas, and are expressed as absolute numbers rather than as rates. If you look at the suicide rates, as in deaths per 100,000, the suicide rate in Carmarthenshire is by far the biggest, with the annual absolute figures being in 2nd -4th place with them in fourth place on rolling 3 year deaths, with all other authorities with higher figures having much bigger populations. The increase in suicides in Carmarthenshire coincided and increased in proportion to the reduction in absolute numbers of acute psychiatric hospital beds per head of population. At the time suicide rates started to climb, rural Carmarthenshire had the highest rates of psychosis in the 3 counties of Hywel Dda. And yet the proportion of beds per head in Carmarthenshire has persistently fallen faster than those in Ceredigion with the highest number of beds per head, and

Pembrokeshire also with significantly more beds per head, and both with very much lower suicide rates. Carmarthenshire has a 1/3 of its population living in poverty, with the majority of these being the rural poor. A significant proportion of suicides here are in the rural population. Hywel Dda also has a lower number of Consultant psychiatrists per population than any other area in Wales. (Though I have yet to be convinced that consultant psychiatrists do anything to prevent suicide, and in my own experience some have contributed to the cause of my own attempts. The low rates of consultants here probably reflect a general problem with staffing rates in mental health in this area.). Even in the new proposals for transforming the health service the plan is to again give Carmarthenshire much fewer of the new recovery beds, than Ceredigion or Pembrokeshire. With 2 and a half times the population of Ceredigion, Carmarthenshire will have the same number of beds as they do.

One of the critical issues is the demographic based approach, as a result of the leadership role of Public health based on figures relating to the groups most at risk. By focusing on population groups rather than on individual circumstances, risk assessment measures keep failing to identify those most at risk and inequalities in services inevitably arise. What we do know from studies in Manchester working with survivors is that 3 factors are consistently present in all suicide attempts and hence likely to be present in all suicides. 1) unbearable suffering, or situation, 2) which is seen by the individual to be inescapable, and 3) where the individual believes there is no help available. This absolutely converges with my own situation, when I attempted suicide. But these factors are not reflected in any of the risk assessment processes.

Although the majority of suicides are in the general population and are not known to mental health services, it does not mean that they did not have a mental health problem, or that they did not seek help. Figures show that the vast majority have visited a GP in the final week of their lives. We need to know more about what happens in this last visit to see if the clues were there, or whether having got there the individual bottles out of talking about the situation. I know from personal experience just how hard it is to talk to professionals about these feelings, and have myself usually left it until it was too late to make much of a difference, and often described those feeling in euphemistic terms which may mean I was not understood. For me this has largely been a result of the extremely negative views of society and particularly of those I would have to ask for help.

We also know that one of the highest risk groups are those who self harm, and that the incidence of self harm is a far better indicator of the size of the problem than the actual number of deaths, as it is a bigger number showing trends more quickly and more obviously than actual deaths. We need to keep on top of data on both self harm and suicide attempts - which are too often recorded as self-harm when the motivation is completely different.

But our services and staff do not notice or understand self-harm or take it seriously. In women it is usually dismissed as Personality Disorder which is considered to be treatment resistant (although it is not), and for which it is claimed that hospital treatment is unhelpful – when the most effective model has been in residential units. The evidence actually suggests, not that hospital is the wrong place for people with personality disorder, but that it is not doing the right things for them. In addition many services are denied to people with Personality Disorder, including community mental health services and crisis team services. There was at one point a Government health circular, specifically telling crisis teams not to deal with patients with a Personality Disorder. The real risk here is that Personality Disorder is massively over-diagnosed, especially in women, and hence those who need hospital care are frequently denied it as a result. The quality of diagnosis is persistently extremely poor, with very few having a sufficient clinical history taken, very few involving evidence from family, friends, neighbours or colleagues, and very very few involving the evidence based psychological instruments, which have been shown in peer reviewed research to be far more accurate than intuitive face to face diagnosis. Sometimes, despite an evidence based tool ruling the diagnosis out, consultant psychiatrists have persisted in their view that the patient has this condition. A psychologist joked to me that the diagnosis was a result of '[redacted] a psychiatrist' – unfortunately there is fairly good evidence that this may, in a significant proportion of cases, be true. As is the observation that it is more often given to highly intelligent, feisty women who ask questions and want explanations – behaviour which appears to make mental health staff extremely uncomfortable. I remember a consultation event where a psychiatrist warming to the value of her input, told about an OT seeing a patient, who had a difficult and conflictual relationship with this OT, and the psychiatrist prided herself in intervening, by recognising –without even meeting the client concerned – that they had a 'Personality Disorder', and therefore should not have a service. Not everyone gets on with everyone else. A conflictual relationship with one person, does not mean that you have a Personality Disorder, but this is the way service users, especially women

who self harm or feel suicidal, are routinely treated. In addition with the greater availability of adult autism assessments and hence understanding of autism in mental health services, it has become apparent that women, particularly, do not have their autism picked up as children, until they present to mental health services later in life. We now know that many women with autism have been mistakenly diagnosed with personality disorder, and that the standard treatments for personality disorder cause damage and harm to people with autism. We also know that people with autism have a lower threshold to psychosis, and that psychotic symptoms are not always taken seriously in this group, or conversely that many autistic individuals have been diagnosed with psychosis, when they are actually autistic. The point is that misdiagnosis leads to inappropriate treatment and inappropriate treatment increases the risk of both iatrogenic harm and suicide.

My personal experience is that no one has ever asked me what led to my suicide attempts, and the contribution made by voice hearing was therefore not identified. Whenever I tried to talk about my voices I was told I was lying. This contributed to the inescapability of this unbearable situation, and the feeling that I would not get help. The experience of an incomprehensible diagnosis of Personality Disorder just added to my distress and confusion, and seriously undermined any limited self-esteem I had left when in a crisis. Experience kept reinforcing that I was right to believe that I would not get help. I could not understand why other people who heard voices were taken seriously and helped with compassion, and I was not only not helped, but often treated with contempt. I was diagnosed with Aspergers last year, after 5 years asking for and being refused an assessment and 14 months on a waiting list, but the diagnosis of Personality Disorder has only just been dropped as a result of better history taking by a new psychiatrist in my care and involvement of my family, and I have only just been diagnosed with psychosis by this consultant, 16 years after seeing my GP about my first voice hearing experience.

It is very clear that where a woman has a poor relationship with a member of mental health staff she stands a very high risk of being diagnosed with Personality Disorder on the basis of this alone. This includes women who make any kind of complaint about mental health services, and underpins the importance of complaints being treated with extreme confidentiality so that complaints do not affect either diagnosis or care. However the current NHS complaints process is not fit for purpose because it does not provide this protection. As a result it contributes to suicide risk.

There is also a tendency to attribute suicide in women with Personality Disorder to accidental death, as self-harm and suicidal behaviour is seen as 'attention-seeking', or as a 'coping mechanism', and therefore any death would be un-intended. This is very likely to be leading to significant under-recording of female suicides. Incremental self harm is persistently regarded as bad behaviour, rather than recognising the real intentions of failed suicide attempts and risk of eventual suicide.

We know that mental health problems also create a suicide risk, as this group has by large orders of magnitude the highest suicide rates. But mental health staff seem (not without notable exceptions) to have the worst understanding and attitudes of any group within society about suicide and self-harm, frequently seeing it as bad behaviour, selfish, 'the coward's way out', as manipulative or attention seeking. I remember hearing a very senior member of staff recounting his feelings about a telephone call from a suicidal person, as feeling 'held over a barrel'. This staff group has the greatest potential impact on suicide rates, and also has the greatest need for retraining. The same staff member triggered two of my suicide attempts first with a very harsh letter which contradicted another Dr's diagnosis regarding an issue I had never discussed with him, and the next year with a particularly vicious and judgemental letter refusing me any further treatment as a result of a confidential letter I had written to a different manager on a subject which had absolutely no relevance at all to the writer of the vicious letter. On both occasions the letters arrived on the Friday of a bank-holiday weekend, when there was no support available.

It is critical that training of staff supports understanding, compassion and staff self-efficacy through feelings of competence and good treatment protocols to follow. The negative perceptions of staff about people who report feeling suicidal or wanting to self harm, says far more about the support they need to cope with the demands of their job and of working with high risk individuals, than it does about the intentions of service users. I believe you cannot change these attitudes without being very clear about what they are, which requires some research, and without having survivors who can bust the many myths about suicide, actually in the training room to challenge assumptions and prejudices.

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- The social and economic impact of suicide

There are estimates of how much suicide costs. It is a very large amount of money.

We also pay very heavily for the negative attitudes to suicide, which cause immense and unnecessary distress to all concerned, and which are magnified by the taboos and reluctance to talk about it openly. You can only think suicide is easy, if you have not attempted it. You can only be angry if you have not experienced the depth of distress which drives it. You can only see it as irresponsible if you have not lived with the experience of being a burden on and source of distress to others, or have lost face and status – which is known to be particularly high risk for people in the public eye, when they are publicly shamed in the media. You can only see asking for help with suicidal feelings as 'attention seeking' rather than taking responsibility, if you have never struggled with it and forced yourself to try to put others first by asking for help when it is extremely difficult to do so. When the messages you hear from others are all so judgemental, if you become suicidal it can be immensely difficult to admit it and hence to ask for help, and sometimes you cannot even admit it to yourself. Feelings of shame and guilt can be so intense, promoting secrecy and avoidance, that you may not even feel that you deserve help. These attitudes make preventing suicide extremely difficult. If you lose someone close to you, you are more likely to commit suicide yourself. Each suicide touches and affects many people around them, including the professionals involved before and after it, who have to deal with the situation and the bereaved.

- The effectiveness of the Welsh Government's approach to suicide prevention - including the suicide prevention strategy *Talk to me 2* and its impact at the local, regional and national levels; the effectiveness of multi-agency approaches to suicide prevention; public awareness campaigns; reducing access to the means of suicide.

Talk to me 2 is not working. The responsibility arrangements, committee structures and accountability/reporting structures are not convergent, are unnecessarily complex, and impede partnership working, due to lack of clarity of where responsibilities lie, and hence promote the opportunity to abdicate responsibility and to do nothing. The leadership with Public health puts it outside of frontline services, and has prevented front line action.   Responsibility needs to be firmly placed at the door of frontline services, and with individual practitioners, with all services having a responsibility to report directly to government on key areas of activity, including how they are collaborating with other

local partners. The role of those effected by suicide is undermined by the arrangements for leadership and accountability, as those organisations supposedly leading (RPBs) do not have the right mechanisms for service user involvement. There is then a requirement for reporting through the LMHPBs, which is undeliverable unless they also lead on the delivery. The LMHPBs do have better service user and carer involvement, potentially including people affected by suicide, but even this varies greatly in quality from health board to health board.

Although there is a real concern, this is not driving change. The regional structure is unclear and clunky. It is not clear which group covers Powys. It seems much more logical to divide regions along health board lines, which are co-terminus with Regional Partnership Boards. We also need to ensure people affected by suicide are in all the regional groups and at the National level, and that they are central to the next up-date of Talk to Me. (Talk to Me 3??) It is critical that Health Boards, and WAST, and not just mental health, have clear lines of responsibility on this due to the role of GPs and emergency services. We need to have someone with Personal responsibility for this at executive level in each health board, to work with a local partnership including the LMHPBs, to deliver government strategy, and we need a specific budget allocation ring fenced for this work. It is very, very clear that apart from the minority known to mental health services there is no specific service to help people who self-harm and are suicidal who do not tick the current boxes for either primary or secondary care eligibility. We know that around 70% of people presenting with mental health problems fall between Local Primary Mental Health Support Services, and Community Mental Health services, and hence get no service.

We also know that GP's are very poorly prepared and resourced to deal with mental health. You do not have to have a mental health problem for your physical health to be dismissed as being caused by one. This is a very dangerous situation. GPs have very limited training in mental health in their core under-graduate training and often do no other training on the subject. This inadequately prepares them for being the first line for support for people who are self-harming or are suicidal. They also have no in house expertise, alongside practice nurses and health visitors, who could improve services and increase capacity and understanding at this level. It is extremely easy to find examples of GPs and A&E staff who have an extremely unhelpful attitude to mental health, which can verge on contemptuous and dismissive, clearly demonstrating a lack of status for mental health and a feeling that it is not their business. The recent suicide of an asylum seeker in Swansea,

after trying everything to get help, without success, demonstrates just how inadequate our services are for this situation. We also know that mental health training of paramedics and A&E staff, as well as staff providing care for terminal and life limiting or chronically disabling conditions is also seriously inadequate. 10% of suicides are in people with such chronic physical health problems

We have a reducing number of GPs, who spend a lot of their time on mental health. It could solve a lot of problems to include the employment of mental health and suicide and self-harm prevention practitioners in every practice, using underused consultation rooms and taking part of the workload off GPs, as requirements within the Primary Care contracts. It is clear that GPs would have far more opportunity to use training in suicide and self-harm prevention, than they have for CPR, and would save more lives by doing so. Suicide and self-harm prevention training needs to be mandatory on the same basis as first aid and CPR.

We need health boards to all have a clear suicide and self-harm prevention strategy within their IMPTs which specifically references where they are working with LMHPB's, RPBs LA's, and with other agencies on this through an overall partnership group on the LHB footprint.

If you want evidence of what's working look in the areas where suicide rates are falling. I believe the only area in the UK doing that is Scotland, where they have a specific government budget and 22 Choose Life coordinators. Taking into account the calculated costs of suicide, the programme more than pays for itself.

The TTM2 strategy recommends evidence based training, but a recent document relating to this showed that there is very little training with such an evidence base. The only training which has demonstrated a fall in suicide rates is the Good Behaviour Game used in schools, which isn't specifically a suicide intervention. It is clear that any training needs to be regularly repeated just as CPR training and first aid training need to be repeated. The benefit of the Good Behaviour Game is that unlike other trainings it meets the best evidence base for learning and development, by including real time practice of new skills in context, and rewards for improvement. Any training with the best content in the world is only as good as the ability of its design and its trainer to change understanding and behaviour. None of the existing trainings have a robust quality assurance structure, with adequate evidence based

training qualifications for trainers about how to train and evidence based teaching supervision structures.

The idea of a ‘once for wales’ training programme for suicide and self-harm, given the lack of evidence base would be unhelpful. We need diversity in the system in order to identify best practice and to support continual improvement. It is important that Universities are more involved in the evaluation of trainings than in their design and delivery. A dual role of doing both creates a conflict of interest, and hence potential evaluation biases, and whilst Universities have a very good record on research quality, their teaching quality is considerably more controversial, with many of their teaching staff not having any teaching qualifications or evidence based teaching supervision structures and processes. It is critical that all trainings are centred around the experience of those affected by suicide and self-harm who can personally describe and answer questions about their state of mind at these times and what did or did not help them.

Getting partners together locally to deliver TTM2 has been a real struggle. There seems to be a tendency for little groups to start and fizzle out through various committees, working without any coordination, with both duplication and gaps. When they find out there is a group somewhere else, the interested parties seem to melt into the background, presumably because it then becomes somebody else’s business.

There is as yet no campaign which has successfully addressed the taboo of talking about suicide and self-harm. This is because we can only overcome the stigma and shame of feeling this way, by accepting that it is a reasonable response to an unreasonable situation. Ironically unless we accept suicide and self-harm, we will never prevent them, because if you cannot talk about it without being judged, you cannot ask for help. This seems to be more the case for men, who seem to be more affected by what people think about them, than women are (partly because women’s cultural and historical expectations of not being respected are engrained and hence they are more accustomised to it). By far the greatest number of suicides is in the group who don’t get help. I had a long talk with a local women recently who was really struggling with her anger at the suicide of a young man who had left 2 children. Because of my experience I was able to talk to her about what it feels like, about the statistics, and about the fear of being judged if you ask for help, and about the need to accept suicide before we can prevent it. The fact is that suicide is not so easy, and not so cowardly as people

generally realise. It takes a great deal of courage and extreme distress to overcome the instinct of self-preservation. The conversation really helped her, as apart from anything else her anger and confusion were really painful for her. We really need to have these conversations for the good of our society, with those who demonstrate such anger and confusion.

- The contribution of the range of public services to suicide prevention, and mental health services in particular.

The first and most important task is to stop public services and the mental health service in particular, from *causing* suicide and self harm. This is only possible with investigations following suicide and self-harm, and particularly following suicide attempts, working with the individual to evaluate service contributions.

We then need a specific service for suicide and self-harm prevention which has no eligibility criteria, apart from the presenting individual feeling so distressed that self-harm and suicide become an option for the individual seeking help. This needs to be available through non-stigmatising environments, not labelled as mental health services, such as GP practices, or well-being projects, and it needs to include an option for space and time away from the situation, to give people the space and protection they need to first face, and then work through their difficulties, based on an essential basis of providing hope of change. There is absolutely no point in taking someone out of an unbearable situation and providing hope only to return them to it with the situation unchanged. (eg returning to an abusive relationship, to homelessness, to unemployment, to isolation, to financial distress, etc).

The Samaritans provides a service beyond compare, and yet is not publicly funded.

It is far better and more appropriate than CALL helpline, which is frankly dangerous when used in a crisis. The CALL helpline is a risk in suicide and must be removed from automatic inclusion in care plans as part of a crisis plan. In my experience their time limit on calls can mean putting the phone down on very high risk individuals which can be enough to precipitate an attempt. Their call handlers can be harsh and judgemental in a crisis. They are very good at giving information, but may be eclipsed by local information lines developed under the Social Care and Well-being Act even in this role.

The Health Boards all need to have a suicide and self-harm prevention strategy with full health board sign off as part of the IMTPs, based on a primary care response, an A&E response, and a response for services dealing with people with life-changing long term health disability, life limiting and terminal illnesses, in addition to a mental health service response. This needs to be developed in co-production with survivors of suicide and those bereaved by it, as well as self-harmers, and to be the direct responsibility of one of the Health Board's executive team. The strategy needs to include making intentions to, or actual self harm, and attempted suicide notifiable, so that we have better records to inform all policy and monitor progress, and a requirement for investigation of all suicide attempts and self harm incidents presented for medical treatment to identify the social causes, any mental health issues, and any impact, positive or negative, from anybody, be they members of the public, employers of the person, people with authority over the person, or public service staff. This is required to build up an evidence base and better understanding of the causes and contributors to these actions, to identify good and bad practice to underpin training programmes. It also needs to include the introduction of mandatory suicide and self-harm prevention training to all front line staff in primary care, emergency care, care for disabling, life limiting and terminal conditions, and for all mental health staff, with equal status to CPR training. All training must be subject to continuous improvement processes and evaluation through service outcomes, in order to establish an evidence base of training that makes the most difference. Strategies need to ensure no one falls through the net, that all are treated with compassion, dignity and respect within a non-judgemental framework, and that all staff have sufficient support and supervision to deal with any negative feelings they have, such as feeling helpless about people's mental distress, or feeling angry about the situation.

It is also critical that NHS complaints processes are made safer for people complaining to assure complete confidentiality so that a complaint against one member of staff will not affect care provided by others, that it will not affect diagnosis, and that services cannot be withdrawn on the basis of relationship breakdown following a complaint, without absolute proof that the complaint was motivated only by fraud or criminal and unprovoked intention to harm the person complained about. It is essential that no one loses a service as a result of a complaint, without being provided with an accessible and appropriate alternative. Complaints that relate to service or staff impact on suicide and self-harm are particularly sensitive and require extensive support for all those involved. It will be very hard for staff to be told that their actions, or

inactions have precipitated self-harm or suicide attempts, or indeed led to suicides, but it is essential to recognise failures in order to learn from them. Staff teams should be supported and helped to change their practice and not be in any way punished unless they 1) refuse to accept responsibility and apologise to the client and/or their family, 2) refuse to change their attitude, practice or approach in the light of findings, or 3) can be shown without doubt to have acted with the *intention* of causing harm to the patient, including intention to precipitate a suicide.

The strategy needs to include a mental health element which addresses the quality of Personality Disorder and Autism screening and diagnosis, the involvement of families and social networks in mental health diagnosis, legal rights of access to a second opinion for any diagnosis of exclusion, like Personality Disorder, the differentiation of suicide attempts motivated by voices and those motivated by psychology, and mandatory training for all mental health staff in suicide and self-harm prevention, with compassion, dignity and respect in a non-judgemental approach.

There needs to be additional support for the social circle of people suffering intentions to self-harm or feeling suicidal. The social circle will be dealing with the same feelings of anger, helplessness and frustration as health staff, and need equivalent support, as well as support to better understand the drivers for these actions in their loved ones, and in how they can help. It may be cost effective and helpful for support and training to be delivered to relevant staff and social circles together, when someone with these difficulties presents to services, as this will be the point when training and support will have the greatest impact. It is critical to promote honest and open, respectful, compassionate and accepting conversations between people struggling with self-harm and suicidal compulsions, and staff, as well as close social contacts in order to address the taboo of not talking at the most critical time, and to break down the judgemental attitudes to these behaviours.

Local Authorities and social services have influence over many of the social determinants of suicide, self harm and mental health. Particular emphasis needs to be given to critical issues such as social inclusion, overcoming isolation, supporting access to services, safe-guarding, employment support, suitable housing, access to leisure services, access to life long education, promoting dignity and respect, a human rights based approach to services, and promoting social acceptance of people who self-harm or struggle with suicidal compulsions.

Local authorities in partnership with the police need to do more about domestic abuse, bullying in schools, colleges, Universities and work-places, and bullying between users of social housing.

The police and Victim Support need to put more focus on the prevention of violent crime, sexual exploitation, modern slavery and harassment, and provide more support not just to the direct victims of crime, but also to the indirect victims, such as those facing allegations, but proven innocent before being charged, and anybody taken in by criminals pretence of being good people, such as friends and family who may feel extremely distressed and betrayed by criminals. These people do not currently get any support, but may be devastated by the situation.

The fire brigade need to be including suicide risk in their assessments of fire safety in people's homes, as fire is a method used for suicide that also puts others at risk including fire service staff. They need to also be able to present a strategy and actions to support their staff to prevent staff suicides, and in this show how they are collaborating with LHB footprint suicide prevention partnerships. Where a fire is used for suicide, they need to have an effective support policy for their staff to help them to deal with this. Our local fire brigade has abdicated responsibility for involvement in the Talk to me 2 strategy because they feel the actions are not their responsibility despite recognising their staff are priority people in the strategy.

The partners within the crisis concordat need to be represented on Health Board footprint partnerships to prevent self-harm and suicide. They have a very critical role to play and need to be up to speed with what all the partners are doing, and to ensure all the partners know what they are doing. As with health board emergency front line staff, all frontline officers and support staff need to have training in self-harm and suicide prevention based on compassion, respect, dignity, acceptance and hope for change within a non-judgemental framework, and have access to support to deal with the emotional repercussions of this kind of work. This work also needs to cover the risks to people 'in contact with' the criminal justice system.

It is critical to change the attitude to 'frequent users' of 999 and emergency services. They are demonstrating an inadequacy of services, rather than being inadequate themselves. There needs to be a more compassionate term used for them, such as 'indicator patients' or 'unmet need patients', or 'currently unserved patients'. Until there is a service for everyone in a self-harm or suicidal crisis most of these

people have nowhere else to go. It is also critical that emergency services, including 999, pre-hospital care and A&E, all accept and embrace the fact that these people are part of their core business and are not a distraction from 'people who really need help for physical injury and life-threatening physical conditions'. Self-harm and suicide attempts are equally life-threatening, or potentially disabling, and deserve the same status and attention as other presentations.

Education establishments need to focus on managing student/pupil workloads, exam stress, and policies to minimise and address bullying, or harassment in their communities. Staff need training to recognise the danger signs for self-harm and suicide, and to have first aid level training in how to help people and where to refer them for longer term support.

Local authorities need to also put more into addressing poverty and supporting people at risk of suicide and self-harm as a result of it. It is clear that council tax for instance is a much higher proportion of the value of the home in the lowest band than it is in the highest band. This inequity which disproportionately disadvantages the poorest, needs to be addressed. In addition charges for social care are disproportionately affecting people on below poverty incomes, where their benefits are only just above the threshold, and for people in marriages or civil partnerships who are not in control of the household budget, and whose budget control is below poverty level. We need better funding for and access to benefits advice, support with benefits appeals and debt management advice.

- The contribution of local communities and civil society to suicide prevention.

Enhancing community and individual responses to people who self-harm and are suicidal is particularly challenging. It requires more identification with afflicted people and more understanding of their distress, whilst discouraging anger and judgemental attitudes. Various art forms, which tell representative stories may help to develop this identification with others in extreme distress. It could be dangerous however, to have survivors tell their own stories as they would be at high risk of both traumatisation over what happened and/or of public anger, especially through anonymous channels such as social media. It is also shown that there is a risk to showing the means,

It also requires education which improves understanding of mental distress and the causes and drivers of suicide and self-harm. Most of all it requires the right support at the right time by the right people within communities affected by these problems, to help them to understand and reduce their anger, and to instead show how a more accepting attitude can help people, and how talking about it in a measured way, can make it easier for people affected to come forward for help. Providing this support will gradually increase the capacity of individuals and communities to be more effective in supporting and helping people who struggle with self-harm and suicidal compulsions. Whilst people like me can make an impact it is essential that survivors of suicide are not expected to fulfil this role, as they would need high levels of support and adequate and fair rewards.

Politicians, high profile individuals, and leaders could do more to keep this issue in the spot light and to chase resources to improve responses to it, as well as providing role model positive responses which do not demonise people who self-harm or attempt or commit suicide. They need to keep making this a priority. In addition we need much better adherence by the press to standards of reporting on these things, given the risks of copy cat actions.

- Other relevant Welsh Government strategies and initiatives - for example *Together for Mental Health*, data collection, policies relating to community resilience and safety.

As already stated, self-harm and suicide attempts, and reports of suicidal feelings/compulsions should be made notifiable to maximise the reliability of data. Key staff such as emergency and primary care staff need training in the relevant codings for suicidal feelings/compulsions, suicide attempts and self harm, to improve data collection. We need detailed investigations of every suicide attempt, to include drivers, social issues, health issues, mental health issues, precipitating events, impact of public sector staff, impact of other people's behaviour on the individual, impact of diagnosis, impact of responses to complaints about the mental health service, impact of quality of Care and Treatment planning, including quality of crisis plans, impact of local availability of acute psychiatric beds, or other services such as psychological therapies and occupational therapies, impact or waiting times for access to services and assessments, and of staff shortages, impact of interventions, or lack of interventions, impact of stigma and discrimination, impact of accessibility problems of services to people with protected characteristics, impact of co-morbid problems, impact of

mis-diagnosis, impact of access to, or no access to social care, and crisis teams. It would be extremely helpful to at the very least differentiate between attempts precipitated by psychology and those precipitated by voice hearing/hallucinations.

We need accountability for providing psycho-social assessments for everybody presenting with self-harm and suicidal feelings/compulsions as recommended by the NICE guidance, which may mean creating roles with appropriate training specifically and only for doing this, due to the shortages of professional staff to do it.

It is essential that government policy looks at diagnoses of exclusion, and 'dustbin diagnoses' (ie given casually when the service finds the person 'difficult') , such as Personality Disorder, and the quality of the diagnostic process. It is essential that people have access to a second opinion where they find this diagnosis does not help them to explain their problems, and where they find the treatments offered do not help. It is essential that Personality disorder is only ever used as a diagnosis where evidence based psychological assessments have been carried out with evidence from the individual's family and social circle regarding their history and presentation when not in the company of mental health staff. It is critical that there are facts in the records, in the form of observations which are not value laden, to underpin any diagnosis, and to ensure that they are not applied only when someone complains. For instance for the same behaviour, the observation 'she was silent' is not value laden, the observation 'she refused to talk' is. It is essential that everyone considered for a diagnosis of psychosis or Personality Disorder is first screened for Autism Spectrum, as the conditions are sometimes difficult to distinguish and require completely different treatment, and autism can change the presentation of psychosis, which can be under-diagnosed in autistic individuals who actually have a lower threshold to psychosis than the neuro-typical population.

The policies need to make individual organisations report on their involvement with suicide and self-harm prevention planning and implementation directly to government, in terms of their own contributions to actions and their contributions to partnership working. There needs to be no place to hide from failure to make this a priority and failure to act in collaboration with all other partners.

It is absolutely critical that survivors of self-harm, and suicide attempts have meaningful opportunity to reflect on the quality of their care, and to provide comments anonymously, and for these comments to be used to

improve services. It is similarly necessary for the people around them to do so, including where the individual dies.

There is currently no service to help people deal with the trauma of a near death suicidal experience, which can contribute to future suicide attempts. Having attempted suicide leads to a lower threshold at which suicide becomes an option, and makes future attempts easier, as it seems to reduce the inhibitions to taking your own life. Few appreciate the trauma of failing to commit suicide, of not even being able to get that right, of being alive when you want to be dead. Surviving suicides have been the most distressing experiences of my life, alongside not being believed about my voices and not being able to get help to control them. Living for years, wishing that I had not survived, even if not currently suicidal has also been a terrible experience. The hardest of all has been the feeling that all my suicidal crises and attempts were entirely preventable had I been accurately diagnosed and appropriately treated. And that I have been left with far more serious mental health problems as a result of persistent failure to recognise autism and psychosis, with repeated failure to provide appropriate treatment as a result of being mis-diagnosed with Personality Disorder. I was persistently refused any second opinion, or any answers to my questions or explanations of what behaviour was disordered, and staff utterly and repeatedly refused to meet with and listen to my family's evidence of what I was like growing up, my mental health and personal history, and by behaviour outside of the mental health service. They simply blocked all discussion about diagnosis and rebuked any questions as a lack of willingness to 'listen to professionals' and characterised my distress about diagnosis as a 'long term conflict'. The only observation in my notes given to justify this diagnosis referenced a complaint about the service, which was, but should not have been, placed on my medical records. My experience has been that coming for help has led to disdain, contempt and punitive responses too often. I survived therefore I wasn't really suicidal. I asked for help, therefore I wasn't really suicidal. 'Considering suicide' was seen as irresponsible and cowardly, rather than there being any recognition of me heroically struggling to overcome the compulsion to die, asking for help was manipulative and attention seeking instead of responsible. .Far too few people recognised just how hard I worked to find a reason to live, and to battle with the voices on my own, or just how difficult it was to ask for help when previous responses to my requests for help had been so judgemental and punitive. I really felt that some staff wanted me to die, and even more often that my life simply wasn't worth enough to be saved. The anger from my own family added to all this. This trauma, is something I and my family continue to live

with, even though I finally have a diagnosis which makes sense and helps and a crisis plan that is meaningful, and treatment and support that is making a difference. It remains hard to be confident that were I in the same position again, the response would be any better.

The failure to provide any funding or resources to support the prevention of suicide is shameful. It sends out the very strong message that Welsh Government doesn't care, and feels that people's lives are not worth saving.

It is critical that the new curriculum on health and social care in schools, has a fixed curriculum, which is influenced by people who have survived mental health problems, rather than being left to individual teachers, as there are clear resilience issues and skills, as well as clear needs to address stigma and discrimination and to create more open minded and compassionate attitudes to mental health, and to give pupils more confidence that their mental health should never be a matter of shame or seen as a weakness of character.

- Innovative approaches to suicide prevention.

We need funding for more research into suicide and self-harm, specifically with a survivor perspective. Survivors ask different and more relevant research questions, and create more effective evaluative processes for training and interventions. We need to evaluate staff attitudes to suicide and self-harm to underpin the design of training and to identify those who most need it.

Training must be designed with survivors and people affected by suicide, and they must have a say in how it is delivered. It may be appropriate to involve them in delivering training, but care needs to be taken to ensure that they are not re-traumatised in the process.

Anyone dealing with self-harm and suicide risk needs a lot of support, and enough techniques to help to give them confidence as helpless feelings of staff compound and contribute to negative attitudes.

The way suicide risk is measured needs to be transformed. It needs to be led by the personal experiences of survivors, and be personal rather than demographic. It doesn't matter what the drivers or risk factors are, if the person sees the situation as unbearable, inescapable, and help as unattainable they are at high risk.

There are many, many things people can do to help others bear their pain, to bring hope of change, and to provide help or facilitate access to it. People ask for help not because they don't want to die, but because they don't want to 'want to die'. People need to be rewarded for the responsibility shown by asking for help. They need compassion and hope that makes it possible to ask for help again if they need to. People need to be asked what is unbearable and inescapable and what help they don't think they will get. Sometimes these situations are remarkably easy to resolve once they are revealed. Sometimes they are more long term and harder and support is needed for much longer. However I have yet to meet a situation where nothing could be done.

It is unacceptable to claim that the cost of effective prevention is too great, and also unrealistic, as the costs of suicide to society far outweigh what it would cost to prevent it.

S 21

Inquiry into Suicide Prevention

Ymchwiliad i Atal Hunanladdiad

Ymateb gan Jane Treharne-Davies

Response from Jane Treharne-Davies

Extent of the problem (numbers, trends and patterns) in Wales may not be well known by those not involved in MH services generally. Those involved (either as SU, carer or service provider) probably do have more awareness of these factors.

Vulnerability of particular groups (e.g. those who have been in care) and risk factors do not seem to be well understood by some service providers (e.g. people discharged from A&E when in distressed state – though this may be lack of resources rather than lack of understanding).

The impact of changes in the benefit system and effect that is having on people's mental health does not seem to be fully appreciated by either government nor service providers - Universal credit is resulting in people being without any money for rent and/or food - leading to states of absolute desperation and hopelessness.

The social impact of suicide can be massive – specifically on those left behind – there are often feelings of guilt and despair that they were unable to help. There seems to be a lack of emotional support for friends of those who have committed suicide (there seems to be more help for relatives but what is the waiting time to access this support?)

Has the impact of the Talk to me strategy been evaluated yet? What are the findings? Is there a reduction in incidence or change in the pattern? I don't know, so I assume many other people also don't know. Where are these findings (if there are any) being published?

How effective are public awareness campaigns? Personally, I haven't noticed any increased awareness campaigning? Reducing access to the means of suicide might just make people change their means (i.e. increased cases of hanging)?

It seems likely that better support for people to maintain good mental health (rather than preventing suicide when things get overwhelming) would be more effective - e.g. better advertising of help available; a better benefits system that does not leave people without money and desperate; more help with housing; better access to health services and social services.

Difficult for current mental health services (and other public services) to be effective when they are faced with relative cuts in their budgets.

More specific training needed for managers in work places to recognise suicide risk factors and know when, and how, to intervene. There seems to be more training and awareness for mental health problems generally but not suicide specifically (I have asked a couple of civil service managers). Also, better training needed for support workers in supported housing to recognise risk factors etc.

Local communities perhaps could be more aware of the problem of suicide and what to look out for with their neighbours - particularly those people who do not have family or friends. Perhaps we need more openness and acknowledgement that isolation and loneliness can affect people of any age. Maybe more drop in centres where people can come without appointments just for a cup of tea, a chat and helpful information would go some way to prevent deterioration in a person's mental health.

Data collection is vital to know if any strategy is effective. Also, very important to act on data findings and provide services that make a difference. This needs to be more than just counting numbers, need to ask people what has made a difference to them (need more qualitative data).

S 22

Inquiry into Suicide Prevention

Ymchwiliad i Atal Hunanladdiad

Ymateb gan Bwrdd Iechyd Prifysgol Aneurin Bevan

Response from Aneurin Bevan University Health Board

Aneurin Bevan University Health Board Response

Health, Social Care and Sport Committee
Consultation on Suicide Prevention

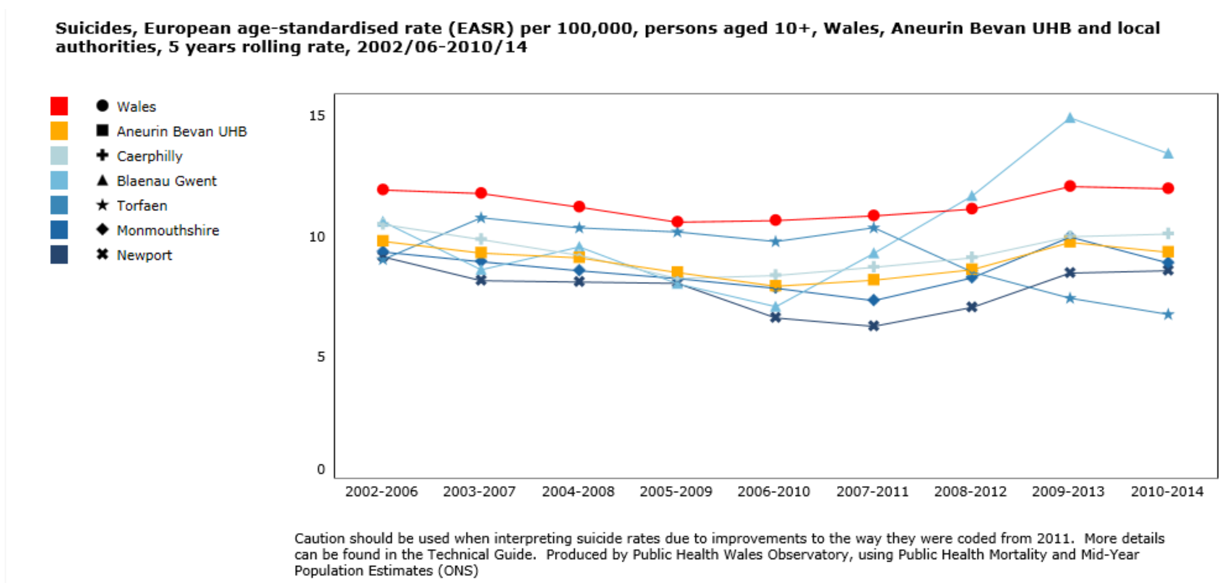
We have provided comments on the consultation topics below, from an Aneurin Bevan University Health Board perspective where there is relevant information, expert opinion or evidence available.

1. The extent of the problem of suicide in Wales and evidence for its causes - including numbers of people dying by suicide, trends and patterns in the incidence of suicide; vulnerability of particular groups; risk factors influencing suicidal behaviour.
2. The social and economic impact of suicide.
3. The effectiveness of the Welsh Government's approach to suicide prevention - including the suicide prevention strategy Talk to me 2 and its impact at the local, regional and national levels; the effectiveness of multi-agency approaches to suicide prevention; public awareness campaigns; reducing access to the means of suicide.
4. The contribution of the range of public services to suicide prevention, and mental health services in particular.
5. The contribution of local communities and civil society to suicide prevention.
6. Other relevant Welsh Government strategies and initiatives - for example Together for Mental Health, data collection, policies relating to community resilience and safety.
7. Innovative approaches to suicide prevention.

1. The extent of the problem of suicide

The Public Health Wales Observatory provides epidemiological data for suicide for the Aneurin Bevan University Health Board (ABUHB) area. Between 2002 and 2014, the suicide rate in Wales and the ABUHB area overall, has remained fairly stable (see Figure 1). There is more fluctuation in rates at a Local Authority level, due in part to the relatively small numbers involved. There is a need to exercise caution in the interpretation of suicide registration data, particularly on a small area basis and over shorter timeframes, because of the small numbers, delays in registration and recording differences can produce unreliable rates. The limitations of the data presents challenges for planning suicide prevention and responding to community needs.

Figure 1 – Trends in suicide rates in Wales, Aneurin Bevan University Health Board and local authorities, 2002/06 – 2010/14.



Overall in the ABUHB area there were 234 suicides registered in the period 2010-2014. Figure 2 compares the suicide rates for 2010-2014 across Wales, and indicates that none of the Gwent local authorities have significantly higher rates than the Wales average.

Figure 2 – Comparison of suicide rates across Wales, 2010-2014

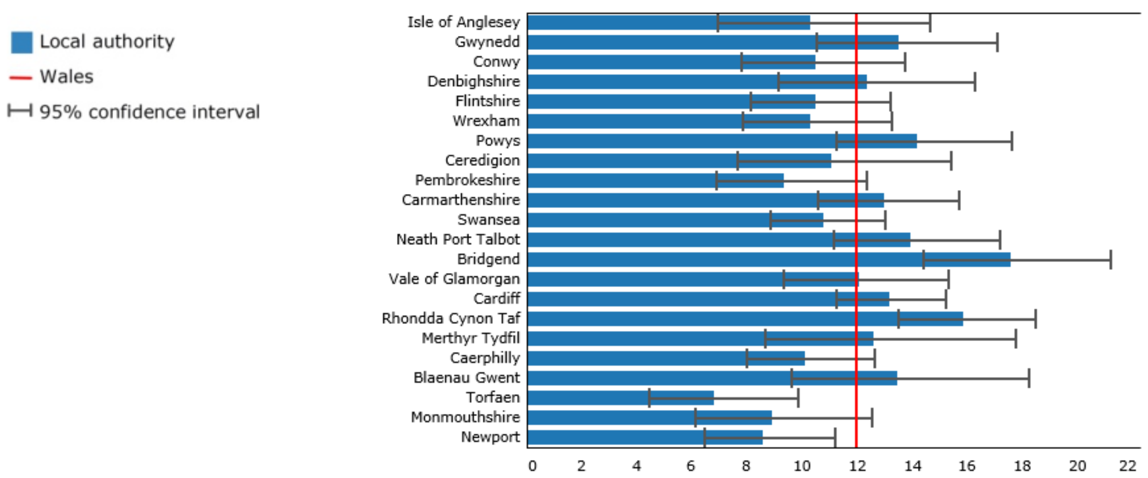
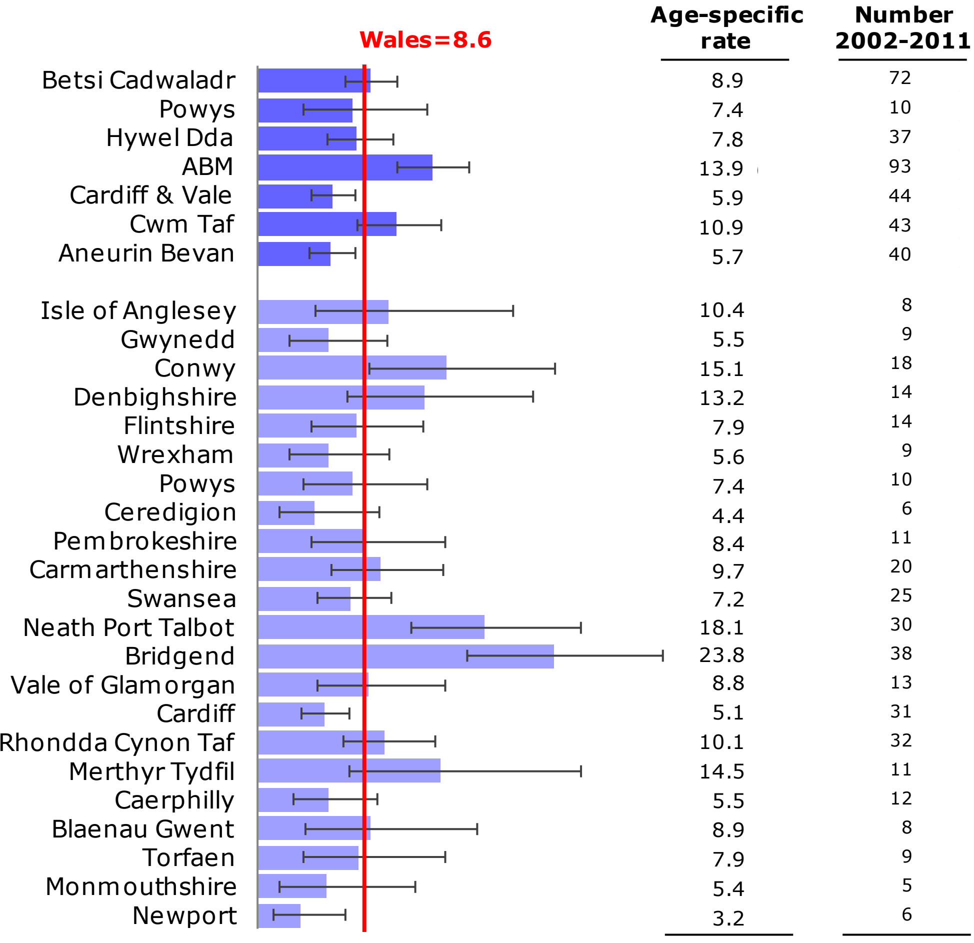


Figure 3 – Comparison of Suicide Mortality, persons aged 15 to 24, 2002-2011 (Public Health Wales, 2013)



Area	Age-specific rate	Number 2002-2011
Betsi Cadwaladr	8.9	72
Powys	7.4	10
Hywel Dda	7.8	37
ABM	13.9	93
Cardiff & Vale	5.9	44
Cwm Taf	10.9	43
Aneurin Bevan	5.7	40
Isle of Anglesey	10.4	8
Gwynedd	5.5	9
Conwy	15.1	18
Denbighshire	13.2	14
Flintshire	7.9	14
Wrexham	5.6	9
Powys	7.4	10
Ceredigion	4.4	6
Pembrokeshire	8.4	11
Carmarthenshire	9.7	20
Swansea	7.2	25
Neath Port Talbot	18.1	30
Bridgend	23.8	38
Vale of Glamorgan	8.8	13
Cardiff	5.1	31
Rhondda Cynon Taf	10.1	32
Merthyr Tydfil	14.5	11
Caerphilly	5.5	12
Blaenau Gwent	8.9	8
Torfaen	7.9	9
Monmouthshire	5.4	5
Newport	3.2	6

Figure 3 compares the suicide rates of young people aged 15-24 for 2002-2011 across Wales. The average age specific rate for Gwent is 5.7 which is significantly lower than the Wales average of 8.6. None of the Gwent local authorities have significantly higher rates than the Wales average.

Vulnerability of particular groups

There is no local evidence available for the suicide risk in specific groups. ABUHB are focussing on priority groups as outlined in the National guidance (in line with the Talk to Me 2 Strategy). These are:

Priority People	**Priority Places**	**Priority Care Providers**
Men in mid life Older people over 65 with depression and co-morbid physical illness Adult Prisoners Children and young people with a background of vulnerability People in the care of mental health services including inpatients People with a history of self harm	Hospitals Prisons Police custody suites Workplaces Schools, Further and Higher Education establishments Primary care facilities Emergency departments Rural areas Deprived areas	People who are first point of contact or first responders, including: Police Fire fighters Welsh Ambulance staff Primary care staff Emergency department staff

The priority groups, particularly those from the most deprived areas, should be explicitly targeted based on the intelligence we have. However other at-risk groups will also benefit from universal interventions to improve mental health and support protective factors, reduce stigma and increase help seeking behaviour.

Interventions to reduce suicide in children and young people should tackle the specific issues identified in the Child Death Review 2006-12 (Public Health Wales, 2014) including:

- Bullying (mostly school related)
- Misuse of drugs and alcohol
- Physical, emotional and sexual abuse
- Self-harm
- Deprivation
- Social connections

Risk factors

Socio economic influences such as poverty (of opportunity as well as financial) and social cohesion play important roles in mental wellbeing. Addressing these psychosocial risk factors requires a wider approach from across society. Essential to prevention is raising children in a society that promotes and facilitates positive early attachments, and prevents and mitigates the effects of Adverse Childhood Experiences.

An education system that builds skills, confidence and resilience is key. Bullying, particularly cyber bullying and the access to web sites that support and promotes suicidal behaviour, also needs to be addressed.

Anecdotal evidence from GPs, as expressed by the Primary Care Cluster Lead for Mental Health, suggest an increase children expressing suicidal thoughts and ideation and rising rates of self-harm as a way of managing distress, particularly in young adults. In children's services some practitioners feel unskilled and unsupported to deal with mental health issues leading to an over-reliance on mental health services. Improved undergraduate and postgraduate training for children services on mental health and wider wellbeing issues are therefore essential.

A society wide understanding of resilience would be beneficial. A life free of adversity is not possible, however, understanding that resilience is often developed by being supported to successfully overcome small adversities, is key. Early year's attachment and exploration of risk through play are the important building blocks of resilience.

2. The social and economic impact of suicide

While there is no hard, local evidence on the social and economic impact of suicide to report, the ripple effect that suicide has on a community is recognised and cannot be underestimated. There are specific financial costs to public services arising from the acute response, legal process and support services for families, colleagues and schools. There are other economic impacts to businesses, for example, when major transport routes are closed.

3. The effectiveness of the Welsh Government's approach

The Government's approach has been welcomed, in particular the supporting evidence base and work on bridge design and media reporting. It's unclear from a Health Board perspective whether there will be additional resources at national level, or whether this will be reliant on the enthusiasm and expertise that can be drawn from local areas.

4. The contribution of the range of public services

The Local Public Health Team are members of the South East Wales **Regional** Suicide Prevention Forum with representatives from Cardiff and Vale and Cwm Taf University Health Boards who are leading suicide prevention work in these areas. The group are able to share information

and engage national and regional-level agencies such as Network Rail and South Wales Fire & Rescue Service.

Representatives of the Regional Suicide Prevention Forum attend the **National** Advisory Group on Suicide and Self-harm (NAG), in order to inform national action and policy. Locally, we see the NAG as playing an important role in providing specialist advice, guidance and 'once for Wales' resources to support local action. For example, it has been successful in training and lobbying Welsh media outlets to improve reporting of suicide, and has co-ordinated production of 'Help is at Hand'. Both these interventions would have been difficult to do effectively at a local level.

However, we recognise that a lack of resources to complete work centrally sometimes limits the capacity of the NAG to progress planned pieces of work, and this has hindered the progress of the local action plan. For example, there was a delay in the production of local planning guidance as well as a national dedicated website which would allow timely access to information and resources (e.g. an up-to-date list of quality assured training courses to support the national training framework). We note that in other nations these pieces of work are either commisioned separately or a funded post supports work undertaken nationally.

The recently issued local suicide prevention planning guidance advocates for more detailed analysis of suicide data to build a picture of groups most at risk and enable effective local suicide prevention work. Due to issues associated with access to data and interpretation of small numbers locally, we consider that real-time suicide surveillance and building of a suicide prevention database is best co-ordinated at a national level. Co-ordination of data collection nationally will improve the quality of the evidence and ensure most efficient use of resources as the numerous organisations could potentially be involved in collating and providing data.

At **local level** effective implementation of Talk to Me 2 is dependent on a multi-agency partnership. Aneurin Bevan Gwent Public Health Team have been leading on the implementation of a local response to Talk to Me 2, alongside partners. The Gwent action plan is implemented by a multi-agency Suicide and Self-Harm prevention Group, accountable to the Gwent Mental Health & Learning Disabilities Partnership Board. Progress is reported as part of monitoring against the national strategy, Together for Mental Health in Wales.

The Gwent Suicide and Self-harm Prevention group includes representation from ABUHB (Mental Health & Learning Disabilities Division, Unscheduled Care Division, Primary Care and Community Division), Gwent Police, South Wales Fire & Rescue Service, Welsh Ambulance Service, Communities First, Samaritans, Mind, Social Services, National Offender Management Service, Prison Healthcare Team and Community Health Council.

Local progress since 2015 includes:

Promoting Mental Well-being and Resilience

There are a range of universal actions being developed to improve mental well-being in the ABUHB area, which are an essential foundation for preventing suicide and self-harm, including:

- Integrated well-being networks developing on an NCN footprint. Work is on-going to strengthen the network that exists to ensure Foundation tier services form an integral part of a holistic approach to community well-being, reducing silo working.
- Mental well-being 'Foundation Tier' provision has been developed by the Primary Care Mental Health Support Service (PCMHSS) through the Road to Well-being programme www.wales.nhs.uk/roadtowellbeing
- A new multi-agency model for Children and Families PCMHSS is being piloted in Newport with plans to roll out across Gwent
- Four of the 12 NCNs have prioritised the National Clinical Priority - Early Intervention CAMHS (Newport North, Newport East, Caerphilly South and Blaenau Gwent West)

Interim Gwent Suicide Prevention Action Plan

Specific suicide prevention actions undertaken 2015-2017 include:

- A Gwent Mental Health Crisis Care Concordat Delivery Plan is in place, and a programme has been initiated to develop a 'Whole Person, Whole System Mental Health Crisis Support Model' to provide a timely, person-centred, effective and efficient 24/7 response for those in crisis and their carers across the whole care system in Gwent. Elements already in place include Approved Mental Health Professionals in the Police Control Room and a protocol for appropriate conveyance of people in mental health crisis.
- Mental Health & Learning Disabilities Divisional Plan includes action on suicide prevention among mental health service users including anti-ligature measures
- Suicide prevention training (ASIST and Safetalk) provided for South Wales Fire & Rescue Service personnel who respond frequently to suicide-related incidents. Training delivered to 120 staff across Gwent, to ensure at least one person on each shift is trained. Adapted training has been delivered to Gwent Police personnel.
- When the national training framework is published, there are plans to identify organisational leads to ensure relevant suicide training is provided to front line professionals and review through an annual audit.
- 'Help is at Hand' guide for people bereaved by suicide promoted locally
- South Wales Fire and Rescue Service have identified places where they are frequently called to suicide-related incidents across the region, including several bridges in the Newport area. They are

working with the Samaritans and Newport Local Authority to affix signage to bridges in Newport, and will continue to work with partners to make identified sites and new structural developments safer.

5. The contribution of local communities and civil society

The Health Board organised a two day workshop on assets based community development lead by Cormac Russell, Managing Director of Nurture, who is an internationally renowned expert on Asset Based Community Development.

6. Other relevant Welsh Government strategies and initiatives

ABHUB consider that other Welsh Government strategies and initiatives such as the Well-being of Future Generations (WBFG) Act, Prosperity for All, Social Services and Well-being (Wales) Act, Together for Mental Health, Together for Children and Young People, Adverse Childhood Experiences should impact on suicide and self-harm prevention. The contribution that each programme of work makes to the suicide and self-harm prevention needs to be acknowledged and linked together.

The proposed education reforms and promotion of community prosperity across age ranges supported by the WBFG Act and Social Care and Well-being Act have the potential to make a positive impact on mental well-being. However, changes to social benefits (universal credit and changing to PIP) may had a negative impact on mental health and wellbeing and personal resilience causing pressures in primary care as a result.

7. Innovative approaches to suicide prevention.

A research project led Swansea University is being conducted into reduction of suicide in the general population via the use of Structured Professional Judgement in Accident and Emergency Departments.

There are innovative approaches to suicide prevention in Torfaen and Newport high schools around the early identification of psychosis and on-line school counselling.

Summary

The strategy Talk to Me 2 and national guidance has been welcomed and supported locally. Despite a lack of local surveillance data and lack of dedicated resources to support the actions, a local interim action plan was produced, following publication of Talk to Me 2. Progress of the interim plan has been reviewed with partners, against the recent Welsh Government guidance, and actions agreed for the coming years. This plan will be presented to the Mental Health and Learning Disabilities Partnership in January 2018 and submitted to Welsh Government in February 2018.

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	The Welsh NHS Confederation response to the Health, Social Care and Sport Committee's inquiry into suicide prevention in Wales.
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Date created:	15th December 2017

Introduction

1. The Welsh NHS Confederation welcomes this opportunity to respond to the Health, Social Care and Sport Committee's inquiry into suicide prevention in Wales. Our response addresses the key points raised by our members during the inquiry process.

2. The Welsh NHS Confederation represents the seven Local Health Boards and three NHS Trusts in Wales. We support our members to improve health and well-being by working with them to deliver high standards of care for patients and best value for taxpayers' money. We act as a driving force for positive change through strong representation and our policy, influencing and engagement work.

Overview

3. Between 300 and 350 people in Wales die from suicide each year. It is a major cause of death among adults across Wales, particularly in the 15-44 age group. In Wales and across the UK, about three-quarters of people who die by suicide are men. The most recent statistics on suicide[i] (published 7th September 2017) show an improvement in Wales of the age-standardised suicide rate for males and females from 13.0 in 2015 to 11.8 per 100,000 people in 2016. The Welsh Government's suicide and self-harm prevention strategy - Talk to Me 2 - was launched in July 2015 and identifies suicide as a 'major public health challenge'.

4. Mental health services have an important role to play in suicide prevention. The Welsh Government's priorities for mental health services in Wales are set out in the Together for Mental Health strategy and the Together for Mental Health Delivery Plan 2016-2019. Mental health service provision is underpinned by the Mental Health (Wales) Measure 2010, which has a preventative ethos. Furthermore, all Local Health Boards have signed up to Time to Change Wales, a national campaign to end the stigma and discrimination faced by people living with mental health conditions.

5. In addition to this response, the Welsh NHS Confederation Policy Forum has submitted a response entitled 'Key Actions to Increase the Effectiveness of Suicide Prevention in Wales', which has been endorsed by twelve health and social care organisations.

a. The extent of the problem of suicide in Wales and evidence for its causes, including numbers of people dying by suicide, trends and patterns in the incidence of suicide, the vulnerability of particular groups, and risk factors influencing suicidal behaviour;

6. Statistics relating to rates of suicide per Local Health Board in Wales are held by Public Health Wales Observatory. However, the nature and extent of suicide ideation and behaviour (that is, thinking about or acting on suicidal thoughts) means that it is often extremely difficult to assess the true number of at-risk people given that only a small number of those at risk of suicide or thinking about suicide will seek support. Studies have revealed how patients avoid services for fear of being detained under the Mental Health Act (1983), as the person's actions may bring them to the attention of the police and to a place of safety[ii]. This suggests that efforts should be geared towards improving access to services and to do so in a supportive and non-discriminatory manner.

7. Evidence received from Local Health Boards reveal no significant differences in the rates of suicide across Wales. Notable progress has been made at Betsi Cadwaladr University Health Board (UHB), which achieved a significant reduction in suicide rates per 100,000 in the five-year period from 2010 to 2014 (the rate was above the Welsh average for the periods 2002-2006 and 2008-2012), and the rate of suicide at Aneurin Bevan UHB has remained consistently below the all-Wales average since 2002. While Local Health Boards do not hold information on the suicide risk of specific groups, there is strong evidence that services across Wales are designed to focus on the priority groups in line with the Talk to Me 2 Strategy. These are defined as middle-aged men; older people over 65 with depression and co-morbid physical illness; adult prisoners; children and young people with a background of vulnerability; people in the care of mental health services including inpatients; and people with a history of self-harm.

8. The Welsh Ambulance Services NHS Trust (WAST) has worked collaboratively to develop alternative ways of working in caring for people who self-harm or have suicidal thoughts. Despite this, significant challenges and variations exist in terms of availability of pathways, support for ambulance staff, clear and consistent approaches for people who present with suicidal thoughts while heavily intoxicated, as well as resources to develop, deliver and maintain new ways of working. Ambulance staff therefore need greater training, education and support to care for, and signpost, vulnerable people to the appropriate services.

9. It is important to emphasise also that there is limited consistency of audit and reporting processes across Wales to assess the impact of interventions. Greater consistency is required to establish the robust evidence base needed to up-scale best practice across Wales.

b. The effectiveness of the Welsh Government's approach to suicide prevention - *Talk to me 2*, the effectiveness of multi-agency approaches to suicide prevention, public awareness campaigns and reducing access to the means of suicide;

10. Health Boards have implemented a number of mechanisms in partnership with agencies to reduce the impact of social and economic factors and emotional disorders on a local level.

11. Cwm Taf UHB, for example, have established a Crisis Resolution Home Treatment (CRHT) service which is open to self-referrals to ensure timely access for people who may be experiencing suicidal thoughts. The crisis practitioners also provide an assessment service at Emergency Department (ED) units for patients who present following self-harm and offer follow up and signposting as appropriate for the most vulnerable patient groups, as well as an Outreach and Recovery Community Service, which is operational seven days a week, to provide care and treatment for those with complex needs and communication difficulties. The Health Board also conducts meetings between CRHT staff and ED staff to review patients who may have multiple presentations to ED in crisis states to review their overall care plan and seek ways of achieving greater stability and support.

12. Local Public Health Teams at Cwm Taf UHB, Aneurin Bevan UHB and Cardiff and Vale UHB, are also members of the South-East Wales Regional Suicide Prevention Forum, which shares information and engages national and regional-level agencies such as Network Rail and South Wales Fire & Rescue Service to address some of the key challenges around suicidal ideation.

13. Representatives of the Forum attend the National Advisory Group on Suicide and Self-harm (NAG), which seeks to inform national action and policy. On a local level, the NAG plays an important role in providing specialist advice, guidance and 'once for Wales' resources to support local action. An example of a recent success has been in training and influencing Welsh media outlets to improve reporting of suicide, and co-ordinating the production of 'Help is at Hand' – a Public Health Wales NHS Trust-led resource for bereaved families.

14. However, a lack of resources sometimes limits the capacity of the NAG to progress planned work areas, and this has hindered the progress of the local action plan and a national dedicated website which would allow timely access to information and resources (e.g. an up-to-date list of quality-assured training courses to support the national training framework).

15. Effective implementation of Talk to Me 2 at a local level is dependent on a multi-agency partnership. In South Wales, the Aneurin Bevan UHB Gwent Public Health Team have been leading on implementation of a local response to Talk to Me 2, alongside partners. The Gwent action plan is implemented by a multi-agency Suicide and Self-Harm Prevention Group, accountable to the Gwent Mental Health & Learning Disabilities Partnership Board. The group includes representation directly from the Local Health Board (via Mental Health & Learning Disabilities Division, Unscheduled Care Division, Primary Care and Community Division), Gwent Police, South Wales Fire & Rescue Service, the Welsh Ambulance Service, Communities First, Samaritans, Mind, Social Services, the National Offender Management Service, the Prison Healthcare Team and the Community Health Council.

16. In North Wales, the Suicide and Self-Harm Prevention Group has an active multi-sector and multi-disciplinary membership who also work collaboratively towards designing and implementing measures designed to reduce incidents of suicide and suicide ideations. The group recently led a number of public awareness campaigns in collaboration with Betsi Cadwaladr UHB, working with the Head of Communications on a campaign targeted at educating the public about the Netflix series '13 Reasons Why'. In July 2017, the Health Board published a one-minute YouTube clip that featured '13 Reasons Why' and explored how concerned adults should safely respond in cases where they feel their children may be showing signs of suicidal ideation, and how young people can access support services. The video and related information was shared on the Health Board website, a Community Advice and Listening Line (CALL) Facebook page, their respective Twitter feeds and was featured in major North Wales news outlets including Wales Online and The Daily Post. The articles also included public awareness messages around suicide prevention and included a link to an online resource written for people in distress.

17. The North Wales Suicide and Self-harm prevention group has also worked to reduce access to the means of suicide, particularly the Menai Bridge. Fourteen Samaritans signs have been erected on the bridge, as well as work to install four phones connected directly to Samaritans helplines on both sides of the carriageway and at each end of the bridge. There have also been early discussions around the installation of thermal imaging cameras which will send an alert to police control centres if someone lingers for too long, especially at dusk/dark. A feasibility study is underway regarding the installation of higher barriers on the bridge. There have also been discussions with the operators of the Pontcysyllte Aqueduct, another high frequency location for suicide in North Wales.

18. Betsi Cadwaladr UHB recently ran a successful suicide awareness and suicide response training day for 100 cross-sector, multi-disciplinary professionals. The training programme supports the development of a common language and approach, promoting a consistent assessment and documentation of the process, and a more integrated response across statutory services, third sector providers and communities. The training included a suite of clinical frameworks, some of which have been adapted for non-mental health settings, including primary care, third sector, education, and the police.

19. In developing the North Wales Suicide and Self-harm Prevention strategic plan, the Health Board also worked closely with Caniad - the combined voice for mental health and substance misuse involvement in North Wales. The Health Board's Self-Care Team have been delivering emotional resilience training across North Wales to members of the community, patients, carers and staff.

20. Elsewhere in Wales, Bridgend Public Service Board has set up a suicide prevention sub-group which has been tasked to produce a suicide prevention action plan and to set up a data working group. This work is being led by Abertawe Bro Morgannwg UHB, and is chaired by a

senior manager from the Health Board's mental health team. The intention is that the working group will produce a rapid reporting system to ensure faster access to the right services and a clearer, more current picture of the current situation in the Bridgend locality.

c. Other relevant Welsh Government strategies and initiatives and methods of data collection;

21. The recently-issued local suicide prevention planning guidance advocates more detailed analysis of suicide data to build a picture of the highest risk groups and enable effective suicide prevention work on a local level. However, due to issues associated with access to data and interpretation of small numbers locally, it is our view that real-time suicide surveillance and building of a suicide prevention database would be most effectively co-ordinated at a national level. Co-ordination of data collection nationally will improve the quality of evidence available and ensure most efficient use of resources given the plurality of organisations that would likely be involved. Staff at Abertawe Bro Morgannwg UHB have established longstanding relationships with Public Health Wales NHS Trust, the third sector, Public Health academia and Local Authority colleagues for sharing information, a practice which has been supported further by the Welsh Mental Health Crisis Care Concordat. The Concordat demonstrates a clear commitment from public sector partners, including all Local Health Boards, all Wales police forces, ADSS Cymru and the Home Office, to work together and to intervene early, if possible, to reduce the likelihood of people presenting a risk of harm to themselves or others because of a mental health condition deteriorating to such a crisis point.

22. Welsh Government strategies and initiatives such as the Well-being of Future Generations (Wales) Act 2015, the Social Services and Well-being (Wales) Act 2014 and Prosperity For All are inextricably linked to suicide and self-harm prevention. However, the contribution that each work programme makes to the suicide and self-harm prevention agenda, and the extent to which these mechanisms are adequately addressing the requirements of the national strategy, is unclear. Data relating to the effectiveness of local suicide prevention measures must be used to produce a more coherent picture of how each element of the national strategy is geared towards achieving its overall objective, namely to increase the effectiveness of suicide prevention in Wales.

d. Innovative approaches to suicide prevention;

23. Various approaches to preventing suicide have been trialled around the world, but given that the majority of people experiencing suicidal thoughts are either unable to, or decide against, accessing their local support services, there is little in the way of reliable data to assess their true effectiveness. One of the best examples however is the Police and Clinical Early Response (PACER) model, which was trialled in Victoria, Australia from 2007 until late 2011.

24. PACER was a joint crisis response from police and mental health clinicians to people experiencing serious mental health conditions – people experiencing suicidal ideations accounted for the largest patient group at 33%. The PACER model centres on a dedicated team comprising a mental health clinician and a local police officer, targeted to times of greatest demand and offering on-site and telephone mental health assistance. PACER differs from usual service provision in that it is a mobile emergency mental health response acting as a secondary police response, informed by 'real-time' police and mental health background information, and attending to the person as quickly as possible at times of crisis.

25. In 2011, the Australian Department of Health evaluated the effectiveness and efficiency of the PACER pilot and found that the intervention provided more timely access to appropriate services; established a more streamlined approach to emergency responses thanks to the collaborative work of police and ambulance teams; resulted in a reduction in the number of admissions to hospital; reduced the risk of behavioural escalation; and reduced the average length of stay of patients referred to hospital.[iii] The project serves to demonstrate that real improvements in addressing suicide ideation are possible, providing dedicated teams are willing to work collaboratively for the benefit of vulnerable people.

Conclusion

26. The NHS in Wales has welcomed the Welsh Government Strategy Talk to Me 2 and Local Health Boards are adopting a variety of local approaches to increase the effectiveness of suicide prevention measures within their localities. The National Guidance on the Strategy has been supported well at a local level, and while Health Boards recognise the significant challenges associated with obtaining high quality data around the most at-risk groups, there is strong evidence that local action plans, particularly those targeted at improving access to primary care services, are yielding positive results.

27. We will continue to support our members in rolling out their individual plans to address the challenges associated with suicide in their areas, with revised plans of each Local Partnership Board, being submitted to Welsh Government in February 2018.

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[i] Office for National Statistics (2017), https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2016registration#by-country-and-region

[ii] National Collaborating Centre for Mental Health, 'Self-Harm: The Short-Term Physical and Psychological Management and Secondary Prevention of Self-Harm in Primary and Secondary Care' (2004).

[iii] A full evaluation of the study was undertaken by the Allen Consulting Group, available here: http://www.acilallen.com.au/cms_files/acgpacerevaluation2012.pdf.

December 2017

Key actions to increase the effectiveness of suicide prevention in Wales

Health and social care organisations have come together through the Welsh NHS Confederation Policy Forum to outline the key areas that the Health, Social Care and Sport Committee should consider when undertaking their consultation on Suicide Prevention.

Suicidal behaviours can be conceptualized as a complex process that can range from suicidal ideation, which can be communicated through verbal or non-verbal means, to planning of suicide, attempted suicide, and in the worst case, completed suicide.

Dying by suicide remains one of the leading causes of death in Wales. It is the biggest killer of men under 50, the leading cause of death for people aged under 35 and one in four deaths which are from external causes among those aged 12-17 are likely to have been through suicide. In 2016, there were 322 suicides in Wales. However, there is much we can do to prevent suicide. Suicide is everybody's business and is not a single task for any particular organisation. The breadth of complex factors involved in suicide risk highlights the need for cross-governmental, cross-sectoral and collaborative action.

The following actions should be considered by the Committee to increase the effectiveness of suicide prevention:

1. Local implementation of Talk to Me 2: An effective suicide prevention strategy at both a local and national level is crucial. Whilst Talk to Me 2 has placed an increased focus on suicide and self-harm in Wales, many of the top-level objectives are reliant on effective local partnership working through the creation of local suicide prevention plans and attendance of Regional Multi Agency Fora. All regions (Mid and West Wales; Cardiff and Vale and Cwm Taf; South East Wales; North Wales) have established multi agency suicide prevention forums which have agreed local reporting structures, which report to the National Advisory Group. It is vital that every Local Authority area in Wales works to a local and national plan because without one, suicide prevention work is much less effective than it could be. It is also positive to note that mental health is a cross cutting theme and a priority area under the Welsh Government's Programme for Government, "Prosperity For All".

2. Early intervention and prevention: Suicide is a major public health issue and as such, suicide prevention requires action by many different stakeholders. Suicidal behaviour is related to many variable and complex risk factors so it is vital that we invest in early intervention and support so we can reduce the risks that might lead to suicidal behaviour. Suicide prevention should not be addressed in isolation, but should be part of a national public health and well-being policy to promote and support a positive approach to mental health.

3. Encouraging people to seek help early and providing support: It is key that practical support is provided to people who have suicidal ideation and appropriate response is provided to people in distress. More should be done to encourage people to seek help early and there needs to be greater awareness of what support is available. Third sector organisations in Wales have the impression that they are seeing more people who are expressing suicidal ideation and we need more learning and sharing about best practice in response. In particular there must be an increased focus on providing support to the 'priority places' which have been identified in Talk to Me 2 (hospitals, workplaces, police custody suites etc) and training for 'gatekeepers' in settings such as schools to support children and young people.

4. The need for a national conversation and ending stigma: Stigma related to suicide remains a major obstacle to suicide prevention efforts. Those who have lost someone to suicide, as well as those who have a history of suicide attempts, often face considerable stigma within their communities. Stigma may prevent people from seeking help and can become a barrier to accessing suicide prevention services, including counselling and postvention support. While efforts to reduce the stigma of suicidal behaviours can benefit from being incorporated into the more general process of de-stigmatizing mental illness, typically, additional efforts to reduce stigma attached to suicidal behaviours are required. Promoting greater public awareness of positive mental health and well-being, suicidal behaviour, potential problems and risks amongst all age group is important. There is a need for a national conversation to challenge stigma and ensure that the public have the skills to talk and listen to support people who are in distress. It is vital that we increase awareness that talking about suicide does not increase the risk but reduces it.

5. Raising awareness of the risk factors and the support available: Risk factors for suicide include mental and physical illness, alcohol or drug abuse, chronic illness, acute emotional distress, loneliness and isolation, socio-economic deprivation, violence, a sudden and major change in an individual's life, such as loss of employment, separation from a partner, or other adverse events, or, in many cases, a combination of these factors. Bullying, abuse and self-harm have also been identified as risk factors in children and young people. The public requires an understanding of the issue and the vital need for an intervention. Through raising public awareness and building the skills and capacity within communities to recognise suicide risk, and improve knowledge of what works to prevent suicide, is important.

6. Reduce the risk of suicide in key high-risk groups: Although different areas will have different priorities, some groups of people are known to be at higher risk of suicide than the general population. These groups include; young and middle-aged men (the highest rate aged 35-54); people in the care of mental health services, including inpatients; Gypsy, Roma and Traveller community; asylum seekers and refugees; people living in areas of socio-economic deprivation; people with a history of self-harm; people in contact with the criminal justice system, including prisoners; specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers; and lesbian, gay, bisexual, transgender and questioning (LGBTQ). It is important that the public and voluntary sector are joined up to respond to particular issues, for example; recession –that people know the options for someone at risk of suicide because of economic difficulties, from debt counselling to psychological therapy; self-harm – ensure there are supports for young people in crisis who are at risk of self-harm; men – ensure information about depression and services is available in "male" settings. There should also be more targeting of high risk groups while maintaining an overall population approach.

7. Suicide prevention training: Agencies need to know how and why they should access good suicide prevention planning training. There needs to be greater awareness surrounding the benefits of a preventative approach to suicide, including training of this kind. Training should be provided to frontline workers both in the public sector but also key frontline sectors who are more likely to meet vulnerable groups. Increased awareness of specialist training provided by organisations, including Samaritans and Mind, should also be highlighted. Suicide Prevention Training is particularly important for those identified as 'Priority Care Providers' such as Job Centre Staff, Emergency Health Staff and teachers.

8. Provide better information and support to those bereaved or affected by suicide: The response provided to bereavement is key. The impact of suicide on the survivors, such as spouses, parents, children, family, carers, friends, co-workers, and peers who are left behind, is significant, both immediately and in the long-term. Family and friends bereaved by suicide are 1.7 times more likely to attempt suicide themselves. Support needs to be provided and awareness around the signs to be aware of and where to refer people to.

9. Community infrastructure: Improving the mental health of a local community can impact strongly on reducing suicide rates. Loneliness and isolation is a risk factor for suicide whilst socialisation and participation is a protective factor. Therefore, it is important to recognise the impact that participating in meaningful occupations or activities, such as the arts, physical and social activities, including via social-prescribing routes, can have on people's health and well-being. It is important that there are facilities and places for people to go to express themselves and connect with others.

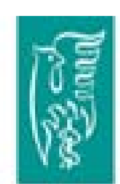
10. Support research, data collection and monitoring: Ascertaining and recording numbers of attempted and completed suicides, and monitoring them, is an integral component in the development of suicide prevention. Local suicide audits are an effective way for public sector bodies to identify and respond to high risk groups in their areas, as well as reveal hot spots. It is best practice for public sector organisations, including Health Boards, Local Authorities and the coroner, to work to develop and undertake a suicide audit. Learning lessons from the response to a suicide to reduce the number of future suicides and better support bereaved families is key.

11. Reducing access to means: There is evidence to suggest that lives can be saved by the use of a variety of measures including: the installation of Samaritans signs; physical barriers; nets and telephone lines at high risk locations for suicide; and improved surveillance, such as CCTV, at possible, or known, high risk locations is crucial. High risk locations could include: bridges, viaducts, high-rise buildings, multi-story car parks, cliffs and level crossings.

This document is endorsed by:

BritishRedCross

Royal College of Occupational Therapists
Coleg Brenhinol y Therapyddion Galwedigaethol



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Cymru

S 24

Inquiry into Suicide Prevention

Ymchwiliad i Atal Hunanladdiad

Ymateb gan Gymdeithas Cwnsela a Seicotherapi Prydain

Response from the British Association for Counselling and Psychotherapy

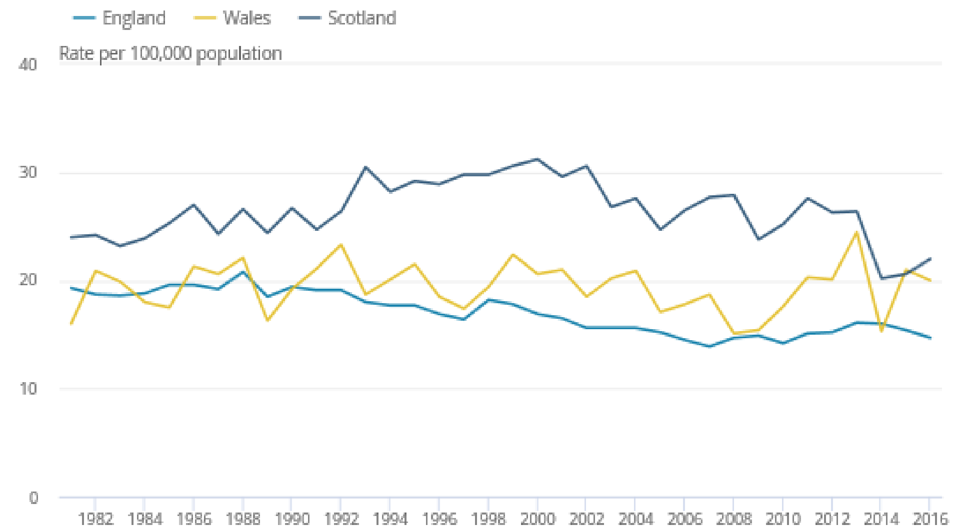
BACP Response to the Health, Social Care and Sport Committee Inquiry on Suicide Prevention

The British Association for Counselling and Psychotherapy (BACP) is pleased to respond to this important inquiry on suicide prevention in Wales. BACP is the UK's leading body for counselling and psychotherapy, we have over 45,000 members in the UK, of which 1,900 are based in Wales working across a range of settings. Evidence clearly demonstrates the important role that talking therapies play in helping to alleviate symptoms which lead to suicide and self-harm.

A significant public health challenge

Suicide remains a significant social and public health problem. Each year in Wales between 300 and 350 people die from suicide, about three times the number killed in road accidents[1]. According to the latest data from the Office of National Statistics, the suicide rate in Wales is the second highest in the UK, with a rate of 11.8 per 100,000 people, compared to Scotland's rate of 15 per 100,000 people[2]. This has fallen from a high of 13.0 in 2015. There are also concerns around the erratic suicide rate for Wales, particularly for males, as clearly demonstrated in the Figure 1. A number of commentators have theorised that this is due to rurality impacting on the accuracy of data collection, placing doubt over the accuracy of the picture. BACP would welcome an examination of this issue by the committee.

Figure 1: Age-standardised suicide rates by country, for males, 1981 to 2016



Source: Office for National Statistics, National Records of Scotland, Crown Copyright, 2017

[1] Welsh Government, Talk to me 2, Suicide and Self Harm Prevention Strategy for Wales 2015-2020

[2] Office for National Statistics, National Records of Scotland, Crown Copyright, 2017

Analysis shows that men are around three times more likely to die by suicide than women. Women are more likely to engage in non-fatal suicidal behaviours that require hospital admission. It is thought that up to 19 people in every 100 will have thoughts of suicide at some point in their life[3]. These thoughts are distressing and can further isolate an individual, creating additional barriers to seeking help.

Whilst this inquiry is focused on suicide prevention, there is a strong relationship with self-harming behaviour which cannot be ignored. A 2015 study found that self-harm patients had a 49 times higher risk of suicide than the general population (Hawton, 2015). Self-harm behaviour regardless of intent is also a serious public health problem in its own right. It is one of the top five reasons for medical admission in the United Kingdom and results in significant social and economic burden due to the utilisation of health services, particularly with respect to unscheduled hospital care, to treat the injury/ overdose. It also has a big psychological impact on the individual, friends, family and professionals who treat them.

Which groups are at more risk?

Earlier this year, Samaritans UK published 'Dying from Inequality[4]', which evidenced the critical relationship between higher individual deprivation and increased suicidal behaviour. This showed that suicide rates are two to three times higher in the most deprived areas. This also identified five groups most likely to be impacted by suicide.

1. Those living in areas of **higher socioeconomic deprivation**
2. **Men** are more vulnerable to the adverse effects of economic recession, including suicide risk, than women.
3. People who are **unemployed** are two to three times more likely to die by suicide than those in employment.
4. Those in **least skilled** occupations (e.g. construction workers) have higher rates of suicide.
5. A **low level of educational attainment** and no home ownership increase an individual's risk of suicide.

We share Samaritans UK's view that suicide prevention strategies should recognise the strong association between suicidal behaviour and area-level socioeconomic deprivation, targeting efforts on both people and places. BACP believes that more should be done to target interventions at these vulnerable groups and to more effectively measure outcomes by these groups.

Psychological therapies for suicide and self-harm

Though both suicidal intent and self-harm usually result from severe psychological distress, BACP believes that neither are in themselves mental illnesses. However, given the link between mental health disorders and an increased risk of suicide it is clear that psychological therapies are an effective intervention for those with an intent to commit suicide or self-harm.

The evidence base demonstrates that a range of psychological therapies can be used to treat the mental distress underlying suicidal tendencies and self-harm, and dialectical behaviour therapy has proven particularly effective in reducing self-harm (Feigenbaum, 2010). Research has shown that Dialectical Behaviour Therapy (DBT), Cognitive Behavioural Therapy (CBT) and problem solving therapy are effective interventions for

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[3] Thematic Review of Deaths of Children and Young People through Probable Suicide, 2006-2012. Amended version published 21 March 2014

[4] Samaritans UK, Dying from Inequality, September 2017

people at risk of suicide (Winter, 2013). Evidence has also shown that psychosocial assessment forms an important aspect of the management of self-harm in hospitals, and is associated with a decreased risk of repeat self-harm (Gunnell, 2013). Problem solving therapy (Bannann, 2010) and DBT (Hawton, 1999) has been shown to reduce repetition and further self-harm. Patients receiving counselling and psychotherapy after deliberate self poisoning showed greater improvement, including a reduction in suicidal thoughts. The positive impact of counselling and psychotherapy was also maintained at six-month follow-up, with nine per cent of those receiving counselling and psychotherapy repeating self-harm compared with 28 per cent of those receiving usual treatment (Guthrie, 2001).

NICE clinical guidelines regarding the use of psychological interventions for the longer-term management of self-harm suggest interventions could include cognitive-behavioural, psychodynamic or problem-solving elements (NICE, 2011). A report by the Royal College of Psychiatrists (2010) has also outlined research evidence which suggests that CBT is effective in reducing levels of depression and incidents of self-harm, and that problem solving therapy can lead to improvements in mood and social adjustment. Research evidence suggests that psychological therapies can also be effective in the prevention of suicide, along with a range of approaches to psychotherapy and counselling (Winter et al, 2013).

We are fully supportive of efforts being made in Wales to improve access to psychological therapies, as this will have a positive impact on tackling suicide and instances of self-harm. Timely access is critical, and BACP, as a member of the ***We Need to Talk Wales*** coalition[5], are calling on Welsh Government to commit to parity of access so that people of all ages to access psychological therapies within 28 days, in primary and secondary care. Dignity and choice are also critical and we support the We Need to Talk Wales call for people to have a choice of therapy, where they want it and when they want it, underpinned by effective information.

Strategic opportunities and challenges

BACP welcomes the Welsh Governments' strategic approach as set out within *Talk to Me 2*[6], and its aim to reduce suicide and self-harm in Wales. This recognises that efforts to tackle this issue are intertwined, and emphasised that improvements will only be achieved through concerted effort, the commitment of all Welsh Government departments and partner bodies. Together for Mental Health and the Mental Health (Wales) Measure 2010 (the Measure) also play a critical role in addressing the treatment and management of mental health disorders, and the rights, responsibilities and duties assigned to individuals and to services.

A key area of concern is the sustainability of the ***Time to Change Wales*** programme, which is a critical component in helping to tackle stigma. Funding for the programme runs out in December 2017 and no communication has been made on what will happen to the programme going forward or plans to replace it. We would welcome an examination by the committee into this matter.

[5] We Need to Talk Wales, Improving Access to Psychological Therapies, 2016
[6] Welsh Government, Talk to me 2, Suicide and Self Harm Prevention Strategy for Wales 2015-2020

Summary of recommendations

This section highlights the recommendations we have proposed throughput our written evidence.

1) We call upon the committee to urgently examine concerns with the accuracy of suicide data collection and reporting, ultimately to help secure improvements and confidence in the data.

2) There is a strong association between suicidal behaviour and area-level socioeconomic deprivation, targeting efforts on both people and places BACP believes that more should be done to target interventions at vulnerable groups and to more to effectively measure outcomes by these groups to measure success.

3) Tackling Stigma is central to tackling suicide, however, BACP is concerned that funding for Wales' flagship programme, *Time to Change*, runs out this month, and no communication has been made on what will happen to the programme going forward or plans to replace it.

4) We call on Welsh Government to commit to parity of access so that people of all ages can access psychological therapies within 28 days, in both primary and secondary care. Dignity and choice are also critical and we support the call for people to have a choice of therapy, where they want it and when they want it, underpinned by effective information.

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Inquiry into Suicide Prevention

Ymchwiliad i Atal Hunanladdiad

Ymateb gan Defnyddwyr Gwasanaethau a Gofalwyr yn ardal Cwm Taf

Response from Service Users and Carers in the Cwm Taf Region

“The front line service needs to be more responsive. GPS in general are still handing out anti depressants rather than referring people on for counselling or talking therapies which are more likely to get to the route of the problem.

Too many people also now are turning to social media for support and I'm still not convinced this is what actually helps people and people who are working and living at a fast rate not taking time out to sort themselves out.

We also need a change in culture. I've known of GPS to tell a male patient to 'man up". “

“Many mental health services are in crisis and are unable to fully support people who are in crisis. Mental Health services are struggling for a multitude of reasons. Mental health needs to be talked about as more than a health issue. It’s as much a poverty and a social justice issue as mental health and poverty often compound each other. When we talk about mental health and suicide we also need to talk about welfare reform, housing, debt advice, homelessness, food banks, credit unions, payday lenders, family support, caring, substance misuse support etc.

The impact of benefit reform cannot be underestimated and the desperation that people can experience under the current benefit reforms can lead to a deterioration in people who are already struggling in terms of their mental health and wellbeing. Third sector organisations are overwhelmed by the numbers of people who are appealing a decision regarding their Personal Independent Payments a

We need to talk about jobs, sustainable good quality jobs and training opportunities.. We need to talk about community, reducing social isolation and similar approaches that are much more than just medication and talking therapies.

There needs to be equal footing beteween mental health and physical health and the stigma and discrimination associated with mental ill health. Mental health and suicide isn’t something that you can throw money at in the hope of sorting it out. Its an issue that requires a much more rounded view. It’s a way of life. It’s a societal issue.

Extent of the problem (numbers, trends and patterns) in Wales may not be well known by those not involved in MH services generally. Those involved (either as SU, carer or service provider) probably do have more awareness of these factors.

Vulnerability of particular groups (e.g. those who have been in care) and risk factors do not seem to be well understood by some service providers (e.g. people discharged from A&E when in distressed state – though this may be lack of resources rather than lack of understanding).

The impact of changes in the benefit system and effect that is having on people's mental health does not seem to be fully appreciated by either government nor service providers - Universal credit is resulting in people being without any money for rent and/or food - leading to states of absolute desperation and hopelessness.

The social impact of suicide can be massive – specifically on those left behind – there are often feelings of guilt and despair that they were unable to help. There seems to be a lack of emotional support for friends of those who have committed suicide (there seems to be more help for relatives but what is the waiting time to access this support?)

Has the impact of the Talk to me strategy been evaluated yet? What are the findings? Is there a reduction in incidence or change in the pattern? I don't know, so I assume many other people also don't know. Where are these findings (if there are any) being published?

How effective are public awareness campaigns? Personally, I haven't noticed any increased awareness campaigning? Reducing access to the means of suicide might just make people change their means (i.e. increased cases of hanging)?

It seems likely that better support for people to maintain good mental health (rather than preventing suicide when things get overwhelming) would be more effective - e.g. better advertising of help available; a better benefits system that does not leave people without money and desperate; more help with housing; better access to health services and social services.

Difficult for current mental health services (and other public services) to be effective when they are faced with relative cuts in their budgets.

More specific training needed for managers in work places to recognise suicide risk factors and know when, and how, to intervene. There seems to be more training and awareness for mental health problems generally but not suicide specifically (I have asked a couple of civil service managers). Also, better training needed for support workers in supported housing to recognise risk factors etc.

Local communities perhaps could be more aware of the problem of suicide and what to look out for with their neighbours - particularly those people who do not have family or friends. Perhaps we need more openness and acknowledgement that isolation and loneliness can affect people of any age. Maybe more drop in centres where people can come without appointments just for a cup of tea, a chat and helpful information would go some way to prevent deterioration in a person’s mental health.

Data collection is vital to know if any strategy is effective. Also, very important to act on data findings and provide services that make a difference. This needs to be more than just counting numbers, need to ask people what has made a difference to them (need more qualitative data).

Health, Social Care & Sports Committee Inquiry into suicide prevention

The Royal College of Psychiatrists is the professional medical body responsible for supporting psychiatrists throughout their careers, from training through to retirement, and in setting and raising standards of psychiatry in the United Kingdom.

The College aims to improve the outcomes of people with mental illness, and the mental health of individuals, their families and communities. In order to achieve this, the College sets standards and promotes excellence in psychiatry; leads, represents and supports psychiatrists; improves the scientific understanding of mental illness; works with and advocates for patients, carers and their organisations. Nationally and internationally, the College has a vital role in representing the expertise of the psychiatric profession to governments and other agencies.

RCPsych in Wales is an arm of the Central College, representing over 550 Consultant and Trainee Psychiatrists working in Wales.

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The Royal College of Psychiatrists in pleased to respond to the Health, Social Care and Sports Committee on their inquiry into suicide prevention. Suicide is preventable if we are given the right training and support, but rates are still high, particularly in certain parts of the population, and growing in others. The Committee recognised through evidence gathered during the inquiry into loneliness and isolation, that these are contributing factor to suicide. We welcome the Committee's in-depth look into this particular area as more can and must be done to prevent deaths and the impact that suicide has on the community.

Main points:

- Suicidal ideation is not a serious mental illness but it is related to poor mental health
- Suicide has a devastating impact on society and is a major public health concern.
- There is still a stigma around suicide and a lack of understanding of, and sometimes willingness to prevent it.
- Most suicides are preventable, so every effort should be made to save lives.
- Once a patient experiences suicidal ideation it is imperative that they are referred to the appropriate services, either in the NHS or third sector, as soon as possible.
- Professionals who are likely to encounter people with suicidal ideation must have training and support.
- Parity of esteem includes staff treating people in distress with respect.
- There must be quicker access to the appropriate psychological therapies, particularly for those in secondary care services.
- Improved liaison services in A&E departments would be able to better manage and care for those who present having self-harmed. These aren't problem people but people with problems who deserve to be treated with respect and dignity.

The extent of the problem of suicide in Wales and evidence for its causes - including numbers of people dying by suicide, trends and patterns in the incidence of suicide; vulnerability of particular groups; risk factors influencing suicidal behaviour.

Statistics

1. Figures published by the Office for National Statistics in 2017 show that the number of completed suicides in Great Britain fell by 3.4% from 5,870 in 2015 to 5,668 in 2016, which is 10.1 per 100,000 population. Approximately three quarters of all suicides are male with the highest rate amongst the 40 – 44 year age group at 15.1 per 100,000. The age group with the highest rate for women is 50 – 54 at 8.1 per 100,000.
2. Every year, approximately 300 people in Wales die from suicide. This figure peaked to 364 in 2012.

Graph 1: The number of completed suicides in Wales, by male and female

Year	Total	Male	Female
2005	317	247	70
2006	293	228	65
2007	296	236	60
2008	304	225	79
2009	286	228	58
2010	305	238	67
2011	324	255	69
2012	364	289	75
2013	358	287	71
2014	311	244	67
2015	335	266	69

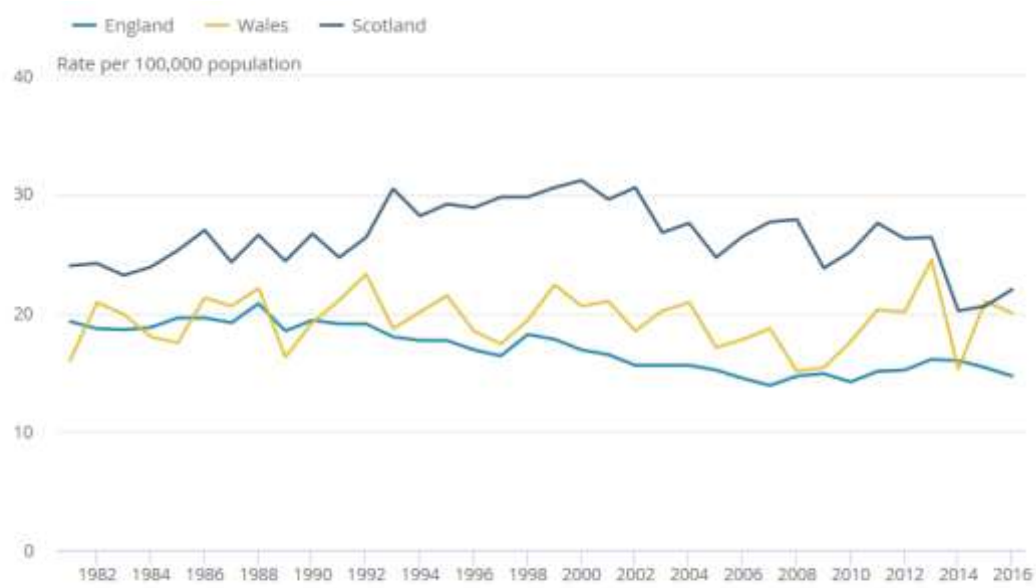
Number of suicides

Year

Source: The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

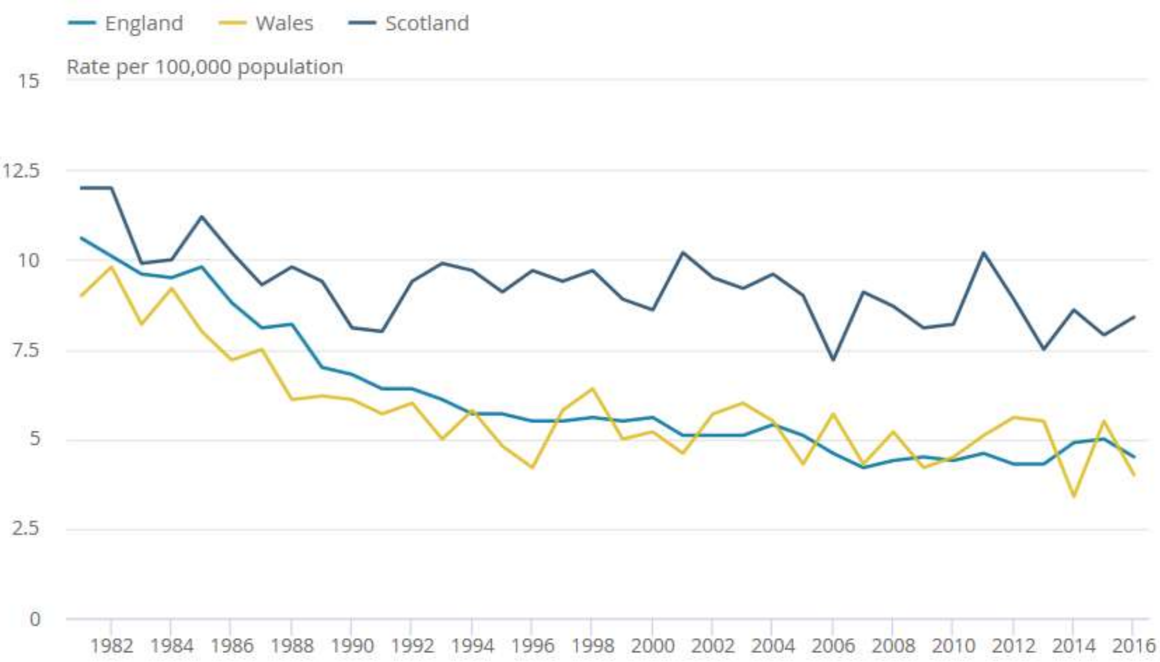
3. The overall rate of suicides has fallen in Wales from 13.0 in 2015 to 11.8 per 100,000 people in 2016; however, this is still higher that the GB average. The lowest rate for Welsh males was in 2008 at 15.1 and the highest was in 2013 at 24.3 suicides per 100,000 males. The figures appear more erratic for Wales and Scotland due to the population size.

Graph 2: The rate of completed suicides in Wales, Scotland and England 1982 – 2016 in men



Source: Office for National Statistics, National Records of Scotland

Graph 3: The rate of completed suicides in Wales, Scotland and England 1982 – 2016 in women



Source: Office for National Statistics, National Records of Scotland

4. During 2005-2015, 28% of suicides in the UK general population were mental health patients, although this figure is slightly higher in Scotland and slightly lower in Wales.[i] This trend has fallen since 2005 and continues to fall but the longstanding downward trend has slowed.
5. Although there is no hard evidence yet to show, there are indications that there could be a rise in completed suicide amongst women between the ages 16 – 34 as they are using more violent means.

Risk Factors

6. There are many reasons why people intentionally take their own lives. Ultimately, suicidal thoughts are triggered by a number of factors that are dependent on an individual's circumstances. However, there are certain factors that increase the risk of attempting or completing suicide.
7. Men are three times more likely than women to complete suicide. This could be attributed to a reluctance to seek help or talk openly about problems that they are experiencing. People suffering from substance and alcohol misuse are much more likely to complete suicide compared with the general population, as are those with psychiatric disorders, particularly those who have recently been discharged from psychiatric inpatient services. (Details of these and other risk factors can be found at Annex A.)
8. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness includes data this year on the less common diagnoses where there is a high prevalence for suicide. These include eating disorders, autism and dementia – all showing a recent rise in rates.

The social and economic impact of suicide.

Social impact

9. Suicide is devastating to those it affects and the impact can be long lasting. Because it is most often preventable, those who are affected by the death of someone through suicide often blame themselves for not having intervened. Their relationship with the suicidal person, their emotional investment in the relationship, often makes it difficult to detect or accept common signs of suicidal behavior.[ii] This impact will resonate within the family and their wider networks, often impacting closer, smaller communities more profoundly. The role of the family in suicide prevention is therefore crucial, albeit very complex.

Economic Impact

10. Suicide has an economic impact as well as a social impact. Depression, which is a major risk factor of suicide, has been identified by the World Health Organisation through the global burden of disease study as one of the leading causes of ill health and economic cost in the developed world. Depression is ranked by WHO as the single largest contributor to global disability (7.5% of all years lived with disability in 2015); anxiety disorders are ranked 6th (3.4%).[iii] The same measures to combat depression will impact on suicide rates.
11. It is important to note that a common factor of suicide is social deprivation. You are at tow to three times increased risk of suicide if unemployed than not. Men in the lowest social class, living in the most deprived areas, are 10 times at greater risk of suicide.[iv]

The effectiveness of the Welsh Government's approach to suicide prevention - including the suicide prevention strategy *Talk to me 2* and its impact at the local, regional and national levels; the effectiveness of multi-agency approaches to suicide prevention; public awareness campaigns; reducing access to the means of suicide.

Welsh Government

12. Suicide is a major policy issue for Welsh Government in their *Together for Mental Health* strategy, and mental health is one of the five key areas in the Welsh Government's national strategy *Prosperity for All*. There are constructive outcomes in the *Delivery Plan for Together for Mental Health*; however, we would advocate that all individuals discharged from inpatient care to have a first follow up within **three** and not five working days of discharge, given the significant risk of suicide to this group (see Annex A).
13. The Welsh Government has produced guidance on suicide prevention, *Talk to me 2* which uses evidence-based research on suicide prevention, relying on a collaboration of local partnerships. All regions in Wales have developed multi agency suicide prevention forums with agreed local reporting structures, and these report to the National Advisory Group.
14. The College is very supportive of Talk to Me 2 but we are yet to see a strong commitment by some local implementation groups. These groups must take ownership of the Welsh Government's commitment to preventing suicide and it is on the Welsh Government to implement their recommendations, to ensure that local implementation groups are effective.

Public Awareness Campaigns

15. Time to Change Wales has made real strides in reducing the stigma around mental health. We would hope that Phase 3 is continued to be supported particularly as there is a focus on men, the workplace, and developing community hubs across Wales.

Reducing Access to Suicide Means

16. There has been a concerted effort by some organisations to reduce access to suicide means and there are good examples of joint working. The Samaritans have worked with Network Rail on a suicide prevention programme that began in 2010. Since then, they have seen a reduction in the number of suicides to 237, the lowest since the programme began. According the Network Rail 16,000 railway employees have received training to intervene in suicide attempts and in 2016/17 rail employees, the police and public intervened in more than 1,593 suicide attempts on the railway. [v] They, and others, have also put up fencing to reduce access to dangerous areas, such as bridges, and there is the use of the signage with contact details.

The contribution of the range of public services to suicide prevention, and mental health services in particular.

17. Public services have been slow to respond to suicide prevention. Parity of esteem for mental health implies that services treat suicide and the conditions that are predisposed to it with the same attention as they do physical illnesses. Yet we continue to see that some people in distress, who self-harm or threaten suicide can be considered as a nuisance or time and money wasters. What perpetuates this is a lack of understanding around suicide and the stigma that is attached to it. Many, even those working in public services, do not see caring for people in distress as their responsibility.
18. Liaison and mental health crisis services are best equipped to deal with people presenting with suicidal ideation in hospitals and in the community, but these services are not always available. We are pleased that the Welsh Government has invested in liaison psychiatry services across Wales and have developed these in all District General Hospitals, and that the College's Psychiatric Liaison Accreditation Network (PLAN) was adopted in all Emergency Departments. In addition, the College, and others, have signed up to the Crisis Care Concordat to ensure that all public bodies responding to people in crisis work together in the best interest of the individual. Although this is good on paper, we still need to see a commitment from some health boards and more investment in health-based places of safety. We are pleased that the Task and Finish Group that oversees the implementation of local plans will continue to meet and is now an Assurance group.
19. A series of high-profile cases have put suicide on the political agenda and brought it to the forefront of the public's consciousness, which is further helped by a general increase in understanding of mental health and wellbeing.

Education

20. In schools, teachers, counselors, and school nurses should be able to spot early the signs of suicidal ideation. The Samaritans run the DEAL project in schools, providing emotional health lessons in school to increase resilience and improve an individual's ability to cope with difficult situations. We are pleased that it is

now a statutory duty for all secondary schools to have a school counseling service. We are also encouraged that Welsh Government has invested £1.4m in a pilot project in three Health Board Areas to provide dedicated Child and Adolescent Mental Health Support in schools. We would like to see the Donaldson's recommendations taken forward as there is potential for the new curriculum to impact on reducing the risk of suicide in young people and give them the skills that they can take with them into adulthood.

Police

21. The police will come into contact with many people experiencing a mental health crisis requiring immediate support. Although police officers are not mental health professionals per se, in a time of crisis, it may be that the police are the best placed to control a certain situation, in particular where an individual may be violent, aggressive, and a danger to themselves or to others. In other instances, police involvement is unnecessary or even detrimental. The Crisis Care Concordat for Wales was signed by the Local Health Boards and the police to ensure that through collaboration, the use of police cells as a place of safety was reduced. We are concerned that collaboration has not been wholly successful throughout Wales. We also worry that there are no improvements in the provision of health-based places of safety to be used under Section 135 and 136 of the Mental Health Act.

END

Annex A

Factor	Estimated increased risk
Male gender	X 3
Current or ex psychiatric patients	X 10
4 weeks following discharge from psychiatric hospital	X100-200
Prisoners (male and female)	X 5-10
Being a male rather than a female prisoner	X 2
Being married	X 1.5
Accommodated in a single cell	X 9
Life sentence	X 4
Suicidal ideation	X 15
Current psychiatric diagnosis	X 6
Psychotropic medication	X 4
Alcohol misuse	X 3
Self-harm	X 30
In first year following self harm	X 66
Aged over 60 with a more than one episode of self harm requiring hospital treatment	X 49
Those aged over 60	
who have experienced bereavement in the last year	X 3.5
who have life problems associated with accommodation (for example impending move into residential care)	X 5
Socioeconomic deprivation	Not known
Substance misuse	
Drug misuse	X 20
Heroin	X 14
Alcohol	X 6
Prescription drugs	X 20
Prescription drugs and alcohol	X 16
Prescription and illicit drugs	X 44
Schizophrenia	
Previous depressive disorder	X 3
Previous suicide attempts	X 4
Drug misuse	X 3
Agitation or motor restlessness	X 2.5
Fear of mental disintegration	X 12
Poor adherence to treatment	X 4
Recent loss	X 4
Bipolar disorder	X 15
Dysthymia	X 15
Anorexia nervosa	X 23
Anxiety disorders	X 6 -10
Personality disorder	X 7
Physical illness	
Cancer	X1.5 – 4
Neurological disorders	Not known
Renal disease	Not known
Chronic pain	Not known
For men being divorced or separated	X 2
Unemployment	X 2 -3
Family history of suicide	Not known

Source: Public Health Wales (2010) Suicide Prevention – update on the summary of evidence

[i] The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Annual Report: England, Northern Ireland, Scotland and Wales. October 2017. University of Manchester.
[ii] Owens, C. et. al (2011) Recognising and responding to suicidal crisis within family and social networks: qualitative study2011;343:d5801
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[iv] Samaritans (2017), Dying by Inequality: Socioeconomic disadvantage and suicidal behaviour, summary report.
[v] https://www.networkrail.co.uk/communities/safety-in-the-community/suicide-prevention-railway/

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Inquiry into Suicide Prevention

Ymchwiliad i Atal Hunanladdiad

Ymateb gan Grŵp Cynghori Cenedlaethol

Response from the National Advisory Group

The National Advisory Group (NAG) advises Welsh Government on suicide and self harm prevention. It is supported by Public Health Wales in the provision of a Chair and organisation of meetings. NAG membership consists of high level representatives from across sectors and services. NAG welcomes the inquiry into suicide prevention, a significant public health problem. We have provided comments on the consultation topics below, following discussion at the group on the 7th of December of a draft prepared by the Chair.

1. **The extent of the problem of suicide in Wales and evidence for its causes - including numbers of people dying by suicide, trends and patterns in the incidence of suicide; vulnerability of particular groups; risk factors influencing suicidal behaviour.**

A key message is that suicide is preventable. Effective suicide prevention needs to address both risk and protective factors across the life course and be informed by strong intelligence and data collection. The data on suicide numbers, trends and patterns produced by the Public Health Wales Observatory to inform the development of the 2015 Suicide and self-harm prevention strategy and action plan for Wales[1,] Talk to Me 2, remains relevant and we recommend this to the inquiry.

The mid- point review of the implementation of Talk to Me 2 will report at the end of February 2018 and will be made available to the inquiry. It will contain an update of this data with commentary on accuracy and timeliness of suicide data, numbers, trends and patterns from the authors.

A briefing paper on the Suicide Information Database for Wales (SID-Cymru)[2] , a research database led by Professor John and held in the privacy protecting SAIL Databank has also been commissioned. This contains linked anonymous routinely collected health and social care data on suicides in Wales since 2001 which can identify further patterns.

The Public Health Outcomes Framework includes a specific indicator for suicide as well as a range of other indicators that are likely to have an impact on suicide.[3]

The evidence on risk and protective factors which informed the 2015 Suicide and Self-harm prevention strategy and action plan for Wales remains highly relevant and we recommend this to the Inquiry.[2] Based on data from Wales the strategy identified the following high risk groups or 'priority people' and 'priority places':

Priority People	**Priority Places**	**Priority Care Providers**
Men in mid life Older people over 65 with	Hospitals	People who are first point of contact or first

depression and co-morbid physical illness Adult Prisoners Children and young people with a background of vulnerability People in the care of mental health services including inpatients People with a history of self harm	Prisons Police custody suites Workplaces Schools, Further and Higher Education establishments Primary care facilities Emergency departments Rural areas Deprived areas	responders, including: Police Fire fighters Welsh Ambulance staff Primary care staff Emergency department staff

This list is not exhaustive and other at-risk groups will also benefit from targeted, specific and/ or universal interventions to improve mental health, reduce stigma, increase help-seeking behaviour and develop protective factors. Additionally the Thematic Review of deaths of children and young people through Probable Suicide identified risk factors and made recommendations for suicide prevention in Wales for young people in Wales[4] including:

- Bullying (mostly school related)
- Misuse of drugs and alcohol
- Physical, emotional and sexual abuse
- Self-harm
- Deprivation
- Social connections

This report highlighted the vulnerability of those under 18 not in education, employment or training. While we recognise that services have been developed to support those who come to the attention of health, criminal justice or social services who have left school no formal system exists across Wales to identify and support those who leave at 16 years and do not come into contact with services. In some other United Kingdom nations the age of compulsory participation in some form of education or training has been raised to 18 and appears to be reducing the numbers of 16-24 year olds not in education, employment and training.

2. The social and economic impact of suicide.

In 1998, suicide constituted 1.8% of the total burden of disease and it is estimated that this will to rise to 2.4% by 2020[5]. There are specific financial costs to public services arising from the acute response and immediate support services, where

they exist, for families, colleagues, professionals and schools. There are other economic impacts to businesses and emergency services, for example, when major transport routes are closed. Add to this the impact that an individual suicide has on the lives and mental health of networks of family, friends, colleagues; professionals, communities and the social and economic impacts continue to increase.

3. **The effectiveness of the Welsh Government's approach to suicide prevention - including the suicide prevention strategy *Talk to me 2* and its impact at the local, regional and national levels; the effectiveness of multi-agency approaches to suicide prevention; public awareness campaigns; reducing access to the means of suicide.**

The existence of a strong, well evidenced and implemented suicide prevention strategy is an essential element in preventing suicide and co-ordinating national and local implementation. Given the range of risk factors for suicide no single organisation can prevent suicide so co-ordination is vital.

Effective implementation of the national strategy at local level is also vital. There are currently three regional fora with plans developed at a range of levels from single local authority area to the whole of North Wales. The mid- point review will map both the Regional Fora, their Terms of Reference and local suicide prevention planning areas.

Local suicide prevention plans are dependent on how highly government prioritises suicide prevention. NAG issued local planning guidance to support their development in June 2017 with completed plans due in February 2018. Centrally expert advice, guidance and support for matters relating to suicide prevention such as suspected linked deaths, means restriction and media reporting has been provided.

It is unclear if any resources are available both centrally and locally for implementation of Talk to Me 2. Adequate resourcing is essential for implementation. Currently there is a reliance on expertise and enthusiasm both nationally and locally. Most guidance developed in other nations is either supported through specific funding or national posts for suicide prevention to support this type of work in liaison with experts. The lack of a dedicated resource in terms of personnel has resulted in the delay of certain pieces of work e.g. local planning guidance, developing the content for a national website. Following the Health Committee Inquiry into Suicide Prevention in England in 2017 a significant government investment into suicide prevention of £25 million over 3 years was announced. Adequately resourcing the measures, services and guidance set out in

the strategy with provision of some cental/ national workforce would create and support a sustainable prevention effort in Wales.

4. **The contribution of the range of public services to suicide prevention, and mental health services in particular.**

   The direct and indirect impacts of the recession and austerity on public and voluntary sectors and community infrastructure, particularly on the provision of safety net services for the most vulnerable or those in crisis should be considered.

   The effective implementation of Talk to Me 2 is dependant on multi-agency partnership. The mid-point review will highlight how such partnership operate across Wales and interact with Regional Fora

5. **The contribution of local communities and civil society to suicide prevention.**

   Community development approaches are effective in building social networks and trust within communities, reducing isolation and exclusion and engaging the more marginalised and hard to reach individuals.[1] More attention and evidence is needed to support local authorities in approaches that reduce social isolation and build social networks.

   There is also a known gap in both provision and expertise in working with individuals, often men, who do not seek help in traditional ways or with 'symptoms' which do not fit traditional treatment criteria. New ways of working need to be developed. Community approaches which are not badged as health or mental health, which are normalised and peer to peer should be explored. Appropriate evaluation with measured outcomes that extend beyond a positive experience to actually measure the effects on suicidal and self-harming behaviours is important. If effective, these would almost certainly be cost effective given the high economic and social costs already described. Such initiatives do operate in Wales but geographical coverage and access to such schemes is variable.

6. **Other relevant Welsh Government strategies and initiatives - for example *Together for Mental Health*, data collection, policies relating to community resilience and safety.**

   Well-being of Future Generations (WBFG) Act, Prosperity for All, Social Services and Well-being (Wales) Act, Together for Mental Health (suicide prevention is a specific objective), Together for Children and Young People, Adverse Childhood Experiences, Crisis Care Concordat, Police and Crime Act (dealing with people in crisis) and the Mental Health Measure will all impact on suicide and self-harm prevention. The contribution that each makes to the suicide and self-harm prevention is acknowledged in Talk to Me 2 and local planning guidance.

Counselling for children and young people- local authorities are required to make reasonable provision supports young people and the proposed changes in education services (Well-being specifically mentioned) may make our young people more emotionally literate and supported in their health and well-being.

The Public Health Outcomes framework has suicide indicators with data at a Health Board and Local Authority level. The Minimum Mental Health Dataset should support data collection in relation to risk factors for suicide. The continued funding of the Suicide Information Database through the National Centre for Mental Health is an excellent resource.

There are issues around the timeliness of suicide data- consideration should be given to real-time surveillance to inform local and national responses. Additionally in England and Ireland self-harm presentation to emergency departments is monitored to inform practice and allow for timely responses.

It should be noted that official suicide statistics may under represent the true scale of suicide. This relates to many issues and is not unique to Wales. However accurate data collection is required to plan and focus suicde prevention efforts. Use of narrative verdicts should be monitored and consideration of the evidential standard of 'beyond a reasonable doubt' should be revisited.

7. **Innovative approaches to suicide prevention.**

Reducing inequalities
There is a social gradient in the distribution of suicide across the population (demonstrated in Wales data), with those living in more deprived areas most likely to take their own lives compared to those those living in more affluent areas. Deprivation and its associations to unemployment, poor housing and homelessness, debt, poverty, social isolation and other poor social conditions contribute to adversity, erode resilience and result in coping strategies such as alcohol, drugs, gambling and an increase in mental distress. Attention must be paid to addressing these causes of suicide, reducing poverty and social inequalities.

Substance misuse and alcohol
Substance use, alcohol and drugs, has been found to have a strong association with suicides.[6] There is a known gap in both provision for, and expertise in, working with individuals presenting with both mental health issues and substance use. There is also a known gap in both provision for, and expertise in, working with individuals, often men, presenting in non-traditional ways, or displaying 'symptoms' that do not fit treatment criteria. New ways of working need to be developed and links across all these services to suicide prevention need to be made and acknowledged.

Internet and Social Media
There are published studies and current research projects exploring the harms and benefits of online behaviours and their impact on suicide and self –harm being

conducted at Swansea University. A paper due to be published on cyberbullying and self-harm contains specific recommendations for policy and practice. Ensuring that policies to address bullying and internet safety include consideration of suicide and self- harm is important. Liaison with the Wales Internet Safety Partnership to drive forward innovation in this area is important.

Evidence based action

Please see local suicide prevention planning guidance for appraised evidence- https://www.samaritans.org/news/guidance-issued-national-advisory-group-regional-fora-local-suicide-and-self-harm-prevention

Evidence based action to prevent suicide should continue to include action to reduce access to means; and support for those bereaved by suicide; interventions to provide support for high risk groups; as outlined in the national strategy. To remain effective national and local action needs to be informed by data analysis and needs assessment.

In considering prevention, we would suggest that a greater emphasis could be given to the lifelong impacts of childhood exposure to violence and abuse; and of the significance of not building resilience through strong and secure attachments in childhood (children looked after). Investing in positive childhood experiences and providing high quality therapeutic and other support in a timely manner for those who need it is likely to pay dividends both to individuals and to society. This ties in well with the emphasis on adverse childhood events from the PHW Hub.

Concerns about the impact of stress and increasing poor mental health on young people at school, college and university could be systematically addressed with clear standards developed for mentally healthy schools and colleges; ensuring that pastoral support and early help and preventative services are developed with students. These initiative are being developed in Wales as described in section 6. As described in the Thematic Review of Probable Suicides in Young People there is strong RCT evidence to reduce victimisation by a fifth in schools and consideration should be given to ensure programmes in schools show fidelity to this evidence base. It also included strong RCT evidence of the effectiveness of Cognitive Behavioural Therapy for child victims of abuse- the provision of such services would go a long way towards addressing both suicide and self harm as well as wider mental health issues in this extremely vulnerable group.

Training in suicide prevention programmes, like ASIST; training in understanding emotional distress; training in building resilience; and or mental health awareness training for front line staff has been found to be beneficial. Further work could be done to develop more tailored programmes for staff routinely exposed to distressed individuals; such as in the emergency services.

There is increasing awareness about developing employer awareness and standards for positive mental health - and many opportunities for employers to play a strong role. Examples include: Mental Health First Aider Schemes, Stress Management, and ASIST Training.

Management of those who self-harm and present to ED

Self- harm is the strongest risk factor for suicide. While suicide is a rare event compared self-harming behaviour over half of those who take their own lives have a history of self-harm. Many of those who self- harm and present to emergency services have difficult experiences. This may be improving as stigma reduces and awareness and training of frontline staff increases. However negative experiences when seeking help impacts on future help-seeking behaviour. Regular reporting on those who attend emergency departments with self-harm, leave without being seen, receive a comprehensive psychosocial assessment, re-attend could inform quality of care. Liaison psychiatry services are important in this care pathway and need adequate resourcing.

Support for those bereaved

We currently have no co-ordinated Wales wide response for individuals bereaved through suicide. While awareness of Help is at Hand has increased a Wales pathway would ensure that those bereaved through sudden unexplained death or apparent suicde receive the appropriate support or atleast know where to seek help. Those bereaved through suicde are at higher risk of suicidal behaviours.

Media reporting

Responsible reporting of suicide is important in suicide prevention. We have adopted the and translated the Samaritans Media Guidelines in Wales. On notification of a clear breach of these guidelines in Wales or in stories relating to Wales the Chair of NAG will write to the Editors involved following discussion at a NAG meeting enclosing a copy of the guidelines. Increasing awareness of this is important and the national website may improve this.

However far more can be done. We have expertise and close working relationships between academics, Samaritans and media reporter in Wales in relation to responsible media reporting of suicide. We have advised and worked closely with reporters on this issue both in a general way and for specific stories. This work should be supported. We should raise awareness in our journalism schools and introduce training sessions on responsible reporting.

Protective factors

This area of evidence and action receives less attention but is vital in any public health approach to prevention suicide and reducing self-harm.

While those with mental ill health are at higher risk, It is estimated that between 50% - 70% of those who die by suicide are not in receipt of mental health services in the year before their death. Suicide therefore needs to be understood as a social, rather than a medical / psychiatric phenomenon. A public health life course approach would provide a helpful way of approaching this.

Maintaining friendships, feelings of belonging and other positive social contacts are known strongly protective factors.

Individual resilience helps us to cope with life's chalenges .The building of resilient people begins in pregnancy and the experience of the first days, weeks and years of life but resilience can be acquired and developed throughout life – approaches such as CBT based approaches can provide individuals with the psychological insights and skills which enable them to regulate their emotions and manage impulsivity.

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Inquiry into Suicide Prevention

Ymchwiliad i Atal Hunanladdiad

Ymateb gan Both Parents Matter Cymru

Response from Both Parents Matter Cymru

CONSULTATION RESPONSE TO THE NATIONAL ASSEMBLY FOR WALES - HEALTH, SOCIAL CARE AND SPORT COMMITTEE ON SUICIDE PREVENTION

SUBMITTED BY

Paul Apreda, National Manager –

ABOUT US

1. FNF Both Parents Matter Cymru is a children's rights charity that provides information, advice and assistance to parents and grandparents with child contact difficulties in Wales. We have recently become a specialist domestic violence support service primarily for men where child contact issues are an element in the abuse they are suffering. The charity also provides the secretariat to the Welsh Assembly Cross Party Group on Fathers and Fatherhood.
2. The charity provides 10 face to face support meetings across Wales – from Carmarthen to Mold and from Bangor to Newport. The meetings provide guided peer emotional and practical support to overcome the pain and suffering of being excluded or marginalised from children and family life.
3. Attendance at the charity's meetings is around 1,000 each year, while our helpline answers about 900 calls.

SUMMARY

4. Suicide is a men's issue. Until the focus of suicide prevention is directed to men – particularly in their middle years - the Welsh Government will continue to waste time, effort and resources on poorly thought out strategies that have little impact on the underlying causes of suicidal behaviour.
5. Talk to me 2 is unfocussed and ineffective as it seems to deliberately ignore the fundamental evidence that suicide is a problem faced by men. The recent Samaritan's report 'Dying of Inequality' does recognise the higher rate of suicidal behaviour in men but fails to provide the focus on this group in an effective way that would bring about change. Our charity has sought to engage with Samaritans Cymru, the National Advisory Group for Talk to me 2 and with the regional fora. Sadly our offers of collaboration have been ignored or turned down.

6. It can only be hoped that the recent tragic suicide at the heart of Welsh Government will provide a spur to re-evaluate their strategies. Many of our service users express the view that men die because the Welsh Government cares little for them.

OUR EVIDENCE

7. We are confident that the committee will be aware of the ONS data showing the prevalence of suicide amongst men with preponderance towards those in the 41-50 age group. This group represents the largest single age group amongst our service users (39% are aged 40-49)
8. The majority (currently 57%) of our service users identify that they are victims of domestic abuse (typically emotional abuse). We suspect that this is an under-reporting based on their lack of understanding of the Cross Governmental definition of Domestic Violence and Abuse.
9. The charity dealt with the second instance of suicide in a service user in November 2017. A review of the circumstances has identified that we need to develop an improved response to service users who disengage when the circumstances of their child contact dispute degenerate. We are urgently seeking funding to improve our ability to respond pro-actively.
10. The failure to recognise the link between the male experience of domestic abuse and suicidal behaviour risks further illustrates the lack of interest in supporting men that is a consistent feature of Welsh Government policy.
11. The abuse that they suffer is linked to the issue of child contact denial that has a very significant impact on their mental health and well-being. From January 2018 we will be incorporating assessments using the Short Warwick-Edinburgh wellbeing scale as well as the de Jong Gierveld loneliness scale to map the difficulties faced by our service users against the Outcomes set out in the Wellbeing of Future Generations (Wales) Act 2015, as well as monitoring 'distance travelled' through engaging with our service.
12. Our charity is building links with mental health teams across South Wales to offer help and support to individuals who present to the crisis teams where they identify that child contact is a significant issue for them.
13. The response that the charity is able to give to our service users is significantly hampered by a lack of funding and a lack of recognition by most public services of the problems faced by men in relation to family life.
14. Our primary source of data around the issues of suicidal ideation comes from the Welsh Dads survey 2017. This is a piece of research undertaken by our charity that seeks to engage a wide spectrum of fathers and father figures to discover their experience of being a father in Wales primarily in relation to their engagement with statutory services. The Welsh Dads survey https://www.fnf-

bpm.org.uk/image/upload/branch/cymru/WELSH_DADS_SURVEY_2017_report_FINAL.pdf received a total of 419 responses with every Local Authority represented.

15. The 2017 survey contained a new question looking at Emotional Well-being and Mental Health. The question was answered by 353 respondents.
16. We identified a number of indicators of poor mental health and asked respondents whether they had experienced any of them. Respondents could identify with multiple indicators.
17. The single largest response was that men had talked about low mood with friends, family and colleagues (41.36%) Unsurprisingly the second highest response (41.08%) came for the 'None of the above' indicator – pointing to the fact that most men don't recognise any significant problems in their role as a father.
18. Significantly more worrying was the high number (75 representing 21.25% of respondents) who stated that they 'felt suicidal and unable to cope'. In the detailed comments a significant number of respondents used the word 'suicide' or 'suicidal' overwhelmingly when they also identified child contact difficulties following separation.
19. Many of the comments left by respondents show the huge difficulties placed upon men who are being excluded from family life following divorce or separation. They also tell us that services primarily funded by Welsh Government show little interest in engaging with them as fathers. We believe that allowing these men to speak directly about their feelings will be the most effective contribution our charity can make to this inquiry. The survey – unlike the regular work of the charity – captures the voices of all fathers and father figures, not simply those who are separated and have child contact problems.
20. Comments received in the Emotional Well-being section identified Mind as a very valuable source of help, whilst GP services were rather less favourably viewed.
21. We do not believe that the Welsh Government's Talk to Me 2 strategy is helpful. We contrast the gender –neutral focus with that of the Violence against Women, Domestic Abuse and Sexual Violence National Strategy that prioritises women as victims / survivors and ignores men completely in identifying 'priority groups'. We note that there is a higher prevalence of male suicide compared to female victims of domestic violence illustrating a clear 'empathy gap' in the way that Welsh Government views these issues and a lack of interest in issues that impact largely on men.
22. In writing this consultation response we reviewed our previous response to the Talk to Me 2 strategy from 2015 and found the experience deeply depressing as no improvement has been made to address the fundamental underlying problems with the strategy has been evident.
23. We also wish to draw the attention of the Committee to the testimony of Erin Pizzey who campaigns to end domestic violence and abuse who spoke about male suicide at a recent event in the Senedd https://www.youtube.com/watch?v=ctdYHoMmJqs

FATHERS VOICES – Welsh Dads survey 2017

24. *'The pressure on fathers is immense. My wife had help with her PND but I have received no help at all with the stresses associated with coping with work, childcare and looking after a wife with PND. Fathers are forgotten about. We are told that a modern man is sensitive and*

it's ok to show emotion yet we are, at the same time, expected to cope with all the family's issues and just get on with it. It's no wonder suicide rates are higher in young men - the expectations are enormous.'

25. *'Everyone assumes that dads can cope, sometimes we can't, there appears to be plenty of emotional support for mums but very little for dads. We're expected to shrug everything off & just carry on working, supporting the mother and helping to look after the baby. At first it's very hard'*
26. *'I have undergone counselling and have also undertaken a stress and anxiety course with Cardiff Mind - both very useful. I feel that wider society do not understand or care about stress, anxiety in fathers and do not care about children having a meaningful relationship with their father after a marriage has broken down.'*
27. *'I was too scared to seek help in case it made me look bad while I was fighting for access, my ex-wife would have used it against me and made me out to be unstable.'*
28. *'Unless you have experienced it you cannot imagine the heartache of being apart from your children. I have gone through all of the above emotions. When you have a mother who is a parental alienator it is devastating for your children and yourself.'*
29. *'I've talked about these issues enough. Every waking moment can be turned to the thoughts of the ongoing abuse my children, my family, and I, suffer at the hands of my former partner. Abuse that is enabled by a wholly inadequate and discriminatory system.'*
30. *'When my wife left she ran with the children to her boyfriends and would call saying "kill yourself" and I would never see the kids again and that was a lot for me. The kids mean the world to me.'*
31. *'I attempted suicide ten years ago when my ex-wife told me if I didn't hand the house over to her she would tell enough lies to ensure I never saw my children again'*
32. *'It's been about 6 years now since seeing her every night. I wake up thinking about her. I cannot sleep. I have sat in my car many a time wanted to end it all. I take things out on my wife I have to go to work but when I am home spend a lot of time on my own up all night. When in work I put on a face they don't know the half of it*
33. *I feel like ending it all sometimes because the system of the family court, Cafcass and others help the mother behave appallingly and do not intervene when she is trying to stop me from seeing the children. It's a tragedy that I am being exploited and controlled by my ex telling me when I can have the children etc. otherwise she'll stop contact. I can't take it anymore.*
34. *Having my children taken away from me. I was very close to my sons. Then having 42 allegations against me just so that she could get legal aid. Suicide seemed the best option. Twice I tried to hang myself and once I stood on a railway track. The Samaritans talked me off the track.*
35. *I never stop thinking about taking my own life. There is NO help available. I just want to share my daughters' lives, that's all. I don't want to be told I'm depressed etc etc. I know that. My life has become totally impossible. I never did anything wrong. I have lost my entire family who have chosen to believe my Ex's lies and my children's not wishing to see me being my own fault. I am completely alone and will almost certainly kill myself at some point; which, as all the mental Health specialists acknowledge, would be a perfectly rational and reasonable thing to do. Its only about....when?*

SUBMISSION ENDS

Health, Social Care and Sport Committee
Consultation on Suicide Prevention

Submission from Connecting with People: An Innovative Approach to Suicide Prevention

Executive Summary

This submission is made by Connecting with People (CwP) which develops and delivers best practice high quality training based on evidence and research-based principles to employees with healthcare and/or safeguarding responsibilities. We are motivated by the belief that self-harm and suicide prevention is better regarded from a 'whole community' perspective within organisations, and our approach has been adopted and delivered to a number of bodies including NHS Trusts and Health Boards, third sector and educational establishments throughout the UK, Jersey, Ireland and South Australia. In South Australia, and some settings in the UK, our training has been added into their suites of mandatory training. It has been the thinking of CwP that potential MH emergencies, such as associated with suicidal thoughts and self-harm, should receive training akin to cardiac resuscitation across the UK.

CwP's approach to suicide prevention combines compassion and governance with the aim of improving the assessment of people at risk of suicide through enhancing the quality, consistency and documentation of assessments and care, and Crisis and Safety Plans. Our aim is to ensure that every person experiencing suicidal thoughts or behaviours at any time and/or who self-harms is taken seriously and supported to co-produce a Safety Plan. This is regardless of the presence of a formal diagnosis at the time of contact. Our programmes build clinicians' knowledge and confidence to help them assess patients in emotional, or any form, of distress who may experience suicidal thoughts, and be able to respond appropriately in a compassionate, inclusive, and non-stigmatising manner.

CwP uses an assessment framework (SAFETool) which allows research to be linked with clinical practice. This is supported by training in suicide and self-harm awareness, mitigation, compassion in the workplace, emotional resilience, and resourcefulness. Other programmes are directed at specific responsible roles such as line management. These programmes support the development of a common language and approach, promoting consistent documentation of the assessment process, and a more integrated response across statutory services, third sector providers and communities as well as workplaces in other sectors.

A web-based app of the SAFETool is available in addition to a paper based version. The app can be fully integrated securely with NHS IT systems. The SAFETool Triage has been developed for use in the community, Primary Care, Secondary Care hospitals, and mental health services (both adult and young people) during the initial triage assessment by practitioners in a first point of contact role or by a first responder professional.

"Suicide is preventable, it is not inevitable. Suicidal people are in extreme emotional pain and are often ambivalent about dying. Their lives can be saved right up until the final moment. People take their own lives when the distress of living becomes too great, or personal circumstances seem intolerable. We need everyone to know that suicidal thoughts are a sign to change something in their life, not to end their life. It is possible to recover with the right support."

Dr Cole-King, Clinical Director of Connecting with People

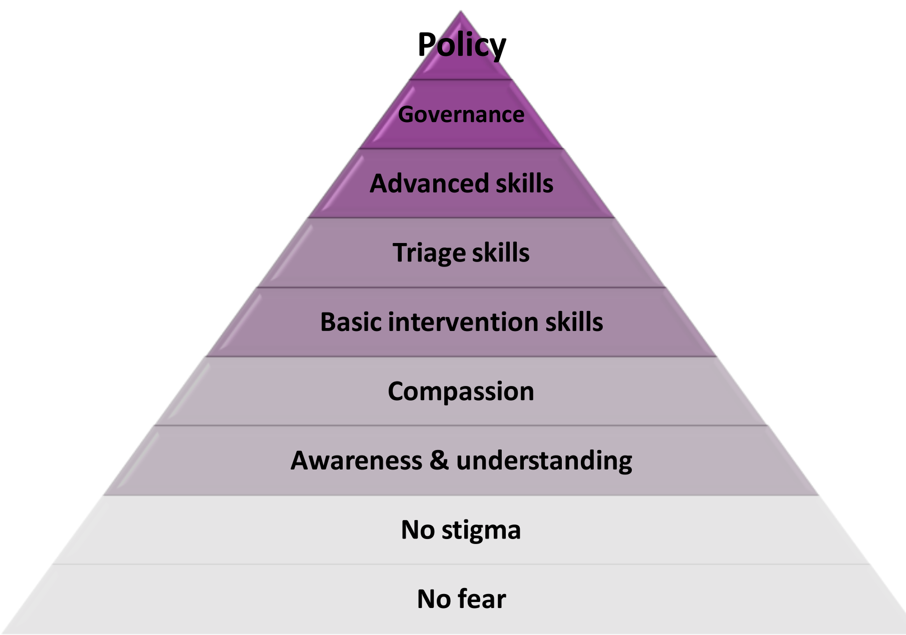
Connecting with People Training Programmes

CwP offers a suite of training programmes, with characteristics of a quality improvement initiative. The training is designed to break through and bypass unconscious barriers to the identification and intervention of people at risk of suicide such as fear, stigma, desensitization, personal experiences of suicidal distress or suicide loss, lack of time (real or perceived), lack of personal agency, and the erroneous sense that suicide is inevitable. CwP was designed to take participants on an emotional and experiential journey in addition to improving the knowledge, skills and confidence of people who come into contact with others in emotional distress, at risk of suicide and/or utilising self-harming behaviours.

CwP promotes the paradigm shift of suicide *mitigation,* which starts with suicidal thoughts being taken seriously and met with compassion and understanding on every occasion. The ethos of CwP is inviting people to consider 'What can I do to support this person to not want to end their life today… this week… this month?' In a Primary Care or frontline role, a compassionate tailored triage assessment should be done, leading to an appropriate and proportionate referral. The Classification of Suicidal Thoughts provides a common language to describe the nature and intensity of suicidal thoughts. Use of common language to describe suicidal thoughts can help to improve the consistency, accuracy and appropriate prioritisation of referrals (Waters & Cole-King 2017). In all cases, the principle is that those who have previously been deemed 'attention seeking' are in fact 'connection seeking' and this requires compassionate engagement every time.

Our training includes a suite of clinical frameworks, some of which have been adapted for non-mental health settings, including Primary Care, the third sector, education, and the police and criminal justice system. Starting from the premise that everyone in society has a role in suicide prevention, CwP offers different training modules designed for a range of different settings, but with the same core messages and a common language. Through this modular framework CwP enables people with very different levels of expertise, competence and confidence to receive training suited to their needs.

CwP training is delivered both on a Direct to Participant basis and also via in-house trainers in larger organisations by staff who have completed a Train-the-Trainer (TTT) programme. All CwP trainers must be licensed and undergo an annual reaccreditation. The material is updated annually which is shared with the trainers at the time of their reaccreditation. We also ensure the trainers have fidelity to the model for consistency, quality and safety. There are seven different 'bite sized' modules of between 2 and 2.5 hours' duration, designed for different sectors, including a module specifically designed for young people over the age of 13. A robust safety protocol for delegates is followed during the training, as delegates can often become distressed given the sensitivity of the subject matter. Live and real stories are used throughout the training, submitted by experts and those with lived experience, whilst at the same time carefully constructed case studies are used for interactive training, all of which is scrutinised and approved by a significant Expert Reference Group.



For the last decade, CwP training has been delivered in several different countries and to many different sectors including health and social care, third sector, education, universities, police, secure services, health and social care students, community members, and carers. It has also been adapted using co-production for different cultural groups.

Important Factors in Healthcare

Understanding which factors differentiate between those who will have thoughts of suicide and those who will act upon those thoughts and attempt suicide, is still elementary (Klonsky & May, 2014;). Demographic risk factors increase the suicide risk of a whole population across its lifetime, but do not predict the suicide of an individual at a single time-point. Furthermore, suicide risk assessment is itself a complex intervention, which means that it is not totally predictable and the process is influenced by practitioner, patient and organisational factors (Cole-King et al., 2013).

Absence of risk factors, however, does not mean the absence of the risk of suicide (Cole-King et al., 2013). Current suicide risk assessment tools are often weighted towards demographic risk factors (which may be as common in the general population) and have largely been developed without a solid empirical basis. This is the finding of a recent *BMJ* 'state of the art' review of suicide risk assessment and intervention in people with mental illness (Bolton, Gunnell & Turecki, 2015).

NICE guidelines (27) on the long-term management of self-harm state "do not use risk assessment tools and scales to predict future suicide or repetition of self-harm". Research has been unable to establish how thoughts of suicide progress from to planning to action. Nock's summary of variables examined in the World Health Organization (WHO) studies notes that they explain 62% of the variance in suicide ideation, but "only 7.1% of the variance predicting suicide attempts among ideators" (Glenn & Nock, 2014, p. S177).

Research has identified several strong predictors of having thoughts of suicide but nothing that strongly differentiates amongst those people who will progress to attempt suicide.

We need a new approach. People experiencing suicidal thoughts and feelings are extremely ambivalent and their life can be saved up until the final moment. Of note, CwP emphasises the fact that all patients need a co-produced Safety Plan and not just those judged to be at a higher risk. Compassionate communication with people at risk of suicide can save lives, is essential to the quality of the information underpinning an assessment, and can be the tipping point back to safety. Researchers call for a 'low level intervention' which can benefit everyone and not just focus efforts on those people judged to be at highest risk.

Even if a patient does not disclose, or has not yet developed suicidal thoughts, a practitioner is guided to co-produce, at the very least, an 'ultra-brief' Safety Plan with their patient to equip and prepare their patient should they ever became suicidal in the future. This in turn builds the patient's own resilience and resourcefulness. If patients do disclose suicidal thoughts, the practitioner can then undertake a triage or tailored assessment including the co-production of a comprehensive Safety Plan. The identification of reasons for living, and activities to support calm, relaxation and distraction whilst anticipating triggers is essential. This is backed up by social and emergency support mapping, whilst the whole process is embedded with building hope and aspiration.

Important Factors in Primary Care

The scale of need across consultations with a GP has been widely stated as 1 in 3 to 4 presentations have some mental health/psychological component, and that regardless of the acuity or complexity of the problems that arrives at the door of GP, they need to be equally capable of managing an appropriate response to these scenarios. We must also remember that the highest cause of death in men under 45 is suicide, hence this is a priority area as the vast majority will be registered with a GP. 91% of people with a mental health problem will be treated in Primary Care (National Survey of patients; 2003).

Only around one third of all suicides occurred in patients who had been in contact with mental health services in the year prior to their death. Of the 1,722 10-19 year olds who died by suicide only 14% were known to specialist services. In Wales during 2005-2015, 817 deaths (23% of general population suicides) were identified as having been in contact with mental health services in the 12 months prior to death (National Confidential Enquiry 2017)

Tension exists in general practice between the 'gold standard' of exploring every suicidal thought or action and the reality of a 10 min consultation (Cole-King & O'Neill 2017) . Clearly time is a factor in the Primary Care sector; time to learn, time to deliver consistent and high quality care, and time to manage one's own needs dealing with highly impactful consultations. However, this is solvable; Primary Care is almost universally already able to deliver excellent supportive care, although basic and emergency mental health skills are widely variable therefore additional skills would simply level the playing field. Primary Care could then manage risk, mitigate risk, and respond to risk far better to include enhanced approaches to congruent referral to Secondary Care. In doing this, it will also avoid the 'bounce' culture that is a regularly stated

criticism about Secondary Care from Primary Care as well as poor referral quality as a stated criticism conversely.

As above, whilst GPs possess the right platform of skills to manage many mental health problems, there is still a confidence and training gap around mental health and suicide. The tools that Primary Care has in place from identification, to assessment, from triage, to response, are significantly diverse, blunt, variable, or even non-existent. Any assessment framework should be comprehensive, easy to use, and consistent not only across Primary Care but recognisable at the interface with Secondary and Community Care.

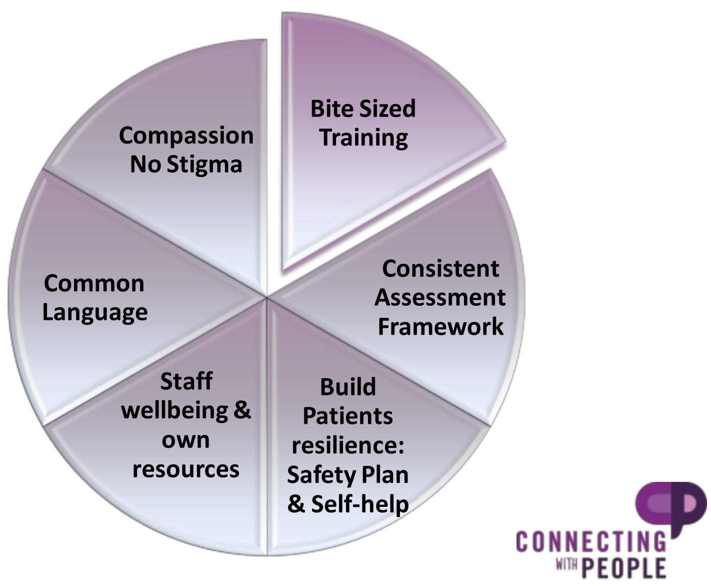
Other factors that play into this are dependent upon the communities that Primary Care serves as there is great variation. We see practices that are located in areas of extreme affluence, others multi-varied, and others still that manage extreme deprivation day in and day out. Although the association with region is complex, there are nevertheless associations with deprivation and suicide both globally and in the UK. Suicide risk in England and Wales showed a two-fold increased risk from the least to the most deprived (Health Statistics Quarterly 31; Autumn 2006). Furthermore, culture, sexuality, faith and beliefs need to also be considered.

Summary of Barriers in Primary Care

- Suicide is seen as the preserve of specialist mental health services;
- It's difficult for busy GPs to access training;
- Training not on an equal footing with training regarding physical health – such as mandatory cardiac resuscitation. There is no MH or suicide/self-harm equivalent of the annual resuscitation training. This, despite the fact that GPs are likely to have more contact with patients in suicidal distress than those with an acute cardiac condition;
- Lack of consistency for a referral decision and no objective or evidence based referral approach;
- Over-reliance on risk assessment tools i.e. PHQ9 and demographic risk factors;
- Challenge of covering the issues that are affecting people when a GP only has ten minutes with a patient;
- Current assessment frameworks are neither GP nor patient 'friendly';
- Current assessment frameworks for patients in distress are often cumbersome, paper-based, or on standalone systems that are not linked to existing clinical systems such as SystmOne and EMIS – the leading Primary Care patient management systems. GPs need a tool that is effective and easy to use.

Suggestions on How to Overcome Barriers in Healthcare

The CwP SAFETool Triage (PHE & HEE, 2016) has been designed for settings where a lengthy assessment may not be required. It rapidly facilitates a low level intervention at the point people become distressed, potentially even *before* they develop suicidal thoughts. The SAFETool Triage includes the most important elements of such an assessment and has been shaped by the CwP Expert Reference Group, which includes international suicide prevention academics, practitioners, and people with lived experience.



SAFETool

The CwP training provides a set of 'tools' to support people to intervene with someone at risk of suicide appropriate to that person's role and expertise. The Suicide Assessment Framework E-Tool (SAFETool) combines all the clinical tools and frameworks to ensure a consistent approach, and that the latest research and best practice are implemented.

SAFETool has been extensively peer reviewed and shaped by the CwP Expert Reference Group (ERG) and published in peer reviewed journals. The ERG includes international academics, practitioners and people with lived experience of suicidal distress, survivors of suicide, carers, and those bereaved by suicide. SAFETool is not intended to replace judgment, but to provide valuable guidance to a front line practitioner on key aspects of an assessment and co-producing a safety plan which helps the distressed person build their wellbeing, resilience and resourcefulness.

SAFETool forms part of the Suicide Response modules and together with the training, its use facilitates the development of a compassionate approach, a common language, consistent documentation and a more integrated response across statutory services, third sector providers and communities. The Suicide Response Part 1 module is designed for people in safeguarding and frontline roles such as emergency care, primary healthcare, secure services roles. It trains delegates in how to use the SAFEToolTriage to support their triage role: a triage assessment, referral and co-production of an immediate safety plan.

A web-based app version of the SAFETool is available and can be integrated securely with NHS IT systems in addition to a paper based version. A shorter version - The SAFETool Triage - was developed for Primary Care, the general hospital, triage assessments by a first point of contact or by a first responder professional (PHE & HEE, 2016). It facilities a low-level intervention at the point people become distressed, potentially even *before* they develop suicidal thoughts or plans.

CwP's SAFETool guides GPs through two very important processes: the assessment process provides a set of questions focused upon the patient's personal background, clinical history and current circumstances to assess their mood, aspects of their mental state and details of their thoughts and feelings of suicide. SAFETool is not intended to replace a doctor's clinical judgment, but to provide valuable guidance (supported by training) to a GP regarding the key aspects to cover whilst supporting practitioners to co-produce an appropriate Safety Plan with patients and helping them to build wellbeing, resilience and resourcefulness.

CwP collaborated with NHS Arden & GEM CSU's Clinical Systems Team to develop an electronic version of the SAFETool for SystmOne, with an EMIS (including EMIS Web) version soon to follow. SAFETool can be easily uploaded onto GPs' desktops and draws upon suicide prevention research. This enables GPs to undertake an appropriately tailored assessment of a patient at risk of suicide and provide an immediate treatment plan and a co-produced Safety Plan.

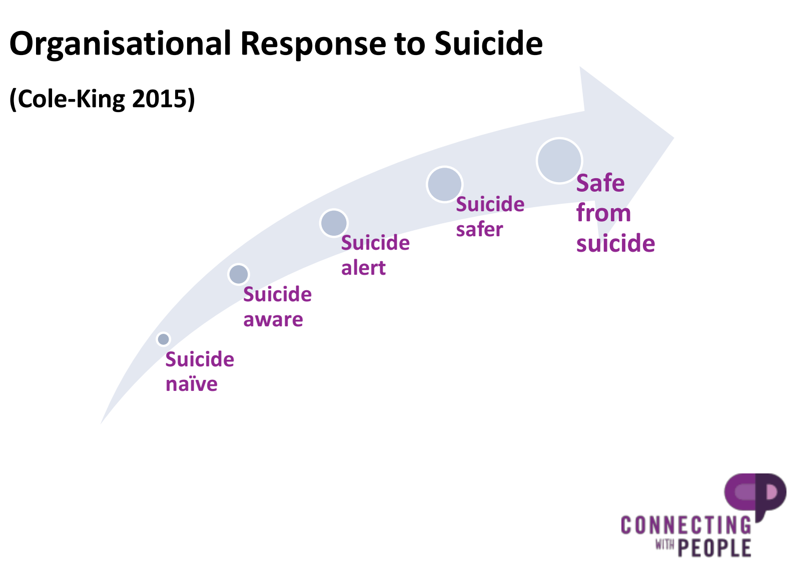
SystmOne is the IT system used by approximately 40% of Primary Care practices across England: EMIS systems are prolific across the UK. The SAFETool Triage guides practitioners to undertake a collaborative, evidenced-based assessment and culminates in the co-production of an appropriate Safety Plan, even if patients are unable to disclose suicidal thoughts (e.g. due to stigma, fear or embarrassment) or have not yet developed suicidal thoughts. In either case, they are invited to co-produce an 'ultra-brief' Safety Plan. Making such a plan develops a patient's own skills to deal with any potential future suicidal thoughts.

Warwickshire, Northamptonshire and Derbyshire have adopted a whole county-wide approach to training GPs

This involves offering training within Protected Learning Time sessions, as well as in convenient locations close to GP practices. The South Warwickshire CCG have also employed the Out Of Hours GP Service to provide cover at GP practices to enable all the GPs in their locality to attend the CwP training and still provide clinical care to patients. Additionally training was provided for school nurses.

Northamptonshire and Derbyshire have adopted a Train-the-Trainer approach and have in-house capability to deliver the training within both Primary and Secondary Care services.

Stages of learning for individuals, teams, organisations and communities



Suicide Naïve: You have little or no knowledge of suicide and do not think that suicide or suicide prevention has any relevance to you or your organisation. Due to this, you are highly likely to be fearful of encounters involving suicide, you may not be aware of the latest evidence, and may also have had negative experiences of this area in the past.

Suicide Aware: You are aware of suicide in general but your understanding is limited to what you see online or in the media; you are aware that you do not have the confidence, skills, or knowledge to know what to do to prevent suicide. This can be extremely anxiety provoking as you are aware of the issues but feel unable to respond safely. This can also cause ‘organisational anxiety’ and unconsciously cause either an excessive or inadequate response to identified risk.

Suicide Alert: You now have the attitudes, skills, knowledge, confidence and governance to identify and respond appropriately to someone at risk of suicide, although this may still not be across the whole organisation.

Suicide Safer: You have an excellent understanding of suicide with the attitudes, skills, knowledge, confidence and governance to identify and respond appropriately to someone at risk of suicide. You have personal experience of preventing suicide and effective interventions with patients at risk of suicide.

Safe from Suicide: This is an aspiration to describe a situation when patients will be **Safe from Suicide** when their family and friends, community and all their health and social care contacts reach the highest levels of understanding, compassion, skills and confidence to identify and respond to someone at risk of suicide according to their role and expected expertise. Your patients have the best possible care and every one they meet will have a high-level understanding of suicide and be able to play their part in an effective intervention and safety plan. Everyone at risk of suicide will have a co-produced safety plan with explicit reference to removal of access to means and will be strategically building their wellbeing, resilience and resourcefulness.

Evaluations and impact

Numerous in–house audits and evaluations of the CwP training programme have been undertaken.
Below is a summary of external evaluations.

Bangor University

An independent evaluation by Bangor University in an Emergency Department showed post training improvements in attitudes, self-reported knowledge in assessing patients, and documentation of compliance with NICE Guidelines. (Knipe M., *et* al 2010).

Feedback from ED staff post-training

(103 participants, 99% response rate):

- **100%** of respondents now believed they had a role in suicide prevention
- **97%** thought the training had increased their understanding of self-harm and suicidal thoughts.
- **85%** agreed they would now be able to show more empathy with patients attending ED following self harm and/or with suicidal thoughts.

STORM Skills CIC

An independent evaluation of CwP training by STORM Skills CIC showed post training improvements in attitudes, self-reported knowledge and confidence (Parker C., Green G. 2016) ***(details on request)***

University of Wolverhampton

The University of Wolverhampton (UOW) pioneered a whole-system approach to student self-harm and suicide, and won the *2017 Times Higher Educational Supplement Award* in recognition of their innovative student support across the university. Thus far, they have trained upwards of 750 people in the CwP programmes including students (nursing, social work, policing) and university staff, the Vice Chancellor, accommodation staff, security staff, student union representatives, conduct and appeals and finance, HR and academic staff. According to an internal audit by UOW:

- January 2015 (before CwP training) **25 students** were referred to the well-being coordinator for suicidal ideation
    - 2015 staff received CwP training (academics, counselors, security staff, catering, housekeeping, cleaners)
- January 2016 – 5 student referrals for suicide ideation
- January 2017 – 0 student referrals for suicide ideation

Police officers

Summary of feedback from a couple of Suicide Awareness modules delivered to Police officers (N= 40, 100% response rate)

- 90% 'know more about the myths associated with suicide and the barriers to seeking help'
- 90% 'have better understanding of the prevalence of suicide'
- 93% 'understand role of empathy and concept of mitigating suicide'
- 93% 'know how to talk to someone who is in emotional distress'
- 88% 'know where to seek help and how to get hold of compassionate leaflets e.g. 'Feeling on the Edge'

Nightline Student Association

The Nightline Student Association (student listening service) adopted CwP in 2013 and deliver the training to their volunteers. An evaluation of the first two years confirmed the of positive impact and cost-effectiveness of CwP with a module cost of £27 per head (Nightline 2014). In 2015, they won the coveted 'Helpline of the Year' award despite other large well known national helplines also being shortlisted.

Nightline feedback from the *Suicide Awareness modules*

N=198

- 96% 'understanding on the subject has increased'
- 97% 'know more about the myths associated with suicide and barriers to seeking help'
- 94% 'have better understanding of the prevalence of suicide'
- 98% 'understand role of empathy and concept of mitigating suicide'
- 97% 'know how to talk to someone who is in emotional distress'
- 83% 'know where to seek help and how to get hold of compassionate leaflets

Secondary Healthcare Trust (details on request)

Internal audit of consecutive attendees of the CwP training (n=800)

Suicide Awareness module: participant feedback form results

- 92% of attendees their "understanding on the subject has increased"
- 94% "know how to talk to someone who is in emotional distress"
- 87% "know more about the myths associated with suicide and the barriers to seeking help"
- 84% "know where to seek help and how to obtain the suite of compassionate leaflets (e.g. *Feeling on the Edge*)

Suicide Response Part 1 module: participant feedback form results

- 91% "feel able to put these learning outcomes into practice if required as a result of this training"
- 93% "understand the value and limitations of risk factor identification and the importance of red flag warning signs"
- 85% "can co-create an immediate safety plan with a patient"
- 82% "can co-create a long term mitigation plan which includes social support mapping and a contingency plan"
- 92% "understand the importance of supervision and self-care"

Testimonials and national recognition

2017 Included Local Government Association 'Suicide prevention A guide for local authorities'

2016 Included in Public Health England/Health Education England 'Mental health promotion and prevention training programmes: Emerging practice'

2016 Cited in Parliamentary Briefing, "On Board with Suicide Prevention"

Endorsed by the Royal College of Nursing

Supported by Royal College of General Practitioners Remote and Rural Forum

Participant Evaluation Forms: feedback results

I find Connecting with People truly inspiring. The experience has helped immeasurably with my confidence to support distressed callers.
(Helpline volunteer)

As a non-practitioner, I liked how the discussion and materials followed a systematic process that was clear, "simple," and comprehensive.. The resources resonate with broad audiences, not just with those in the mental health field. On a personal note, I was a mother of two suicide-risk daughters. Had I had the Suicide Assessment Framework as a resource, I would have been light years ahead of where I was in trying to help them, the family, their mental health providers, school staff, and myself.
(Healthcare Manager)

It was useful to learn that there aren't any risks in trying to reach out to a suicidal stranger and that you can't make them worse by broaching the topic.
(Nightline volunteer)

The best course/teaching sessions I have attended as a postgraduate. The course not only offered practical advice on how to discuss patient's suicidal thoughts, but more importantly how to reduce the patient's risk of suicide. I now feel able and confident to create and discuss a 'safety plan' for the patient. I feel empowered that by discussing a patient's suicidal thoughts I can assess them more accurately, will refer patients more appropriately to Secondary Care services, and by discussing simple practical solutions that I can actually reduce their risk of dying. This course should be compulsory for all GPs in training.
(General Practitioner)

*Inspiring (*full time carer for wife)

Excellent...the sooner the training gets rolled out across all sectors the better.
(Third sector development officer)

I used to think people who killed themselves were incredibly selfish now I can see how desperate they must have been.
*(*Consultant in a General Hospital***)***

I learnt a lot more about what 3rd sector services are out there, plus apps + websites to offer support or options rather than feeling trapped + helpless.
(Youth worker)

A new way of thinking about how to tackle suicide.
(Red Cross volunteer)

Resources for People at Risk of Suicide developed by Connecting with People

Staying safe if you're not sure life's worth living has practical, compassionate advice and links for people in distress http://www.connectingwithpeople.org/StayingSafe

The ***U Can Cope*** film (22 minutes long) inspirational stories of three people for whom life had become unbearable but who found a way through with support and three self-help resources http://www.connectingwithpeople.org/ucancope

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Inquiry into Suicide Prevention

Ymchwiliad i Atal Hunanladdiad

Ymateb gan Unigolyn

Response from An Individual

Inquiry into Suicide Prevention

HISTORY OF S ILLNESS

My name is . I am 42 years of age and live with my husband and three children. On the 2nd December 2016 my brother in law, , took his own life due to depression at the age of .

was an extremely intelligent man with everything to live for. He went through University and gained a Bachelor of Arts and Masters Degree. went on to work as Sports Manager at University. Unfortunately, went through a very acrimonious divorce. During his divorce his ex-wife stopped all access to their two children and it was a very difficult time for all the family. saw a solicitor to enable him to have access to the children and after a very lengthy process he was granted weekly access, unfortunately this cost over £36.000 and he was forced to take voluntary redundancy in order to pay the solicitor fees.

spent most of his time after his redundancy looking for a permanent job. He joined an agency where he was given hours as a supply teacher in the comprehensive schools in and . applied for many posts but was deemed 'over-qualified' and he found this very difficult. As time passed, even though was seeing the children he became very distant, obsessed with trying to find work.

In January 2016 started coming to my home almost every day. He informed me that he was feeling very low in mood and did not see the point in anything anymore. We talked for hours about how we could make things better but he struggled to see anything in a positive way. As the weeks passed became more and more depressed to a point where he was coming to see me and spending the entire time crying, rocking back and forth and telling me that he felt extremely depressed. At this point I advised that he needed to see his doctor and I offered to go along with him. He informed me that he had already been to see his GP in the past and he had been on anti-depressants for a while but they were not working as well.

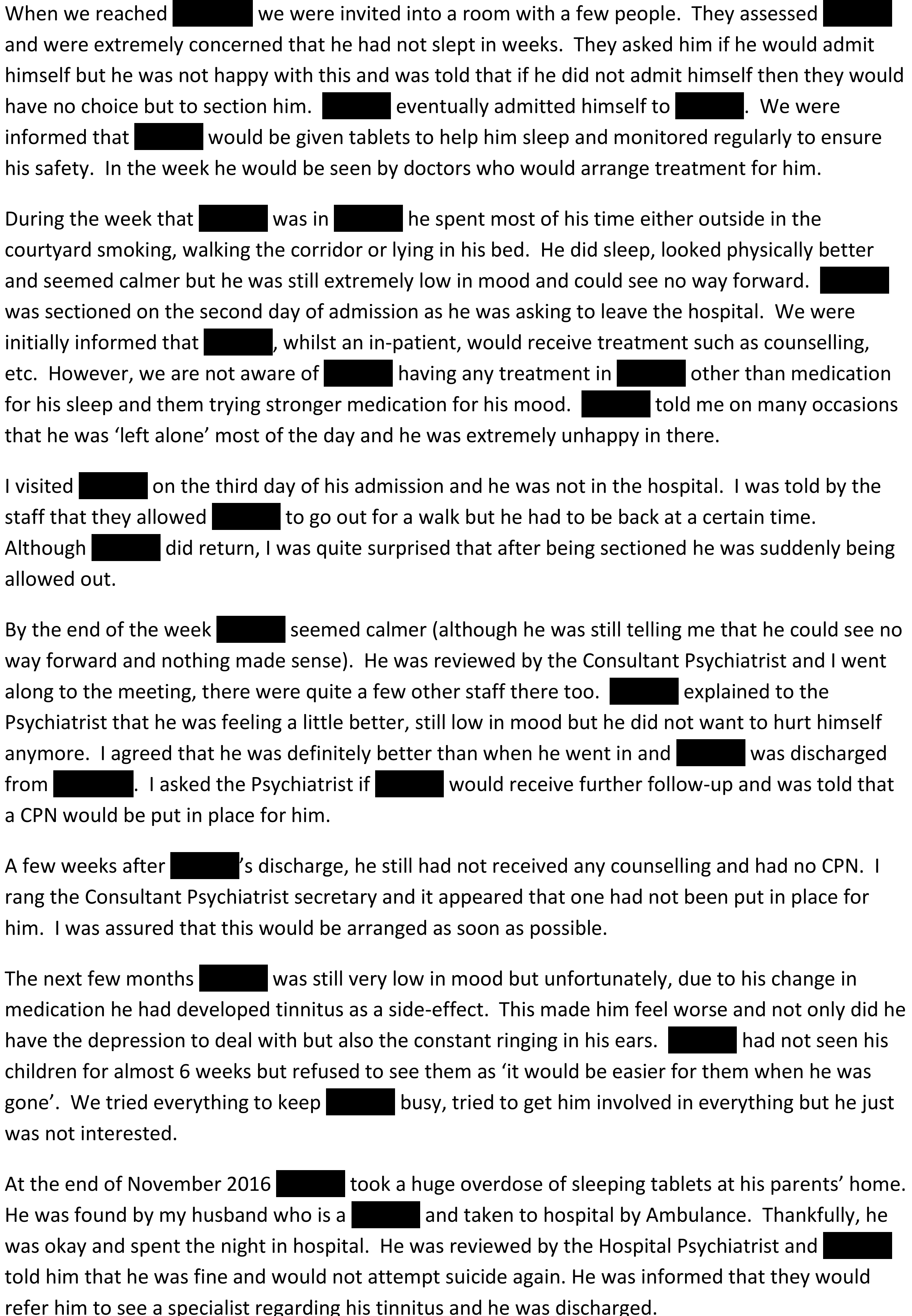
I attended the GP surgery with and the GP arranged for to see a Community Psychiatric Nurse in the GP Surgery for assessment. I went along with and we sat in the office with a female nurse for almost 2 hours. explained to her that he felt very depressed and that nothing made him happy. He explained that he had gone through a very bad divorce and had lost his children. She asked him if he felt like he wanted to hurt himself and he said he had thought about it but he had no intentions of doing anything about it. explained to me on a few occasions that he was not 'brave enough' to take his own life. The nurse explained to that counselling would help and that they would change his prescription. Unfortunately there was a very long waiting list to see a counsellor and would have to wait.

During the next few months █████ went from crying constantly to talking about the same things over and over again. He would come and see me almost every day and if I was not at home he would ring me on my mobile. He would panic if he could not talk to me and was scared that I would die and he would have nobody to talk to (even though his family tried to be very supportive). █████ constantly went over his divorce and the issues that went along with it. He would repeat the same things over and over and this would go on for 3-4 hours at a time. █████ returned to his GP surgery and his GP changed his prescriptions on a few occasions but nothing seemed to be helping.

By June 2016 █████ had started to talk about taking his own life. At this point I knew that he needed to be seen urgently and I asked him to arrange another appointment with his GP. █████ was given an appointment to be seen at █████ by the Mental Health Team. I went along with █████ to this appointment and █████ was seen by two professionals, a male and a female. █████ told them how he felt and that he had thought of taking his own life. He told them that he thought about the same things over and over and that he could not stop thinking. He explained that he couldn't concentrate when he was at work as a supply teacher and that nothing made sense to him anymore. The male professional was very calm and supportive with █████ but the female was finding █████ very frustrating, unfortunately █████ picked up on this and asked her if she was 'finding him frustrating'. She replied 'yes █████, I am, because you are not willing to accept any help and we are trying to help you'. I did not find this very professional but I assumed that they were the experts on this and knew what they were doing. They told █████ that depression did not last and in 6 months he would feel much better. █████ told them that 'he would be the one to prove them wrong'. He was adamant that he would never feel any better. When asked if he knew how he would take his own life he informed them that he had not thought about it and even though he had considered it he currently had no suicidal intentions. This was all they needed to transfer █████ back to primary care!!!!

After months of █████ constantly wanting to talk to me, suddenly in August he stopped. He informed me that he was okay and did not need to speak to me anymore and put the phone down on me. I was very wary of this and it deeply concerned me. I rang █████ again and asked him why he did not feel he wanted to talk to me and he told me he had made his decision. He again put the phone down on me and again I called him back. After pushing him to tell me what he meant he finally admitted to me that he had bought a rope and in the morning, after dropping his child off at school, he was going out in his car with the intentions of taking his own life. I informed his parents immediately of what he had said and first thing in the morning my husband drove to the house and took █████'s car keys from him. █████'s dad took the little one to school and I drove down after dropping off my children at school.

When I reached the house █████ was in a terrible state. It looked like he hadn't slept in weeks and he was very annoyed that we had stopped him going out. I begged him to let me take him to the doctors but he was adamant that he wanted to 'end his life'. I rang the doctor's surgery, who were amazing, and asked me to bring █████ immediately to the surgery. It took some time to convince him to come with me but he eventually did and was seen by the GP. The GP rang █████ expressing her concern that █████ would hurt himself and we were asked to take him straight there.



When we reached ██████ we were invited into a room with a few people. They assessed ██████ and were extremely concerned that he had not slept in weeks. They asked him if he would admit himself but he was not happy with this and was told that if he did not admit himself then they would have no choice but to section him. ██████ eventually admitted himself to ██████. We were informed that ██████ would be given tablets to help him sleep and monitored regularly to ensure his safety. In the week he would be seen by doctors who would arrange treatment for him.

During the week that ██████ was in ██████ he spent most of his time either outside in the courtyard smoking, walking the corridor or lying in his bed. He did sleep, looked physically better and seemed calmer but he was still extremely low in mood and could see no way forward. ██████ was sectioned on the second day of admission as he was asking to leave the hospital. We were initially informed that ██████, whilst an in-patient, would receive treatment such as counselling, etc. However, we are not aware of ██████ having any treatment in ██████ other than medication for his sleep and them trying stronger medication for his mood. ██████ told me on many occasions that he was 'left alone' most of the day and he was extremely unhappy in there.

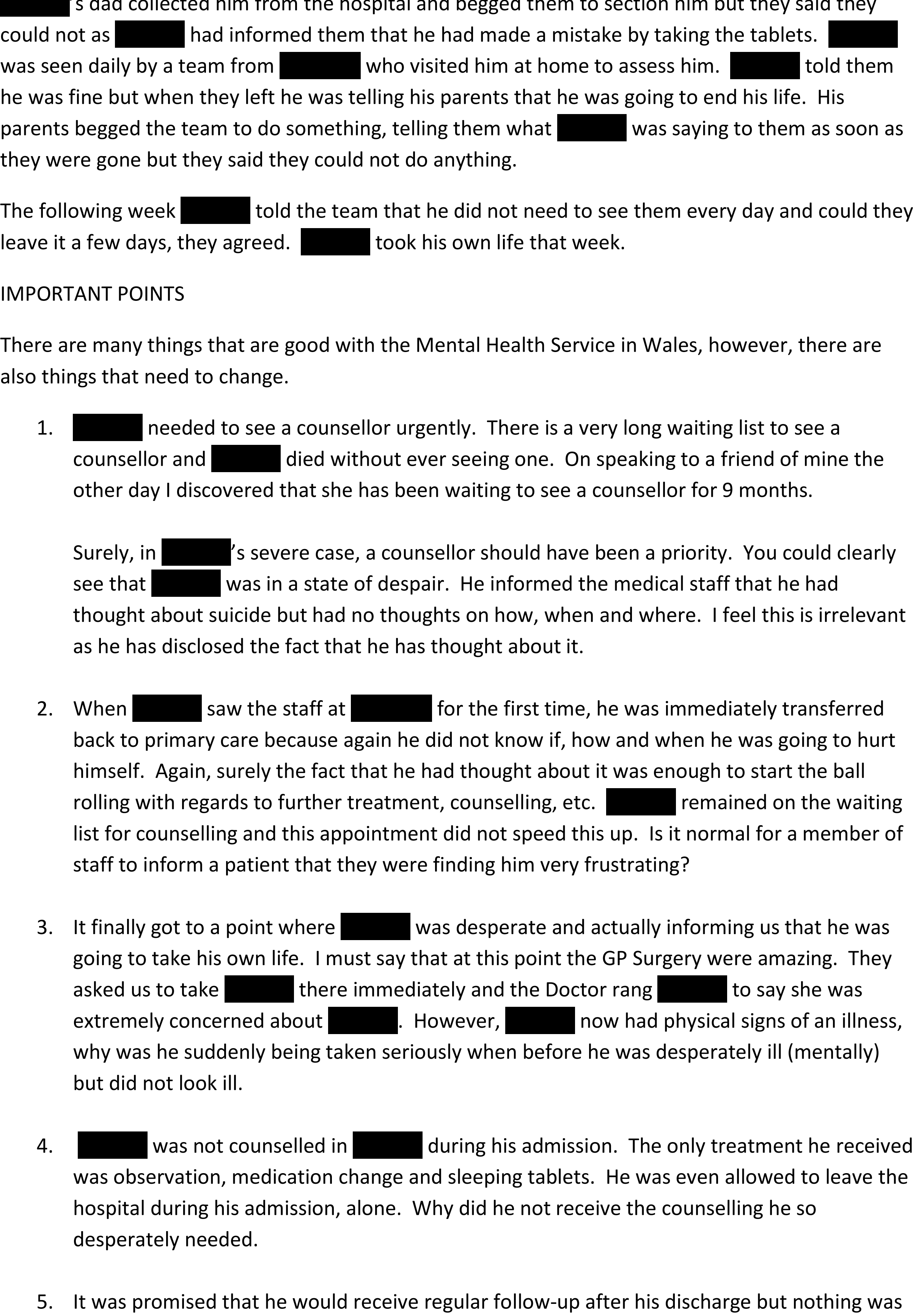
I visited ██████ on the third day of his admission and he was not in the hospital. I was told by the staff that they allowed ██████ to go out for a walk but he had to be back at a certain time. Although ██████ did return, I was quite surprised that after being sectioned he was suddenly being allowed out.

By the end of the week ██████ seemed calmer (although he was still telling me that he could see no way forward and nothing made sense). He was reviewed by the Consultant Psychiatrist and I went along to the meeting, there were quite a few other staff there too. ██████ explained to the Psychiatrist that he was feeling a little better, still low in mood but he did not want to hurt himself anymore. I agreed that he was definitely better than when he went in and ██████ was discharged from ██████. I asked the Psychiatrist if ██████ would receive further follow-up and was told that a CPN would be put in place for him.

A few weeks after ██████'s discharge, he still had not received any counselling and had no CPN. I rang the Consultant Psychiatrist secretary and it appeared that one had not been put in place for him. I was assured that this would be arranged as soon as possible.

The next few months ██████ was still very low in mood but unfortunately, due to his change in medication he had developed tinnitus as a side-effect. This made him feel worse and not only did he have the depression to deal with but also the constant ringing in his ears. ██████ had not seen his children for almost 6 weeks but refused to see them as 'it would be easier for them when he was gone'. We tried everything to keep ██████ busy, tried to get him involved in everything but he just was not interested.

At the end of November 2016 ██████ took a huge overdose of sleeping tablets at his parents' home. He was found by my husband who is a ██████ and taken to hospital by Ambulance. Thankfully, he was okay and spent the night in hospital. He was reviewed by the Hospital Psychiatrist and ██████ told him that he was fine and would not attempt suicide again. He was informed that they would refer him to see a specialist regarding his tinnitus and he was discharged.



█████'s dad collected him from the hospital and begged them to section him but they said they could not as █████ had informed them that he had made a mistake by taking the tablets. █████ was seen daily by a team from █████ who visited him at home to assess him. █████ told them he was fine but when they left he was telling his parents that he was going to end his life. His parents begged the team to do something, telling them what █████ was saying to them as soon as they were gone but they said they could not do anything.

The following week █████ told the team that he did not need to see them every day and could they leave it a few days, they agreed. █████ took his own life that week.

IMPORTANT POINTS

There are many things that are good with the Mental Health Service in Wales, however, there are also things that need to change.

1. █████ needed to see a counsellor urgently. There is a very long waiting list to see a counsellor and █████ died without ever seeing one. On speaking to a friend of mine the other day I discovered that she has been waiting to see a counsellor for 9 months.

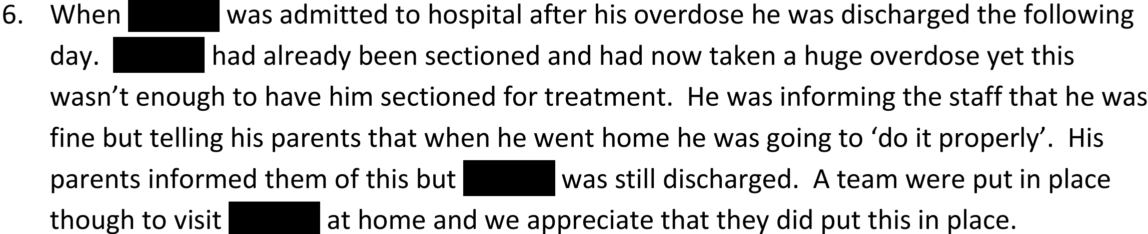
   Surely, in █████'s severe case, a counsellor should have been a priority. You could clearly see that █████ was in a state of despair. He informed the medical staff that he had thought about suicide but had no thoughts on how, when and where. I feel this is irrelevant as he has disclosed the fact that he has thought about it.

2. When █████ saw the staff at █████ for the first time, he was immediately transferred back to primary care because again he did not know if, how and when he was going to hurt himself. Again, surely the fact that he had thought about it was enough to start the ball rolling with regards to further treatment, counselling, etc. █████ remained on the waiting list for counselling and this appointment did not speed this up. Is it normal for a member of staff to inform a patient that they were finding him very frustrating?

3. It finally got to a point where █████ was desperate and actually informing us that he was going to take his own life. I must say that at this point the GP Surgery were amazing. They asked us to take █████ there immediately and the Doctor rang █████ to say she was extremely concerned about █████. However, █████ now had physical signs of an illness, why was he suddenly being taken seriously when before he was desperately ill (mentally) but did not look ill.

4. █████ was not counselled in █████ during his admission. The only treatment he received was observation, medication change and sleeping tablets. He was even allowed to leave the hospital during his admission, alone. Why did he not receive the counselling he so desperately needed.

5. It was promised that he would receive regular follow-up after his discharge but nothing was done. In fact, the only reason anything was put in place was because I chased this up myself.



6. When was admitted to hospital after his overdose he was discharged the following day. had already been sectioned and had now taken a huge overdose yet this wasn't enough to have him sectioned for treatment. He was informing the staff that he was fine but telling his parents that when he went home he was going to 'do it properly'. His parents informed them of this but was still discharged. A team were put in place though to visit at home and we appreciate that they did put this in place.

7. The team that visited were fabulous but why did they not take on board what 's parents were telling them about him threatening to take his own life. was telling the team that he was okay but he wasn't and we feel that the family's views need to be taken into account.

8. Even though the family were informing the team about what was saying, the team still did what asked and did not come back to the house. took his own life a few days later.

CONCLUSION

I fully understand that mental health problems are extremely difficult to manage but I feel that things need to change. Counselling needs to be made available immediately, especially in cases where the person is threatening to take their own life.

Whilst in hospital with mental health issues, the patient needs to receive more care to deal with the issues they have and not be left to constantly mull over these issues because they are being left alone. They need to discuss their worries and how they feel and counselling should be readily available. Should they really be allowed out whilst being sectioned for their own safety?

Families matter – listen to what the families are saying as they spend every hour with this person, listening to what they are saying. The families know when their loved one is being honest or trying to deceive someone. More time should be spent talking to the families of the patient to get their opinion on how the person is and how their mood has been.

Classes could be run for families of patients suffering with mental illnesses to make them more aware of what is happening to their loved one and what to look out for. I spent many hours researching 's condition on the internet but this information needs to be readily available for people who do not have this option.

 was suffering and his depression was getting worse due to the tinnitus, an unfortunate side-effect of his medication. Surely, in this case, an immediate referral and appointment should be made as this would be one less thing for that person to worry about.

I know that money is tight within the NHS but I do feel that more should be put into the Mental Health Departments and maybe more time spent trying to understand this dreadful illness.

S 31

Inquiry into Suicide Prevention

Ymchwiliad i Atal Hunanladdiad

Ymateb gan Bwrdd Iechyd Prifysgol Hywel Dda

Response from Hywel Dda University Health Board

Mental Health and Learning Disabilities Directorate

Quality Assurance and Practice Development Team

Clinical Governance Framework including learning from untoward incidents.

The Mental Health and Learning Disabilities Directorate within Hywel Dda University Health Board (MHLD HDUHB) have carried out a thematic review of all the Untoward Incidents (UI) reported and investigated within the Directorate from April 2016 to the current date. The themes identified have informed a work plan for the Quality Assurance and Practice Development Team (QAPDT). The QAPDT was formed in January 2017 with a remit of service improvement, learning from events with a robust mechanism for assurance of implementation of the lessons learned and sharing of good practice across all teams.

The team have led on benchmarking the incidents as described above against the National Confidential Inquiry Suicide Homicide 2016 20 year review which provided Quality/Safety Standards for organisations. These standards were set with an evidence base that demonstrated through adopting these standards organisations reduced the levels of suicide within their organisation. The QAPDT has benchmarked their local findings against these standards and generated an action plan to address areas for improvement in service provision/standards as well as share good practice across teams.

The mechanism for engaging staff at all levels of the organisation has been established and is being rolled out in a phased approach across the directorate. This includes Quality Assurance and Practice Development workshop sessions/clinical governance meetings which are attended by local team leader and clinicians on a monthly basis. The teams are engaged in contributing to improvements within services such as written control documents, audit development and compliance, spot checks and developing clinical excellence in line with NICE guidance and local and national lessons learned.

The QAPDT focussed upon managing the investigations in line with the welsh government expectations in relation to timeliness of completion (60 days) as well as the improved quality of the investigation process and final report. In house training has been delivered to investigators and the approach to investigations has proactively engaged staff from all disciplines and levels as well as carers and families as appropriate.

Further information relating to the development of this process is noted below as it is noted within the quality/safety standards of the NCISH 2016 that those Trusts/Health Boards who implement a robust way of managing UI's have reduced incidents of suicides due to the learning effect.

The implementation of learning and assurance associated with this has identified a gap in data collection and resource available to analyse the themes of the audits. This is being taken forward as a business proposal to the Senior Management Team.

The regional fora for suicide and self harm prevention is being actively attended by the Head of Nursing for MH&LD and the fora has been tasked with providing welsh government with a regional action plan to Welsh Government as to how the Suicide and Self harm Strategy will be implemented in early 2018. Following this a local forum co chaired by Health (Head of Nursing MHLD) and Local Authority (Head of Service) leaders is being established within the HDUHB area. This will create an action plan at a local level which will include key stakeholders including carers, service user representatives and 'first responders' in order to address local priorities such as identifying and reducing the means to suicide locally such as bridges, railways, multi storey buildings. This will be linked in with the partnership groups already in operation.

Themes for learning
Action plans from investigations closed since April **2016** have been reviewed and actions are underway and monitored through the local quality assurance meetings which have been set up as part of the clinical governance structure. The themes which have emerged are as follows:

1. **Carer involvement** at assessment and risk management planning;
2. Q**uality risk assessment and contingency planning** (issues around accuracy of risk assessment, no or insufficient contingency planning, actions taken by teams (i.e. discharge) do not correlate with risk identified)
3. **Documentation** (rationale for decision making and MDT discussions, accuracy and timelines of CTP etc)
4. **Clinical interventions** and access to psychological therapies (little or no evidence of interventions by staff teams, pathway unclear/waiting lists etc)
5. **Discharge**/DNA/engagement process (unclear **rationale** for discharge, opt in letters and DNA following with immediate discharge even though significant risk identified).

Carer involvement at assessment and risk management planning;

Investors in Carers Workshops continue to be held with excellent uptake from teams. All inpatient wards are on track to achieve their Bronze award by January 2018. Some wards are working towards their Silver award.
Community teams are making progress with achieving the Bronze award and some have already achieved this.
The Triangle of Care is currently being piloted in a Crisis Team and an Older Adult Inpatient Unit to be rolled out after review of the pilot during April 2018. This includes assessment of carer needs and identifying a 'care plan' for the carer themselves. Joint work with non statutory provider is in place.

The 15 Steps Challenge is being rolled out with the first challenges having taken place on acute mental health wards. An engagement event is taking place in early December to encourage more carer and service user representatives to sign up and join the challenge team from across MH and LD services. This event is being supported by local non statutory providers although led by HDUHB. The 15 steps challenge is part of the governance framework adopted from NHS England as good practice. The

challenge has derived from a carer's experience of walking into a ward and 'sensing what kind of care her daughter would receive within 15 steps of walking into the ward'. This experience has been translated into a toolkit which prompts questions of the challenge team which is made up of service user/carer representatives and senior staff from the organisation with a view to provide constructive feedback from a service user/carer perspective.

This event is being organised by QAPDT and will form part of the governance arrangements around service user and carer representatives visiting wards. Further dates for 15 steps will be set after this training is completed.

An Audit tool for documentation review has been developed (further detail under 'documentation' and begun roll out in September 2017 which captures carer involvement in Care and Treatment Planning (CTP) process.

Consent to share and confidentiality processes workshop is required to provide clarity and improve confidence of staff in this area.

Quality risk assessment and contingency
WARRN Training – There has been an increased promotion of risk management training with an assessment of need for priority areas to take this training. There has been 100% increase in WARRN training of clinical staff across teams with a plan to roll out further over the coming two years.

Training and support is offered on a team by team or individual basis when in relation to the use of care partner where requested.

STORM training is available to staff which is prioritised for crisis team staff and trainers require an update in the training they are delivering in line with the latest version of STORM.

Documentation, CTP and Care partner
Training/workshops have been carried out for teams in relation to CTP and Care Partner.
In response to lessons learned from incidents, audits and inspections and in agreement with managers through QA forums, the monthly audit for case records has been agreed to be reinstated.
The monthly audit has been updated to reflect timeliness as well as quality of documentation standards against the Delivery Unit, Health Inspectorate Wales and MHA Measure (2010), lesson learned, service user, carer and staff feedback. A workshop session has been delivered to operational managers to ensure clarity of standards within the audit and consistency in their individual assessments.
This has been rolled out across Adult MH community teams since October 2017 with the remainder of the directorate being rolled out in a phased approach. Quality assurance meetings will monitor compliance, performance and improvement plans.
This audit will be carried out monthly and provides immediate results to the team leader.
The audit auto populates graphs and charts for prompt analysis and review in conjunction with Audit department.

The workload that this is generating will require review and additional corporate team support.

Clinical interventions
One CRHT in a rural setting has carried out a focussed piece of work in order to raise awareness and confidence of staff in the use of clinical interventions such as emotional coping skills and crisis management and seen a marked reduction in the number of referrals made to TDS. There is agreed consultation advice and support being provided by TDS. This will be rolled out across all teams and needs analysis for skill development is required.
Training needs analysis required and the Head of Nursing is in process of re-evaluating the mandatory training requirements of staff groups and roles as well as the reporting and monitoring structures of said training.

National Confidential Inquiry for Suicide & Homicide
The learning from the investigations has been benchmarked against quality/safety indicators recommended within the 20 year review. An action plan has been formulated and presented to QSEASC in September 2017. This is a high priority piece of work. Local teams are being made aware of common themes and actions required through QAPD meetings and some pro active work has already been rolled out in Ceredigion and Llanelli. All work streams carried out by the QAPD Teams are informed by lessons learned and pro active improvement.

There are a number of work streams underway in relation to learning from events:

Investigation process
The process for managing the investigation process has been refined with significantly shorter turnaround on investigations than there has been historically. The investigation process now includes clinical teams, carers and implementation of lessons learned. The quality of the investigations has improved with recommendations and actions being embedded into practice.
The clinical governance structure now in place across adult mental health services sets the framework for review and implementation of the actions.

Immediate assurance/improvement actions have begun to be taken as a result of incidents occurring. The immediate actions during quarter 1 consisted of:

- Circulation of relevant policies and procedures to teams with a request for assurance that all team members had read and understood;
- posters displayed in relevant clinical areas;
- training arranged as required; and
- spot checks following the awareness raising.

Spot checks are being carried out in responses to lessons learned and a planned audit and spot check cycle is now in development.

Investigation training

There has been a request for additional training in RCA and investigation process for staff as there is a limited number of staff formally trained.

An in-house training programme was provided during September. Positive feedback has indicated further date is in the diary. With the staff trained, a rota system for completing investigations is being adopted for allocation and support from operational service leads. This has increased the pool of investigators for Serious Incident investigations. The team has developed a toolkit for all involved in the investigation process and actively engages the clinical teams to contribute to and engage in the lessons learned.

Training/workshops – delivered

Investigation workshop – delivered to Medical staffing as part of the post grad session. This provided update on investigation process as well as a workshop session where medics scrutinised the documentation for current serious incidents investigations. This valuable continuation has been fed back to investigators of the cases. This is encouraging medical staff to be more involved in the management of investigations, understanding the lessons learned and implementing the action plans as well as role modelling good practice. Medics are engaged in developing the process further and supporting teams to improve standards within practice.

Quality Assurance meetings/workshops

The Quality Assurance meetings are underway for Adult Services with positive feedback from teams. These meetings are being rolled out across the rest of the directorate over the coming year. These forums provide an opportunity for communication and discussions relating to clinical issues which have a direct impact upon the quality of the services being delivered and received.
During 2017 all localities have unscheduled care provision on a 24/7 basis. This provides an opportunity to prompt assessment and treatment in line with NSISH standard.

The police triage team is in place over a 4 day period currently with a view to progressing this further.

Joint working with general health colleagues has been agreed in order to develop a training package for general health nurses.

Joint working with general health colleagues in order to develop pathways and formal communication between services as well as transfer documentation. Risk assessment when there is a change of clinical environment and observation and engagement of patients on general wards to have an identified risk of suicide/self harm.

Roll out of co occurring substance misuse and mental health training is on schedule to be completed by April 2018.

The quality assurance meetings are part of a wider governance structure/framework which has been introduced across the directorate during 2017. The structure includes

a clinical incident review group, a written control document group, a patient experience, carer experience, a safeguarding and medication optimisation group. Communications are shared through these groups and into the Health Board channels.

Talk To Me 2: Suicide and Self-Harm Prevention Strategy 2015-2020

In Hywel Dda we have made good progress towards the Talk To Me 2: Suicide and Self-Harm Prevention Strategy 2015-2020 (T2M2).

We have:

- Met the requirement to attend the Regional forum over the last 3 years
- A plan to develop a job description and person specification for a Talk to Me 2 Coordinator to drive the work required from delivering the T2M2 strategy. Resources for this post are already being committed
- Committed to a delivery group on suicide and self-harm prevention in the early days of the LMHPB

Our challenge now going forward is to:

- Engage with the Regional Partnership Board and the Health Board, and possibly the local health and well-being boards, to ensure high level commitment to drive the strategy and action plan
- Make sure those driving this work have the passion and resources to prioritise it and are able to bring the right people to the table to make the decisions required
- Local Mental Health Partnership Boards are responsible to report on action plans, supported by Regional T2M2 groups.

The Contact Detail for the Mid & South West Wales Chair: Robert Goodwin, ██████████ (PA). The National Advisory Group on suicide and Self-harm monitors progress, and produces an annual report. The Welsh Government monitors statistics on suicide and self harm rates, admissions to hospital and population mental health well-being scores. We can all work together to improve wellbeing. The strategy and action plan can be found at: http://gov.wales/topics/health/publications/health/reports/talk2

Dear who it may concern.
I am writing this letter
because unfortaly I have had a lot to do with young
people & Suicide
Causes
1. Breakup of Marriage Daddy Runs of with Doris
Manny Runs of with Michael Kids surplus to
requirements as one young soul who killed herself when told
to go home because she was causing trouble I have not got
a fucking home to go to noone wants me.
2. Remedy sheltered Housing and all the help in
the world no girl of 17 should be on the streets.
3. Drugs unfortialy they have a lot of input on youth
Suicide I dont for one minute suggest all suicide is due to
drugs or drink.
Remedy fast access to Rehab the young 16 to 20 year old
quick access to Mental Health no good saying 6 months.
4. Build one Bed flats for young people at moment
chance of young people getting council as much chance
of Pope Married the Queen.
5. Unemployed Jobs not Zero hours shop call center
etc. apprentiships especially for kids coming out of
care
5. of course I relize this will cost Money but
one flat one apprentice if saving a young life worth it
6. Perhaps this Poem a young person gave me will
help see why the young people feel so alienated.
I will not give my name because the Kids
trust me and I will not betray that
even tho it goes against the grain to write
a anonymous letter

2.

The hurt Child

The hurt child will turn into a fearsome creature
and bite you where you stand
The hurt child will grow a skin and the world you
have given it or not given the world is not a gift
the world is not a gift a gift has to be accepted
freely and the child had no choice and there will be
a fight and the hurt child will lose the fight and they
and will go lurking into the village
will cause panic in the streets and Havoc in the
parks and they will say help us Help us and
no one will only the man in the white Van
who sells us pills and white stuff
Then we can fly high and find love and see white
doves oh so many with drugs to relieve the Pain
of no job nowhere to go and noone to love us
and noone to care what we do
and sometimes the hurt child finds peace at the
end of a rope
It is no good to say to the
child here is food here is a bed to lay your head
there is no end to the drug dealers greed
We give you all you need
But they won't be happy till you are dead
R.I.P all you hurt Children

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Inquiry into Suicide Prevention

Ymchwiliad i Atal Hunanladdiad

Ymateb gan Relate Cymru

Response from Relate Cymru

Consultation response Relate Cymru: Suicide Prevention

December 2017

The Committee is calling for evidence about:

- The extent of the problem of suicide in Wales and evidence for its causes - including numbers of people dying by suicide, trends and patterns in the incidence of suicide; vulnerability of particular groups; risk factors influencing suicidal behaviour.
- The social and economic impact of suicide.
- The effectiveness of the Welsh Government's approach to suicide prevention - including the suicide prevention strategy *Talk to me 2* and its impact at the local, regional and national levels; the effectiveness of multi-agency approaches to suicide prevention; public awareness campaigns; reducing access to the means of suicide.
- The contribution of the range of public services to suicide prevention, and mental health services in particular.
- The contribution of local communities and civil society to suicide prevention.
- Other relevant Welsh Government strategies and initiatives - for example *Together for Mental Health*, data collection, policies relating to community resilience and safety.
- Innovative approaches to suicide prevention.

1. Contact Details

Your name:	Gwilym Roberts
Organisation (if applicable):	Relate Cymru
Email	[redacted]
Contact telephone number	[redacted]

Relate Cymru exist to build stronger relationships in Wales.

Relationship breakdown is a well acknowledged, common contributor to suicide. Also, having strong relationships is a well acknowledged contributing factor to stronger mental health.

Choice of evidence-based therapies

Currently missing from *Together for Mental Health* delivery plans is any mention of the importance of patients' *choice* of psychological therapy. Priority Area 7 stipulates that 'People with a mental health problem have access to appropriate, evidence-based and timely services' (which requires the expansion of psychological therapies to increase access), but the Delivery Plan currently does not include as a priority area the importance of patients' choice of evidence-based psychological therapy.

However, the *Together for Mental Health* strategy includes as one of its six high-level outcomes "Individuals have a better experience of the support and treatment they receive and have an increased feeling of input and control over related decisions", and notes that not only should "People of all ages benefit from evidence-based interventions delivered as early as possible and from improved access to psychological therapies", but also that "Wherever possible, [people] should be able to exercise choice".

It is therefore disappointing that the Delivery Plan makes no mention of ensuring people can exercise choice of evidence-based therapies. Individual choice requires that the full range of NICE-recommended therapies is made available. However, in Wales the NICE-recommended therapy Couple Therapy for Depression is not commissioned – which means that choice of this evidence-based therapy is not available. Furthermore, the Welsh Government's Policy Implementation Guidance, *Psychological Therapies in Wales* (http://gov.wales/docs/dhss/publications/120326psychologicalen.pdf) makes no mention of Couple Therapy for Depression.

The evidence is clear, however, that Couple Therapy for Depression – which is the only NICE-recommended talking therapy for depression which focuses on the couple[i] – is effective. Evidence from the Improving Access to Psychological Therapies programme in England indicates that Couple Therapy for Depression achieves a recovery rate of 52.0% (the target is 50%, although the national recovery rate is currently 44.8%), compared to Cognitive Behavioural Therapy (by far the most common psychological therapy) which achieves a recovery rate of 44.1%.[ii]

The strong evidence for the link between relationships and mental health should also make choice of evidence-based therapy, including Couple Therapy for Depression – a priority in the Delivery Plan. The evidence is now clear that relationship quality and mental health are closely linked, with relationship distress linked to depression[iii] and anxiety.[iv]

- People who live in distressed and troubled relationships are three times as likely to suffer from mood disorders (e.g. depression), and two and a half times as likely to suffer from anxiety disorders, as people who do not experience such relationship distress.[v]
- Poor quality relationships are a risk factor for depression,[vi] and while evidence supports the conclusions both that poor relationship quality leads to depression and that, in its turn, depression leads to poor relationship quality, there is stronger support for the former,[vii] with longitudinal studies showing that marital dissatisfaction predicts increased depressive symptoms over time,[viii] and adults in the lowest-quality relationships are twice as likely to develop depression as those in the highest quality relationships.[ix]
- Some studies find over 60% of those with depression attribute relationship problems as the main cause of their illness.[x]
- Studies indicate that treatment of relationship distress may have the potential alleviate up to 30% of cases of major depression.[xi]

We would like to see everyone having access to the mental health support that is most effective for them – including Couple Therapy for Depression. This requires up-skilling mental health service commissioners, service providers, and frontline professionals such as GPs to better recognize the link between relationships and mental health.

We would like to see the Welsh Government introduce a clear policy ambition setting out the level of meaningful choice that should be available to patients through GP referred talking therapy services, going beyond simply increasing the number of clients who are able to make a choice, to consider whether this is a fully-informed choice **from a diverse range of options that includes Couple Therapy for Depression**. There are a range of mechanisms which need to be explored to achieve this aim:

- **Clearer guidance and training for commissioners** to ensure that they understand the benefits of the full range of NICE-recommended talking therapies and the importance of meaningful choice.
- **Similarly, guidance and training for those signposting into talking therapy services** (e.g. GPs) to ensure that patients are offered an informed choice of therapy from the full range of NICE-recommended psychological therapies.
- **Improved information and brokerage support directly to people accessing talking therapy** services to ensure that all patients can make choices about the psychological therapies that are best for them.
- **Indicators on choice** among talking therapy users included in **commissioning frameworks**.

In Wales we need to see Couple Therapy for Depression commissioned so that everyone with a mental health problem referred to a talking therapy can access the most effective therapy for them

In relation to access to Welsh language support, we know that providing talking therapies via phone and via webcam have been beneficial for clients who want counselling in the Welsh language. As a proportion of Wales' counsellors and therapists are able to deliver in Welsh, it is sensible to develop new ways to allow a wider range of clients access to their services.

In addition, being able to access support from our homes, is often preferable to clients, especially in rural areas where travel to a counsellor is challenging or for those with mobility problems.

The *Together for Mental Health* strategy includes an important definition of wellbeing from the WHO which includes the recognition that "[Wellbeing] is enhanced by conditions that include supportive personal relationships", and this is supported by a wealth of evidence:

- Research shows the importance of good-quality relationships for health, life satisfaction, and wellbeing.[xii]
- Relationship distress is linked to depression and anxiety,[xiii] and people who live in distressed and troubled relationships are three times as likely to suffer from

mood disorders (e.g. depression) as people who do not experience such relationship distress.[xiv]

- While evidence suggests the poor relationships-depression link runs in both directions, there is stronger support for depression as an effect of poor quality relationships,[xv] and marital dissatisfaction predicts increased depressive symptoms over time.[xvi]
- Studies find over 60% of those with depression attribute relationship problems as the main cause,[xvii] and indicate that treatment of relationship distress may alleviate up to 30% of cases of major depression.[xviii]
- Researchers estimate that 14% of adults who have very poor quality social relationships will experience depression later in life, compared to seven per cent of adults with high quality relationships.[xix]
- Relate's report with New Philanthropy Capital on the links between relationships and long term health conditions highlighted how health and relationships interplay with each other, with good quality relationships being crucial protective factors which shield us from the effects of long term health conditions, aid recovery, and can prevent illness in the first place, while poor quality relationships are risk factors.[xx]
- Relationships with friends and family are top of the nation's list of things that matter most to wellbeing, joint with health (89%).[xxi]
- The Office for National Statistics (ONS) identifies relationships as a domain which influences subjective wellbeing[xxii] and includes satisfaction with family life, social life, and the extent to which people have a spouse, family member, or friend to rely on in its national wellbeing measures.[xxiii]
- The 2008 Commission on the Measurement of Economic Performance and Social Progress (the 'Stiglitz Commission') counted social connections and relationships among its eight recommended core components for measuring national wellbeing.[xxiv]
- The 2014 Commission on Wellbeing and Policy similarly recently recognised the role of relationships in wellbeing, noting that across the world, the quality of home life – which is ultimately based on family relationships – is a universal ingredient of life satisfaction.[xxv]
- The ONS also recognises that social capital – our relationships, networks and shared values that enable our society to function – is a key influence on our wellbeing.[xxvi]

In the light of this evidence for the importance of relationships to wellbeing, we are therefore disappointed that the *Together for Mental Health* Delivery Plan makes no mention of relationships and their importance for achieving the admirable objectives it sets out.

In particular, we contend that the following policy recommendations would be highly beneficial to support the achievement of the *Together for Mental Health* strategy:

- **'Relational' training for health professionals**

Frontline professionals are not widely supported to talk to patients about their relationships, and given increasing pressures on time as well as the absence of any targets around relationships, these issues are rarely prioritised.[xxvii] GPs, for instance, do not always know what support services are available to refer people onto, and

responses tend to vary between signposting to counselling services and simply prescribing medication.[xxviii] Similarly, research in the UK in 2010 found the vast majority of couples had never spoken to their health visitor about their relationship, with only four-to-ten per cent having done so and few having found it helpful[xxix] - and a more recent study confirms this picture.[xxx]

However, due to the strong link between mental health and relationships as evidenced above, health professionals regularly come into contact with relationship issues. 30-40% of people have approached their GP about relationship issues,[xxxi] and 92% of GPs report patients have raised issues about personal relationship problems with them over the last month.[xxxii] Given this link, it is therefore imperative that psychological wellbeing practitioners in GP-referred talking therapy services actively assess whether a patient's relationship with their partner is a factor in that patient's depression.

Training and educational marketing for frontline professionals who are likely to come into contact with mental health and relationship issues, such as GPs, psychiatrists, psychologists, health visitors, social workers and others involved in mental health care, would help to up-skill professionals in relational approaches. Training for frontline professionals has been shown to lead to improvements in couples being signposted to appropriate relationship support services and resources.[xxxiii]

- **Preventative relationship support, especially for people with long-term conditions**

We would like to see a focus on relationships in public health embedded as a core part of a prevention strategy. In particular, in recognition of the links between relationships and long-term health conditions - and the evidence that good-quality relationships can protect against deterioration, aid recovery and even prevent us from becoming ill in the first place, while poor-quality relationships are health risks[xxxiv] - we would like to see the NHS providing preventative mental health and wellbeing support to people living with long-term conditions – those with the conditions, their carers/partners, and families. We would like to see the Welsh Government establishing targets for the numbers of people living with a long-term health condition having access to support for their relationships as a part of person-centred care.

- **Relationships should be inserted into national health policy frameworks, including outcomes frameworks.**

In order to review existing frameworks and ensure relationships are given the place they deserve, we recommend that the Welsh Government establishes an inquiry into relationships in health policy to make recommendations on how relationships should be included in policy frameworks, including the NHS Wales' and Public Health Wales' outcomes frameworks.

- **Couple, family and social relationships should become a core part of the work of local Health Boards.**

The Welsh Government should issue guidance, encouraging Health Boards to evaluate the quality of relationships and support relationships as core social determinants of health and wellbeing. In addition, local couple, family and social relationships should be addressed in needs assessments.

- **Directors of Public Health should consider the best way to gather data on the quality and stability of relationships at the local level, in order to inform decisions made by local authorities and commissioners.**

The absence of any standardised local data or strategies to support family relationships impedes the ability of commissioners and planners to direct services and of researcher to further understand the links between relationship quality, stability and other outcomes. Work is needed to develop a measure of family functioning available at the local authority level, which includes parental self-efficacy and relationship quality. Use of such a measure would help identify areas of need, as well as better understand the antecedent characteristics of family functioning. Reporting on this data annually would allow for better local scrutiny of local decisions to improve the quality and stability of relationships.

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S 34
Inquiry into Suicide Prevention
Ymchwiliad i Atal Hunanladdiad
Ymateb gan Unigolyn
Response from An Individual

Dear Sirs

I am writing with personal evidence regarding suicide.

I would be extremely grateful if my name could be kept anonymous as I do not want my son recognised in this capacity.

In August 2017 my son became very unwell with depression. He had been battling this for three years whilst away in university. Being a young man he had not discussed this with his family so we were unaware. As a young teenager he had cut his arms and I did not find out for several years.

One Saturday evening, [redacted] went into his room to find him collapsed with a cord around his neck. He was not coherent so we rang an ambulance. He then became very agitated and upset and tried to leave the house. My husband stopped him but we ended up ringing the Police. We waited around forty minutes for an ambulance. During that time he was extremely distressed, trying to self harm and not making sense. I felt that he should have been sectioned for his own safety.

After being assessed by paramedics I went with him to A&E at [redacted] around midnight. By 6am he had not been seen. I spoke to a nurse who informed me that there was no-one qualified in mental health care to see him anyway.

We went home and rang the Out of Hours GP service. We took him to an appointment that morning. He was afraid to go and also felt embarrassed.
He was with the GP for a few minutes. Basically, he was told that if he felt like that again he should go back to AQ&E. We left and my son felt like he had wasted the GP's time.

My husband was not satisfied and rang back. We were given another appointment that afternoon. We saw a different GP who was far more thorough, spoke to us and started putting care into place.

My son then attended a mental health outpatient appointment at [redacted] Hospital. He still didn't want to discuss this with the family, so went to the appointment alone. He was seen by two female colleagues. They did not introduce themselves or give an outline of the appointment and what to expect. They went straight into personal and difficult questioning. They surmised that my son didn't have mental health issues and they couldn't do anything to help. Yet again, he was humiliated and felt that he had wasted their time. Our GP has remarked that mental health services at [redacted] is very poor.

At the second out of hours appointment, the receptionist gave me the details of a charity: "Jacob Abraham Foundation". I rang them the next day and arranged for my son to have an assessment. They fitted him in within 48 hours and rang to give me

support at length. After his initial assessment he reported that “it was the best thing he’d ever done”. This possibly saved his life.

They saw him for several sessions, free of charge. They are at the end of the phone 24 hours.

It is very sad that a charity has to pick up the pieces. Suicide amongst young males has reached epidemic proportions in South Wales.

We were lucky. We were signposted to the correct help. There will be young men with no families and no idea where to seek help.

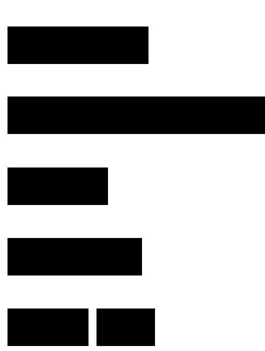
This is an issue which needs to be addressed with immediate priority.

Regards

1

Suicide Prevention (call for evidence)

Submitted by



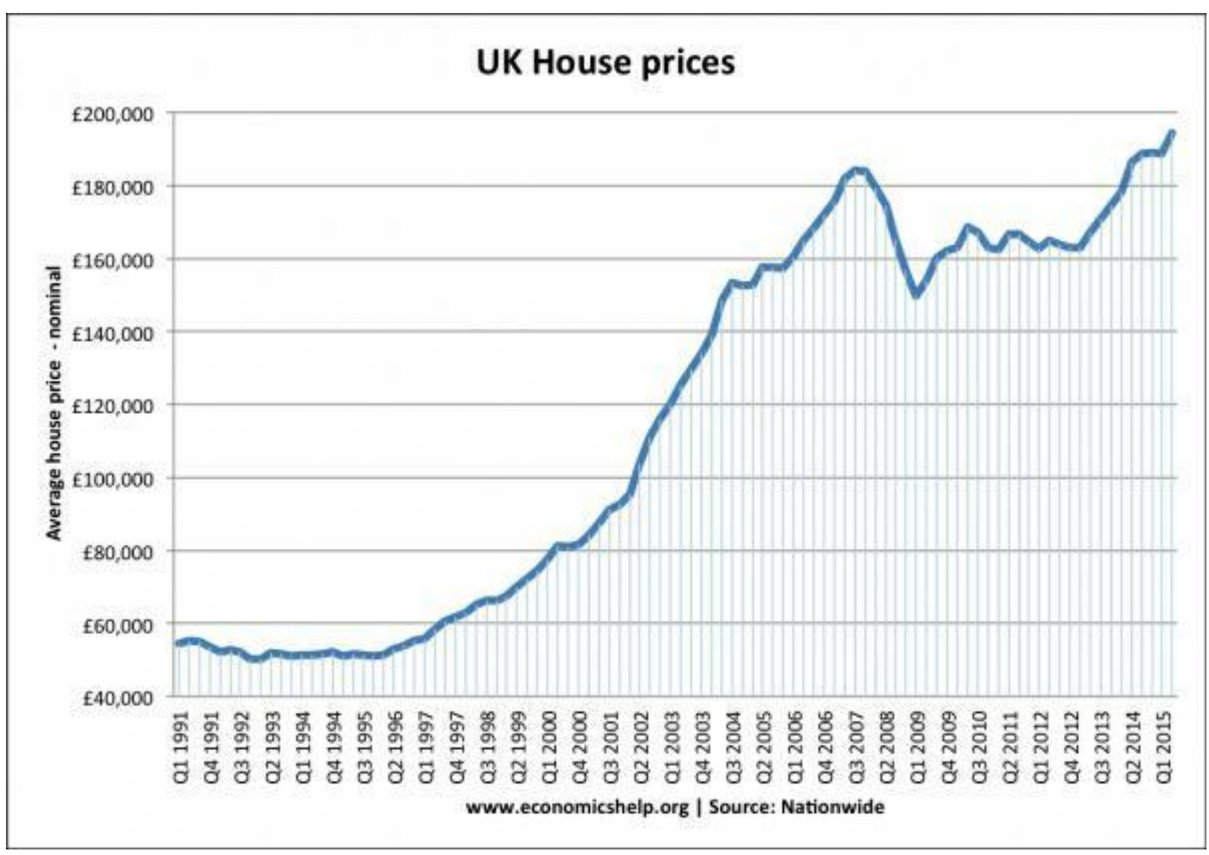
- The extent of the problem of suicide in Wales and evidence for its causes - including numbers of people dying by suicide, trends and patterns in the incidence of suicide; vulnerability of particular groups; risk factors influencing suicidal behaviour.

I am 53 years old, I have attempted suicide numerous times over my lifetime.
The root cause of suicide is lack of hope for the future, this leads to despair.
There are many things that cause people to lose hope.
The inquiry asks for statistical evidence on suicides, this is difficult because coroner inquests are not available for conducting research.
Please see government national archives link below.
http://www.nationalarchives.gov.uk/help-with-your-research/research-guides/coroners-inquests/

Economic reasons for suicide.
In 2014 the bank of England published an article called " money creation in the modern economy". Following this article there was a house of commons debate titled " money creation in the modern economy".
To my knowledge the Welsh assembly has never had such a debate.
The debate found that commercial banks create 97% of the money we use. The commercial banks effectively create money out of thin air when they lend! The debate also found that approximately 10% of this new money was used for productive purposes e.g. lending to businesses), approximately 12% was used for consumerism e.g. (credit cards & personal loans), nearly 80% was used for the funding of purchasing existing assets e.g existing homes & financial assets.
This creation of new money for purchasing existing assets has increased house prices beyond the reach of many Welsh constituents, it has also created an increase in housing rent. Those with assets have prospered, those without have been left behind.
I believe it is our monetary system itself that has caused the most suicides in Wales. It has destroyed hope and created despair. It doesn't matter how hard the average Welsh person works, house prices will increase faster than they can save. The Welsh assembly urgently needs to debate " money creation".

A survey of MPs by the pressure group " positivemoney" found that 85% of MPs were unaware of who created the majority of our money. I can only assume that a survey of Welsh assembly ministers would return a similar result. How it is possible for any government to manage an economy and society when they are unaware of how money is created and how it is allocated?

Please see UK house price graph below by the nationwide. In 1997 the banking system was deregulated, in 2013 the government introduced " help to buy".



Social reasons for suicide.

Divorce when children are involved, usually after separation the mother will get residency of the children. Men are often left without a home, without furniture and without access to their children. Legal costs of child contact court cases can run into the thousands, combined with child support payments this often puts loving fathers over the edge and they take their own lives. I have experience of family law it is grossly unfair to fathers.

Occupational reasons for suicide

A recent study by the office of national statistics found that construction workers were 3.7 times more likely to commit suicide than the average.
Please see link below to ONS data study.

3

https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/suicidebyoccupation/england2011to2015

I have worked in construction as a carpenter for 35 years.
The majority of workers in construction are self employed sub contractors.
Before the year 2000 contractors employed directly the sub contractors they needed to undertake projects. The contractor would keep a list of his/her trusted sub contractors for future projects. This helped maintain quality standards, sub contractors who did poor work were not used on the next project. This system also gave the sub contractors security of work.
In 2000 the Labour government introduced IR35 tax regulation, in essence this tax legislation meant that contractors could be prosecuted for false self employment. Contractors could be held liable for sub contractors national insurance contributions. Contractors immediately dismissed their trusted sub contractors and used employment agencies for their labour needs. This meant that the workers no longer had security of work, it also caused building quality to fall. Employment agencies use umbrella payroll companies to avoid IR35 false self employment regulations. So the workers still work on a self employed basis, however now they have to pay on average £20 per week to the umbrella payroll companies for payment of their wages. The construction industry has now introduced the " construction skills certificate scheme" (CSCS). The Welsh government has helped promote this scheme via public procurement. CSCS now requires all card holders to be qualified to NVQ2 level. A one day NVQ2 assessment for an experienced carpenter like myself cost approximately £1,500. Without a CSCS card even an experienced carpenter like myself is now banned from entering sites. The " construction industry training board" (CITB) classes sub contractors as employees so they have no direct access to CITB grants for NVQs. Only employers can claim CITB grants. I have never heard of any umbrella payroll company applying for a CITB grant for their workers. However CITB does collect a levy from umbrella payroll companies.
By promoting CSCS the Welsh government has put the cost of employers training liability onto the shoulders of construction employees. I believe that IR35 false self employment regulation and the promotion of CSCS by the Welsh government without funding the training requirements has helped put construction workers at the top of the occupational suicide list!
I have contacted the Welsh government via my Assembly Minister about CSCS and the lack of funding for NVQs, I received a reply from ken Skates AM. Ken Skates informed me that the Welsh government is not responsible for CSCS and he offered no funding. Technically the Welsh government are responsible for CSCS, they promoted it and turned it into a construction industry " good practice".

- social and economic impact of suicide.

No comment

- The effectiveness of the Welsh Government's approach to suicide prevention - including the suicide prevention strategy *Talk to me 2* and its impact at the local, regional and national levels; the effectiveness of multi-agency approaches to suicide prevention; public awareness campaigns; reducing access to the means of suicide.

- I believe the Welsh government are trying to fix the symptoms not the causes!

- The contribution of the range of public services to suicide prevention, and mental health services in particular.

- No comment

- The contribution of local communities and civil society to suicide prevention.

  No comment.

- Other relevant Welsh Government strategies and initiatives - for example *Together for Mental Health*, data collection, policies relating to community resilience and safety.

  No comment.

- Innovative approaches to suicide prevention.
  No Comment.

S 36

Inquiry into Suicide Prevention

Ymchwiliad i Atal Hunanladdiad

Ymateb gan Mind Cymru

Response from Mind Cymru

Mind Cymru's evidence to the Health, Social Care & Sport Committee's Inquiry into Suicide prevention

Introduction

We welcome the Committee's inquiry into suicide prevention and the renewed focus it has brought to this important area of work. In preparing our submission, we consulted with both our supporters and our network of Local Mind's – who deliver a range of mental health services across Wales. Below is a thematic overview of the responses we received.

Public engagement on suicide prevention

We wanted to make it easy for individuals to share their views with the Committee on the actions necessary to improve suicide prevention. We also wanted to consult so that our own work in this area is well informed by the views of our beneficiaries and supporters, many of whom have lived experience of mental health problems.

We emailed a survey link to our network of campaigners on 27th November 2017 asking for their views on three questions related to suicide prevention:

- How could mental health services and support in Wales be improved to prevent someone from feeling suicidal?
- What needs to improve in mental health services to better support someone who is feeling suicidal?
- What other measures, outside of mental health services, could be put in place to help prevent suicide?

This paper gives an overview of the 75 responses received. Many responses were clearly from people with personal experience of crisis, suicidal ideations or that of a friend or family member.

Key issues

How could mental health services and support in Wales be improved to prevent someone from feeling suicidal?

Primary care, waiting times & access to talking therapies

Reducing waiting times for access to mental health support and specifically talking therapies was cited as a key factor in many responses. Respondents felt that lengthy waiting times caused

their mental health to deteriorate and that quicker and easier access to mental health services would help prevent suicide.

> *"I feel suicidal a lot. I would like to be able to speak to a doctor straight away and not wait for a call back. maybe if the waiting lists weren't so long for therapy so many people wouldn't reach the point of feeling suicidal."*

> *"I live in Cardiff and there are long waiting lists for support groups for mental health issues. You are not told how long the waiting list will be which can make mental illness worse."*

Many respondents mentioned high-thresholds for accessing mental health services and the need for earlier-intervention to prevent people from becoming more unwell.

> *"Not really any help at all unless you try suicide or something else as drastic first."*

> *"As early intervention as possible, particularly with children; easier access and every referral should have an assessment at least."*

> *"Early intervention, especially for young people (CAMHS are refusing a lot of referrals)."*

Another issue that was frequently mentioned was the need for better ongoing support and better follow-up following an intervention or course of therapy.

> *"Increased funding to reduce waiting times for psychotherapy and allow ongoing support (rather than just a course of therapy) for those with chronic mental health issues."*

> *"Improve access to CMHT to prevent people hitting crisis. I've been under crisis team several times and gone into inpatient unit but CMHT would not take me on and hence I keep hitting crisis when I'm very suicidal. The CMHT could support me and help me from not hitting crisis. It's all fire fighting and no long term recovery approach."*

> *"Quicker and above all more caring response when help is asked for + Reliable caring follow up"*

Crisis care & 24-hour support

Improving crisis care services was a common theme found throughout the survey responses and was highlighted as a crucial factor in improving suicide prevention. The key issue described here was the need to improve out-of-hours support by providing access to 24-hour services staffed by qualified mental health professionals.

> *"There has to [be] an improvement in out of hours services when someone who is feeling vulnerable can approach someone who has some experience in dealing with such issues. There is currently an over reliance on the police and other emergency services who are not equipped to deal with these people in crisis."*

> *"There needs to be someone to reach out to 24 hours a day, seven days a week."*

"Easier and instant access to mental health outreach nurses and a mental health doctor at A/E"

Mental health & suicide awareness training

Better training for those working in public services (including, but not exclusively health-related services) was suggested to help tackle suicide rates. The rationale behind these suggestions is for more public-service professionals to be able to spot the signs of people at risk of suicide and provide a more compassionate response to those in crisis or experiencing poor mental health generally.

"More empathy and better support from GPs, perhaps regular suicidal training for all health professionals."

"Better mental health training and awareness across all areas of health, social and educational support."

What needs to improve in mental health services to better support someone who is feeling suicidal?

Many of themes found in response to this question mirrored those highlighted in question one, particularly around access to better crisis care support. The availability of crisis centres/cafes or simply places of safety – that can be accessed 24 hours a day – was seen as a priority in reducing the risk of suicide.

"There should be places of safety people can go 24/7."

"Primary Care services should have a 24 hour observation/crisis house."

"Crisis team open later than 9pm, crisis centre/cafe opening up to give people somewhere safe to go ..."

Other respondents called for support and assessments to be made available to people in their own home.

"A 24/7 system. The ability to be able to come to the home instead of having to make long journeys to be assessed when you don't want to leave the house."

What other measures, outside of mental health services, could be put in place to help prevent suicide?

Stigma

A clear theme throughout the survey was the stigma that people feel around speaking out about suicidal thoughts and poor mental health. People described the extent to which this

stigma is felt – in health services, the workplace and across society more generally. Reducing the stigma attached to poor mental health was seen as a crucial step in supporting people to access support and therefore reducing the risk of suicide.

> *".... raise awareness of Mental Health issues so that things are more open and people who are feeling suicidal/severely distressed can be comfortable bringing things up."*
>
> *"... reducing the stigma of suicide so people with suicidal thoughts feel able to talk about it without fear of being judged. Greater awareness and support within the workplace."*
>
> *"Talking about mental health should be the norm, no stigma."*

Education & awareness

Similarly, better education and awareness in schools and colleges was highlighted as a priority in preventing the risk of suicide, both as a means of normalising conversations about poor mental health and supporting people to better manage and recognise when their mental health is deteriorating.

> *"Better education in schools about mental health & wellbeing and where to find support - helping to reduce stigma and increase awareness."*
>
> *"Awareness in schools colleges and the work place."*

Social factors

The impact of austerity and welfare reform were another key theme in response to this question. Social isolation and loneliness caused by cuts to community services as well as poverty and poor housing were all highlighted as risk-factors that could lead to higher suicide rates.

> *"Funding for community ventures and activities to encourage activity and inclusion."*
>
> *"Change the benefits system. Reduce poverty and unsafe housing"*

Engagement with Local Minds

There are 20 local Minds in Wales. They provide information and advice on mental health issues, and many offer talking therapies, wellbeing groups, education and training. Each local Mind in Wales is an independent charity that works together in partnership with Mind. They are funded by donations, grants and income from services they deliver services on behalf of local councils, the NHS and others.

Given their wealth of experience delivering services, we wanted to ensure that Local Minds had the opportunity to share their experiences and thoughts on how suicide prevention could be improved locally. Four Local Minds wished to have their feedback included in this submission, namely; Brecon Mind, North East Wales Mind, Merthyr & the Valleys Mind and Vale of Clwyd Mind.

Key Issues

Though not directly commissioned to deliver suicide prevention services, Local Minds provide information, support & services to people experiencing poor mental health which supports suicide prevention. Additionally, some Local Minds provide suicide prevention training whilst others deliver grant-funded projects on suicide awareness

> *"We have just secured £10k from the Big Lottery Awards for All Wales to launch our #ItTakesBallsToTalk service – targeting 2000 men aged 16 – 45 by raising awareness of suicide prevention services and offering talking treatments"*
>
> *"We provide all staff with 'safe talk' training; this equips staff with the necessary skill in order to open up a conversation about suicide."*
>
> *"We have a staff member who is accredited to deliver ASIST (suicide intervention skills) SafeTALK (suicide awareness) courses."*

Access to mental health services

As with supporters, a clear theme running through responses from Local Minds was the need for improved access to mental health services – from preventative primary care services to 24-hour crisis-care support. These were viewed as crucial step to improving suicide prevention.

> *"Mental health services, generally, in North East Wales are stretched to breaking point, our observation is that more people are getting to crisis point, often because the preventative services they need to stay/get well are not available."*
>
> *"There are no out of hours crisis services … this means the times that most people need support for crisis aren't covered at all."*

Pathways for crisis support

As organisations that deliver mental health services, advice and support locally – Local Minds can often be the first point-of-contact for someone experiencing crisis and/or at risk of suicide. Their responses highlighted the need for an agreed process and clear pathways between third-sector organisations and local mental health teams to ensure timely and appropriate support is available to those at risk of suicide.

> *"There are no pathways between the NHS and community support groups and charities for crisis support and assessment."*

The standard response from health staff to people asking what to do in a crisis is to go to A&E."

Local Minds also noted that, in the absence of an agreed pathway, police were often relied upon to fill-the-gap left by under-resourced mental health services. The uncertainty as to whether those at risk of suicide should be supported to attend A&E or whether the police should be alerted - highlights the need for much greater clarity and public awareness in this area.

"We do our best to establish they are safe before they leave us but if we are concerned we would speak to the Community Mental Health team ... Unfortunately the response from them is usually to call the police."

"We are often left holding the person with only the police to call."

Awareness training

Another priority for Local Mind's in improving suicide prevention was the need for better training and awareness – in schools, workplaces and elsewhere – to challenge the stigma associated with suicide and encourage those at risk to seek help.

"There is very little training or awareness raising being done in the local community (e.g. schools, organisations, workplaces) around suicide prevention."

"Targeted suicide awareness initiatives in schools, FE and the workplace."

Conclusion

This response is based on the experiences of Mind supporters (many of whom have lived-experience of mental health problems) and Local Minds responsible for delivering mental health services across Wales. The responses highlight a number of key areas seen as crucial to improving suicide prevention, specifically; access to mental health services (including talking therapies and crisis-care), earlier intervention and better education and awareness to tackle stigma and encourage people to seek help when they need it.

We hope that the Committee finds this evidence useful to their inquiry.

Together for Children and Young People

Law yn Llaw at Blant A Phobl Ifanc

Together for Children and Young People (T4CYP) was launched in February 2015 following Welsh Government designating children and young people's emotional and mental health a priority. With cross cabinet commitment, this multiagency service improvement programme aims to work at pace to consider ways to reshape, remodel and refocus the emotional and mental health services provided for children and young people in Wales.

T4CYP welcomes the opportunity to comment on the review into the *Talk to Me 2* (T2M2) suicide and self harm prevention strategy and work programme. Answers to the enquiry questions are outlined below:

1 Suicide and self harm response:

- ***The extent of the problem of suicide in Wales and evidence for its causes - including numbers of people dying by suicide, trends and patterns in the incidence of suicide; vulnerability of particular groups; risk factors influencing suicidal behaviour.***

Suicide continues to present a major public health challenge, with no significant improvement in absolute numbers over the past year. For groups such as young people it is one of the major causes of death in the age group whilst older adults remain the highest risk group in absolute terms. There is a large body of evidence that identifies risk factors. Socio economic influences such as poverty (of opportunity as well as financial) and fragmented social cohesion, play important roles. All areas of government have a role to play. Two particular issues of note are access to means, and rising rates of self-harm as a way of managing distress, particularly in young adults.

Whilst significant progress has been made on road and bridge design and availability of medication, much more is required to impact on the role of alcohol and psychoactive substances in suicide and self-harm. The rising concerns regarding the mental health and well being of children with some using self harm as a consequence is being addressed by T4CYP. Whilst crisis response and access times have improved, addressing the psychosocial risk factors that create the issue requires a wider approach from across society. Raising our children in a society that promotes and facilitates positive early attachments, prevents and mitigates the effects of Adverse Childhood Experiences (ACEs) early trauma is essential to prevention in the long term. An education system that builds skills confidence and resilience is another key building block. More specifically addressing the key issue of bullying, particularly cyber bullying and the access to web sites that support and promotes suicidal behaviour is key to long term success in tackling the issue.

2 The social and economic impact of suicide:

- ***The ripple effect of a suicide or cluster of suicides in an area on its social and economic cohesion cannot be underestimated. More specific costs on public service acute response, legal process, and support services for remaining families, colleagues and schools are more evident along with the cost to business when a major transport route is closed.***

- ***The effectiveness of the Welsh Government's approach to suicide prevention - including the suicide prevention strategy Talk to me 2 and its impact at the local, regional and national levels; the effectiveness of multi-agency approaches to suicide prevention; public awareness campaigns; reducing access to the means of suicide.***

T4CYP has worked closely with T2M2. The products it has produced regarding the evidence base, and means to prevent self harm and suicide are excellent. The work on bridge design and its ongoing battle to help the press report responsibly is of particular note. The difficulty it faces, as with many cross cutting issues, is its impact as action can be left to someone else and competing, department specific targets and pressures take precedence. The team itself is small and progress across the country has been dependant on the enthusiasm and the seniority of those leading in the local areas. The stigma associated with the issue and mental health in general means the public awareness campaigns can be limited in their impact, due to lack of obvious local ownership and can too easily be seen as something that effects "someone else"

- ***The contribution of the range of public services to suicide prevention, and mental health services in particular.***

See response above. In children services across society the majority of practitioners feel unskilled and unsupported to the point the mental health services are seen as solely responsible, when the evidence suggests major impacts from wider areas of life. Improved undergraduate and postgraduate training on this issue and wider well being issues are an essential. Crisis responses from Child and Adolescent Mental Health Services (CAMHS) have improved, but when the specific precipitating factors lie in other areas of a young person's life, it is very difficult to find willing collaboration. There are some examples of excellent care however. Newport Health Service and the joint working between Betsi Cadwaladwr UHB and their Schools are exemplars.

- ***The contribution of local communities and civil society to suicide prevention.***

  See above. The position is variable often depending on the immediate relevance of the issue to the particular community. Unfortunately the contribution is not systematic across Wales or consistent.

- ***Other relevant Welsh Government strategies and initiatives, for example; Together for Mental Health, data collection, policies relating to community resilience and safety.***

We have commented on some of the impacts of T4CYP but this can only be effective in the context of a system that fosters positive mental health and resilience in our country. The key steps to developing resilience need to be clarified and then infused across society. An understanding that resilience is often developed by being supported to successfully overcome small adversity needs to be understood, rather than believing adversity should never occur, is an important first step. Early year's attachment and exploration of risk through play are important building blocks. The importance of the proposed education reforms and promotion of community prosperity across age ranges supported by the Wellbeing of Future Generations Act and the Social Care and Well Being Act have potential positive impact too.

- ***Innovative approaches to suicide prevention.***

See above in addition to those identified by the T2M2 plan.

Response to the Health, Social Care and Sport Committee inquiry on Suicide Prevention in Wales

Introduction

Citizens Advice Cymru welcomes the opportunity to provide evidence to the Health, Social Care and Sport Committee inquiry into Suicide Prevention. We would also welcome the opportunity to discuss the extent of the problem of suicide in Wales and any of the issues raised in this paper with the Committee, in particular the role of local Citizens Advice in suicide intervention and prevention.

About us

Citizens Advice is an independent charity, founded in 1939, covering England and Wales. In Wales we have a network of 19 local Citizen Advice, all individual charities, staffed by nearly 800 dedicated volunteers and staff. We provide advice on a range of everyday issues to anyone who needs it, from debt, money and welfare benefits to housing, employment, discrimination and relationships. Our financial education sessions and income maximisation programmes also help people to take control of their finances and ensure those in need are claiming all the financial support they are entitled to.

We remove the barriers to advice by going to places where people need us most, delivering advice from over 375 community locations in Wales, as well as offering services over the phone and online. Every year across England and Wales millions of people turn to us. This gives us a unique insight into their needs and concerns. We use this knowledge to campaign on big issues, both locally and nationally. So one way or another, we're helping everyone – not just those we support directly.

During 2016-2017 local Citizens Advice in Wales helped over 114,000 people with more than 436,000 problems. Nearly half of all clients we helped in 2016-2017 (49%) are disabled or have a long term health condition (compared to the

population average of 23%), of these 22% self-identify as having a mental health condition.

On average, a Citizens Advice client with mental health issues will have 5 separate advice problems, from unmanageable debts to employment, housing and access to welfare benefits. This compares to 3.5 problems for other clients.

Our response

The extent of the problem of suicide in Wales and evidence for its causes

Citizens Advice Cymru provides advice and support to some of the most vulnerable people in Wales, this gives us unique insight into their lives and crucially, the issues affecting them. Anecdotal evidence, over the past year, shows local Citizens Advice reporting an increase in the numbers of clients with suicidal ideation, many of these clients have reached crisis point and feel unable to cope.

In 2016, there were 322 suicides in Wales, as reported by the ONS. The ONS goes on to say the rate in Wales has fallen from 13.0 in 2015 to 11.8 per 100,000 people in 2016. The most vulnerable group continues to be males, although the rate varies by age group, approximately 75% of all suicides are male. Although we don't have exact numbers on those experiencing suicidal ideation, local Citizens Advice have recorded over 45 detailed case notes relating to clients with suicidal ideation, many of these cases relate to financial matters and in particular, access to welfare benefits.

Although the issues surrounding suicide are very complex there is a wealth of evidence, including our own case studies, showing the links between socioeconomic deprivation, including debt and financial crisis, mental health problems and suicidal behaviours. **We believe there needs to be more support for those facing financial crisis.** (See Annex)

Paul's story

Paul had several non-priority and priority debts, local Citizens Advice office discussed Paul's options and Paul chose to apply for a Debt Relief Order, which was approved. A total of £2,211 was written off. Paul was advised that he may be eligible for PIP and, following a face-to-face assessment, Paul was placed in the enhanced daily living component generating a weekly income of £82.30. We successfully supported Paul through his first tier tribunal appeal against stopping his award of Employment and Support Allowance, generating an annual income of £8,528. Paul told us his health had vastly improved and he

no longer had to worry financially because he had no debts and his income had increased.
*names have been changed for the case study examples to protect anonymity

The social and economic impact of suicide

The social and economic impact of suicide is widespread and there are various estimates that attempt to put a monetary value on suicide. Whilst we do not have any specific comments on the wider economic costs, we know the social impact is wide ranging, impacting on bereaved families, friends and colleagues; the local community and workplace; and those who supported the individual concerned, either formally through interventions and advice, or informally. The ripple effect cannot be underestimated and the need to **ensure support is available for those impacted by suicide is essential** via local support support groups and through access to information and advice**.**

We know that for local Citizens Advice the social (i.e. impact on staff, volunteers, their family and friends and communities where they live and work) and economic impact of suicide is significant.

The financial cost to local Citizens Advice is impacted by the additional support needs of clients with suicidal ideations, the impact on colleagues and knock-on impact on other clients regarding waiting times and delayed appointments. Local Citizens Advice across Wales are reporting an increase in clients with suicidal ideation. Supporting these clients requires additional time and investment, this can prove challenging for some local Citizens Advice due to a number of factors including meeting targets set by funders; the impact on advisors of supporting clients with suicidal ideation and limited access to wider community resources and trained support.

Local community services are a key element in preventing suicide and suicidal ideation, **more investment is needed to allow local services to become more responsive and planning and coordination across services locally, including third sector partners, should be developed further**.

The effectiveness of the Welsh Government's approach to suicide prevention

The Welsh Government's approach to suicide prevention has broad support, as a good foundation for a suicide prevention strategy in Wales. We believe Talk to me 2 provides a solid base that includes setting out the strategic aims and objectives to prevent and reduce suicide and self harm in Wales. We support the view that no one organisation or government department can tackle the issue in isolation.

We were pleased to note that Welsh Government has made mental health a priority area as outlined in 'Prosperity for all: the National Strategy' and a cross-government priority. **We fully support the pilot to run a mental health focused social prescribing pilot scheme funded by Welsh Government.**

In regard to the Together for Mental Health strategy, we were disappointed to note that the delivery plan was predominantly health focused and we believe did not adequately take into account the wider role of local authorities and community based services in supporting people's mental health and wellbeing. In particular, the role of social care services was noticeable in its absence. This was clearly demonstrated within the strategic contextual information where no reference was made to the Social Services and Well-being (Wales) Act, nor does the information reference the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act, both of which we believe are pertinent to the effective delivery of *Together for Mental Health*. Citizens Advice Cymru believe the delivery plan could be stronger by making clear links to, and identifying joint outcomes with the implementation of these pieces of legislation.

Despite the noted link between debt, financial problems and mental health as well as the noted issue of the impact of welfare reform on people with mental health problems, we do not feel that this is adequately reflected in the *Together for Mental Health* delivery plan. In a similar manner, despite references to Local Primary Mental Health Support Services (LPMHSS) role in providing appropriate information and advice to promote well-being, the delivery plan focuses on health based lower level interventions only.

We believe the plan should include specific reference to ensuring specialist debt and welfare rights advice services are available within the LPMHSS to ensure adequate access for people with mental health problems during welfare reform. To date, only 2 Local Citizens Advice are commissioned by a local health boards (in partnership with their local authority) to deliver debt and benefits services for mental health clients. There are a number of benefits to this approach including;

- warm referrals; ensuring the individual concerned does not have to navigate through a range of advice options, meaning they get the support they need.
- being located in health settings, in particular mental health settings, to be on hand when people are in crisis.
- to build contacts with colleagues across different sectors but within the same community.

The contribution of the range of public services to suicide prevention, and mental health services in particular

The role of public services and in particular mental health services is crucial, as is the role of the third sector, we are a key partner in supporting people with suicidal ideation and suicidal behaviours. This support has proved essential for some of our most vulnerable clients.

To ensure local services are able to support individuals we believe **more attention should be given to local suicide prevention plans and wider community resources** which recognise the additional time needed to support people experiencing suicidal ideation.

The contribution of local communities and civil society to suicide prevention

Local communities and civil society have an important role in reducing suicide. Loneliness and isolation is one of the risk factors for suicide. Building community cohesion and community services is a key element in reducing suicide.

Citizens Advice Cymru believe local communities should have access to training to offer support locally via local community hubs and put in place plans to identify vulnerable groups/people locally and work with those groups to offer early intervention and develop knowledge on the services available, including access to advice and other services that can help reduce suicidal ideations.

Innovative approaches to suicide prevention

Citizens Advice Cymru have a vision that every workplace and community across Wales has a trained suicide champion. We believe this would help

reduce the numbers of suicides in Wales and provide early access to help and support for the most vulnerable. We believe this should be included in local suicide prevention plans and would support Samaritans recommendations for 'Local Action' which calls for training for all frontline staff.

At Citizens Advice Cymru we believe suicide prevention can be achieved through increasing suicide awareness, alongside ensuring the right support is in place to tackle the root causes of an individual's feelings, this should include access to free and impartial advice. We propose having a suicide champion, similar to the Time to Change employee champion (but with a specific focus on suicide) in each workplace and possibly in every community. Not only does early intervention work in preventing suicides it can also reduce the stigma around suicide by increasing awareness and ensuring the right support mechanisms are put in place. **We also believe Welsh Government should create a fund for training suicide champions working closely with employers, third sector and local community hubs.**

A suicide champion would:

- be fully trained in suicide awareness and be able to identify and support people with suicidal ideation
- assist colleagues and others in understanding suicidal ideation and offer support for those working with people experiencing suicidal ideation
- be able to identify and refer to further support networks
- work with other organisations to influence local suicide prevention plans and strategies
- support community services and hubs.

Jane's story

Jane was admitted to hospital after a suicide attempt. She'd been working part time but had accrued significant debts. Jane was due to appear in court for council tax arrears and had received an eviction notice on her private rented flat as a result of rent arrears.

Citizens Advice worked with Jane to restructure her debts, stabilise her housing and sort out the employment issues.

Resolving these problems whilst she was in hospital helped to reduce Jane's anxiety and put her back in control of her life.

Conclusion and recommendations

We believe Welsh Government's suicide prevention strategy Talk to me 2 has increased the focus on suicide and suicide prevention in Wales. Citizens Advice Cymru recommend the following actions to raise awareness and prevent suicide in Wales:

- More support for those facing financial crisis through access to free and impartial advice, ensuring specialist debt and welfare rights advice services are available within the Local Primary Mental Health Support Services and other key locations
- Ensure support is available and easy to access for those impacted by suicide
- More awareness and investment is needed to allow local services to become more responsive to people with suicidal ideation
- Local communities, including the third sector, should have access to training resources
- Provision should be made by Welsh Government for funding to train and promote suicide champions across Wales working closely with employers, workers and their representatives, local community hubs and the third sector.

For further information regarding this response please contact:

Michelle Lewis, Senior Policy Officer, Wales

Email: [redacted]

Telephone: [redacted]

Annex

Welfare reform, debt, financial difficulties and mental health

Research shows that debt and financial difficulties affect people's health and wellbeing as well as being linked to stress and and anxiety[1]. The nature of debt is changing in Wales, with increasing numbers of people on fixed low incomes (e.g. pensioners, benefit claimants and low wage earners) having difficulty to meet the everyday costs of living. For instance, we have seen a marked increase in people seeking help with council tax arrears. In 2014-15, people seeking help with council tax arrears increased by 51 per cent against the previous year (2013-14), and it became the largest single debt-related issue seen across the Citizens Advice service in Wales. Similar rises in debt levels have also been seen in relation to other household bills, such as water and sewage debts, fuel and utility debts and rent arrears. For further information please see our Advice Trends publications.

Since 2011-12 benefits-related problems have dominated the advice provided by local Citizens Advice in Wales. They currently account for 39 per cent of all issues we see. Between April and December 2015 just over 40,000 people were helped with over 116,400 benefits-related problems. Debt remains the second biggest problem area accounting for 29 per cent of all problems. Over 20,700 people were helped with more than 88,000 debt problems during the same period, a slight drop compared to the same period in 2014.

People living with a disability or long-term health condition are over-represented amongst Citizens Advice clients in Wales compared to the population as a whole, approximately two-fifths of clients (49 per cent) describe themselves as living with a disability or long-term health condition, compared to the population average of 23 per cent[2].

For people with mental health problems who are out of work and reliant on welfare benefits, welfare reform has been noted to adversely affect these people leading to increased hardship and negative impacts on their mental health conditions. Most claimants for Employment Support Allowance (ESA) must undertake Work Capability Assessments (WCA) as both part of the application process and at ongoing intervals to assess their 'functional capability' to work. The assessments have been widely criticised for failing people with mental health problems in particular, as they do not adequately take into account the

[1] For example, see: Pleasence et al (2007) *A Helping Hand: The Impact of Debt Advice on People's Lives*; T Williams (2004) *Review of Research into the Impact of Debt Advice*; and C Turley and C White (2007) *Assessing the Impact of Advice for People with Debt Problems*
[2] Disability in England and Wales, 2011 and Comparison with 2001, ONS, January 2013

impact of fluctuating or complex mental health conditions on a person's ability to work[3].

Case Studies: Rhondda Cynon Taff Citizens Advice[4]

Rhondda Cynon Taf Citizens Advice have one of the only health funded debt and welfare benefits service in our network. It is specifically for people with mental health or substance misuse problems and their carers in light of the negative impact of welfare reform on people's mental health conditions. Below are recent case studies:

Ann is a mental health service user referred for help with an appeal against the decision to refuse her claim for Personal Independence Payment (PIP). We supported Ann with accessing medical evidence and assistance with drafting a submission to the Tribunal Service. At appeal the decision was overturned and Ann was awarded the enhanced rate of daily living and standard rate of mobility. On top of this, Ann is also now entitled to an additional amount of Employment and Support Allowance (ESA) due to premiums being added to her benefit. Overall, she is now better off by a total of £166.10 per week, which she stated will make a huge difference to her and ease the financial burden of being reliant on a benefit income.

Bob was referred by the Primary Care Mental Health Services for support with his welfare benefit entitlement. He was supported to make a claim for PIP on the basis that he had both daily living needs and mobility needs. Following completion of the application he was awarded the enhanced rate of the mobility component and the standard rate of the daily living component. This yields an annual income increase of £5852.60, allowing Bob to automatically be eligible for a Blue Badge and qualifying him for 100% of his road tax to be paid.

*names have been changed for the case study examples to protect anonymity

In our report One day at a time, we looked at the cumulative impact of welfare reform in Wales. 49 benefit claimants took part in the qualitative research[5] who were of working age and affected by two or more changes to their benefits. We found that their ability to cope with the cumulative impact of these changes varied dependent on individual circumstances but that nearly all the participants

[3] Dr Litchfield, *An Independent Review of the Work Capability Assessment* – year four December 2013
[4] Names have been changed to preserve anonymity
[5] The qualitative study used a small sample size, giving indicative rather than definitive findings.

(94 per cent) felt their mental health had been negatively affected by the recent changes. A combination of financial hardship and the fear of action being taken against them has led to increased stress, anxiety and depression for many.

Some people directly attributed their condition to the changes they'd experienced while others believe the changes have led to a deterioration of an existing mental health condition. This highlights the wider impact on mental health and wellbeing as a result of welfare reform which is noted as disproportionately affecting Wales when compared to the UK as a whole.

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Inquiry into Suicide Prevention
Ymchwiliad i Atal Hunanladdiad
Ymateb gan Professional Cricketers' Association
Response from the Professional Cricketers' Association

Information from the Professional Cricketers' Association

Working in this space we have worked on various interventions to support our members with mental health education and support.

- 24 Hr helpline - Delivered by Cognacity Harley street practice available to all members and family
- counselling
- Mental health education and talks
- An app to develop coping skills
- Mental health ambassadors (Players who have opened up and talked about their struggles)

Just some of the support tools in place.

I'm not sure if you are aware that a number of players association have signed up to the mental health charter to share practice and show innovation to look after this area.
https://www.sportandrecreation.org.uk/pages/about-us
https://www.sportandrecreation.org.uk/policy/the-mental-health-charter/introduction-to-the-mental-health-charter-for

One thing we want to do moving forward is support the cricket national governing body on more national based campaigns involving not just professional players but having an impact on general society through the sport and our players. Something we have discussed and I'm sure will develop in time.

My personal belief is that it's great you are working hard in this area to review lobby and develop provisions. I honestly feel the government/NHS need more support to provide more interventions and responsive Treatments. It's a complex and difficult illness and only growing from the research we all see. Personally we have seen the lacking support in a crisis situation and it's not a great position for anyone to be in.

Y Pwyllgor Lechyd, Gofal Cymdeithasol a Chwaraeon
Health, Social Care and Sport Committee

Inquiry into Suicide Prevention

Response from national charity

GED FLYNN

Chief Executive

PAPYRUS Prevention of Young Suicide

Head Office: 28-32 Milner Street, Warrington, Cheshire, WA5 2AD

Registered Charity No. 1070896

1 March 2018

INTRODUCTION

a) PAPYRUS Prevention of Young Suicide is a national UK charity founded in 1997 by parents who had lost children to suicide. Today, it has members and supporters from across the UK who share the common belief that **many young suicide are preventable**.

b) Our primary focus as a national charity is to prevent suicide in young people aged up to 35 years. **In the UK, suicide remains the leading cause of death in this age group in both genders.** PAPYRUS works towards building a society which speaks openly about suicide and has the resources to help young people who may have suicidal thoughts.

c) A majority of PAPYRUS trustees have lost a child or young sibling to suicide and most of those who join or actively support the charity have been touched personally by young suicide. PAPYRUS promotes the unique contribution to suicide prevention made by:

   i) those who are touched personally by the death of a young person to suicide (parents and families who have lost a young person to suicide, colleagues, friends, communities)

   ii) young people who suffer with emotional distress, self-harm, experience suicide ideation or engage in 'suicide behaviours'

   iii) those who care for / work with a young person who may be at risk of suicide

d) PAPYRUS has three office bases in the UK – Warrington, London and Birmingham. The charity runs a national helpline called **HOPE**Line**UK**, taking calls, texts and emails from young people at risk and from caregivers (parents, friends, colleagues and professionals) every day of the year from 10am through 10pm.

e) PAPYRUS offers training to professionals and communities on suicide awareness, prevention and intervention skills. We work in communities to create suicide safer communities with and for young people.

f) PAPYRUS is a campaigning organisation, pressing for change, rooted in the experience of our members, supporters and those who access our support or engage in our projects. Through our social media campaigns, we aim to raise awareness of the contribution that each one of us can make to **#saveyounglives.**

[1]

[1] **#SpotTheSigns** this film can be viewed here: https://papyrus-uk.org/help-advice/resources/spot-the-signs

SUBMISSION

1. As a member of the National Advisory Group, PAPYRUS welcomes the opportunity to speak to share evidence with the Health, Social Care and Sport Committee **in Welsh Government**.

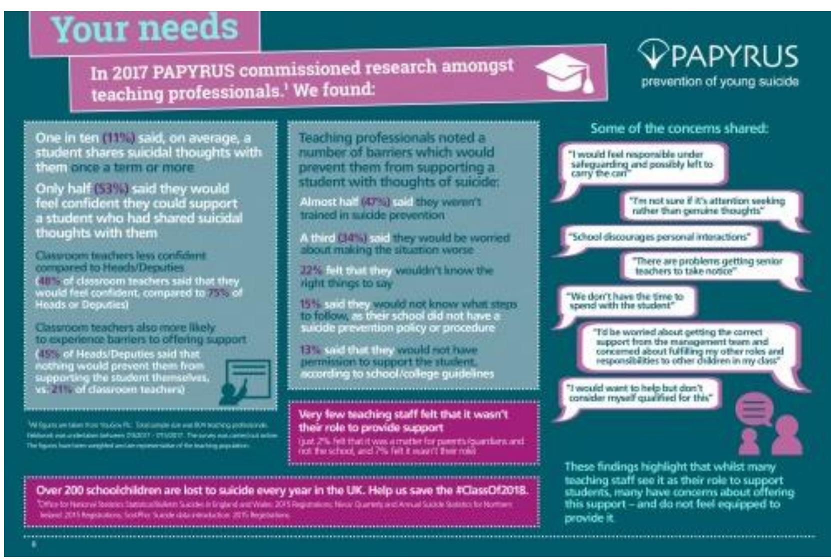
2. The charity has been involved in the National Suicide Prevention and Self-Harm Reduction Advisory Group since its inception, represented by Ged Flynn, PAPYRUS Chief Executive.

3. PAPYRUS believes that a there should be an acknowledgement in strategy and suicide prevention plans that suicide is **the leading cause of death in young people - males and females under 35.** We are beginning to get the message out there about male suicide but not about young suicide. 200 children (10-180 die each year by suicide. This is information that the public has to dig for; it should be a public health priority.

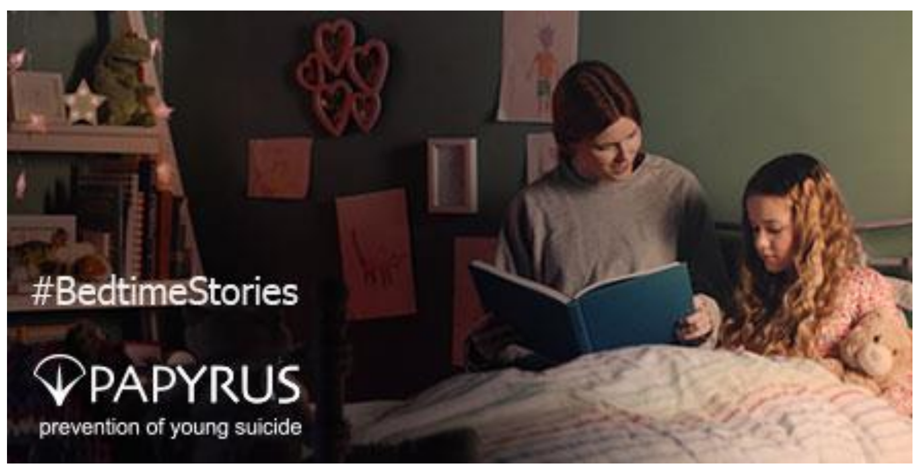
4. **Suicide Among Children – Building Suicide Safer Schools & Colleges**
PAPYRUS is leading a campaign this year to highlight that **at least 200 children die every year to suicide.** We believe that there is significant under-reporting of child suicides because of stigma and the demand for coroners to reach the highest standard of proof before determining a suicide conclusion. PAPRYUS has developed a very accessible **guide for schools** to help them prevent suicide. It covers identifying the signs that children and young people often share that they are distressed and considering suicide; it contains a how to guide on intervention techniques and skills; it also talks schools through how to respond to a death by suicide in their community. The Guide is available to download for free on the PAPYRUS website.[2] While the current inquiry of the Committee is focusing on over 14 year olds, we must not lose sight of the impact of adverse childhood experiences and the fact that children as young as 9 years of age are contacting PAPYRUS with the desire to die by suicide. Many mental illnesses have their roots in childhood and adolescence. PAPRYUS urges legislators to consider this when making policy in mental health and suicide prevention. We cannot continue to deny that children die at their own hand and often before they are 15!!

[2] https://www.papyrus-uk.org/about/our-campaigns/save-the-class-of-2018#preventionguide

A YouGov poll commissioned by PAPYRUS in late 2017 surveyed teachers across the UK. It showed a great desire among school staff to support young people who are experiencing suicidal thoughts but many held a deeply-rooted fear or a significant lack of preparedness to do so. We need to equip all Welsh schools to prioritise suicide prevention: they need to be ready to say "We are doing all we can to help protect children and young people from suicide." Currently, this is not the case:



5. **Building a Suicide-Safer Online Environment** is a vital part of saving lives, especially for our young people who often "live online". PAPYRUS has worked tirelessly to highlight the suicide-specific dangers on recipe sites and pro-suicide sites. Some remain despite the efforts of PAPYRUS and its partners to reduce access to these: they inform readers on how to kill themselves, lethality rations and how to obtain means. **In a recent study with Bristol** University, PAPYRUS members shared experiences of how their children and young people had been influenced by such online information. Many of their young people had searched how to die before enacting their suicide. We now have the new challenge of social media and ephemeral information apps such as SnapChat which provide platforms for short exposure to long term dangers (sexting, anonymous image transfer, etc.). In its most recent campaign in this area, PAPYRUS produced a hard-hitting online film asking parents about their child's online activity. This has gone viral and, indeed international(!). **#BedTimeStories** is worth a watch and is available here: https://www.papyrus-uk.org/help-advice/resources/bedtimestories-online-bullying



"Thank you for your advice and support. I had no idea what to do or say when my child said she felt worthless and would be better off dead."

Mother of a 9 year old boy who called our HOPELineUK service.

6. **Local and Regional Suicide Prevention plans are 'getting there' but need resources and key accountable leads.** PAPYRUS was involved in the preparation of Public Health England Guidance for Local Authorities in Planning Suicide Prevention Activity and Strategy in their communities. Much of this thinking is now shaping the implementation of *Talk To Me 2* across Wales. It is pleasing to see that regional suicide prevention chairs are now in place across Wales, helping to champion and support this agenda through the regional groups.

7. **People affected by suicide have an important contribution to make to prevention.** PAPYRUS exists to recognise and foreground the unique contribution made to suicide prevention by those for whom suicide/suicidality is a **lived experience** (*bereaved parents/caregivers, young people at risk, those who experience and engage with services to support their mental health or reduce suicide risk*).

8. **We need to change the law.** PAPYRUS believes that HM Government should act with urgency to address and reduce stigma created and perpetuated by the State. Suicide is no longer a crime but the State often deals with it as though it still were. Specifically, there is a pressing need to change the law to allow HM Coroners to reach a suicide conclusion at inquests, based on the civil standard of proof (*on the balance of probability*), rather than the criminal standard (*beyond all reasonable doubt*). In its desire to get the law changed, PAPYRUS has the support of many other leading mental health charities, lots of people bereaved by suicide, the Chief Coroner, members of the National Suicide Prevention Alliance, members of the National Suicide Prevention Strategy Advisory Groups (Westminster and Wales respectively) and many others. Despite its best efforts and this widespread support for a change in the law, PAPYRUS has been unable to get the support of the Ministry of Justice to address this important issue. **It would be good to have the support of Welsh Government here too.** Please see Annex 1 for background evidence.

9. **Services are stretched.** PAPYRUS listens regularly to thousands of young people and those who care for them. Many callers to our HOPELineUK services struggle with the support they receive from services which are under-resourced or inconsistent in their care. Often, families report being left in despair as services cannot offer timely or professional support to a young person at risk. Waiting lists are often a problem. Children and young people contact PAPYRUS as a lifeline; many of these are desperate for local face-to-face support but are unable to cope between appointments, remaining at significant suicide risk on a waiting list. This can be unbearable to many young people. Parents, partners and friends often do not know where to turn. We often hear from patients or their parents and caregivers that "*the local mental health crisis team seems to be in crisis*". Some report that opening times are "office hours only" – mental health crises often happen at night when local services are unavailable. Similarly we hear that young people in the care of CAMHS or Transition (child to adult) services are often left in crisis and, even when they receive a service, find staff who are ill-equipped to manage suicide risk effectively.

10. **Support for People Affected by Suicide** This remains a postcode lottery. A woman told us that she received two long phone calls from Victim Support on having had her laptop stolen. Yet, when her daughter died, nobody spoke to her and offered any help. She asked, does the State value my computer more than my child? Postvention services and support systems are of value in their own right. Suicide is an unimaginable tragedy for family, friends, others affected, indeed whole communities. Moreover, it is an important prevention measure: those who have been touched personally by a suicide are at heightened suicide risk themselves. This is an urgent priority, enshrined in our strategy yet remains poor in terms of services available in Wales.

11. **Suicide training for front line workers in the NHS is limited and not being prioritised.** PAPYRUS is aware of so many stories where young people who died by suicide had been let down by a practitioner who did not ask about suicide or, where they did ask, did not follow up appropriately. On HOPELineUK, too, we often hear that a caller has been to the GP but had never asked about suicide. We always do ask. Many GPs seem to minimise the expressed distress, particularly when the patient is an adolescent. Further, there is a catalogue of stories about medics and other professionals completing Personal Health Questionnaires (PHQ9) type assessments and not knowing how to follow up with appropriate support when suicide risk is clearly identified. Many do know that they must refer but the pathway is not always clear to secondary or specialist services. This means that some young people end up at Emergency Departments with little effective support or, even worse, get missed and remain at high risk. Many young people then take their own lives.

    There should be a radical reappraisal of the need for GPs and other frontline health professionals to be trained to be suicide-aware and able to intervene effectively where suicide risk is present. Medics and nurses should be required to learn suicide awareness and intervention skills (such as ASIST) before graduating. This should be mandatorily updated frequently just like CPR training for GPs. The likelihood of having a patient suffer unconsciousness or heart failure at a surgery is far lower than the volume of suicide risk being presented daily to GPs yet there is no requirement for suicide prevention training for GPs currently.

    <u>Risk assessments</u> often used to assess whether a person is likely to harm or die because of thoughts of suicide are largely ineffective and only help the person completing them rather than the person at risk.

12. **SHARING INFORMATION TO SAVE LIVES**

Confidentiality between patient and doctor is an important principle. However, the safety of the patient is paramount and therefore **sharing of information** may well need to happen in order to save life. The current National Suicide Prevention Strategy for England states that, '*there are clearly times when mental health service practitioners, in dealing with a person at risk of suicide, may need to inform the family about aspects of risk to help keep the patient safe*.' Where the individual is under 18, the issue is even clearer: GMC Guidelines for all doctors dealing with 0-18 year-olds state that they should disclose information if this is necessary to protect the child or young person, or someone else, from risk of death and serious harm. The guidelines make clear that the doctors' ultimate responsibility is safeguarding and protecting the health and wellbeing of children and young people.

Despite this, PAPYRUS is aware of countless cases where parents and close caregivers are not always informed of what is happening when their young person is at risk. Young people at risk and their primary caregivers ought to be included in the **care pathway** wherever possible. Often we hear that parents, in particular, are the last to find out about suicide risk in their young family member, despite professionals knowing that risk. **PAPYRUS believes that, wherever possible, information must be shared to prevent suicide where there is risk to life.** The Consensus Statement[3] of the Royal Colleges and the Department of Health must be properly promoted, disseminated and used at local practice level among all health professionals.

PAPYRUS has recently written to all Chief Executives of NHS Trusts across the UK to encourage information sharing. The letter asks NHS bosses to support their staff in making best interest decisions where life is at risk from suicide ideation or suicide behaviours. Where such a decision to share information is challenged, the NHS trust lead is asked to back their colleague in the courts should it comes to litigation. We have already had several trusts take up this idea. We believe that it encourages existing best practice, it removes the fear of being sued or challenged, and ultimately saves lives.

"How can it be OK for me to be told by my GP only after my son's suicide that he had made several previous attempts on his life?"

Father of a 17 year old boy who took his life.

[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/271792/Consensus_statement_on_information_sharing.pdf

Annex 1

Reaching a Suicide Conclusion by HM Coroner

1. Coroners play a key role in dealing with the aftermath of suicide. We believe that many coroners play a significant damaging role in stigmatising suicide and reinforcing outdated attitudes to those who take their own lives. There is the most compelling evidence to suggest that the increasing reluctance of coroners to return a suicide verdict is linked to the outdated view that suicide is a crime.
2. It is important to note that coroners use a criminal standard (beyond reasonable doubt) when reaching a suicide verdict. This practice is not enshrined in the Coroners and Justice Act, or in the Coroners Rules, but in Case Law which has been brought about, primarily by those who wish to challenge a coroner's conclusion (perhaps because of the stigma associated with suicide, the financial implications of a suicide verdict, or because of the difficulty they have coming to terms with the fact that a person they love has taken their own life).
3. In our brief review of the case law it is evident that prior to the decriminalisation of suicide in the Suicide Act of 1961, there were good reasons to challenge a suicide verdict, certainly to avoid the stigma of committing a criminal act and the financial disadvantages it brought. Case law established that the presumption had to be against returning a suicide verdict and reaffirmed the need for coroners to establish 'intent' on the part of the deceased person. The point is made that suicide is a crime and must be proved by facts and not conjecture. For good reason, a suicide verdict was only to be returned when there was clear evidence of intent (Southall v Cheshire News Company Limited (1912) 5 BWCC 251; R v Huntbach, ex partre Lockley [1944] 1 KB 606).
4. Following the Suicide Act of 1961 which stated; "the rule of law whereby it is a crime for a person to commit suicide is hereby abrogated", there were a number of legal challenges of a coroner's suicide verdict.
5. These challenges focused around intent and it is clear that the appeal judges had a view of suicide behaviour that was 'of its time'. We can see from two important cases were the deceased young men stepped before an oncoming train, the appeal judges felt evidence from parents, family and friends, that the individuals were in a positive frame of mind prior to their deaths, should not have led to a suicide verdict. It is clear from these accounts that both young men killed themselves. (R v Dyfed Coroner ex parte Evans 24 May 1984 (DC); Jenkins v HM Coroner for Bridgend and Glamorgan Valleys [2012] EWHC 3175 (Admin)).
6. There is a weight of examples where young people have hidden their suicidal thoughts from those closest to them and were noted to be both outgoing and cheerful prior to killing themselves. Indeed, having resolved themselves to take their own life, they were more settled and calmer than they might previously have been. (The intention to kill themselves is demonstrated by the fact that they bought a suicide kit online and used it to take their own life, as was the case for my own son.)
7. This case law, which shows a poor understanding of suicide behaviour, has led to the practice of applying the most stringent of tests in cases of suicide, such that coroners are increasingly reluctant to deliver a suicide verdict, despite clear evidence that death was indeed self-inflicted. We can cite various high-profile cases where almost everyone would consider the person killed themselves except the coroners who reached a conclusion of 'accidental death'.

8. The clearest reference we can find to the application of such a high standard of proof is in R v West London Coroner, ex parte Gray [1986]. Lord Widgery CJ in R v City of London Coroner, ex p Barber [1975] 3 All ER 538 at 540, [1975] 1 WLR 1310 at 1313 said:

   > 'If that is a fair statement of the coroner's approach, and I sincerely hope it is because I have no desire to be unfair to him, it seems to me to fail to recognise what is perhaps one of the most important rules that coroners should bear in mind in cases of this class, namely that suicide must never be presumed. If a person dies a violent death, the possibility of suicide may be there for all to see, but it must not be presumed merely because it seems on the face of it to be a likely explanation. Suicide must be proved by evidence, and if it is not proved by evidence, it is the duty of the coroner not to find suicide, but to find an open verdict. I approach this case, applying a stringent test, and asking myself whether on the evidence which was given in this case any reasonable coroner could have reached the conclusion that the proper answer was suicide.'
   >
   > It will be noted that Lord Widgery CJ alluded to the stringent test, but without reference to what may be called the conventional standards of proof. I cannot believe, however, that he was regarding proof of suicide as other than beyond a reasonable doubt. I so hold that that was and remains the standard. It is unthinkable, in my estimation, that anything less will do. So it is in respect of a criminal offence. I regard as equally unthinkable, if not more so, that a jury should find the commission, although not identifying the offender, of a criminal offence without being satisfied beyond a reasonable doubt.
   >
   > As for the other verdicts open to a jury, the balance of probabilities test is surely appropriate save in respect, of course, of the open verdict. This standard should be left to the jury without any of the refined qualifications placed on it by some judges who have spoken to some such effect as 'the more serious the allegation the higher the degree of probability required'.

9. The significance of this ruling is to once again give suicide the same status as that of a criminal offence, despite the fact that it was decriminalised 14 years earlier.

10. The result of this and other case law has been to reinforce negative views of suicide, create an increasing reluctance to return a suicide verdict and as a consequence, return the act of suicide to the position it was prior to being decriminalise in the Suicide Act of 1961. For all intents and purposes suicide is still treated as a criminal act. (The continued use of the term 'committed' suicide is a reflection of our continued tendency to criminalise those who take their own lives.)

11. We understand the reluctance of many parents/partners or family members to hear a suicide conclusion returned following the death of a family member, but the consequences of not being open and acknowledging that the person was instrumental in bringing about their own death is to increase the stigma around suicide. This increases the reluctance of those who are considering ending their lives to acknowledge and speak about their suicidal thoughts. It impedes help-seeking. In addition it has the unintended consequence of hiding the true extent of this major public health concern in the UK.

    Ends

S 41

Inquiry into Suicide Prevention

Ymchwiliad i Atal Hunanladdiad

Ymateb gan Y Comisiwn CydraddoIdeb a Hawliau Dynol

Response from the Equality and Human Rights Commission

Equality and Human Rights Commission response to the Health, Social Care and Sport Committee's Inquiry into suicide prevention

About the Equality and Human Rights Commission

The Equality and Human Rights Commission (the Commission) is a statutory body established under the Equality Act 2006. It operates independently to encourage equality and diversity, eliminate unlawful discrimination, and protect and promote human rights. It contributes to making and keeping Britain a fair society in which everyone, regardless of background, has an equal opportunity to fulfil their potential. The Commission enforces equality legislation on age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. It encourages compliance with the Human Rights Act 1998 and is accredited by the UN as an 'A status' National Human Rights Institution. Find out more about the Commission's work at:www.equalityhumanrights.com.

Introduction

The Commission welcomes the Chair's letter of February 9 inviting us to provide written evidence to inform the Committee's Inquiry into suicide prevention in Wales.

Our response focuses on our Is Britain Fairer? & Is Wales Fairer? reports and the findings of our Inquiry into non-natural deaths of adults with mental health conditions in prisons, police custody and psychiatric hospitals.

Is Britain Fairer? and Is Wales Fairer?

The Commission has a statutory duty to report on equality and human rights progress in England, Scotland and Wales. Our Is Wales Fairer? 2015 report brought together evidence to answer the question as to whether Wales was fairer than it was when we published our first review five years before. The report looked at areas of life such as health, education, work, justice and individuals' role in society and the changes that have taken place in each of these. Based on the evidence, the report identified seven key equality and human rights challenges for Wales, and a number of particular priorities for each of these challenges.

One of the seven challenges and its priorities was to:

Improve access to mental health services and support to people experiencing poor mental health.

- Improve access to mental health services.
- Reduce the rate of suicide especially amongst men.

The report states that in Wales the suicide rate for people aged 15 and over substantially increased between 2008 and 2013, up from 10.7 to 15.6 per 100,000 inhabitants.

While the incidence of suicide has increased for all groups of people, the increase is especially marked for men compared with women. The suicide rate has increased for certain age groups: it doubled for people aged 55 to 64 and increased by around 60% for those aged 35 to 54. It is also particularly high for middle-aged men (Office for National Statistics, 2015).

Is Britain Fairer? (2015) states that during the review period (2008 to 2013) suicide rates increased in England and Wales, but decreased in Scotland (although its suicide rate remained the highest in Britain). The gap between men and women widened in the UK as a whole, with middle-aged men having the highest suicide rates:

Between 2008 and 2013, the overall suicide rate increased slightly in England (from 10.0 per 100,000 inhabitants to 10.7) and to a greater extent in Wales (from 10.7 to 15.6 per 100,000 – most visibly among the 35–64 age groups).

The male suicide rate increased in both countries resulting in a widening of the gap between males and females in Wales and England.

In the UK, the suicide rate of males aged 45–49 increased significantly between 2007 and 2013 from 19.4 to 26.8 deaths per 100,000 population, while that of the overall population (counting both men and women) increased from 10.6 to 11.9 per 100,000 over the same period (ONS, 2015).

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH, 2014) highlighted the continued high risk of suicide by patients with mental health issues, within 12 months of mental health service contact. Patients at particularly high risk were those who were recently discharged from hospital (especially in the first one or two weeks) and those who were under crisis resolution and home treatment who were also living alone.

The Commission will be publishing updated Is Britain Fairer? and Is Wales Fairer? reports in 2018. We will share our updated evidence with the Committee.

Preventing deaths in detention of adults with mental health conditions

In 2015, the Commission published a report of our Inquiry into non-natural deaths of adults with mental health conditions in prisons, police custody and psychiatric hospitals in England & Wales in the years 2010 to 2013. Our inquiry focused on non-natural deaths which fall into one of the following categories: self-inflicted/suicide, deaths caused by another person including homicide, deaths; the cause of which is unknown and accidental deaths.

Our Inquiry primarily looked at existing evidence across the three sectors from 2010 to 2013, to examine how organisations complied with their obligations under Article 2 of the European Convention on Human Rights (the Right to Life).

The report's main findings included (please note the report is dated 2015):

For detained patients in hospitals we were not able to access much of the information that follows a non-natural death, such as individual investigation reports. Detained patients are a particularly vulnerable group in the UK who are being held in order to keep them, and others, safe. The care given to them must reflect their specific needs and it is incumbent on society to monitor this care.

In healthcare settings…the Government should take steps to ensure it can be confident that independent investigations are indeed taking place, that staff are supported to speak candidly about events and there are no deaths in psychiatric hospitals that could have been prevented. The Commission considers this to be such an opportunity to reduce the deaths of detained patients that we intend to take this forward with those responsible for providing and regulating psychiatric care in hospitals.

In relation to prisons, the debate about how people are detained needs to go beyond the minimum standards that keep people alive. Those responsible for detention must ensure that people are not punished for behaviours that are viewed as disruptive but in fact are symptomatic of illness. Prisons need to monitor the numbers of prisoners with mental health conditions and their severity so that they can reflect on them and make appropriate arrangements for treatment and support.

It is impossible to talk about the high levels of people with mental health conditions in prisons without questioning whether imprisonment is the appropriate place. As many others have previously stated we remind

the Government that the aim of the penal system should be about rehabilitation as well as punishment. For some people the need for tailored rehabilitation that meets their particular needs might be better served within the community or psychiatric hospitals. This would also mitigate the pressures on prison resources.

In prisons, there was an increase in non-natural deaths between 2012 and 2013, with a further increase in 2014. HM Inspectorate of Prisons (HMIP) have cited their concerns about the increase in people being imprisoned. They and the Prisons Probation Ombudsman (PPO) have also voiced concerns about staff reductions, tougher regimes and less resources and possible links between the deaths and these factors. Any link between these factors and the increase in non-natural deaths since 2013 is complex and needs to be better understood. Therefore those responsible for keeping prisoners safe should work together to understand and address these issues. Any deterioration in conditions of detention and adverse impact on those with mental health conditions should be monitored and remedied.

In the course of our Inquiry we came across cases from PPO investigation reports where deaths have resulted from the failure to identify a prisoner's mental health condition and where concerns were identified but not shared with colleagues. These deaths could have been prevented if prisons got the basics right.

There are very few deaths within police custody, however every year a number of people with mental health conditions die while being detained. The role of the police is not to provide clinical care to people in need of support however they are often the first on the scene so they cannot ignore the need to be able to respond appropriately while minimising the use of restraint. This should always be done in partnership with local health providers (including ambulances).

There is a considerable amount of work being done nationally and locally. These should help ensure quicker assessments and access to clinical care and that people are not being held inappropriately within police cells.

The police should record and publish the use of restraint in order to allay concerns that there is discriminatory use against people with mental health conditions and people from ethnic minorities.

The Report's recommendations were addressed at government, regulators and inspectorates and the leaders and managers of individual institutions. They were:

- Recommendation 1: Structured approaches for learning lessons in all three settings should be established for implementing improvements from previous deaths and near misses, as well as

experiences in other institutions. As part of this, there should be a statutory obligation on institutions to respond to recommendations from inspectorate bodies and to publish these responses.

- Recommendation 2: Individual institutions in the three settings should have a stronger focus on meeting their basic responsibilities to keep detainees safe including implementing recommendations, improving staff training and ensuring more joined up working. Where this is not currently the situation this should explicitly be part of the inspection regimes.
- Recommendation 3: In all three settings there needs to be increased transparency to ensure adequate scrutiny, holding to account and the involvement of families.
- Recommendation 4: The Equality and Human Rights Commission's Human Rights Framework should be adopted and used as a practical tool in all three settings. Adopting it as an overall approach as well as ensuring compliance with each individual element will reduce non-natural deaths and should help to inform and shape policy decisions.

Follow-up report

In March 2016, the Commission published a follow-up report to our 2015 inquiry into non-natural deaths of adults with mental health conditions who were detained in prisons, police custody or psychiatric hospitals. The follow-up report examined the steps taken to act on our recommendations over the previous year and was based on information provided to us by inspectorates and regulators we worked with, data, reports and other publications on the subject.

Analysis of evidence showed that changes were being made in some areas where we had concerns in our inquiry, but some key areas still need to be addressed. Data on the number of non-natural deaths in the three settings shows that the overall trends are:

- the number of non-natural deaths is continuing to decrease for detained patients.
- the number of non-natural deaths has continued to increase year on year for prisons.
- the number of non-natural deaths is low, but numbers are fluctuating for police custody.

Following extensive consultation with other regulators and stakeholders over the year, we have revised our recommendations for change. These reflect learning from good practice and where urgent changes are required.

Case study: Dyfed Powys Police street triage service

The Inquiry report included a case study of the Dyfed Powys Police street triage service. Dyfed Powys police launched a street triage service in 2015 for responding to calls where potential mental health issues were identified. The street triage project is an ongoing initiative that sees police and mental health services work together to ensure people get appropriate care when police are called to a person in distress.

The aim was to ensure that the least intrusive options were used whenever possible. Section 136 detentions typically take up a considerable amount of police time. Use of police custody for these detainees has dropped by nearly 50 per cent in the first 12 months, which represents a considerable efficiency saving. Initially, significant effort and persuasion were needed to embed effective partnerships across police, health and social services.

The size and rural nature of the area have influenced the type of triage service developed. A hybrid model was adopted that combined an unmarked police vehicle with telephone support to front line officers. Mental health nurses are now based in the head-quarters and help assess information as it comes through.

A training programme, which started in December 2015, aims to deliver mental health awareness training to every officer in the force, up to chief constable level. Importantly mental health practitioners have been involved in designing and delivering this, including enhanced training for those in the triage team.