Agenda – Health, Social Care and Sport Committee

Meeting Venue:
Committee Room 4 – Tŷ Hywel
Meeting date: 17 May 2018
Meeting time: 09.15

For further information contact:
Claire Morris
Committee Clerk
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Informal pre-meeting (09.15 – 09.30)

1 Introductions, apologies, substitutions and declarations of interest

(09.30)

2 Suicide Prevention: Evidence session with the Royal College of Occupational Therapists and British Psychological Society

(09.30 – 10.15) (Pages 1 – 38)

Genevieve Smyth, Professional Advisor, Royal College of Occupational Therapists
Peter Hewin, Senior Occupational Therapist
Dr Kathryn Walters, Consultant Clinical Psychologist, British Psychological Society

Research brief
Paper 1 – Royal College of Occupational Therapists
Paper 2 – British Psychological Society

Break 10.15 – 10.20

3 Suicide Prevention: Evidence session with the Royal British Legion and Combat Stress

(10.20 – 11.05) (Pages 39 – 49)

Antony Metcalfe, Wales Area Manager, Royal British Legion

Paula Berry, Regional Operations Manager – Central, Combat Stress

Paper 3 – Royal British Legion

Break 11.05 – 11.15

4 Suicide Prevention: Evidence session with Dr Sallyanne Duncan, University of Strathclyde and Dr Ann Luce, Bournemouth University

(11.15 – 11.45) (Pages 50 – 53)

Dr Sallyanne Duncan, University of Strathclyde

Dr Ann Luce, Bournemouth University

Paper 4 – University of Strathclyde

Break 11.45 – 11.50

5 Suicide Prevention: Evidence session with Dr Rhiannon Evans, Cardiff University

(11.50 – 12.20) (Pages 54 – 61)

Dr Rhiannon Evans, Cardiff University

Paper 5

Lunch break 12.20 – 13.15

6 Suicide Prevention: Evidence session with the Royal College of General Practitioners Wales

(13.15 – 13.55) (Pages 62 – 69)

Dr Rebecca Payne, Chair, Royal College of General Practitioners Wales

Paper 6

Break 13.55 - 14.00

7 Suicide Prevention: Evidence session with Prof Louis Appleby, University of Manchester

(14.00 - 14.40)

Prof Louis Appleby, University of Manchester

8 Paper(s) to note

(14.40)

8.1 Suicide Prevention: Letter from the Chair of Children, Young People and Education Committee - 3 May 2018

(Pages 70 - 71)

Paper 7

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

(14.40)

10 Suicide Prevention: Consideration of evidence

(14.40 - 14.50)

Agenda Item 2

Document is Restricted

Royal College of Occupational Therapists

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

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

Executive Summary

Key points to note from this submission include:

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

Submission

1. Innovative approaches to suicide prevention

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

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

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

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

Services have responded by fixating on risk rather than need to such a degree that the era when mental health services were focussed on severe and enduring mental illness (SMI) is long gone. Services have become a battleground for entitlement, a merry-go-round of

assessment, and to a lesser extent management of risk, with precious little to offer in the way of rehabilitation or recovery.

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

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

2. Survivor legacy

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

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

3. Value of occupation.

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

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

A 25 year old man had been suffering from severe depression with suicidal thoughts and self-harm. He had been in hospital for about 6 weeks and was discharged back into the community where he started working with the occupational therapist. There was little improvement in his mental health, he had not responded to CBT and had been off work sick.

When the occupational therapist met him, he did not want to get out of bed and was voicing suicidal ideation. He lived in a rural location and was worried about losing contact with his two young sons because they were distressed at seeing their father so depressed.

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

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

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

About the College

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

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

Contact

For further information on this submission, please contact:

Genevieve Smyth
Professional Advisor
Royal College of Occupational Therapists
[redacted]

The British Psychological Society
Promoting excellence in psychology

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

Suicide Prevention

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

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

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

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

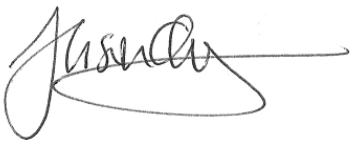
Please direct all queries to:-

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

About this Response

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

We hope you find our comments useful.



Alison Clarke
Chair, BPS Professional Practice Board

Dr Paul Hutchings CPsychol AFBPsS
Chair, Welsh Branch

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

Suicide Prevention

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

all associated with suicide risk. The key psychological risk/protective factors for suicidal ideation and suicidal behaviour are indicated in the table below and the evidence for these factors is summarised in O'Connor & Nock, 2014.

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

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

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

Postvention: Providing support after suicide

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

There is emerging evidence supporting beneficial effects of a number of interventions, including counselling postvention for survivors and outreach at the scene of suicide (Szumilas & Kutcher, 2011). In addition, evidence-based guidelines for responding to suicide in a secondary school setting have been published recently (Cox et al, 2016). However, further research is required into the effectiveness of postvention services and interventions on reducing suicide and attempted suicide/self-harm.

Suicide deaths are often incredibly traumatic, the method of death is frequently violent and survivors are often plagued with the "re-experiencing" symptoms of trauma, such as flashbacks, nightmares and intrusive thoughts. These can occur even if the survivor did not witness the death scene. Re-experiencing, when accompanied with avoidance and hypervigilance symptoms, is characteristic of PTSD, and therefore counsellors need to be equipped to recognise and manage these symptoms or refer the person for trauma-focused cognitive therapy or another recognised PTSD treatment (NICE, 2005).

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

Organisational Postvention

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

Response plans

Postvention response plans typically include the coordination of resources, dissemination of information and the provision of support for those most affected by

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

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

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

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

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

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

Adults
Recently, two systematic reviews have synthesized the worldwide RCT evidence on the effectiveness of interventions for self-harm (Hawton et al 2015, Hawton et al 2016a). These reviews demonstrate that there is now strong evidence that psychological therapies such as problem solving behaviour, dialectical behaviour

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

Suicide Prevention Inquiry

Health, Social Care and Sport committee – National Assembly for Wales

The Royal British Legion written evidence

1.0 About us

1.1 The Royal British Legion is at the heart of a national network that supports our Armed Forces community through thick and thin – ensuring that their unique contribution is never forgotten. We were created as a unifying force for the military charity sector at the end of the First World War, and still remain one of the UK's largest membership organisations. The Legion is the largest welfare provider in the Armed Forces charity sector, helping veterans young and old transition into civilian life. We help with employment, financial issues, respite and recovery, through to lifelong care and independent living.

For further information, please visit www.britishlegion.org.uk

Mae'r Lleng Brydeinig Frenhinol wrth galon rhwydwaith cenedlaethol sy'n cefnogi ein cymuned lluoedd Arfog doed a ddelo – gan sicrhau nad yw eu cyfraniad unigryw fyth yn cael ei anghofio. Fe'n crëwyd i uno'r sector elusennau milwrol ar ddiwedd y Rhyfel Byd Cyntaf, ac rydym yn parhau yn un o'r sefydliadau uchaf ei aelodaeth yn y DU. Y Lleng yw'r darparwr lles mwyaf yn sector elusennau'r Lluoedd Arfog, gan helpu cyn-filwyr, yn hen ac yn ifanc, i symud yn ôl i fywyd fel sifiliad. Rydym yn helpu gyda chyflogaeth, materion ariannol, seibiant a gwella, hyd at ofal am oes a byw'n annibynnol. Yn 2015/16, fe wnaethom ymateb i dros filiwn o geisiadau am help – mwy nac erioed o'r blaen.

Am wybodaeth bellach, ewch i www.britishlegion.org.uk

2.0 General comments

2.1 The Legion is pleased to have the opportunity to provide written evidence to the Health, Social Care and Sport Committee's inquiry into suicide prevention. Our evidence is focused on the research available for members of the Armed Forces community and our welfare delivery and experience working across Wales.

2.2 The Legion believes that it is important at the outset of this submission to highlight that the majority of people who serve in the Armed Forces go on to transition well into civilian society, enjoying comparatively good health compared to the general population. Furthermore, the overall incidence of suicide and self-harm in the UK Armed Forces is lower than in the general population, and evidence suggests that the longer an individual stays in the military, the lower the suicide risk. However,

some members of the Armed Forces community do experience issues that can lead to suicide and self-harm, and for the most serious cases it is imperative that all providers are working in collaboration to provide a safety net for those in crisis.

2.3 The Legion does not provide a crisis service for those experiencing suicidal ideation or intention. However, the Legion does encounter beneficiaries who are facing such serious issues and we do all we can to ensure these people get the vital support they need. The Legion works closely with a number of crisis support organisations such as Samaritans and the Emergency Services and provides timely and appropriate signposting to these, in the event of someone experiencing suicidal ideation or intention. Where appropriate, urgent referrals are also provided to the Legion's Outreach Service which delivers ongoing welfare support to beneficiaries and who will undertake detailed risk assessments of the beneficiary.

2.4 The Legion's Outreach Service supports vulnerable beneficiaries and their families to find practical and sustainable ways to make positive changes, achieve their potential and lead fulfilling lives. The Legion's Outreach Officer in Wales works closely with both the beneficiary and any identified specialist services or organisations that can assist beneficiaries at traumatic times such as local authority crisis teams. The Outreach Officer will also engage with other Legion staff and specialists to identify issues that may be causing stress and seek to tackle these through targeted interventions.

2.5 The Legion's Contact Centre who deliver our Advice and Information Line, has policies and procedures in place for situations where an individual presents themselves as at risk, and where there are safeguarding issues. Callers to the Contact Centre are informed as part of the welcome message that calls will remain confidential unless there is a risk to themselves or others or where they disclose involvement in a crime.

2.6 Full training is provided to Contact Centre staff, who may be in a situation where at risk or safeguarding calls are presented to them. Contact Centre staff are also provided with supporting documentation as a tool for dealing with at risk calls, advising them on what action they should take.

2.7 The Legion Contact Centre's *Child & Vulnerable Adult Protection Policy* aims to ensure that arrangements are in place for the prevention, management of and immediate response to allegations about harm and/or abuse. Where a staff member hears something that indicates abuse or harm may occur they must ensure that they:

- Have correct and up to date details for the enquirer;
- Check that the reason for concern is explored as fully as possible;
- Remind the individual of the possible need to break confidentiality;
- Ensure that the individual is getting support from the correct organisation;
- Raise their concerns with their immediate line manager or other senior manager at the end of the call. Staff should never see a concern as too minor to raise.

2.8 The Legion provides Welfare staff with mental health first aid training which incorporates suicide and self-harm. More broadly, Legion staff guidance regarding incidents of risk/safeguarding outlines the need to urgently escalate crisis cases (such as suicidal ideation or intention) to the appropriate level of senior staff or

management. In addition, frontline welfare staff in Wales have undertaken suicide intervention training.

Case study 1

Mr. X is a 30-year-old Army veteran with PTSD. He approached the Legion for support in early 2018 as he was struggling with his mental health and he was homeless. Mr. X was in a desperate situation and stated that he had been homeless for almost two years and couldn't cope any longer.

Mr. X was dealt with initially by the Contact Centre advisor where he disclosed suicidal thoughts and a plan to hang himself that evening if he had to sleep on the streets again. Mr. X has a history of suicidal thoughts and had been in and out of hospital. The call resulted in the Contact Centre advisor keeping Mr. X on the phone whilst the emergency services were called to his location. Mr. X was safe when found by the police but had a ligature around his neck and was taken to hospital for a psychiatric assessment.

The following day Mr. X was discharged and contact was made with him. The Legion made numerous referrals to Alabare, the Wallich and Shelter to see what support could be offered to Mr. X in regards to his housing situation. The Legion made contact with Housing Options in order to advise them of Mr. X situation to relieve some of the stress on Mr. X having to go over his story again in order for to be assessed.

A referral to our Regional Outreach service was made to support Mr. X with his engagement with the local authority and other agencies. As a result of our engagement, Mr. X was offered specialist support and appropriate accommodation was sourced through SSAFA. Contact was maintained throughout the whole process until Mr X was safely housed.

Mr. X continued working with SSAFA in regard to his rent arrears with the local authority, and assistance was provided to support Mr. X in completing a PIP application.

Case study 2

Mr. Y called the Legion's helpline displaying signs of emotional breakdown and stating he was contemplating taking his own life and that it was difficult to gain any understanding of his current predicament. A referral was made to the Legion's Outreach Service.

Contact was made immediately with the client. Outreach Officer engaged with Mr. Y, allowing him to discuss his problems and feelings. Outreach Officer explained the role of the service, ways support could be offered, self-help tools and treatment options. Mr. Y was attempting to access mental health services and was also in the criminal justice system following an offence. This was causing Mr. Y extreme worry and distress. Mr. Y had no support networks he felt he could rely on.

Outreach Officer met with Mr. Y and jointly formulated a plan to take forward together. Outreach Officer contacted local authority housing to register client as homeless and seek support. Mr. Y was also registered with the RFEA and Poppy factory to seek employment support. Outreach Officer also contacted Veterans NHS Wales.

In the following period, the Outreach Officer attended the housing appointment with the local authority to support the client. An application for assistance was made with private rented housing via the Legion's Case Officer. Appointment with RFEA was attended by Mr. Y and Outreach Officer. Client also accessed Veterans NHS Wales treatment.

Throughout all this interaction with Mr. Y, the Outreach Officer was able to build trust and rapport with him, offering support and practical assistance at all stages.

Mr. Y, his wife and child are living in a new area, more conducive to a stable life. Mr. Y is in full-time work and attending therapist appointments, dealing with issues in a positive way. He has coping strategies in place and has an action plan for stressful situations, which includes a Mindfulness app on his smartphone which he uses every day.

3.0 Talk to me 2. Suicide and Self Harm Prevention Strategy for Wales 2015-2020.

3.1 The Legion commends the overall aims of the *Suicide and Self Harm Prevention Strategy for Wales*, and the key objectives underpinning it that aim to improve awareness, knowledge and understanding of suicide and self-harm amongst the public; to deliver appropriate responses to suicide and self-harm; to provide information and support for those bereaved or affected by suicide and self-harm; to support the media in responsible reporting and portrayal of suicide and suicidal behaviour; to reduce access to means of suicide; and to continue to improve understanding of suicide and self-harm in Wales and guide action.

3.2 While the Legion welcomes the inclusion of Armed Forces personnel in the strategy, we note that this reference is in the context of the Armed Force's role as priority care providers. While this remains a key responsibility for Armed Forces personnel, the Legion has noted that this is the sole reference to the Armed Forces community in the strategy.

3.3 The Legion recommends that reference to the Armed Forces in the strategy should be extended to veterans, and not focus solely on care providers. This is in light of the inclusion of veterans as a priority group in the *Together For Mental Health Delivery Plan*, as outlined in section 4 below. This, coupled with the evidence around suicide and self-harm in the Armed Forces outlined in sections 5 – 8 of this paper, highlights that the Armed Forces community would benefit from tailored support for these issues. We recommend the inclusion of the Armed Forces community, including veterans, as a specific population to support in the *Suicide and Self Harm Prevention Strategy for Wales*.

4.0 Together for Mental Health: Delivery Plan: 2016-19

4.1 In April 2016, the Legion provided a response to the Welsh Government's *Together for Mental Health: Delivery Plan: 2016-19.* In the response, the Legion commended the overall aim of the delivery plan and the principles underpinning it.

4.2 In particular, the Legion highly commended the Welsh Government's support of Veterans' NHS Wales (VNHSW), through its commitment to increase funding. Subsequent investment in the service – as called for in the Legion's 2016 Assembly

election manifesto – is to be welcomed along with the inclusion of embedded peer mentors within the service, something the Legion called for in 2016.[1]

VNHSW reports that approximately 46% of all new veterans describe having suicidal ideation in recent weeks at their initial assessment. A minority will also have thought of a plan on how they could commit suicide. VNHSW is not a crisis service and will refer veterans to their local NHS crisis teams or Community Mental Health Teams if they require additional support above what VNHSW is currently funded for.

4.3 The Legion is pleased to note that funding to Veterans NHS Wales was further extended at the start of 2018, to a total of £900,000.[2]

4.4 The Legion also commended the inclusion of the priority goal for veterans in the Delivery Plan in point 7.7: ***"To ensure mental health services for veterans in Wales who are experiencing mental health problems are sustainable and able to meet that populations needs in a timely and appropriate manner."***

4.5 However, the Legion was disappointed that the service delivery goals and key actions related to veteran mental health provision were particularly limited in the Delivery Plan. In its response, the Legion recommended the creation of a mental health service delivery plan for the Armed Forces community (to use in tandem with the main delivery plan), or at the very least, an extension of the priority goal relating to veterans.

4.6 Other recommendations included:

- Service delivery plan to be specific about the health needs of veterans and their families.
- Service delivery plan to provide specific action points that address veterans and Armed Forces families' mental health treatment provision.
- Service delivery plan to target those in the Armed Forces community at risk of mental health problems and the least likely to seek help.
- Inclusion of performance measures on 1) What statutory services identify veterans in their data capture, to ensure that members of the Armed Forces community are identified and therefore able to receive the services to which they are entitled, as called for in the Legion's Wales Manifesto in 2016[3], and 2) How often priority treatment is being used in healthcare referral processes.
- Inclusion of an action point for the Welsh Government to issue guidance on priority treatment, with good practice examples. The Legion gratefully recognises the Welsh Government's recent dissemination of a health circular on priority treatment for veterans[4], however we also believe that there is more to be done on the promotion and implementation of priority treatment in practice.
- Inclusion of an action point to specifically publicise information on mental health services available to Welsh veterans and their families, including UK wide services.

[1] Together for mental health Delivery plan 2016-2019 – The Royal British Legion response, April 2016
[2] http://www.bbc.co.uk/news/uk-wales-42570492
[3] The Royal British Legion, 2016. Building A Better Future For The Armed Forces Community In Wales.
[4] Welsh Health Circular: Armed Forces Covenant - Healthcare Priority for Veterans

5.0 Suicide rates in-Service

5.1 For the twenty-year period 1998-2017, a total of 309 suicides and open verdicts occurred among UK Regular Armed Forces personnel[5]. This is broken down as 215 male and 13 female suicides, and 77 male and 4 female open verdicts. There were four coroner-confirmed suicides among UK Regular Armed Forces in 2017, with an additional 12 awaiting verdicts that may result in a suicide verdict once Coroner Inquests are held.

5.2 Suicide rates across all three Services have fallen since the 1990s. However, rates among Army personnel remained higher than the other Services throughout the majority of the period. Naval Service rates increased in the period 2008 to 2013, however the number of deaths each year remains small and the increased rate was the result of a changing structure of the Naval Service population and not an increase in the annual number of suicides. Suicide remains a rare event in the UK regular Armed Forces and the overall rate in each of the Services is low. For the twenty-year period 1998-2017, there was no significant difference in suicide rates between the three Services.

5.3 The UK Regular Armed Forces have seen a declining trend in male suicide rates since the 1990s. For the twenty-year period 1998-2017, the male suicide rate for the UK Regular Armed Forces was statistically significantly lower than the UK general population[6].

5.4 Historically, Army males aged 20 years and under were the only group with a statistically significant increased risk of suicide, compared to the UK general population. However, for the last twenty-year period, the rate of suicide in young Army males was the same for males of the same age in the UK general population. The suicide rate among males aged 16-59 years in the UK general population in 2016 (latest data available and used as a proxy for 2017) was 18 per 100,000 compared to a UK Armed Forces rate of 8 per 100,000 in 2017.

5.5 Suicide rates for females in the Armed Forces are too low for statistical analysis. The proportion of male suicides in the UK general population increased in 2016 and has remained at approximately 75% of all suicides in the UK general population since the early 1990s[7], suggesting that male suicide rates are generally higher across the UK.

5.6 In 2016, rates of suicide in the UK general population were higher among middle-aged men compared to other age groups[8]. Unemployment and economic hardship in middle-aged men within the UK general population may explain the higher rate of suicide in these age groups, whereas UK regular Armed Forces personnel are in employment with a regular income, and so may be protected against these risk factors.

[5]Ministry of Defence. Suicide and Open Verdict Deaths in the UK Regular Armed Forces: Annual Summary and Trends Over Time 1 January 1984 to 31 December 2017.
[6] Ministry of Defence. Suicide and Open Verdict Deaths in the UK Regular Armed Forces: Annual Summary and Trends Over Time 1 January 1984 to 31 December 2017.
[7] Office for National Statistics, 2017. Suicides in Great Britain: 2016 registrations
[8] Ibid

5.7 A number of other factors specific to Service life may also play a role in reducing the risk of suicide in the UK regular Armed Forces compared to the UK general population. This may include the strong group loyalty, bonding and mutual dependence encouraged at all levels in the Services, particularly in small combat units.

5.8 The overall rate for the UK Regular Armed Forces and the rates presented for each Service may change when outstanding coroner verdicts are returned on deaths that have occurred since 2013, potentially resulting in increased or decreased suicide rates.

5.9 Furthermore, data collected on suicide among Serving personnel excludes data on Reservists, amongst others[9], as Defence Statistics do not receive routine notifications of all deaths among Reservists and non-Regulars. Evidence has indicated there is an increased prevalence of probable PTSD and common mental health disorders amongst deployed Reservists compared to Regular personnel and non-deployed Reservists[10]. Given the increased likelihood of mental health issues among deployed Reservists, it may be worthwhile to collect data on suicide rates within this group, to explore whether there is increased incidence of suicide or self-harm.

6.0 Suicide methods in-Service

6.1 The most common methods used to commit suicide in the UK regular Armed Forces are[11]:

- Hanging, strangulations and suffocations (52%)
- Firearms and explosives (17%)
- Poisoning by gases and vapours (7%)

6.2 This finding is broadly consistent with the most common methods of suicide in the male UK general population for 2016, where hanging, strangulation and suffocation accounted for 59% and poisonings accounted for 18% of all male suicides. The most common method of suicide amongst females in the UK Regular Armed Forces was also hanging, strangulation and suffocation accounting for 11 out of 17 (65%) suicides between 1998 and 2017 - comparable with females in the UK general population. UK Armed Forces suicides using firearms and explosives are not comparable with the UK general population due to UK laws restricting access to firearms.

6.3 The likelihood of committing suicide is related to access to and knowledge of effective methods. The use of 'poisoning by gases and vapours' was the most

[9] Data on suicide excludes the Home Service of the Royal Irish Regiment, full time Reservists, Army Reserves and Naval Activated Reservists who were not deployed on operations at the time of their death, as Defence Statistics do not receive routine notifications of all deaths among Reservists and non-Regulars, and because reliable denominator data to produce interpretable statistics were not available.
[10] Fear et al., 2010. What are the consequences of deployment to Iraq and Afghanistan on the mental health of the UK armed forces? A cohort study, *The Lancet*.
[11] Ministry of Defence, 2018. Suicide and Open Verdict Deaths in the UK Regular Armed Forces: Annual Summary and Trends Over Time 1 January 1984 to 31 December 2017.

common method of suicide in the UK Armed Forces until UK legislation was changed in 1993 to fit catalytic converters to vehicles. Following this there was a steep decline in the rate of suicide by gases and vapours. The change in policy in the mid-1990s restricting access to weapons in the Army also resulted in a fall in the rate of suicides by 'firearms and explosives'.

7.0 Suicide after leaving the Armed Forces

7.1 The MOD does not currently collect information on suicide rates among veterans. However, in terms of post-operational rates of suicide, the MOD has found no excess of suicide rates in veterans of the 1990/91 Gulf War[12] and the 1982 Falklands campaign[13], along with lower rates compared to the UK general population.

7.2 In response to a written question in 2016 about the rate of suicide among personnel who had seen active service in Afghanistan and Iraq, the Ministry of Defence said the suicide rate among those deployed was lower than those who had not deployed:

"For the period 1 August 2002 to 31 December 2015, the rate of coroner confirmed suicides and open verdict deaths amongst those who had previously deployed to either Iraq or Afghanistan and were still in Service at the time of their death was 0.9 per 1,000. This compared to a rate of 1.6 per 1,000 for those UK service personnel who have not been identified as having deployed to either Iraq or Afghanistan prior to their death."[14]

7.3 In 2009, Kapur and colleagues at Manchester University examined the rate, timing, and risk factors for suicide in all those who had left the UK Armed Forces between 1996 and 2005[15]. The risk of suicide in men aged 24 years and younger was approximately two to three times higher than the risk for the same age groups in the UK general population. However, the risk of suicide for veterans aged 30-49 years was lower than that in the general population. Overall, the rate of suicide was not greater when compared to the general population.

7.4 Risk of suicide was greatest in males, those who had served in the Army, those with a short length of service, and those of lower rank. The majority of suicide victims had not been in contact with specialist mental health beforehand. The rate of contact with specialist mental health was also lowest in the age groups at greatest risk of suicide. Risk of suicide was persistent, but may have been at its highest in the two years following discharge.

7.5 Causes of increased risk for suicide could not be proved, but the authors suggest three main possibilities: stress of transition to civilian life, exposure to adverse experiences during Service, or pre-existing vulnerabilities prior to Service. Evidence appeared to somewhat support the notion of pre-existing vulnerabilities, as findings indicated that untrained personnel with short lengths of service had a particularly high risk of dying by suicide after leaving the military.

[12] Ministry of Defence, 2016. 1990/1991 Gulf Conflict UK Gulf Veterans Mortality Data: Causes of Death.
[13] Ministry of Defence, 2014. Ministry of Defence, A study of deaths among UK armed forces personnel deployed to the 1982 Falklands campaign: 1982 to 2013, 2014
[14] HL3467 [on Armed Forces: Suicide], 30 November 2016
[15] Kapur et al., 2009. Suicide after leaving the UK Armed Forces – A Cohort Study, *PLoS Medicine.*

7.6 Further research has examined the mental health among post-National Service veterans aged 16-64 and found for females, a significant association between veterans status and having suicidal thoughts. Early Service Leavers were more likely to be heavy drinkers, to have suicidal thoughts and to have self harmed than longer serving veterans[16].

7.7 The studies cited above are almost 10 years old and may merit repeating. Furthermore, in light of stabilising suicide rates among young Serving males, it is worth exploring whether changes to mental health care in the military are impacting on self-harm and suicide during and after Service.

8.0 Self-harm in the Armed Forces

8.1 Rates of deliberate self-harm among UK Armed Forces personnel as whole were low in 2016/17, at 2.8 per 1,000 personnel (0.3% of all personnel)[17]. However, this reflects a statistically significant increase of 26% in the rate of reported self-harm since the start of reporting in 2010/11. It is not clear whether this is a true rise in self-harming rates, or is due to improved reporting. However, this increase is in line with mental health referrals of personnel to a specialist clinician at a MOD Department of Community Mental Health (DCMH).

8.2 Groups in-Service at highest risk of self-harm between 2010/11 and 2016/17 were:

- Army personnel
- Female personnel
- 'Other' ranks
- Personnel aged under 24
- Untrained personnel (in five of the seven years presented)

8.3 Female and young personnel risk groups are broadly similar to the general population, as these groups have been found to be at greatest risk of presentation at a hospital with a self-harm episode[18]. Previous research with the Army[19] and Navy[20] has also found increased risk of self-harm behaviour amongst females.

8.4 Research into intentional self-harm (self-harm and attempted suicide) amongst Serving and veteran UK Armed Forces personnel has found associations between intentional self-harm and: being young, having a shorter term of service, increased childhood adversity, and a range of other health outcomes - including PTSD[21] .

[16] Woodhead et al., 2010. Mental health and health service use among post-national service veterans: results from the 2007 Adult Psychiatric Morbidity Survey of England, *Psychological Medicine.*
[17] Ministry of Defence, 2018. Deliberate Self Harm (DSH) in the UK Armed Forces 1 April 2010 – 31 March 2017.
[18] Skegg, 2005. Self-harm. *The Lancet.*
[19] Blatchley et al., 2005. Deliberate self-harm in the regular army: A report on available data. Defence Analytical Services Agency.
[20] Slaven and Sharpley, 2002. Audit of deliberate self-harm cases in the Naval Service 1999–2001. Institute of Naval Medicine.
[21] Pinder et al., 2011. Self harm and attempted suicide among UK Armed Forces personnel: Results of a cross-sectional survey. *International Journal of Social Psychiatry.*

8.5 In the same study, ex-Service personnel reported lifetime prevalence of intentional self-harm more than double that of Serving personnel (10.5% vs 4.2%, respectively). However, the study did not establish whether episodes reported by ex-Service personnel took place before, during or after Service. Among this group, the possibility of reverse causation must be considered: self-harm acts may be an indirect trigger to leaving Service, thereby increasing the apparent prevalence.

8.6 Further research into the higher risk groups of Army personnel, untrained personnel, younger personnel, and ex-Service personnel may be merited, in order to identify vulnerabilities that may lead to increased incidence of self-harm.

8.7 True self-harm rates are difficult to establish due to under-reporting and associated stigma. Consequences of self-harm can also be managed by an individual at home and may not be reported to a medical professional[22]. In addition, UK Armed Forces personnel may report to an NHS Accident and Emergency facility following a self-harm episode and may not come to the attention of the military primary healthcare community or the Chain of Command. As such, it is likely that self-harm rates amongst the Armed Forces are higher than reported.

8.8 Furthermore, the ONS does not collect data on rates of self-harm in the UK general population, making comparisons of UK Armed Forces self-harm rates with the UK general population difficult and reliant upon small location based studies. However, available evidence suggests that the Armed Forces population appears healthier, with a lower lifetime prevalence of attempted suicide and self-harm, within the range of general population estimates.

9.0 Policy background

9.1 The Ministry of Defence has in recent years paid greater focus to the mental health of Regular and Reserve personnel and it is now a priority for the Department under the *Defence People Mental Health and Wellbeing Strategy 2017 to 2022*. Suicide and self-harm is one of the four core areas of the Mental Health Steering Group, along with stigma reduction; occupational stress; culture and behaviours.

9.2 The Strategy does not specify explicit suicide prevention tactics. However, it does identify measures designed to prevent the onset of mental health illnesses. These include pre-deployment training to develop resilience to situations faced, pre- and post-deployment briefings and post-operational decompression, resilience training throughout Service life with specific training for those in command, peer to peer support, and welfare and chaplaincy support.

9.3 Externally, the MOD also supports various initiatives targeting mental health, including the recent launch of a 24-hour mental health helpline for Serving personnel and veterans. Other external initiatives include NHS England's Veterans' Mental Health Complex Treatment Service (VMH CTS) - an enhanced local community

[22] McAllister, 2003. Multiple meanings of self harm: A critical review. *International journal of mental health nursing.*

based service for ex-Service personnel who have military attributable complex mental health problems that have not been resolved earlier in the care pathway.

For further information about this submission, please contact the Legion's Public Affairs and Public Policy team XXX

Agenda Item 4

Written evidence to the Health, Social Care and Sport Committee of the National Assembly of Wales in relation to their Suicide Prevention Inquiry

Dr Sallyanne Duncan, University of Strathclyde, Glasgow.

I was asked to comment on the following points:

- Evidence regarding impacts of reporting of suicide (and dramatic portrayal of suicide) on readers/audiences, including on children and young people. Evidence about the 'contagion' effect'.

  Reporting suicide responsibly requires sensitivity and compassion due to the potential harmful effect on vulnerable people. Some academic researchers believe there is a correlation between irresponsible coverage and imitative or copycat suicides. A connection between the way journalists report suicide and vulnerable people's susceptibility to repeat the action by taking their own lives has been made by numerous scholars (for example, Gould & Davidson, 1988; Phillips, 1974; Pirkis & Blood, 2001; Pirkis, Blood, Beautrais, Burgess, & Skehan, 2006; Pirkis et al., 2007; Stack 2003, 2005; Velting & Gould, 1997; Wasserman, 1984). However, these studies do not necessarily show cause, i.e. that media reporting of suicide *causes* other vulnerable people to kill themselves but they do indicate a connection between the two, and on that basis journalists are cautioned to take care and consider the impact of their reporting.

  Another perspective is that suicide stories can be in the public interest because they can educate people about broader social and public health deficiencies, as noted by Samaritans in their *Suicide facts for journalists* section of their website. A positive impact is that the media can raise awareness, inform the public about the signs to look for, how to get help, and that suicide is preventable.

  The effect on the suicide rate is said to depend on the amount, duration, and prominence of media coverage (Gould, 2001). Imitative or copycat incidents are more likely when the suicide appears on the front page, has a large headline, and is heavily publicised. However, it is less clear what types of content can have a detrimental effect. Some evidence suggests celebrity suicides, particularly when they are on the front page, lead to copycat incidents. Fink et al (2018) found a 9.85% increase in suicides in the USA following the death of Robin Williams. In this case media reporting was criticised for being excessive and for breaching suicide reporting guidelines, especially regarding detailed description of method. However, the authors do acknowledge other factors could have influenced this increase. Other research indicates that non-celebrity stories also have a significant impact, although to a lesser extent, if they receive enough publicity. Young people are especially susceptible to copycat suicides (Samaritans, 2016). However, Luce (2016) warns against selective coverage aimed at particular groups e.g. students, young people, as this can adversely affect public understanding by creating incorrect impressions and fostering myths.

  Additionally, there is increasing evidence that the internet and social media can also influence copycat behaviour (Luxton et al., 2012), which is a particular concern regarding young people because they are the most prevalent users. Therefore, news outlets' online content, their use of social media platforms and their sharing strategies require greater vigilance as the immediacy and easy facility to share content via social media could increase the risk of copycat suicides (NUJ Guidelines, 2014). That said, Luce (2016) takes exception to the media principally being held responsible for imitative suicides when other factors could influence such acts. "It has long been thought that the media causes suicide, and while there is *some* research available to support the theory that celebrity suicides influence statistics, it has long been a bugbear of mine that the media take the blame carte blanche for causing suicide." (p.100).

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- How responsible reporting/portrayal of suicide is encouraged e.g. use of guidelines, codes of practice.

Codes of conduct/practice and media reporting guidelines are the main means by which responsible reporting/portrayal is encouraged. Both the Editors' Code of Practice, which forms part of the Independent Press Standards Organisation's (IPSO) regulatory system, and the IMPRESS Standards Code have clauses on suicide, which those publications who have signed up to their regulatory system are expected to follow. These are:

IPSO: Clause 5: When reporting suicide, to prevent simulative acts care should be taken to avoid excessive detail of the method used, while taking into account the media's right to report legal proceedings. This is explained in greater detail in The Editors Codebook (see https://www.editorscode.org.uk/downloads/codebook/codebook-2018.pdf) where they discuss method, copycat suicides and reporting inquests.

IMPRESS: Clause 9: 9.1 When reporting on suicide or self-harm, publishers must not provide excessive details of the method used or speculate on the motives. They offer further guidance on Clause 9.1 to assist journalists in interpreting the clause (see Guidance on 9. Suicide at https://impress.press/standards/impress-standards-code.html)

Ofcom provides similar advice for broadcasters on their website, although this is not exclusively for journalists. The BBC Academy offer similar advice relating to reporting mental health and working with the bereaved. These are publicly available and useful resources for teaching journalism students.

The NUJ Code of Conduct does not have an explicit clause on suicide but its Clause 6 would be applicable here. "[A journalist] Does nothing to intrude into anybody's private life, grief or distress unless justified by overriding consideration of the public interest."

Additionally, for more than 20 years the NUJ has produced its own guidelines offering extensive advice on a range of topics. They are publicly available on their website (https://www.nuj.org.uk/news/mental-health-and-suicide-reporting-guidelines/) and are easily searchable by Google. Other guidelines e.g. Samaritans and WHO are similarly available.

IPSO recently announced they will also publish regular blogs, written by Samaritans and based on detailed research, that will advise journalists on reporting suicides in public places, inquests, self-harm, young suicides and suicide clusters. Samaritans will also cover their media advisory service, which provides practical recommendations, guidelines and factsheets for journalists on areas such as working with bereaved families in the aftermath of a suicide, and reporting on rail suicides and murder-suicides.

Other organisations do similar work. For example, the Public Health Agency in Northern Ireland has produced a film to help journalists report sensitively. It contains interviews with people bereaved by suicide and journalists who have reported suicide. It can be viewed at https://vimeo.com/121983892. This type of material is also a valuable teaching aid for journalism academics.

Lecturers in higher and further education can play an important role in encouraging responsible reporting through discussions in their classes in media ethics, law and practical journalism. At the University of Strathclyde both undergraduate and postgraduate students study the NUJ guidelines specifically as well as Samaritans and WHO guidelines. Guest speakers – journalists, suicide prevention representatives and those bereaved by suicide – are also be invited to talk to the students about their experiences.

Professional publications and websites such as Press Gazette, holdthefrontpage.co.uk and journalism.co.uk regularly run articles about responsible reporting of suicide, thus disseminating messages by some of the organisations noted above to a wider audience of journalism professionals.

- How well/widely guidelines etc. are implemented.

Some research indicates that journalists' awareness, use and opinion of guidelines is generally low or inconsistent, and that news articles contain several breaches of key advice. These studies tend to focus on specific countries e.g. Austria, China, (see Bohanna & Wang, 2012; Nutt et al, 2014; Chu et al, 2018). I am not aware of any similar published study of the UK. I am currently working with colleagues from Bournemouth University on research that explores journalism students' perspectives on media reporting of suicide. Some of this work tests their awareness of advice contained in media guidelines. We are currently gathering data with a view to analysing it in the near future.

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- How is adherence to guidelines etc. monitored. What is done to identify when breaches occur and what sort of action is taken following breaches?

  Because of their voluntary nature adherence to guidelines tends not to be monitored in any formal way by media organisations themselves or the NUJ. Several stakeholders do monitor media reporting of suicide and will contact news outlets to challenge their reporting and advice on better approaches, thus adopting a constructive way forward. These include Public Health Agency in NI, See Me (Scotland), Choose Life (Scotland) and Samaritans.

  If one of the press regulators receives a complaint about a perceived breach of their code then they can assist the complainant and the publication to resolve the matter informally or it might be investigated by their complaints team. If the complaint is upheld the publication would be expected to publish the full ruling and possibly an apology. This is mostly a reactive process that is dependent on those at the centre of the story or interested third parties making a complaint. Regulators tend to take action themselves only in high profile cases.

- What kind of joint working goes on between organisations to promote responsible reporting/portrayal of suicide?

  Please see some of the examples discussed in the section, *How responsible reporting is encouraged*. Organisations such as See Me (Scotland), Choose Life (Scotland) and Samaritans work closely with the media to promote responsible reporting by advising them on stories they are working on or by putting them in contact with media trained volunteers who have experience of suicide and are prepared to share their stories.

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3 May 2018

Health, Social Care and Sport Committee Inquiry into Suicide Prevention:
Oral evidence by Dr Rhiannon Evans

1. Overview

I welcome the opportunity to provide oral evidence to the Committee. I present this evidence on behalf of the Centre for the Development and Evaluation of Complex Interventions for Public Health Improvement (DECIPHer) at Cardiff University, which has a specific focus on improving the health and wellbeing of children and young people. The following evidence considers previous and current research undertaken by the Centre, in addition to referencing the wider research evidence.

The following evidence primarily focuses on self-harm prevention and intervention, which is the substantive expertise of the Centre. Self-harm is defined as any act with a non-fatal outcome, where an individual engages in behaviour or ingests a substance with the intention of causing harm to themselves. Self-harm is employed as a broader category than self-injury, as it includes both the infliction of damage to the external surface of the body and self-poisoning. Self-harm with or without an associated suicidal intent are not differentiated here, as they are arguably located along the same continuum. Self-harm is a risk factor for suicide, hence the importance of prevention and intervention. Young people who present to an emergency department for self-harm are more than sixteen times as likely to die by suicide.

2. Self-harm Prevention and Intervention in Educational Settings

Despite a proliferation in the number and range of interventions intended to address adolescent self-harm, there is a limited evidence-base for effective approaches particularly within educational settings. To date the evidence base is much stronger for suicidal ideation, suicide attempt and suicide than for self-

harm (Wasserman et al., 2015). Some support tools for adolescent self-harm are available, such as Signs of Self-injury (SoSI), which is informed by the Sign of Suicide Prevention Programme, but only preliminary evaluation of these programmes have been reported.

Cardiff University, University of Bristol, University of Bath and University of Exeter were funded by the GW4 collaboration to undertake a mapping of schools' existing provision around student self-harm, with the aim to develop effective intervention (Evans et al., 2015). The study comprised a survey of 153 secondary schools across Wales and South West England. In Wales, the School Health Research Network (SHRN) supported the survey. SHRN collects bi-annual data on student health and wellbeing, in addition to data on the school environment, to support health planning. All secondary schools in Wales are now part of the network.

Findings from the study indicate that emotional health and wellbeing are the priority for secondary schools, and for many, further investment in anxiety management and resilience may mitigate student self-harm. On site counselling and CAMHS are the most frequently provided services for student self-harm. Counselling was ranked as the most useful approach by 25% of schools. Key to the data were that only 54% of staff have received training on student self-harm, with only 22% of schools stating the adequacy of the training to be high or very high. This is despite the fact that 86% of senior managers and 74% of teachers have been involved in intervening with cases of student self-harm. The study also explored barriers to addressing student self-harm. Inadequate staff training was cited as a major barrier in 48% of cases. Additionally 80% of schools stated that fear of encouraging students to engage in self-harm was a major or minor barrier.

3. Self-harm and Suicide Prevention and Intervention in Social Care Settings

Care-experienced children and young people are at an elevated risk of suicide related outcomes. A recent systematic review undertaken by DECIPHer found that individuals who reside in care are more than three times as likely to attempt suicide than non-care experienced individuals (Evans et al., 2017).

NICE guidance on supporting the mental health and wellbeing of individuals in care has focused on multi-agency team working that is inclusive of different professions. However, these structures are not considered to be working effectively (House of Commons Education Committee, 2016). Explanations of these failings have tended to focus on lack of time and resources.

A recent DECIPHer study explored the lived experiences of foster and residential carers who manage self-harm within the care setting (Evans, 2018). Almost all carers had direct experience of self-harm amongst the children and young people they care for. Carers reported that support for this professional role was lacking, with training in identifying risk factors and providing intervention often only occurring following a young person's suicide. As such provision is reactionary rather than proactive, and more significant investment is required to adequately equip carers.

Carers also indicated tensions in inter-professional working, and the feeling of being seen as 'glorified babysitters', with their expertise being routinely discounted. These tensions were particularly evident within contacts with clinical professionals. Carers suggested the need to enhance the professional standing of their professional group. There have been recommendations from the foster care sector, including the introduction of accredited and standardised pre- and post-approval training (Lawson & Cann, 2016). There is further focus on incorporating learning about their role into social work (and other professionals) training to improve understanding and collaboration, and ensuring that carers' views are always invited and taken into consideration by

those involved with the team around the child. However, there needs to be a more concerted and sustained effort to improve inter-professional working.

4. Experiences of Children and Young People Presenting to Emergency Departments for Self-harm or Suicide-related Outcomes

Presentations by children and young people to emergency departments for self-harm is a major concern. Data report that 18,788 individuals aged <18 years in England and Wales were admitted to hospital or treated at an emergency department (ED) in 2015-2016, which is a 14% increase on 2013-2014 (NSPCC, 2016).

NICE guidance on the short-term management and prevention of recurrent self-harm prescribe the care pathway that individuals should receive within the first 48 hours of presentation for self-harm. This includes treatment for medical injury and a psychosocial assessment to ascertain need and risk. Receipt of appropriate services remains limited, with only 60% of individuals (aged ≥11 years) obtaining a psychosocial assessment (Kapur et al., 2008), despite it being associated with a 51% decreased risk in repeat episodes by persons with no psychiatric treatment history and a 26% decreased risk in those with a treatment history (Bergen et al., 2010). Health care professionals have stated the need for more prompt assessment, with this issue being especially pertinent in the UK. In Wales NICE guidance implementation remains under-examined. Public Health Wales (2014) have recommended that Welsh Government develop mechanisms to ensure appropriate service delivery in accordance with this guidance. However to date there is no systematic mechanism for understanding service users' experience of short-term management and prevention care pathways.

A further issue around short-term management and prevention services is the quality of care provided. Positive experiences of care are vital as negative

treatment by health care professionals can inhibit future help-seeking and exacerbate recurrent behaviours. Evidence reports largely negative attitudes amongst clinical staff. A systematic review indicates that individuals who self-harm are viewed less positively than other patients, with repeated self-harmers being particularly vulnerable to negative perceptions (Saunders et al., 2012). There is limited evidence about the impact of service-user age upon professionals' attitudes, although one study does report that 98% of staff disagree with the statement that children and adolescents who self-harm waste NHS resources (Crawford et al., 2003). Negative professional attitudes are reflected in service users' accounts of clinical provision, where staff are reported to foster poor communication strategies with patients and to possess a limited knowledge of self-harm (Taylor et al., 2009).

DECIPHer is currently undertaking a Health and Care Research Wales funded study to explore the experiences of short-term provision for children and young people who present at the University Hospital of Wales. The Self-HARm provision in Emergency Services (SHARES) study will aim to improve service provision for this population, in addition to the service for accompanying carers.

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Agenda Item 6

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

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

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

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

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

Summary

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

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

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

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

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

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

Suicide risk assessment in primary care

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

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

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

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

Maximising the effectiveness of suicide risk assessment in primary care

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

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

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

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

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

Difficulty referring patients

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

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

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

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

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

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

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

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

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

Training

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

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

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

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

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

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

Zero suicide strategy

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

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

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

Resourcing

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

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

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

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

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

iii NCISH, p.3

iv NCISH, p.3

v

Pearson, 2009.

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

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

Agenda Item 8.1

Cynulliad Cenedlaethol Cymru
Y Pwyllgor Plant, Pobl Ifanc ac Addysg

National Assembly for Wales
Children, Young People and Education Committee

Dr Dai Lloyd AM
Chair, Health, Social Care and Sport Committee
National Assembly for Wales

03 May 2018

Dear Dai,

Mind over matter: A report on the step change needed in emotional and mental health support for children and young people in Wales.

Further to previous correspondence, I wanted to draw your attention to the publication of the Children, Young People and Education (CYPE) Committee's report into its inquiry into the emotional and mental health of children and young people. Given the common interest of both our committees in emotional and mental health, I hope the report and its recommendations will be of interest to colleagues on the HSCS Committee, especially in light of your ongoing inquiry into suicide prevention.

Paragraphs 231 – 235, 264 and 291 of our *Mind over matter* report outline the evidence we received in relation to suicide. In summary we were told that:

- 2016 saw the highest number of suicides among 15-19 year olds in Wales, which was the highest number in five years, and the second highest in 12 years;
- While there has not been a discernible increase in suicides among children and young people under 18 years old (remaining consistently at around 12 suicides a year), recent increases in reported suicides were among 18 and 19 year olds;
- The transition between child and adult services is a time of particular vulnerability, with an increase in suicide rates among 18 and 19 year olds;
- Young people leaving care in the UK are five times more likely than their peers to attempt suicide; and
- Enabling people to talk about self-harm and suicide reduces, rather than increases, attempts at both.

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In light of the alarming evidence presented of a significant increase in self-harm admissions to A&E among children and young people in the last three years, and the increased rate of suicide among 18-19 year olds during 2016, our **recommendation 15** calls on the Welsh Government, within six months of our report's publication, to outline how resources could be directed towards enabling crisis teams in all health boards to provide training and cascade expertise to other frontline services, particularly colleagues in A&E, in border areas (to improve cross-border relations with those centres most often accessed by Welsh domiciled patients), and in schools (to normalise conversations about suicide and self-harm in particular).

In response to the evidence received in relation to the importance of enabling people to talk about suicide, our **recommendation 16** calls on the Welsh Government to work with expert organisations to:

- provide, within three months of our report's publication, guidance to schools on talking about suicide and self-harm, to dispel the myth that any discussion will lead to "contagion";
- prioritise the issuing of guidance to schools where there has been a suicide or suspected suicide; and
- ensure that basic mental health training, including how to talk about suicide, becomes part of initial teacher training and continuous professional development, so that all teachers are equipped to talk about it.

We expect to receive a response to our recommendations from the Welsh Government by Thursday 7 June. We will ensure that a copy of the response is shared with you so that it – along with our report – can help inform your important inquiry into suicide prevention.

Yours sincerely,

Lynne Neagle AM
Chair