Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Health, Social Care and Sport Committee
HSCS(5)-10-18 Papur 1 / Paper 1

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