Agenda – Health, Social Care and Sport Committee

Meeting Venue:
Committee Room 4 – Tŷ Hywel
Meeting date: 21 March 2018
Meeting time: 09.15

For further information contact:
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Informal pre-meeting (09.15 – 09.30)

Public meeting

1 Introductions, apologies, substitutions and declarations of interest

(09.30)

2 Suicide Prevention: Evidence session with National Advisory Group on suicide and self-harm prevention

(09.30 – 10.15) (Pages 1 – 26)

Professor Ann John, Professor of Public Health and Psychiatry, Swansea University, and Chair of the National Advisory Group on suicide and self-harm prevention

Research brief
Paper 1

Break (10.15 – 10.20)

3 Suicide Prevention: Evidence session with Mind Cymru and Connecting with People

(10.20 – 11.05) (Pages 27 – 47)

Sara Moseley, Director, Mind Cymru

Glenn Page, Senior Policy and Campaigns Officer, Mind Cymru

Dr Alys Cole-King, Connecting with People

Alex Cotton, Connecting with People

Paper 2 – Mind Cymru

Paper 3 – Connecting with People

Break (11.05 – 11.15)

4 Suicide Prevention: Evidence session with ProMo-Cymru and Papyrus

(11.15 – 12.00) (Pages 48 – 63)

Stephanie Hoffman, Head of Social Action, ProMo-Cymru

Nicola Simms, Lead for helpline Practice, Quality and Operations, ProMo-Cymru

Ged Flynn, Chief Executive, Papyrus

Paper 4 – ProMo-Cymru

Paper 5 – Papyrus

5 Paper(s) to note

(12.00)

5.1 Paper by Prof Ann John on Suicide Information Database – Wales

(Pages 64 – 70)

Paper 6

5.2 GMS Systems Framework Contract Procurement and All Wales Medical Performers List: Letter from Dr Rebecca Payne, Chair, Royal College of General Practitioners Wales

(Pages 71 – 72)

Paper 7

5.3 Outcome of GMS Systems Framework Contract Procurement: Correspondence between the Chair and the Cabinet Secretary for Health and Social Services

(Pages 73 – 76)

Paper 8

6 Motion under Standing Order 17.42 to resolve to exclude the public from the remainder of the meeting

(12.00)

7 Suicide Prevention: Consideration of evidence

(12:00 – 12:10)

8 GMS Systems Framework Contract Procurement: Draft correspondence

(12.10 – 12.15) (Pages 77 – 80)

Paper 9

9 All Wales Medial Performers List: Draft correspondence

(12.15 – 12.20) (Pages 81 – 86)

Paper 10

Agenda Item 2

Document is Restricted

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 depression and co-morbid	Hospitals Prisons Police custody suites	People who are first point of contact or first responders, including:

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	Workplaces Schools, Further and Higher Education establishments Primary care facilities Emergency departments Rural areas Deprived areas	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.

References

1. http://gov.wales/topics/health/publications/health/reports/talk2/?lang=en

2. John A, Dennis M, Kosnes L, et al. Suicide Information Database-Cymru: a protocol for a population- based, routinely collected data linkage study to explore risks and patterns of healthcare contact prior to suicide to identify opportunities for intervention. http://bmjopen.bmj.com/content/bmjopen/4/11/e006780.full.pdf

3. http://www.publichealthwalesobservatory.wales.nhs.uk/phof201

4. http://www2.nphs.wales.nhs.uk:8080/ChildDeathReviewDocs.nsf/5633c1d141208e8880256f2a004937d1/ce6956a584dd1f6b80257c9f003c3fa1/$FILE/PHW%20probable%20suicide%20web.pdf

5. Bertolote, J, M., and Fleischmann, A. (2002). Suicide and psychiatric diagnosis: a worldwide perspective. World Psychiatry, V1(3). pp. 181 – 185. Available at: http://bit.ly/2ce5ANo

6. The Marmot Review. (2010). *Fair Society, Healthy Lives*. Available at: http://bit.ly/1hs5CeE

7. University of Manchester. (2015). *National Confidential Inquiry into Suicide and Homicide Annual Report*. Available at: http://bit.ly/2cqtVQg

Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Health, Social Care and Sport Committee
HSCS(5)-10-18 Papur 2 / Paper 2

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.

This document is endorsed by:

> *"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"*

This document is endorsed by:

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."*

This document is endorsed by:

> *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.

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

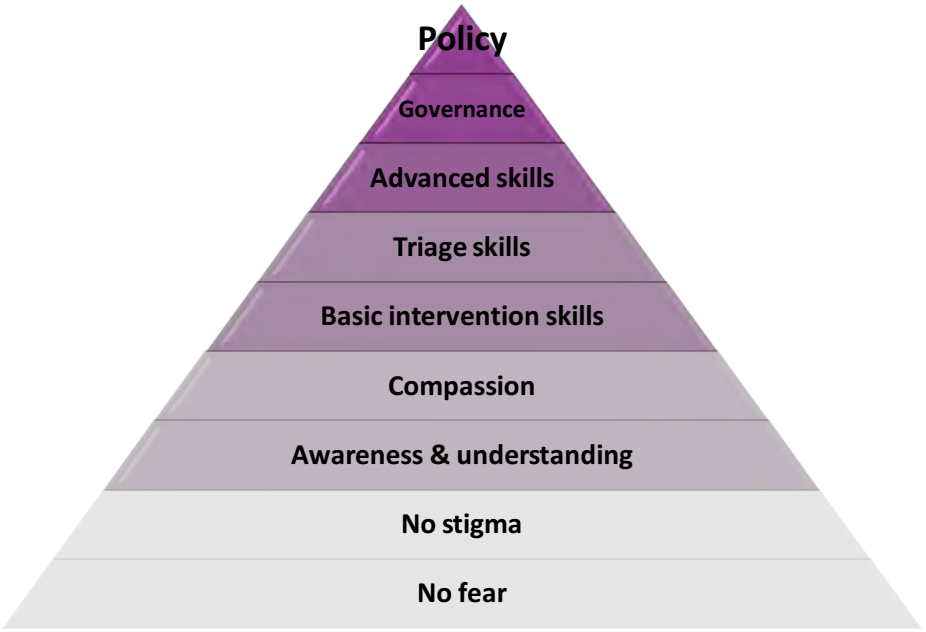
CwP offers a suite of training programmes, with characteristics of a quality improvement initiative. The training is designed to break through and bypass unconscious barriers to the identification and intervention of people at risk of suicide such as fear, stigma, desensitization, personal experiences 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.

Suicide prevention training hierarchy (Cole-King 2017)



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.

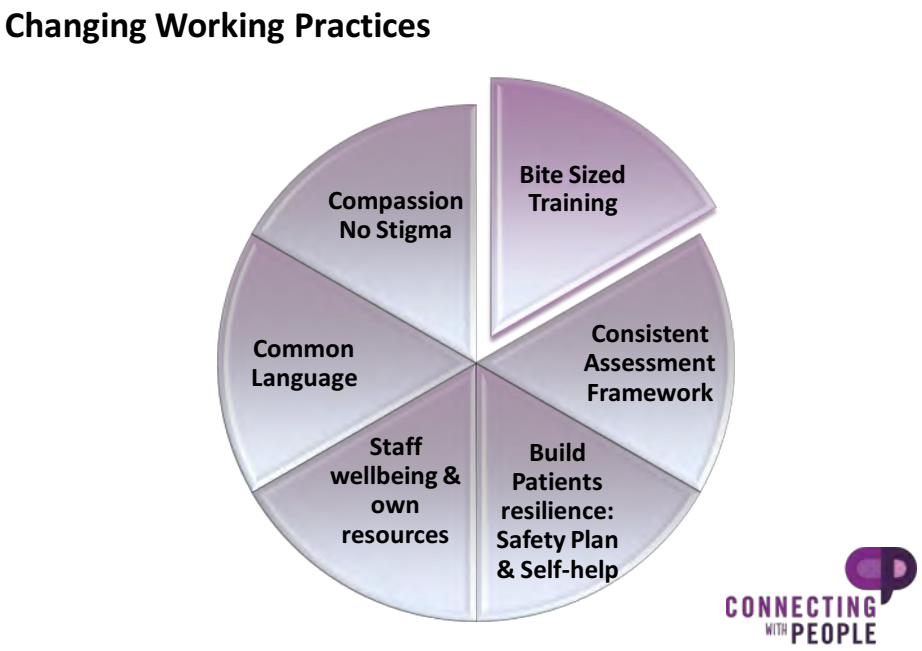
Other factors that play into this are dependent upon the communities that Primary Care serves as there is great variation. We see practices that are located in areas of extreme affluence, others multi-varied, and others still that manage extreme deprivation day in and day out. Although the association 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.

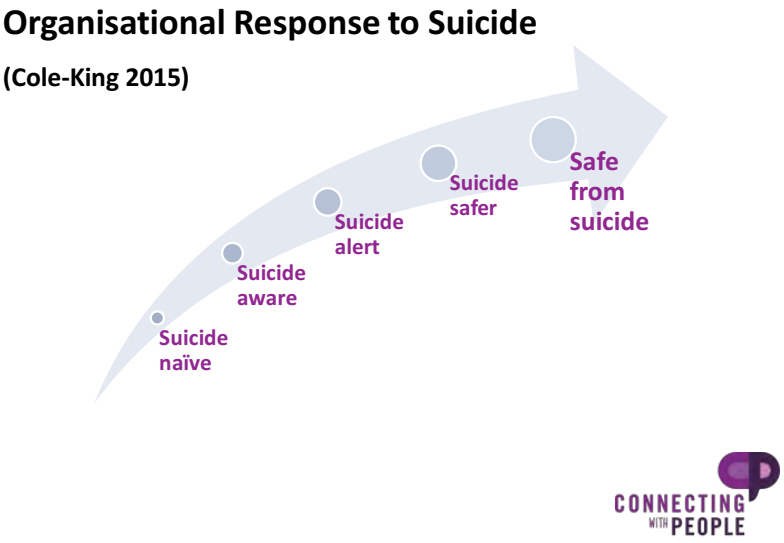
SystmOne is the IT system used by approximately 40% of Primary Care practices across England: EMIS systems are prolific across the UK. The SAFETool Triage guides practitioners to undertake a collaborative, evidenced-based assessment and culminates in the co-production of an appropriate Safety Plan, even 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

References

Bolton, J. M., Gunnell, D., & Turecki, G. (2015). Suicide risk assessment and intervention in people with mental illness. BMJ, 351(nov09 1

Cole-King, Green, Gask, Hines & Platt. 2013 Suicide mitigation: a compassionate approach to suicide prevention, Adv Psychiatr Treat 19 (4)

Cole-King, A. and Jenkins, P.L. (1997). A prospective study of psychiatric patients who attempt deliberate self harm. *Proceedings of Winter meeting of Royal College of Psychiatrists*, Cardiff, January.

Cole-King A, O'Neill S. (2017) Suicide prevention for physicians: identification, intervention and mitigation of risk in mental Health In Primary Care Mental Health Gask L, Peveler R, Royal College of Psychiatrists Second Edition (in submission)

Dickens, C. and Guy, S. (2017) "3 Minutes to Save a Life". How one University is addressing student emotional distress to mitigate the risk of suicide. Mental Health Practice (submitted under peer review)

Glenn, C. R., & Nock, M. K. (2014). Improving the short-term prediction of suicidal behavior. *American Journal of Preventive Medicine, 47*(3S2), S176-S180. doi:10.1016/j.amepre.2014.06.004

Klonsky, E. D., & May, A. M. (2014). Differentiating Suicide Attempters from Suicide Ideators: A Critical Frontier for Suicidology Research. Suicide and Life-Threatening Behavior, 44(1), 1–5. http://doi.org/10.1111/sltb.12068

Knipe M, Thornton C, Cole-King A, Slegg G, Hughes H, Peake-Jones G C.(2010)Emergency Department professionals' compliance with nice guidelines for patients presenting with suicidal thoughts or self harm. Accepted *Royal College of Psychiatrists, Faculty of Liaison Psychiatry, Annual Residential Conference Cardiff*

Mann J., Apter A,. Bertolote J., Beautrais A., (2005) Suicide Prevention StrategiesA Systematic Review. *JAMA.*;294(16):2064–2074

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.

Parker C., Green G. 2016 A Formal Evaluation of *Connecting with People* Programme. In process

PHE & HEE, 2016. Mental health promotion and prevention training programmes: emerging practice examples, London, Public Health England. P41-45. PHE publications gateway number: 2016283

Nightline Association Trustees Annual Report 2014 https://drive.google.com/file/d/0Bziwbyi_v7bgNFVxTHlqTFQ5UU0/view [last visited 20/11/17]

Sudak D, Roy A, Sudak H, *et al* (2007) Deficiencies in suicide training in Primary Care specialties: a survey of training directors. *Academic Psychiatry,* **31,** 345–349.

Waters K, Cole-King A. (2017) Assessing risk of suicide and self-harm in Psychiatric and Mental Health Nursing: The craft of caring (Third Ed.) Chambers

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

SUBMITTED BY PROMO-CYMRU - DECEMBER 2017

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: [redacted]

Website: http://www.promo.cymru/
Company Limited by Guarantee: 1816889
Registered Charity: 1094652

Y Pwyllgor Lechyd, Gofal Cymdeithasol a Chwaraeon
Health, Social Care and Sport Committee

Inquiry into Suicide Prevention

Response from national charity

PAPYRUS
prevention of young suicide

GED FLYNN

Chief Executive

PAPYRUS Prevention of Young Suicide

[redacted]

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.

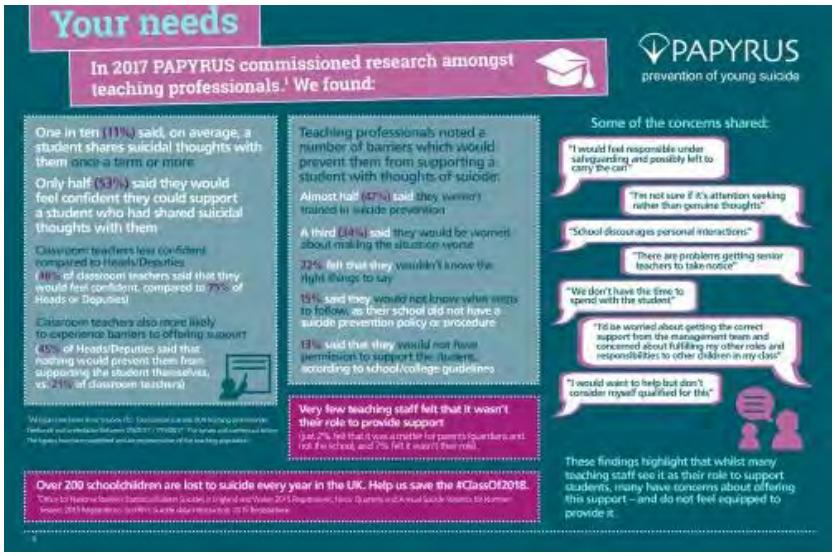
3. PAPYRUS believes that a there should be an acknowledgement in strategy and suicide prevention plans that suicide is **the leading cause of death in young people - males and females under 35.** We are beginning to get the message out there about male suicide but not about young suicide. 200 children (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.

    Risk assessments 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

This paper has been provided under the Assembly's pilot Academic Fellowship Scheme, which enables academics to work at the Assembly on a specific project, for the mutual benefit of the academic and the Assembly.

Suicide Information Database- Wales (SID-Cymru)

Ann John, Professor of Public Health and Psychiatry, Swansea University Medical School

Every suicide is a tragedy and causes distress for family, friends, professionals and the wider community. Although the factors that contribute to a suicide are many and complex, suicide is potentially preventable. Knowing who dies by suicide and when is essential to suicide prevention efforts, since it allows us to identify changes over time, enabling responsive priorities to be set to inform policy and practice and document the impact of any interventions. In Wales there are a number of sources of information on suicide but two important ones are data from the Office of National Statistics provided by Public Health Wales and the Suicide Information Database- Wales (SID-Cymru), based at Swansea University and part funded by Health and Care Research Wales through the National Centre for Mental Health (http://www.ncmh.info).

Understanding suicide data

However there are a number of issues to consider when thinking about what suicide statistics mean:

- Definitions

Everything presented here refers to the Office for National Statistics (ONS) classification of suicide. In this definition suicide includes where the underlying cause of death was intentional self harm (ICD-10 code X60-X84) or an event of undetermined intent (Y10-Y34), but excluding Y33.9 before 2007.

In 2016, the National Statistics definition of suicide was modified to include deaths from intentional self-harm in 10 to 14 year old children in addition to deaths from intentional self-harm and events of undetermined intent in people aged 15 and over.

- Under-reporting of suicide

It is widely acknowledged that official statistics may underestimate the 'true' numbers of suicide in the United Kingdom and across the world. Deaths may be misclassified where a coroner cannot

establish that the intent of the individual was to take their own life. Where such a death is recorded as 'undetermined intent' it will be included in suicide statistics but where it is coded as accidental it will not. The latter occurs, for example, in single vehicle road traffic accidents.

Coroners record a conclusion of suicide based on the principle of 'beyond doubt' rather than 'balance of probabilities'. This may be difficult to determine. Stigma may also play a role when assigning a cause of death as suicide.

- Narrative verdicts

It should be noted that following a coroner's inquest into a death, the coroner may decide to use a narrative verdict to report their conclusions as to the cause of death. Some narrative verdicts do not specify whether the fatal injury was accidental or involved deliberate intent to self-harm. The ONS call these verdicts 'hard-to-code'. There has been concern about an upward trend in 'hard-to-code' narrative verdicts, with numbers increasing in Wales from 52 in 2006 to 147 in 2010. Since such verdicts force ONS to code some probable suicides as accidents, e.g. accidental hanging (ICD-10 W75-76) or accidental poisoning (X40-49), it was thought that official suicide figures could be underestimating the true picture. As a result of these concerns, ONS took action by providing both their own coding staff (in January 2011) and also coroners (in October 2011) with additional guidance on narrative verdicts. These actions appear to be having a positive impact, with ONS reporting a 49% drop in hard-to-code narrative verdicts in Wales between 2010 and 2011 registrations. However a reduction in the number of hard-to-code narrative verdicts could lead to an apparent rise in the numbers of suicides from 2011 onwards, when in fact the rise could be partly due to improved reporting from coroners and improved coding by ONS. Conversely reported numbers of suicides are likely to be underestimated, particularly between 2006 and 2010.

- Delays in registration

Official data are subject to delay in availability. Before a suicide death can be registered an inquest must be completed (England and Wales); the length of time for this from death is variable. For this reason the information provided by Public Health Wales is

presented by year of registration rather than year of death where as that from SID-Cymru is by year of death.

- Year on year fluctuations

When looking at trends over time it's important to look over a relatively long period not any one year in isolation. There will be year on year fluctuations that are unlikely to be a reflection of 'true' changes in trends.

- Small populations

Where populations are small, for example where males and females are analysed separately, rates can be unreliable since a small change in the number of suicides will have a large impact on rates. When this occurs it is demonstrated by relatively wide confidence intervals (bars around points in graphs, ranges in brackets). In these analyses any comparisons should be interpreted with caution and particular attention paid to overlapping error bars where differences are then not statistically significant i.e. we cannot really say there is a 'true' difference.

- Age standardised vs. crude rates

Age standardised rates have been standardised to the European population so comparisons can be made. This is because the age structure of a population impacts rates i.e. if looking at stroke one area may contain a higher proportion of older people so rates would be higher but this would be expected. Crude rates are not standardised in this way.

Suicide data for Wales

A detailed analysis of data in Wales is being produced for the mid-point review of 'Talk to Me 2', the current Wales strategy for suicide and self- harm prevention. In Wales there were 322 suicides in those aged 10 years and over in 2016, 28 less than the 350 recorded in 2015 but 75 higher than the 247 recorded in 2014. In 2013 there were 393 suicides in Wales, the highest recorded figure since 2002.

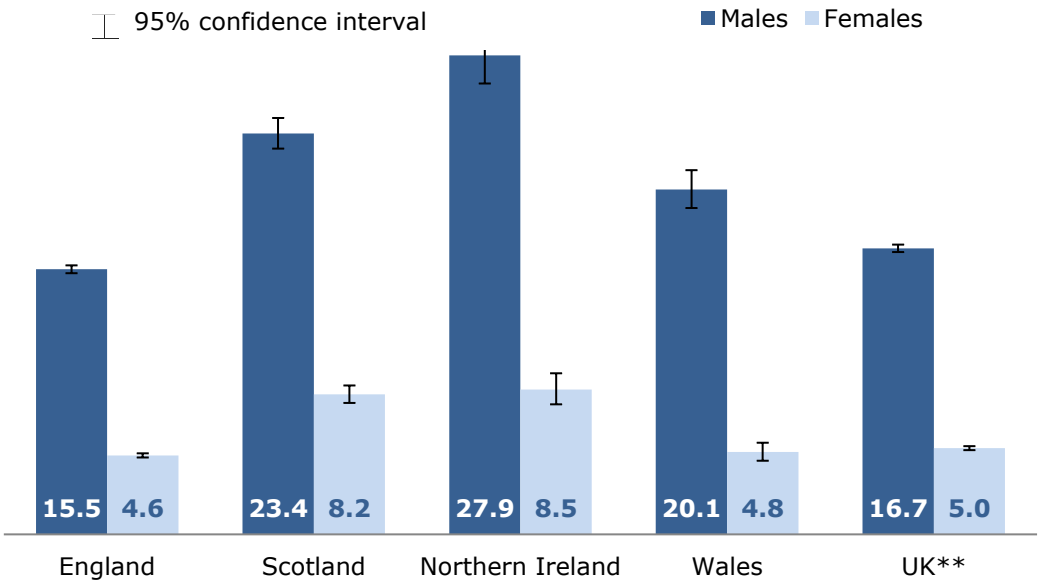
- Wales in comparison with other UK nations

There are differences in coding in Scotland and Northern Ireland where additional codes are used (Y87.0 and Y87.2), 'Sequelae of intentional self-harm/ event of undetermined intent'. This means that there may be differences between the nations so comparisons across the United Kingdom nations should be interpreted with caution.

The rate of suicide in Wales (2012-2016) was higher than that of the UK average for males (Figure 1) but equivalent for females.

Figure 1

Suicides, European age-standardised rate (EASR) per 100,000*, males and females aged 10+, UK Nations, 2012-2016
Produced by Public Health Wales Observatory, using data from ONS, NRS & NISRA



*Includes deaths from intentional self-harm for persons aged 10-14. Adjusted 2013 ESP weightings used to calculate EASRs due to the availability of data for different age groups
**UK is derived from the sum of England, Scotland, Northern Ireland and Wales and does not include deaths of non-residents

SID-Cymru

SID-Cymru anonymously links, at an individual level, electronic routinely collected data about all persons in Wales, over 10 years of age, who were recorded to have died by suicide between the 1st January 2001 and the 31st December 2015. Currently the focus is on the prior health, nature of previous contacts with services and wider social circumstances of all those who die through suicide

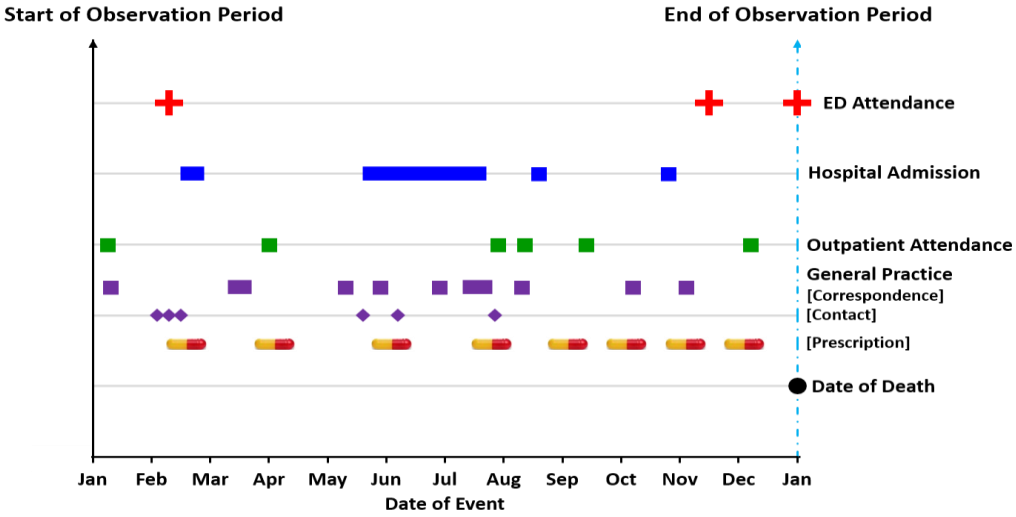
(known and unknown to mental health services) to inform prevention, policy and practice.

It is hosted within the Secure Anonymised Information Linkage (SAIL) Databank which links together the widest possible range of person-based data using robust privacy protecting anonymisation techniques for health related research. The SAIL Databank contains vast amounts of data routinely collected on a daily basis by health and social care systems to support people's care.

This study, for the first time in the United Kingdom, links routinely collected primary care, emergency department (ED) attendance and hospital admissions at a whole population level to identify patterns of service contact for those who die by suicide prior to their deaths. There is a particular focus in this project on the opportunities for prevention in primary care and emergency departments. Data from SID-Cymru informed the 'Thematic review of deaths of children and young people through probable suicide, 2006-2012'. The review made a number of recommendations to various agencies, such as minimum unit pricing for alcohol and on the care of under 18 year olds with alcohol related or self – harm emergency department attendances. A repeat review is being conducted this year.

Currently SID-Cymru links across the Office for National Statistics Annual District Deaths Extract (ADDE), the Welsh Primary Care GP dataset (WGP), the Patient Episode Database for Wales (PEDW), the Outpatient Dataset (OPD) and the Emergency Department Data Set (EDDS). There is a Sid-Cymru protocol which reports on this in more detail (http://bmjopen.bmj.com/content/4/11/e006780), and information on datasets held within the SAIL Databank are available online (www.saildatabank.com).

So for an individual…



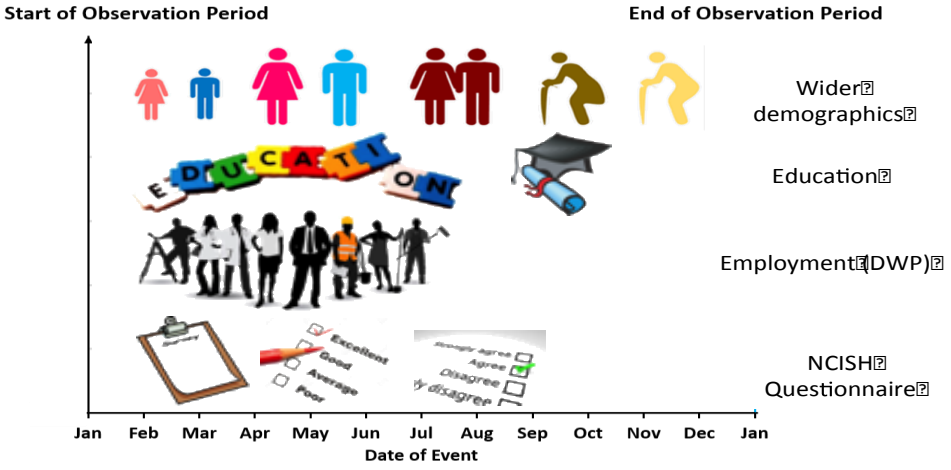
A total of 4289 people resident in Wales who died by suicide, with a date of death from 2001-2015, are currently included in SID-Cymru with 42890 controls of the same age and sex who were alive on their date of death. Just over three- quarters of those who died by suicide were male, which is in keeping with the research literature. There was a socio-economic gradient in those who died by suicide (14% from the least deprived quintile of area deprivation and 26% from the most deprived) which was not evident in controls. This highlights that activities preventing suicide need to address inequalities. Those who died by suicide had contact with their GP as much as those who did not in the year prior to their deaths but this was more likely to be for mental health problems (19% vs. 4%) or self-harm (7% vs. 0.2%).

SID- Cymru provides evidence that suicide prevention activities need to occur across all health settings not just in mental health services. Increased awareness is required for all priority care providers. However, it also highlights that over a quarter of those who die by suicide have had contact with mental health services in the year prior to their death. For this reason SID-Cymru has partnered with the National Confidential Inquiry into Suicide and Homicide to link to SID-Cymru the in-depth questionnaire data they hold on those people in Wales who had contact with mental health

services in the year prior to their deaths with the aim of identifying further risk factors.

No single organisation or sector can prevent suicide in isolation. In the future it is planned to link the health data in SID-Cymru with further social care and other priority care provider data creating a huge resource to inform prevention efforts, policy and practice in Wales so fewer people die by suicide.

Future linkage to inform policy and practice…..



Royal College of General Practitioners
Coleg Brenhinol Meddygon Teulu
CYMRU WALES

08 March 2018

Dai Lloyd AM
Chair, Health, Social Care and Sport Committee
National Assembly for Wales
Cardiff Bay
CF99 1NA

Committee evidence session Wednesday 07 March 2018

Dear Dai Lloyd AM,

Thank you for the opportunity to give evidence to the Committee on Wednesday 07 March.

I felt the sessions on EMIS and the Medical Performers List were both constructive, with reasonable consensus on some positive ways forward.

EMIS

RCGP Wales is particularly grateful that you allocated an additional session on EMIS. In my evidence I outlined some of the support practices will need; giving practices financial support, staffing support, comprehensive staff training and sensible timings for migration is essential. This is outlined at length in my letter to the Cabinet Secretary for Health, and I would like to take the opportunity to reiterate the importance of supporting practices.

I hope the Committee will be able to help ensure that any encouraging signs regarding support to practices will be followed up on, in a way that practices feel on the frontline. GP morale was mentioned during the session and RCGP Wales is still receiving feedback from disillusioned members who are concerned about the upcoming change. While there have been clear commitments that the financial resource for the support needed will be provided, clarity is needed on the funding streams for this support.

For RCGP Wales, the priority is to ensure practices receive the support they need to minimise any potential disruption to patient care.

Performers List

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I was pleased with the degree of consensus on the Performers List. Four main themes were covered: making it easier for GPs to practice in different areas within Wales; making it easier for GPs to work across England and Wales; making it easier for UK trained GPs who have worked abroad to return to Wales, and allowing a potentially increasing number of UK doctors who have trained as GPs in countries such as Australia and New Zealand to return to practice in Wales. At a time when the GP workforce is so stretched, RCGP Wales would greatly welcome improvements in all of these areas.

There was unanimous agreement that existing processes could be streamlined, to ensure the existing system is doing what it is supposed to be doing. There also seemed to be consensus behind moving towards mutual recognition between each country's separate lists, which is consistent with evidence submitted by my colleague Dr Jonathan Leach and which I believe offers an achievable goal.

The Performers List risks placing artificial barriers between GPs and treating patients and we would welcome action to remove them.

The next steps

You indicated that the Committee would write to the Cabinet Secretary taking forward the key themes from our evidence session. RCGP Wales would be grateful for any assistance you are able to provide in securing positive change in both of these important areas.

Thank you once again for your invitation, and RCGP Wales looks forward to working with the Committee in the future.

Best wishes,

Dr Rebecca Payne
Chair
RCGP Wales

Cynulliad Cenedlaethol Cymru
Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

National Assembly for Wales
Health, Social Care and Sport Committee

Vaughan Gething AM
Cabinet Secretary for Health and Social Services

15 February 2018

Dear Vaughan

Outcome of GMS Systems Framework Contract Procurement

Following the outcome of the recent GMS Systems Framework procurement for the future provision of GP clinical systems, the Committee has been contacted by several GPs voicing concern over the intention to award the contract to the two chosen suppliers – Vision Health Ltd and Microtest Ltd.

Concerns have been raised in correspondence to the Committee regarding the impact the change in suppliers could potentially have on GP practices, and with practices' involvement in the procurement process. The Committee notes from the 'Frequently Asked Questions' document accompanying the outcome letter issued on 29 January that GPC Wales and Health Board representatives are working with NWIS and the Welsh Government to identify ways to support practices through the system change, including financial support.

Further to the responses you provided to questions asked by Members in the Chamber, now that the deadline for making a legal challenge against the outcome has passed, I would be grateful if you could provide an urgent update as to what support will be provided to GP practices, particularly those who have already invested in the Emis system. Furthermore, given the level of concern raised by GPs, the Committee also requests that consideration be given to extending the May 2018 deadline by which practices will be required to make a choice as to which of the two systems they wish to transfer.

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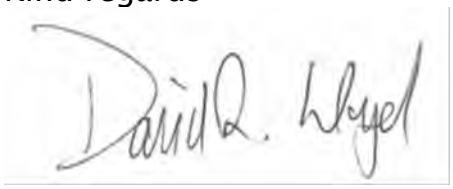
I look forward to receiving your response at the earliest opportunity.

Kind regards



Dr Dai Lloyd AM

Chair, Health, Social Care and Sport Committee

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd a Gwasanaethau Cymdeithasol
Cabinet Secretary for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref MA - P/VG/0984/18

Dr Dai Lloyd
Chair
Health, Social Care and Sport Committee
National Assembly for Wales
Cardiff Bay
CF99 1NA

15 March 2018

Dear Dai,

Thank you for your letter of 15 February regarding the recent procurement process for GP systems in Wales and the possible impact of a change in suppliers.

You will have seen that on 27 February I issued a letter out to all Members, setting out the process and the decisions made. I also attached the joint letter from NHS Wales Informatics System (NWIS), General Practitioners Council (GPC) Wales and the Information Management & Technology (IM&T) Programme Board; which sets out the reasons behind the decision and the failure of EMIS Health Ltd to meet tendering requirements.

I recognise the potential impact on practices which current use the EMIS Health Ltd system and have been clear that a process will determine what support is required to ensure a smooth migration. Road shows are taking place in April 2018 to provide information to practices, enabling them to make a decision around which system to use under the new framework contract; Vision or Microtest. Extending the deadline for practices to choose which system to switch to will impact the migration planning and the ability to provide support to all of those practices. Specific concerns from practices on which option to migrate to can be addressed during the road shows by NWIS.

This is a collaborative approach to defining the required support and practices from across Wales have been asked to be part of the Stakeholder Reference Group to set out what support is needed. I remain committed to ensuring that there is a smooth migration of affected practices.

It is planned that the first GP practices will migrate or upgrade to new systems in January 2019, with the final migration due to be completed by July 2020. Throughout this period, until a practice migrates, GP practices can be assured that existing systems and services will continue to be supported by current suppliers under the existing contract arrangements.

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I hope this has provided reassurance that we are committed to ensuring GPs have the systems they need to deliver services and will provide the support required during this transition phase.

Yours sincerely,

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd a Gwasanaethau Cymdeithasol
Cabinet Secretary for Health and Social Services

Agenda Item 8

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Agenda Item 9

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