

Everybody's Business

A report on suicide prevention in Wales

December 2018



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A report on suicide prevention in Wales

December 2018



About the Committee

The Committee was established on 28 June 2016. Its remit can be found at:
www.assembly.wales/SeneddHealth

Committee Chair:



Dai Lloyd AM
Plaid Cymru
South Wales West

Current Committee membership:



Dawn Bowden AM
Welsh Labour
Merthyr Tydfil and Rhymney



Angela Burns AM
Welsh Conservatives
Carmarthen West and South
Pembrokeshire



Neil Hamilton AM
UKIP Wales
Mid and West Wales



Helen Mary Jones AM
Plaid Cymru
Mid and West Wales



Julie Morgan AM
Welsh Labour
Cardiff North



Lynne Neagle AM
Welsh Labour
Torfaen



Rhianon Passmore AM
Welsh Labour
Islwyn

The following Members were also members of the Committee during this inquiry:



Rhun ap Iorwerth AM
Plaid Cymru
Ynys Mon



Jayne Bryant AM
Welsh Labour
Newport West



Caroline Jones AM
Independent
South Wales West

The following Member attended as a substitute during this inquiry:



David Melding AM
Welsh Conservatives
South Wales Central

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Chair's foreword

The numbers of deaths by suicide in Wales is staggering. We undertook this inquiry to understand what is currently being done and where action is needed to drive the change and improvements that are required to reverse this worrying trend.

All deaths by suicide are preventable and we can all help by having a greater awareness of suicide risks and an understanding of how we can make a difference by responding compassionately to people in distress.

Suicide is everybody's business, that's the key message we've heard; that's the message we all need to remember and share. Suicide can affect anybody, there isn't a community in Wales where people haven't been touched by suicide.

We all have our part to play in reaching out and offering support to those in need. We know that if someone is having suicidal thoughts, receiving support from someone else can make a big difference. We shouldn't rely on medical professionals or the emergency services to provide that support, we can all help by offering an opportunity to talk. We need to raise awareness of the small things we can all do, and spread the message that talking to someone in distress won't make the situation worse.

Many people feel unable to talk about their mental health, mainly due to the stigma that still surrounds admitting they have a problem. We need to overcome this issue so that everyone feels comfortable to seek the help they need without fear of being judged.

Access to appropriate and timely specialist services is key in ensuring people get the support they need. There must be parity in the support available for mental and physical health conditions, so that people can access appropriate support when they need it to prevent reaching a point of crisis.

There is a lot of work being done to raise awareness of the risks of suicide and I would like to praise the excellent work being done by third sector organisations in putting support in place for those affected. There is a momentum building, but a greater direction is needed to really drive forward the change still needed.

We have made a series of recommendations in this report, which if implemented, would be a big step forward in making Wales a zero suicide country.

Dr Dai Lloyd AM, Chair

Recommendations

Recommendation 1. We recommend that a suicide prevention training framework should be adopted and implemented across all public services in a similar way to the framework for domestic violence, where training requirements are specified depending on the role. In particular, GPs would be one of the groups of professionals with greater training / skills requirements, and it is important that they and their practice staff have confidence to ask the right questions, and respond compassionately and effectively when dealing with patients who may be at risk of suicide. We believe that the National Advisory Group should take this forward as an immediate priority, particularly given that a training framework has already been developed and is being launched in England.....Page 22

Recommendation 2. We recommend that the Welsh Government should take the lead in promoting existing materials, such as the “See. Say. Signpost.” training resource as part of a campaign to raise public awareness and embed the message that suicide is everybody’s business and can happen in any community at any time..... Page 26

Recommendation 3. We recommend that the Assembly Commission offers suicide prevention training for Assembly Members, Assembly Members Support Staff, Commission staff and contractors. We hope that, as well as equipping Assembly Members and staff to respond appropriately, this will show an example to other employers, and we would urge the Welsh Government to promote suicide prevention training to all of its staff. Page 26

Recommendation 4. We recommend that the Welsh Government and National Advisory Group work with Network Rail and the Samaritans to evaluate the success of the Small Talk Saves Lives campaign with a view to rolling this out to a wider range of organisations. Page 26

Recommendation 5. We recommend that the Welsh Government take urgent action to ensure that all GPs in Wales are aware of and understand the GMC guidelines on sharing information and the consensus statement agreed by the UK Department of Health, Royal Colleges and other partners. We support the campaign by Papyrus to encourage chief executives of NHS bodies to provide assurance that they will support staff who make a best interest decision to break patient confidentiality in order to protect life.....Page 30

Recommendation 6. We recommend that the Welsh Government must take all necessary steps to ensure parity between mental and physical health services. This should be tied to “A Healthier Wales”, and the Welsh Government must ensure that its plans for the development of health and social care services give the same priority to mental health and wellbeing as to physical health. This includes ensuring the allocation of appropriate resources, and that patient outcomes, in terms of improved mental health, are measured and reported. If the Welsh Government is serious about achieving parity between mental and physical health, it must consider whether the introduction of meaningful targets would ensure health boards give sufficient focus to improving mental health services and patients’ experience of care. Page 40

Recommendation 7. We recommend that the effectiveness of the urgent referral route for GPs implemented by Hywel Dda Health Board be evaluated with a view to rolling this approach out across all health boards in Wales..... Page 40

Recommendation 8. We recommend that the Welsh Government develops of an all-Wales triage model which would see community psychiatric nurses based in police control rooms. We believe this work should be carried out in line with the six month timescale set out in the Children, Young People and Education Committee’s *Mind Over Matter* report (its recommendation 15):

- That the Welsh Government, within six months of this report’s publication, in relation to crisis and out-of-hours care:
 - work with Welsh police forces to scope an all-Wales triage model which would see mental health practitioners situated in police control rooms to provide advice when children and young people (and other age groups, if appropriate) present in crisis;
 - 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);
 - ensure that follow-up support is being provided by health boards after discharge, provide information on how health boards monitor this provision, and commit to making this information publicly available to ensure transparency and accountability;

- ensure that all health boards are adhering to the requirement to hold designated beds that could be staffed adequately for unders-18s in crises, indicating how this will be monitored and reported in future, and what steps will be taken if such beds are not available;
- implement with pace and in a uniform way across health boards the single point of access approach to specialist services, to ensure timely and appropriate access to support, urgent or otherwise; and
- reflecting on the results of the review of crisis care, outline what more needs to be done to deliver a safe and cost-effective 24/7 crisis care service in all areas of Wales, how that will be done, and by when. Page 41

Recommendation 9. We recommend that the Welsh Government takes urgent action to establish to what extent those discharged from inpatient care are currently receiving follow-up care within the targeted timescale and provide an update to the Committee within three months. This should include steps to ensure that IT systems can identify whether this is happening.Page 42

Recommendation 10. We recommend that the Welsh Government introduces six monthly monitoring and reporting of the target in the Together for Mental Health Delivery Plan that all patients discharged from inpatient care receive follow up care within the specified timescale.Page 42

Recommendation 11. We recommend that, in light of the evidence that suicide risk is greatest on the third day after discharge, the target for patients discharged from inpatient mental health care to receive a first follow-up appointment should be changed to ensure that patients are followed up within 48 hours.Page 42

Recommendation 12. We recommend that a target be introduced for waiting times for psychological therapies to ensure that those in need receive this support within a suitable timescale. Accessing appropriate therapy early can provide the intervention that's needed and prevent someone from requiring crisis care at a later stage.Page 42

Recommendation 13. We recommend that the Welsh Government accepts the call made in the mid point review of Talk to me 2 to develop and implement a Wales-wide postvention strategy for suicide, and that this work should be taken forward as an immediate priority. This should include details of follow up support for individuals bereaved by suicide, and in organisational settings. It should

incorporate the recommendation in Mind over matter that guidance should be issued to all schools on talking about suicide (and as a priority, to schools where there has been a suicide or suspected suicide). The Welsh Government should ensure that sufficient ring-fenced resource is available to implement this postvention strategy. Page 49

Recommendation 14. We recommend that the Welsh Government and Public Health Wales actively promote the availability of the Help is at Hand Cymru resource. This should include proactively engaging with third sector support groups and ensuring that frontline staff, particularly emergency services, who have contact with those bereaved by suicide are not only fully aware of Help is at Hand Cymru but, crucially, have access to copies of the resource so that this can be distributed to those bereaved at the point of need. As this resource is already available, this should be implemented within 3 months. Page 49

Recommendation 15. We recommend that the Welsh Government should, as part of an all-Wales postvention pathway, give active consideration to providing funding for support groups for those bereaved by suicide, so that people across Wales are able to access much-needed support. We believe such groups can play a key role in supporting the mental health and wellbeing of those bereaved through suicide. This could in turn lead to reduced demand for NHS services. Page 50

Recommendation 16. We recommend that the National Advisory Group and regional suicide forums should engage with people who have personal experience of suicide ideation, including survivors of suicide attempts and people bereaved by suicide to ensure that all suicide prevention activity is informed by lived experience. Page 52

Recommendation 17. We recommend that the Welsh Government works with NHS employers in Wales to ensure that all employees who have dealt with cases of suicide/attempted suicide are able to access appropriate support. Page 55

Recommendation 18. We recommend that the Welsh Government recognise male suicide as a national priority and allocate appropriate funding to identify and implement new approaches to reducing the stigma associated with mental health to encourage men to talk about and seek help. This should include scope to roll out existing projects more widely. Page 64

Recommendation 19. We endorse the recommendation of the mid-point review of Talk to me 2 that the implementation of NICE guidance on self-harm be a priority for the Welsh Government. This should be implemented within 6 months of the publication of this report. 64

Recommendation 20. We recommend that the Welsh Government ensures that its forthcoming loneliness strategy reinforces the message that loneliness and isolation should be central considerations when budget and policy decisions are made. Page 65

Recommendation 21. We recommend that the Welsh Government takes a lead in the current work with HEFCW and for it to expect further and higher education providers in Wales to introduce Student Mental Health Charters. This work should be done in time for the start of the 2019-20 academic year to ensure that students in Wales benefit from the work as soon as possible. Page 71

Recommendation 22. We recommend that relevant staff from the Welsh Government and other agencies receive appropriate training, such as the Samaritans' "Working with compassion" kit, to show a greater awareness and understanding of the higher suicide risks associated with rural communities, particularly among farmers and their families. This would enable them to respond compassionately when dealing with bereaved families, and promote a greater understanding of the difficulties families in this situation can face in not only carrying on with their day to day farming business, but also in meeting timescales associated with Welsh Government farming processes. We would encourage relevant Government staff to use their discretion to alleviate further stress on bereaved families, for example by deferring farm inspections in appropriate circumstances. Page 71

Recommendation 23. We recommend that the Welsh Government liaises with the Home Office with regard to reviewing the process for assessing and managing prisoners' risk of suicide and self-harm to ensure that it is sufficiently robust to identify those at risk and provides the right support for those who are managed through the process. Page 71

Recommendation 24. We recommend that the Welsh Government ensures that the Children, Young People and Education Committee's Mind Over Matter recommendations are implemented in order to improve and protect the mental health and wellbeing of children and young people in Wales. On suicide specifically, we recommend that the Mind Over Matter recommendation on guidance to schools (its recommendation 16) should be taken forward as an immediate priority:

- That the Welsh Government, in relation to suicide specifically, work with expert organisations to:
 - provide, within three months of this report's publication, guidance to schools on talking about suicide and self-harm, to dispel the myth that any discussion will lead to "contagion";
 - work with expert organisations to 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. Page 79

Recommendation 25. We recommend that the Welsh Government writes to all planning authorities in Wales emphasising the importance of ensuring that all new structures include measures to prevent them being used as a means of suicide..... Page 81

Recommendation 26. We recommend that the Welsh Government identifies the most appropriate agency to identify known suicide locations and places signage in those areas encouraging people to seek help..... Page 81

Recommendation 27. We recommend that the Welsh Government explores what formal arrangements could be put in place to promote and monitor adherence to the guidelines, given the negative impact that the irresponsible reporting of suicide can have. This should include looking at arrangements in place elsewhere, including the Republic of Ireland..... Page 86

Recommendation 28. We recommend that the Welsh Government engage with universities, the Samaritans and other relevant parties such as the National Union of Journalists and publishers to explore how training for journalists at university, through continuous professional development or on the job training could include the importance of adhering to the guidelines on reporting suicide and promoting an understanding of the negative impact of irresponsible reporting. Page 87

Recommendation 29. We recommend that the Welsh Government engages with the UK Government on its Internet Safety Strategy Green Paper to ensure that action is taken to protect children and young people online. Additionally, we are keen to see the potential for social media to have a positive impact on people's mental health and wellbeing maximised. We believe that all

opportunities to promote good mental health through social media/internet sites should be explored, for example through more active promotion of sources of support.....Page 91

Recommendation 30. We recommend that the Welsh Government / National Advisory Group provides a clear steer to the regional forums to ensure a consistent approach to their membership, structure and reporting arrangements. The Welsh Government should monitor the effectiveness of the regional forums to ensure that they deliver sustainable and consistent outcomes across Wales, and provide regular updates to the Committee..... Page 100

Recommendation 31. We recommend that the Welsh Government / other public bodies (LHBs / LAs) make specific funding available for suicide prevention to ensure that it is sustainable in the long term. The Welsh Government should work with the National Advisory Group to ascertain how much funding is needed to ensure this sustainability, and ringfence the appropriate amount..... Page 100

Suicide can affect anybody and its effects are devastating and wide-reaching. We believe that suicide prevention must be an urgent priority for the Welsh Government and that there are steps which could be taken immediately, as set out in this report. As such, the Committee will be seeking an update from the Welsh Government/National Advisory Group on progress in the areas for action we have identified after a six month and a 12 month period from publication of this report.

1. Background

There were 360 registered deaths from suicide in Wales in 2017. This is an increase from the 2016 figure (322 registered suicides). There has been no apparent downward trend over time. The rate in Wales in 2017 was higher than in the majority of years since 1981. It is also likely that official suicide statistics may under-represent the true scale of suicide due to the need to establish “beyond reasonable doubt” that suicide was the cause of death in a coroner’s inquest. Around three-quarters of people who die from suicide are men, in Wales and across the UK. 278 men in Wales died by suicide in 2017.¹

1. The Welsh Government’s suicide and self-harm prevention strategy Talk to me 2 was published in July 2015 and covers the period 2015-2020. It followed Talk to me, the 2009-2014 national action plan to reduce suicide and self-harm in Wales. A mid-point review of the implementation of Talk to me 2, undertaken by Public Health Wales and Swansea University, reported in March 2018.²

2. Talk to me 2 acknowledges, but does not duplicate, other relevant Welsh Government strategies. In particular, actions aimed at improving mental health and wellbeing, and the provision of mental health services, are not included in Talk to me 2 as these issues are dealt with in the Welsh Government’s Together for mental health strategy and under the Mental Health (Wales) Measure 2010.

¹ Office for National Statistics, Suicides in the UK, 4 September 2018

² Mid point review of the implementation of Talk to me 2

3. We agreed to undertake this inquiry into suicide prevention to examine the extent of the problem of suicide in Wales and what can be done to address it, including the consideration of:

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

Engaging and gathering evidence

4. From 16 October to 8 December 2017 we ran a public consultation. We received **55 responses** from a range of organisations and from individuals. In addition, we heard oral evidence from a number of witnesses and met with representatives from the Jacob Abraham Foundation and Tir Dewi to discuss their experiences. We heard oral evidence from the Cabinet Secretary for Health and Social Services (the Cabinet Secretary) on 27 June 2018.

5. The Committee Chair also met with an individual whose son had tragically taken his own life after struggling with mental health issues for a number of years. This was a distressing and very complex case, and we commend the individual concerned for her courage in sharing her story with us and her determination to ensure that lessons are learned. Although we are not including specific details of

the case here for reasons of anonymity, a number of the issues highlighted reflect messages we've heard throughout our evidence gathering. These include the need for:

- a more compassionate response from clinicians to self-harm/suicide;
- improved assessment of suicide risk in individuals;
- better communication with the families/carers of those identified as at risk of suicide; this includes sharing information appropriately with families, and also listening to them and taking on board their concerns about their family member;
- effective care planning, and coordination of care, for patients with complex needs particularly;
- more joined-up services, including the pathways between primary and secondary care;
- improved access to psychological therapies, which can play an important role in suicide prevention;
- greater support for those bereaved through suicide.

6. Alongside the valuable contributions from other stakeholders, which are discussed throughout this report, this important evidence has helped shape the Committee's recommendations.

7. One of the clearest messages that has emerged through this inquiry has been the need to reduce stigma around suicide, including taking the fear out of ordinary people talking about suicide. These issues are discussed in detail in this report.

8. We would like to thank all those who have contributed to our work.

2. Suicide is everybody's business

A key message from stakeholders is that suicide is everybody's business. Raising awareness among the public, as well as those working in frontline services, will encourage help-seeking behaviour and a more compassionate response to people in distress.

2.1. Training for front-line staff

9. Evidence from a range of stakeholders suggested that there would be merit in frontline staff across various professions receiving training in suicide awareness. We heard from the Samaritans that:

“Achieving much more consistent training for people on the front line, who are likely to encounter people who are suicidal, is something that we can make some real progress on.”³

10. We heard concerns that a lack of understanding and compassionate response from front-line staff could result in people who self-harm not receiving the help they need. Professor Keith Lloyd from the Royal College of Psychiatrists believed this was partly a consequence of the lack of parity between mental and physical health conditions, and cited emergency departments as an example of where this sometimes occurs:

“the parity of esteem thing also comes into play in terms of accident and emergency departments. So, there's a huge need for training and awareness raising amongst emergency department staff, some of whom still have a rather negative attitude towards people who self-harm. That can lead to people not subsequently seeking help. If someone consistently turns up with abdominal pain, they'll probably get taken fairly seriously, but if somebody continually turns up having cut themselves, they won't be.”⁴

³ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 81

⁴ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 144

“it’s about how those staff recognise that they need to treat equally the people with mental health problems as they do people with physical health problems.”⁵

11. Written evidence from the RCGP stated that there “is a role for increased training for GPs and all health professionals to improve suicide risk assessment and treatment”, and Dr Rebecca Payne also spoke of the importance of training being available to other team members, including receptionists, call handlers and out of hours staff.⁶

12. Sara Mosely of Mind Cymru told us that, given that the majority of people who take their own lives have been in contact with their GP, the organisation was calling for a mandatory element of training for GPs as currently GPs and other staff working in primary care aren’t required to undertake mental health training:

“it’s actually incredibly difficult when you’re really busy, you’re seeing lots of different people, and you haven’t been trained in this area, to understand fully perhaps where you might need to refer people on or where there might be a greater cause for concern. So, that is something that I think is incredibly important, because, of course, the focus in Wales is primarily on primary care.”⁷

13. Dr Alys Cole-King from Connecting with People commented that GPs are generalists, and whilst it would be unfair to expect them to be specialists in everything, they would be expected to “triage effectively and safely and to know when and how to refer, to know the language of referral”.⁸

14. Claire Bevan from the Welsh Ambulance Service NHS Trust (WAST) told us that feedback from staff who had undertaken specific suicide prevention training demonstrated that it was effective, but admitted that the Trust had more to do in terms of increasing the number of staff receiving the training:

“in relation to skills and clinical practice, and developing and working with health boards around pathways, we know that we’ve got an awful lot more to do. But the feedback from staff who have attended the training has been overwhelming, and being able to see individuals’ confidence rise when they’ve been through, for example, the ASIST training, whether they’re on the telephone triage or whether they are

⁵ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 154

⁶ Health, Social Care and Sport Committee, Record of Proceedings, 17 May 2018, paragraph 305

⁷ Health, Social Care and Sport Committee, Record of Proceedings, 21 March 2018, paragraph 90

⁸ Health, Social Care and Sport Committee, Record of Proceedings, 21 March 2018, paragraph 106

face-to-face, you know, responding to somebody in the community. We've got around about 3,000 staff. We've got another 2,000 community first responders. We have a lot of staff to support through this training, and it's going to take some time.”⁹

15. Claire Bevan acknowledged that there were stigma-related issues around patients with a history of self-harming, and told us that work was underway within WAST around dignity and patient experience:

“That is actually promoting how we are becoming more aware of our interactions when we are caring for somebody with a mental health crisis or in a self-harm situation.”¹⁰

16. Assistant Chief Constable Drake of South Wales Police told us that police forces have “invested significantly across Wales in all aspects of mental health training”, including a two-day course with a specific module on suicide and suicide prevention. He said that 1,000 officers from South Wales Police had received the training and that it was being rolled out to all front-line staff. He concluded that it would be important to continue to deliver the training and to roll it out across organisations.¹¹

17. We heard that British Transport Police are supported by the Samaritans to deliver “managing suicidal contacts” training to its staff:

“the managing suicidal contacts training really gives them the skills to go out there and deal with the interventions day after day when they're dealing with people who are in crisis and either having to detain them through section 136 of the mental health Act or get them to a place of safety.”¹²

18. Alex Cotton from Connecting with People told us of work she had been undertaking with the police on street triage in the Coventry area, which she believed had resulted in an “increase in compassion in the police”. She said the training allowed the police to respond appropriately to situations and resulted in a reduction in admissions to A&E and in the use of ambulances.¹³

⁹ Health, Social Care and Sport Committee, Record of Proceedings, 7 June 2018, paragraph 291

¹⁰ Health, Social Care and Sport Committee, Record of Proceedings, 7 June 2018, paragraph 328

¹¹ Health, Social Care and Sport Committee, Record of Proceedings, 7 June 2018, paragraph 160

¹² Health, Social Care and Sport Committee, Record of Proceedings, 7 June 2018, paragraph 479

¹³ Health, Social Care and Sport Committee, Record of Proceedings, 21 March 2018, paragraph 93

19. We heard from Alison Kibblewhite from South Wales Fire and Rescue Service that staff from specific areas of the fire and rescue services had received training, particularly in areas where there are higher instances of suicide. She said that 109 staff had been trained in safeTALK and ASIST so that they can interact with people who are in distress. She believed there to be scope to increase the number of staff trained, estimating that around 2,500 to 3,000 further firefighters could benefit from training, and suggested that training could be rolled out to corporate and operational staff in a similar way to violence against women training.¹⁴

20. Ian Stevens of Network Rail told us that around 16,500 rail industry staff had received suicide prevention training, which equated to approximately 1 in 6 railway staff, and acknowledged there is a long way to go before all 210,000 staff are trained. He explained:

“We do prioritise. So, front-line staff—those who are likely to come into contact with people who may be vulnerable—are the first people we look to train. So, usually, platform staff, but, of course, we’ve got staff who are out working trackside, so they may come across those vulnerable people. So, they will be trained as well.”¹⁵

21. Mr Stevens explained how Network Rail had worked with the Samaritans to condense its day-long “managing suicidal contacts” course into a half an hour video, which is shown during staff safety briefings. He told us that the video had been effective in raising the understanding of suicide among the wider rail industry, adding that most people then go on to undertake the Samaritans course.¹⁶

22. Dr Alys Cole-King emphasised the importance of an integrated approach to suicide prevention and ensuring that it is everybody’s business:

“It is absolutely not the preserve of specialist services. We need to democratise suicide prevention, in that everybody has the right to know how to keep themselves safe and to know how to keep those around them safe.”¹⁷

¹⁴ Health, Social Care and Sport Committee, Record of Proceedings, 7 June 2018, paragraphs 164-167

¹⁵ Health, Social Care and Sport Committee, Record of Proceedings, 7 June 2018, paragraph 502

¹⁶ Health, Social Care and Sport Committee, Record of Proceedings, 7 June 2018, paragraphs 503-504

¹⁷ Health, Social Care and Sport Committee, Record of Proceedings, 21 March 2018, paragraph 87

23. Dr Cole-King referred to training undertaken by staff at the University of Wolverhampton, where staff from across all areas of the university – the vice chancellor, cleaners, academics, security, NUS and HR staff, had been trained to intervene in a compassionate and proportionate way. She said this “shows promise that you can train people from different areas to intervene in a safe way so that ...you can help prevent the crisis”.¹⁸

24. We heard that training should be proportionate to the job role. The mid-point review of Talk to me 2 calls for the adoption of a multi-agency competence framework for self-harm and suicide prevention. This could be based on the National Collaborating Centre for Mental Health’s series of self-harm and suicide prevention competence frameworks, and implemented across all agencies in a similar way to the Welsh Government training framework for domestic violence, where all public service roles fall into one of six groups in the framework, with a minimum training requirement for each group. For example, at the most basic level (Group 1), all public service staff are required to have a basic understanding and awareness of what violence against women, domestic abuse and sexual violence is, how to recognise it, and what help is available. There was support among witnesses for this approach, Avril Bracey from the Mid and South West Wales Regional Forum compared told the Committee:

“we’ve got this push from Welsh Government on domestic violence - we have a structure for reporting, we have targets for training. Training is a big issue in suicide and self-harm, and, for domestic violence, we have a steer from Welsh Government that says 100 per cent of our front-line staff have to do that basic awareness. I think suicide and self-harm are as important.”¹⁹

25. Professor Ann John believed that mandatory training for some professions would help in removing the fear element that often prevents someone from reaching out to someone in distress by giving them confidence to signpost that person for help:

“I think the reasons people don’t ask is fear. And that’s about holding all that difficulty and what you do with it... I don’t think we should expect everyone to be a trained professional, but you can make people feel comfortable with having that conversation, knowing that that conversation isn’t going to make someone go out and feel worse. Really, people want to have these conversations, and then part of that training

¹⁸ Health, Social Care and Sport Committee, Record of Proceedings, 21 March 2018, paragraph 109

¹⁹ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 201

would be knowing where you send people to or what you do with that, and what the limits are. The thing about training is that they show you what you can do, but proper training also shows you when you reach the limits of what you should do.”²⁰

Our view

26. We heard compelling evidence in support of the specific suicide prevention training implemented by a range of organisations and how successful that training has been in empowering staff to intervene should they encounter a person in emotional distress. We were encouraged to hear that many organisations are providing training and that this is valued by staff, but the scale of the problem means that more people should be trained as a matter of urgency.

27. GPs, in particular, play a key role, and the need to ensure they have confidence to ask the right questions, and respond compassionately and effectively when dealing with patients who may be at risk of suicide. Anybody could find themselves in a situation where they encounter a person in distress, but particularly staff in frontline services whose role it is to respond to calls for help. It is vital that those staff receive appropriate training so that they have the confidence to respond effectively and compassionately and to understand how their actions can make a difference. We believe that these should include the roles identified in Talk to me 2 as being priority care providers.

28. We wholeheartedly support the suggestion that all staff in public service roles undertake suicide prevention training in a similar way as they would training on domestic violence awareness. We know that suicidal thoughts and behaviour are so prevalent that training for public service staff should be given the same focus as other types of training, for example, we heard that GPs are far more likely to have contact with people who are feeling suicidal than to people in need of CPR. We believe that suicide prevention training should be an urgent priority for public service staff to ensure that they are equipped to recognise when a person is in distress and can effectively intervene by offering or signposting to available support.

29. We were particularly encouraged by the proactive approach taken by Network Rail and its collaboration with British Transport Police and the Samaritans in providing accessible training for its staff. This approach is an exemplar in that, by responding to address the impact of suicide incidents on its

²⁰ Health, Social Care and Sport Committee, Record of Proceedings, 21 March 2018, paragraph 79

own operations and customers, it recognises how, as an organisation, the steps it takes in equipping its staff can be beneficial in suicide prevention.

Recommendation 1. We recommend that a suicide prevention training framework should be adopted and implemented across all public services in a similar way to the framework for domestic violence, where training requirements are specified depending on the role. In particular, GPs would be one of the groups of professionals with greater training / skills requirements, and it is important that they and their practice staff have confidence to ask the right questions, and respond compassionately and effectively when dealing with patients who may be at risk of suicide. We believe that the National Advisory Group should take this forward as an immediate priority, particularly given that a training framework has already been developed and is being launched in England.

2. 2. Public awareness

30. We heard strong support from stakeholders for raising public awareness around how to offer support to those in distress. Witnesses told us that training resources aimed at the general public are already available, and there is scope to roll these out more widely. Network Rail described the success seen so far from its recently-launched Small Talk Saves Lives campaign, in partnership with Samaritans, British Transport Police and the wider rail industry. This is aimed at giving members of the public the confidence to intervene and help prevent suicide on the rail network. Ian Stevens from Network Rail told us that “interventions are a cornerstone of what we do” and that staff were trained to recognise some of the signs of suicide to “be confident and comfortable to go up to somebody and ask them ‘Are you okay?’”. He went on to say:

“We made about 1,700 life-saving interventions last year. So, that would be staff, British Transport Police, members of the public, and our view was that if it was working so effectively for the rail industry with our staff, why would we not look to extend that to customers? So, that was the start of the Small Talk Saves Lives campaign. Where we hope that will ultimately go will be to debadge that from the rail industry, and that Samaritans will then take that out into the community and the general population, to share that messaging, because it’s not railway orientated, it is community orientated.”²¹

²¹ Health, Social Care and Sport Committee, Record of Proceedings, 7 June 2018, paragraph 472

31. Mr Stevens was aware of instances where Network Rail staff had been able to use the skills learnt through the training they'd received to make interventions in their own communities.²² He also told us how Network Rail was eager to share its training with third parties, referring to instances – particularly in areas with higher risks of suicide, where it had worked with local community groups.²³

32. Chief Inspector Cleland concurred that training a wider range of people, not just those working on the front-line was beneficial, and the success of which was evident in the number of interventions made:

“We encourage people to take it up, and not just operational staff but all staff. So, from a police point of view, we don't just encourage our police officers to go on the training; we encourage our admin staff to go on it, the back-office staff, because we see it as a life skill and not just an operational need. It's something they can take outside of work and still utilise

it reflects in the figures we get in interventions, life-saving interventions. If I just look at the figures, we've had 4,000 over the last three years, which is 4,000 lives saved, and that's because people feel more confident to just go up to somebody and speak to them, which just speaks volumes in itself, really.”²⁴

33. Angela Samata, Ambassador for Survivors of Bereavement by Suicide (SoBS), highlighted the free, 20 minute online training resource See.Say.Signpost produced by the Zero Suicide Alliance. She suggested that the training could be promoted in workplaces to raise awareness. For advice on how to help someone at risk, information is available on the page opposite.

34. Stakeholders called for a “suicide prevention” public awareness campaign aimed at encouraging everyone to reach out and help when they're aware someone is struggling. Sarah Stone from the Samaritans said it would be fantastic to develop a “nation of good listeners”,²⁵ however Angela Samata suggested that, as well as listening, people also need to be equipped to signpost to appropriate sources of help.

35. Encouraging the wider public to engage with suicide prevention training was also welcomed by the Royal College of Psychiatrists, Professor Keith Lloyd

²² Health, Social Care and Sport Committee, Record of Proceedings, 7 June 2018, paragraph 475

²³ Health, Social Care and Sport Committee, Record of Proceedings, 7 June 2018, paragraph 507

²⁴ Health, Social Care and Sport Committee, Record of Proceedings, 7 June 2018, paragraph 510

²⁵ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 89

compared such training with training for CPR or the use of defibrillators, which is increasingly common in most communities.²⁶ He stressed the importance of talking about suicide and described the notion that talking about it increases the risk of suicide as a “myth”.²⁷

36. Alison Kibblewhite also endorsed raising public awareness of knowing how to respond in a situation where a person may be in distress:

“early investment further down the line is really good, and that’s about, as well, raising public awareness in general—that they see a person who might be in distress, make the call to the emergency services. Once we are there, very few people take that final step because we interact. So, if we can get there quickly, it’s a more successful outcome, definitely.”²⁸

37. The Cabinet Secretary told us that he would be willing to consider whether the Welsh Government could take a lead in promoting resources such as “See. Say. Signpost” to raise suicide prevention awareness amongst the public.

The Zero Suicide Alliance provide the following advice as part of its See. Say. Signpost campaign to raise awareness on talking to someone who might be suicidal:

There’s no easy way to ask someone if they intend to kill themselves. But it won’t make it more likely. But, at the same time, skirting around the issue won’t help. The best approach is to be sensitive yet direct by asking such questions as:

- Are you thinking about hurting yourself?
- Are you thinking about dying?
- Are you thinking about suicide?

Remember, mentioning suicide to someone who’s already thinking about it will NOT encourage them to go through with it.

²⁶ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 159

²⁷ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraphs 174 - 175

²⁸ Health, Social Care and Sport Committee, Record of Proceedings, 7 June 2018, paragraph 257

Talking and listening

- Don't ever be put off approaching someone who you think may be at risk of suicide because you don't know what to say.
- One of the best things you can do for a person who may be feeling suicidal is to simply encourage them to talk about their feelings. And to make sure you really listen to what they're saying.
- Talking about someone's problems is not always easy and it may be tempting for you to try to offer a solution. But often the most important thing you can do to help is listen to what they have to say.
- It's also important that the person who needs help doesn't feel judged by those who are trying to support them.
- For instance, comments such as "Don't you think you might be drinking too much?" can sometimes make the situation worse. Reassurance, respect and support are what can help during these difficult periods.

Opening up through asking questions

- Asking questions can be a useful way of letting a person remain in control while allowing them to talk about how they're feeling.
- Try not to influence what the person says, but give them the opportunity to talk honestly and openly. This is helped by asking open-ended questions such as "Where did that happen?" and "How did that feel?", encouraging them to keep on talking.
- On the other hand make sure you avoid statements that could possibly end the conversation, such as "I know how you feel" and "Try not to worry about it".

Getting professional help

- Although talking to someone about their feelings is invaluable in helping them feel safe and secure at the time, these feelings may not last. It will probably require long term support to help someone overcome their suicidal thoughts.
- This will most likely be easier with professional help, for example, sharing your concerns with a GP. Not only can a professional deal with the underlying issues behind someone's suicidal thoughts, they can also offer advice and support for you.

If there is an immediate danger, make sure they are not left on their own

Our view

38. We fully support the message expressed by stakeholders that suicide everybody's business, we also believe that suicide prevention is everybody's opportunity. All communities across Wales will be affected by suicide, and so it cannot be left to the emergency service alone to intervene in a distressing situation, we all have a role to play. It is crucial to spread the message that talking about suicide won't make a situation worse. Raising awareness among the public, as well as those working in frontline services, will encourage help-seeking behaviour and a more compassionate response to people in distress. Ultimately, raising public awareness will enable people to recognise the signs of distress in another person and to understand how they can intervene in such a situation which could lead to saving someone's life.

39. We have heard about various ways of raising awareness already being used, and how easily these could be transferred in to a wider campaign of public awareness. A public awareness campaign need not be an onerous or expensive exercise, existing resources are readily available, and these can be used as the basis of a public awareness campaign focusing on empowering people to offer effective support to those in distress. We have seen how previous campaigns targeting specific conditions, such as stroke, have played an important role in educating the public to recognise signs and thereby take appropriate action sooner. Given that suicide rates are so high, we believe that suicide prevention awareness warrants the same level of focus.

Recommendation 2. We recommend that the Welsh Government should take the lead in promoting existing materials, such as the "See. Say. Signpost." training resource as part of a campaign to raise public awareness and embed the message that suicide is everybody's business and can happen in any community at any time.

Recommendation 3. We recommend that the Assembly Commission offers suicide prevention training for Assembly Members, Assembly Members Support Staff, Commission staff and contractors. We hope that, as well as equipping Assembly Members and staff to respond appropriately, this will show an example to other employers, and we would urge the Welsh Government to promote suicide prevention training to all of its staff.

Recommendation 4. We recommend that the Welsh Government and National Advisory Group work with Network Rail and the Samaritans to evaluate the success of the Small Talk Saves Lives campaign with a view to rolling this out to a wider range of organisations.

The above recommendations rely on the promotion of existing training materials, as such we believe these should be implemented immediately.

2.3. Sharing information

40. We heard concerns regarding the lack of information sharing between doctors and the families of people who spoke of suicide ideation or who had attempted suicide, usually due to concerns about breaching patient confidentiality. Ged Flynn of Papyrus referred to a stark example when, following the death by suicide of a 17 year old boy, the GP told the boy's father that it had been his third attempt to take his own life:

“I always start this subject by sharing a story, with his permission, of a father of a 17-year-old boy who went to make sense of a very recent death of his son, which looked like suicide, and within a couple of days the GP said to him, ‘Now, I can tell you this is his third attempt.’ Incredulously, the father said, ‘Why couldn’t you tell me before?’, and the GP, rather apologetically, just simply said, ‘Confidentiality.’”²⁹

41. Dr Keith Lloyd concurred that doctors not sharing information with the families of people who express suicide ideation, despite the GMC guidelines, is an issue that should be addressed:

“Doctors have very clear guidance—GPs, all of us—from the General Medical Council about when we can breach confidentiality. We know that if somebody is very dangerous or a risk to other people, there is clear guidance around how we breach confidentiality. Medical practitioners are much less confident about doing that where issues around self-harm and suicide are at play. One of the big issues for families is, ‘Nobody told us he felt like this.’ You hear that time and time again.”³⁰

42. We discussed the issue with representatives from the Royal College of GPs who felt it was important for doctors to discuss with the patient whether they would be content for the GP to disclose the information to their family, Dr Rebecca Payne told us:

“I think the first thing is that we need to have the conversation with people. Me as a doctor saying, ‘I’m really worried about you; can I have a conversation with your family?’ And a lot of the time, people say ‘yes’. So,

²⁹ Health, Social Care and Sport Committee, Record of Proceedings, 21 March 2018, paragraph 202

³⁰ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 117

first, that needs to happen. Then, when they've said 'yes', actually, that conversation needs to happen...We need to make sure that it's then scheduled and that conversation happens."³¹

43. Dr Payne went on to say that cases where the patient does not consent for their family to be informed were more difficult for doctors to gauge the most appropriate thing to do:

"it's really difficult because it is so hard to tell who is going to be at risk of committing suicide and who's not. You then get into some very tricky issues about whether it is okay to breach confidentiality... If somebody is clearly about to do something, it's a bit easier in a way. You can call the police, you can call the ambulance service, you can do stuff knowing you're doing it in the patient's best interest. But somebody who's come to see you and they've got a few risk factors...is it appropriate then to start phoning around the family without consent? Well, I think most of us would say probably not."³²

44. Dr Payne suggested that, in circumstances where a doctor is concerned about a patient, doctors should discuss the issue with their medical defence unions to seek advice on when it would and would not be appropriate to break consent, adding that:

"if we could crack good information sharing between different parts of the system, that would be a great start."³³

45. Ged Flynn told us that the National Advisory Group at a UK level had worked with all the royal colleges to agree a consensus statement "which documented why all those key professional bodies agreed that there were limits to confidentiality where life was in danger". He said the broad principle of the statement was that information can usually be shared to protect life within certain parameters, however he was concerned that many GPs were unaware of the statement.³⁴

46. Mr Flynn went on to say that he had recently written to all chief executives of NHS Trusts across the UK, highlighting that many medical staff do not share

³¹ Health, Social Care and Sport Committee, Record of Proceedings, 17 May 2018, paragraph 416

³² Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 417

³³ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 418

³⁴ Health, Social Care and Sport Committee, Record of Proceedings, 21 March 2018, paragraph 203

information due to the fear of being struck off. He told us that he had heard of one Trust where:

“the chief executive wrote to all his colleagues and said, ‘If you make a best interest decision, where life is in danger, you document that, you share it with your line manager as to why you’ve done it. If in doing so you get into trouble, I will back you in court. I will have your back. I will support that decision.’”³⁵

47. He subsequently wrote again to every chief executive of every NHS trust in the UK suggesting that they adopt the same approach, which had generated a positive response. Mr Flynn told us:

“Part of me thinks this is common sense, but it’s just breaking down a big problem into little bite-size chunks and saying, ‘If this is just “I need permission”, then give them the permission and it will save lives.’”³⁶

48. Dr Liz Davies, accompanying the Cabinet Secretary, acknowledged that sharing information was an issue:

“Papyrus wrote to us...They asked us to circulate the accurate form of the guidance. So, as the General Medical Council states, you shouldn’t share information, but even the GMC is quite clear that if it’s in the patient’s interest that you should share information, you should do so. So, Papyrus asked us to share that interpretation in order to get more consistency, but you’re right to highlight it as an issue, and it is something that we need to continue to work on because, still, there are misconceptions about patient confidentiality—when it applies and when it doesn’t apply.”³⁷

Our view

49. It is clear from the evidence we heard greater clarity for medical professionals is needed with regard to sharing information with the families of patients who have expressed suicidal intentions or attempted to take their own lives. The families of people who die by suicide are often unaware that their loved one is experiencing such a level of distress, and is in urgent need of help.

³⁵ Health, Social Care and Sport Committee, Record of Proceedings, 21 March 2018, paragraph 204

³⁶ Ibid

³⁷ Health, Social Care and Sport Committee, Record of Proceedings, 27 June 2018, paragraph 85

50. We understand that doctors are bound by patient confidentiality, but the General Medical Council guidelines are clear that, in cases where there is danger to life, doctors are able to discuss suicide risk with the patient's family. We are concerned that some doctors are unaware of the guidelines and the consensus statement agreed by the UK Department of Health, Royal Colleges and other partners, and believe action should be taken to raise their awareness. This could in part be achieved through suicide prevention training for GPs and practice staff.

Recommendation 5. We recommend that the Welsh Government take urgent action to ensure that all GPs in Wales are aware of and understand the GMC guidelines on sharing information and the consensus statement agreed by the UK Department of Health, Royal Colleges and other partners. We support the campaign by Papyrus to encourage chief executives of NHS bodies to provide assurance that they will support staff who make a best interest decision to break patient confidentiality in order to protect life.

3. Greater parity between mental and physical health

Access to appropriate and timely specialist services is key in ensuring people get the support they need. There must be parity in the support available for mental and physical health conditions and access to services is crucial in ensuring such parity exists.

3. 1. Primary care

51. We've heard concerns about the ability of GPs to access timely, specialist mental health support when they're concerned about a patient's suicide risk, including for example high thresholds for "urgent" assessment, and GPs being unable to speak directly to a psychiatrist to communicate their concern about a patient.

52. The evidence from the Royal College of General Practitioners stated that 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."³⁸

53. Dr Rebecca Payne told us that GPs were "really struggling as a profession, having identified that people are at risk, to get the help and support they need for them".³⁹ She referred to a specific case where she had referred one of her patients for specialist mental health services, but he was not identified as being at high risk of suicide but subsequently took his own life.⁴⁰

³⁸ Written evidence, S 17 Royal College of General Practitioners

³⁹ Health, Social Care and Sport Committee, Record of Proceedings, 17 May 2018, paragraph 317

⁴⁰ Health, Social Care and Sport Committee, Record of Proceedings, 17 May 2018, paragraph 314

54. Dr Jane Fenton-May concurred that GPs were finding it increasingly difficult to get access to emergency mental health services for their patients, saying:

“the mental health services are saying that unless they’re actually in the process of committing suicide some time, they won’t see them as an emergency patient.”⁴¹

55. Dr Payne went on to say that GPs should be able to speak directly to a psychiatrist or other clinician, and that a GP’s own assessment of risk should be given proper consideration:

“when we phone up, we want a number that works, we want to speak to somebody who listens to what we say and isn’t just going tick, tick, tick on a list. But if we as experienced GPs say we’re worried about somebody, actually, that, in and of itself, is an independent risk factor, but very often it just seems it’s like ‘tick, tick, tick, they don’t meet enough’, and that gut instinct isn’t taken into account.”⁴²

“Being able to talk to a psychiatrist is very, very helpful, and that’s got harder and harder to do... But the simplest thing is there needs to be somebody on-call who answers the phone and can move things forward, particularly overnight.”⁴³

56. Representatives from health boards told us of actions taken to improve access to specialist mental health services. Nadine Morgan told us that, currently, in the Hywel Dda UHB area, GPs who refer their patients “can have a very prompt response, within a period of four hours, if the level of need is great”.⁴⁴ She went on to say that the health board was moving towards implementing a new model which would allow “a single point of referral” for mental health services whereby:

“it doesn’t necessarily mean that another practitioner or another clinician needs to make that referral, and people will be able to go in on a walk-in basis and have that 24 hours, seven days a week.”⁴⁵

57. Dr Liz Davies, Senior Medical Officer accompanying the Cabinet Secretary explained that “the system for accessing emergency care has been streamlined”. She said that across Wales, a GP can get an appointment for a patient in an

⁴¹ Health, Social Care and Sport Committee, Record of Proceedings, 17 May 2018, paragraph 316

⁴² Health, Social Care and Sport Committee, Record of Proceedings, 17 May 2018, paragraph 369

⁴³ Health, Social Care and Sport Committee, Record of Proceedings, 17 May 2018, paragraph 373

⁴⁴ Health, Social Care and Sport Committee, Record of Proceedings, 7 June 2018, paragraph 40

⁴⁵ Health, Social Care and Sport Committee, Record of Proceedings, 7 June 2018, paragraph 41

emergency situation within four hours, or in an urgent situation within 48 hours by ringing the relevant community mental health team and asking to speak to the duty worker. She concluded that:

“I think there have been problems in the past, but I think there have been significant steps to address those problems.”⁴⁶

3. 2. Psychological therapies

58. Stakeholders told us that a greater focus on early intervention is needed, and highlighted the significant role of psychological therapies in suicide prevention. We heard from Dr Kathryn Walters that there was strong evidence around the success of dialectical behaviour therapy (DBT) as a “potentially life-saving treatment for people”.⁴⁷ Dr Walters went on to say that although DBT is offered in Wales, she believed that:

“part of the issue around mental health services is there is not the parity of esteem between mental health and physical health services.”⁴⁸

59. Dr Walters referred to the death by suicide of the 15-year-old girl who was due to receive DBT six to eight months before she died, but the clinician who would have been her one-to-one therapist went off sick and no cover was provided. She told us:

“She couldn't access it, and I do find myself wondering if someone were referred for chemotherapy whether they would find themselves in the same position. And the difficulty, I guess, is we're always in the position that it's hard to say unequivocally what we have prevented from happening in mental health services. It's back to that complexity. But it does distress me that we struggle so much. There are services where people go on maternity leave and there just isn't cover, and I'm not sure that exists in the same way in physical health services.”⁴⁹

60. Evidence highlighted lengthy waits to access these services, particularly in secondary care. Professor Keith Lloyd (Royal College of Psychiatrists) told us:

“in the area where I work, it's easier for a GP to refer somebody to psychological therapies than it is for me as a consultant psychiatrist.

⁴⁶ Health, Social Care and Sport Committee, Record of Proceedings, 27 June 2018, paragraph 62

⁴⁷ Health, Social Care and Sport Committee, Record of Proceedings, 17 May 2018, paragraph 54

⁴⁸ Health, Social Care and Sport Committee, Record of Proceedings, 17 May 2018, paragraph 56

⁴⁹ Ibid

And I do know that if I do refer somebody, the wait is in the order of 18 months currently. That's simply not acceptable, and that comes down to investment in services."⁵⁰

61. Professor Lloyd echoed concerns around parity of access to mental health compared with accessing physical health services, he said:

"The Royal College of Psychiatrists has consistently argued for parity of esteem around mental health and physical health. You see that in terms of psychological therapies and it comes back to investment and spend—not just having a ring-fenced budget, but actually spending the money that's allocated to mental health, and that comes back to the things that are actually monitored by health boards, by Welsh Government for health boards to meet their targets. If you had to wait that long to be seen in an emergency department, you can imagine what would happen."⁵¹

62. We heard that people waiting for psychological therapy often call the Samaritans whilst waiting, Sarah Stone said as an organisation they were very aware of the "distress that sort of waiting causes."⁵² Susan Francis, also from the Samaritans, said that having to wait was "cruel":

"it needs to be an instant appointment for them, to get that specialist help that they need."⁵³

63. Dr Walters told us that although the Welsh Government had allocated additional funding for accessing psychological therapies over the last five years, more people are accessing those services as awareness of them increases, saying:

"There's this idea that our services are focused at the top of the iceberg and there is a whole lot of unmet need that we may start to uncover and identify the more we offer services. So, obviously, it's intolerable that people wait the length of time they do for accessing psychological therapies, and I'm really grateful for the new moneys, but I'm wary that we may find ourselves in a similar position, even though we've had more investment, because more people will just come forward. At the moment, there are services where GPs won't even bother referring people for psychological therapies, then we get into the issue around

⁵⁰ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 134

⁵¹ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 143

⁵² Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 93

⁵³ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 96

prescription because it's quicker and it's easier. But I think there's still a huge amount of demand.”⁵⁴

64. The Cabinet Secretary told us that it was unacceptable for people to wait longer for therapies than they should:

“some of the waiting times are not acceptable. We are investing more, and we'll need to see if that investment deliver results that mean that people don't wait an excessive length of time for that support, whether it's going to be urgent at the crisis end, or at the more standard end, because all of those things matter to avoid problems escalating.”⁵⁵

3. 3. Crisis care

65. We heard concerns about implementation of the crisis care concordat, particularly the lack of 24 hour access to mental health professionals and health-based places of safety, and an over-reliance on the police to support vulnerable people in distress.

66. Professor Keith Lloyd told us he believed that crisis care provision had not been invested in as much as it should have been

“I don't think we have invested in those to the extent that we should. It comes back to the parity of esteem thing. If we were talking about cancer services, this would be a national scandal, but because it's mental health, we don't think about in the same way. If we were talking about paediatrics or child health, it would be a national scandal, but it's mental health. So, in terms of crisis services, they are very busy; they are under-resourced. If we are increasing emotional resilience and if we are encouraging people to talk to us—'Talk to Me 2'—then we have to have the services behind that to give them the service.”⁵⁶

67. Mind Cymru expressed its concerns that, often, it's the police who respond in crisis if that support isn't available 24 hours day from health boards, Sara Mosely told us:

“when you're at the point of crisis, somebody needs to be there 24/7 to respond to that. What people are telling us and what we're seeing is that all too often that's the police, because if you look at some of the

⁵⁴ Health, Social Care and Sport Committee, Record of Proceedings, 17 May 2018, paragraph 94

⁵⁵ Health, Social Care and Sport Committee, Record of Proceedings, 27 June 2018, paragraph 12

⁵⁶ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 150

freedom of information requests we've put to health boards, very, very few of them have got that provision that's available 24/7 where you know where to go if you are in desperate need and you're in crisis."⁵⁷

68. Glenn Page referred to the results of a survey put to Mind Cymru's supporters which demonstrated that:

"outside of the nine-to-five hours, there's not a clear idea of where people should be supported to go. Something that came through clearly in the survey was that people are left with nowhere to turn but perhaps the police or presenting at A&E, and so what we really need is 24-hour provision, or certainly that's what people want—is to be able to access those services at any time."⁵⁸

69. Assistant Chief Constable Jonathan Drake of South Wales Police told us that around 12% of all police incidents are directly related to people in mental health crisis, and that a particular challenge for the police is when crisis occur during the early hours of the morning when "there's a more limited range of partners around".⁵⁹ He suggested that there are opportunities to reduce the length of time that officers are spending with people in crisis, and to involve mental health professionals at an earlier stage. ACC Drake and Will Beer of Aneurin Bevan UHB both referred to locating a mental health professional within police control rooms, which is happening in some areas 24 hours a day, as being an effective triage model when responding to people in crisis. Will Beer described the benefits as being:

"One of the developments that has happened in recent years is that we now have an AMHP—a mental health professional—within the police control room. I know in some areas that's available 24/7. In our health board, that's 8 o'clock in the morning until 2 o'clock in the morning. So, the police will have access to that expert advice and support at the end of the phone and that mental health professional will have access to the health board's clinical system as well as the police records and so will develop a clear picture about what's going on and can give the right advice."⁶⁰

⁵⁷ Health, Social Care and Sport Committee, Record of Proceedings, 21 March 2018, paragraph 92

⁵⁸ Health, Social Care and Sport Committee, Record of Proceedings, 21 March 2018, paragraph 96

⁵⁹ Health, Social Care and Sport Committee, Record of Proceedings, 7 June 2018, paragraph 195

⁶⁰ Health, Social Care and Sport Committee, Record of Proceedings, 7 June 2018, paragraph 50

70. One of ACC Drake's key recommendations was to locate community psychiatric nurses (CPNs) in police control rooms as standard to support officers when responding to individuals in crisis, but identified the sustainability of long term funding as a challenge:

"in south Wales, we're commissioning that service presently. We'll identify 12 months of funding; the challenge is sustaining that provision longer term. That's where we struggle at the moment. Across Wales, most of that is funded by policing, and there's some contribution from health boards. There's a real question about whether we can sustain that provision. But when I look around the UK, looking at good practice, it seems that triage, sharing information at point of crisis is absolutely key in terms of protecting people."⁶¹

71. The Welsh Government's written submission states that the further development of crisis and out of hours services will be a priority for health boards under the Transformation Fund,⁶² and the Cabinet Secretary acknowledged that improvements are needed in access to crisis care. He referred to additional resources being available through the mental health transformation fund for community and crisis care:

"On the mental health transformation fund, we've taken about £7 million to invest in that, with a focus on community and, indeed, on crisis care as well, because I wouldn't try and look you or anyone else in the eye and say, 'Everything's fine', because it isn't. That's why we're investing more."⁶³

72. The Cabinet Secretary told us he "was aware of and interested in"⁶⁴ the initiatives involving locating mental health professionals in police control rooms. He said that looking at how staff are located would be part of considering how emergency services can better work together on issues such as mental health.

3. 4. Follow-up care

73. The Welsh Government's Together for mental health delivery plan 2016-19 includes as a performance measure that "All individuals discharged from inpatient care to have a first follow up within 5 working days of discharge".

⁶¹ Health, Social Care and Sport Committee, Record of Proceedings, 7 June 2018, paragraph 197

⁶² Health, Social Care and Sport Committee, written evidence, 27 June 2018, paper 1

⁶³ Health, Social Care and Sport Committee, Record of Proceedings, 27 June 2018, paragraph 12

⁶⁴ Health, Social Care and Sport Committee, Record of Proceedings, 27 June 2018, paragraph 121

74. The Royal College of Psychiatrists recommends that a first follow-up should take place within three working days, given the significant risk of suicide among this group. Its evidence paper refers to an estimated increase risk of suicide in the four weeks following discharge from psychiatric hospital is 100-200 per cent. Professor Keith Lloyd told us that greater investment would be needed to achieve that:

“the sooner services follow-up people with severe enduring mental illness who’ve been in hospital the better. Now, I’ve got to say that my colleagues who work in community mental health teams work very hard. There’s a question of the resourcing for them to be able to do that. So, that is our ideal. That’s the standard I think we should aspire to. That will not happen without greater investment in the delivery of services—not the budget for services but the spend for services.”⁶⁵

75. Written evidence from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) highlights that suicide risk is highest during and soon after inpatient care. It says that following discharge from hospital, the peak risk of suicide is on day 3, demonstrating the need for early follow-up and for care planning at the time of discharge.

76. Despite there being a target in place, Mind Cymru told us that it had conducted a number of freedom of information requests in 2017, the results of which had demonstrated that only one health board was recording whether patients were receiving follow-up care within 5 days of being discharged. Consequently, Glenn Page said:

“we can’t be certain that this follow-up is happening.”⁶⁶

77. On 7 June, health board representatives agreed to write to the Committee with further information about the numbers of patients receiving timely follow-up, but highlighted some concerns about the ability of current ICT systems to audit this.. Some information was subsequently provided by Aneurin Bevan University Health Board and Powys Teaching Health Board, although we are not assured that this information is routinely collected and monitored across Wales.

78. In relation to the difficulties around fully understanding whether patients were receiving timely follow-up care, the Cabinet Secretary explained:

⁶⁵ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 129

⁶⁶ Health, Social Care and Sport Committee, Record of Proceedings, 21 March 2018, paragraph 98

“Part of our challenge in understanding how current targets are met is the reality that our information technology systems are not optimal, and so to be able to give ourselves all the assurance we would want, you’d want that to be systematised. We’re moving towards having an IT system—the Welsh community care information system, which is often referred to as ‘WCCIS’. That won’t be in place until 2021, but that will mean that we’ll have a way to more accurately understand what our system is delivering.”⁶⁷

79. The Cabinet Secretary was aware of the call to reduce the target for follow-up care from five to three days following discharge, and said that consideration would be given to revising this:

“The current target is being reviewed because we’ve heard that evidence as well. And so, in taking forward the next delivery plan for mental health, we may well have change in that target and that expectation, because we’ve heard that evidence too.”⁶⁸

Our view

80. The difficulties expressed by GPs in being able to access specialist mental health support for their patients were alarming, and we were very concerned at the disconnect in the evidence provided by the Cabinet Secretary and health boards and the situation described by GPs themselves. It is unacceptable that GPs, when they identify that a patient is in need of specialist services, are unable to access those in a timely way. When a GP identifies an urgent physical condition in a patient, they can immediately refer the patient to a hospital emergency department for treatment or tests, the same must apply for mental health conditions. Someone experiencing a mental health crisis must be taken as seriously as someone having a cardiac arrest or other serious physical condition and be offered the same level of help.

81. We heard positive evidence around the system implemented by Hywel Dda Health Board, where a GP can refer a patient for specialist care and receive a response within four hours in urgent cases. We believe that such support for GPs is crucial, and if this approach is successful within the Hywel Dda Health Board area, it should be rolled out across health boards.

⁶⁷ Health, Social Care and Sport Committee, Record of Proceedings, 27 June 2018, paragraph 83

⁶⁸ Ibid

82. Ensuring parity of esteem between support for mental and physical health conditions is paramount, it is unacceptable that mental health services are not prioritised in the same way as physical health. Appropriate support must be available when people are in need of help, we know that psychological therapies can play an important prevention role or early intervention before someone gets to the point of crisis, yet we heard about long waiting times in accessing these therapies. We believe that more recognition should be given to the role of psychological therapies in suicide prevention and access to those services should be improved as a priority to ensure parity with physical health services. We have heard the Cabinet Secretary acknowledge that there needs to be improvement in accessing mental health services, but the Welsh Government now needs to demonstrate this by taking real action. Although the Cabinet Secretary has stated that resources will be available through the Transformation Fund for the development of crisis and out of hours services, we are aware that the fund is under immense pressure to fulfil several projects, so we are concerned that mental health will not receive parity in the allocation of funds.

83. We have heard that locating community psychiatric nurses in police control rooms has been shown to be an effective triage model when responding to people in crisis. The Children, Young People and Education Committee also recommended this approach in its recent [report](#) on the emotional and mental health of children and young people. We are encouraged that this approach has shown to be effective and believe that this provision should become standard across Wales.

Recommendation 6. We recommend that the Welsh Government must take all necessary steps to ensure parity between mental and physical health services. This should be tied to “A Healthier Wales”, and the Welsh Government must ensure that its plans for the development of health and social care services give the same priority to mental health and wellbeing as to physical health. This includes ensuring the allocation of appropriate resources, and that patient outcomes, in terms of improved mental health, are measured and reported. If the Welsh Government is serious about achieving parity between mental and physical health, it must consider whether the introduction of meaningful targets would ensure health boards give sufficient focus to improving mental health services and patients’ experience of care.

Recommendation 7. We recommend that the effectiveness of the urgent referral route for GPs implemented by Hywel Dda Health Board be evaluated with a view to rolling this approach out across all health boards in Wales.

Recommendation 8. We recommend that the Welsh Government develops of an all-Wales triage model which would see community psychiatric nurses based in police control rooms. We believe this work should be carried out in line with the six month timescale set out in the Children, Young People and Education Committee's *Mind Over Matter* report (its recommendation 15):

- That the Welsh Government, within six months of this report's publication, in relation to crisis and out-of-hours care:
 - work with Welsh police forces to scope an all-Wales triage model which would see mental health practitioners situated in police control rooms to provide advice when children and young people (and other age groups, if appropriate) present in crisis;
 - 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);
 - ensure that follow-up support is being provided by health boards after discharge, provide information on how health boards monitor this provision, and commit to making this information publicly available to ensure transparency and accountability;
 - ensure that all health boards are adhering to the requirement to hold designated beds that could be staffed adequately for unders-18s in crises, indicating how this will be monitored and reported in future, and what steps will be taken if such beds are not available;
 - implement with pace and in a uniform way across health boards the single point of access approach to specialist services, to ensure timely and appropriate access to support, urgent or otherwise; and
 - reflecting on the results of the review of crisis care, outline what more needs to be done to deliver a safe and cost-effective 24/7 crisis care service in all areas of Wales, how that will be done, and by when.

84. We know that there is significant risk of suicide among mental health patients discharged from inpatient care, therefore we are concerned that limitations with current IT systems make it difficult to fully understand whether those patients are receiving a first follow-up within five working days of discharge. We requested this information from health boards, but it was not received. Urgent action is needed to ensure that health boards can identify how soon after discharge patients receive follow-up care. We acknowledge the Cabinet Secretary's comments around moving towards the new Welsh community care information system, however, we are concerned that should it not be in place until 2021, we still a long way from being confident as to whether such a vulnerable group of people receive the timely support and care they need when discharged.

85. We've heard from several expert stakeholders that the peak risk of suicide is on day three following discharge from inpatient care. We are therefore concerned that there is a disparity between this evidence and the Welsh Government's target of receiving follow-up care within the current standard of five working days. It is crucial that patients receive the support they need at the most appropriate time, in the same way as a patient discharged from hospital following treatment for a physical condition would. We believe that the target should be amended so that patients receive a first follow up within three days of discharge, and are pleased that the Cabinet Secretary has alluded to the possibility of revising the target in light of the evidence.

Recommendation 9. We recommend that the Welsh Government takes urgent action to establish to what extent those discharged from inpatient care are currently receiving follow-up care within the targeted timescale and provide an update to the Committee within three months. This should include steps to ensure that IT systems can identify whether this is happening.

Recommendation 10. We recommend that the Welsh Government introduces six monthly monitoring and reporting of the target in the Together for Mental Health Delivery Plan that all patients discharged from inpatient care receive follow up care within the specified timescale.

Recommendation 11. We recommend that, in light of the evidence that suicide risk is greatest on the third day after discharge, the target for patients discharged from inpatient mental health care to receive a first follow-up appointment should be changed to ensure that patients are followed up within 48 hours.

Recommendation 12. We recommend that a target be introduced for waiting times for psychological therapies to ensure that those in need receive this

support within a suitable timescale. Accessing appropriate therapy early can provide the intervention that's needed and prevent someone from requiring crisis care at a later stage.

4. Support for people affected by suicide, capturing lived experience

For each of the deaths by suicide in Wales each year, it has been suggested that an average of 6 people are deeply affected, although this figure is now thought to be far greater. It is known that people who have been bereaved through suicide are at higher risk of suicide themselves.

86. The devastating impact of a suicide on family, friends and the wider community has been highlighted to us, and we heard compelling evidence that access to support services for those affected by a suicide needs to be improved. We know that those bereaved by suicide are at a higher risk of suicide themselves, so support for this vulnerable group must be recognised as a key element of suicide prevention. The Samaritans stated in its written evidence:

“We must provide better information and support to those bereaved or affected by suicide.”⁶⁹

87. We heard that for every death through suicide, many other people would be affected by it. Recent research by Julie Cerel found that each suicide results in 135 people exposed (knew the person), and that each suicide affects a large circle of people, who may be in need of clinical services or support following exposure.

88. We have heard that a more effective, coordinated response following a suicide is needed - the mid-point review of Talk to me 2 calls on the Welsh Government to support the development of a Wales-wide postvention pathway.⁷⁰

89. Avril Bracey supported the call for a national postvention pathway:

“what we would like is to have a national postvention pathway for those affected by suicide. That would be good, but also access and pathways in, and management of people who are surviving. You know, proper pathways from A&E—those kinds of things.”⁷¹

⁶⁹ Written evidence, S 08, Samaritans Cymru

⁷⁰ Postvention is action taken to support people who are bereaved or affected by suicide, such as family, friends, colleagues and peers.

⁷¹ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 249

90. We were grateful to hear from Angela Samata, Ambassador for SOBS about her personal experience of losing her husband to suicide. Ms Samata told us that the way she and her children were treated by agencies such as the police and ambulance service enabled her to be in the position of being able to share her experience with us, she said:

“When I look back on it now, the reason I can sit here in front of you today is because of the way that I was treated, and the way that my family and my children were treated, in those minutes, days, hours and weeks after Mark’s death. I can absolutely pinpoint that it was the way that I was treated by the police, the way that I was treated by the ambulance service and the way that I was treated by the coroner’s office that enables me to sit and give evidence to you today, because I was treated so well and I was so taken care of. The whole situation—you are navigating your way through a land that you never, ever thought that you’d inhabit. Your family is plunged into a process that you never, ever thought in your wildest nightmares that you would be part of. So, the way that we were treated was fundamental to where we all are today, and it has enabled me to go on and do the work that I’ve done and to sit alongside others and to very much stand on the shoulders of giants who have already started this work.”⁷²

91. She went on to describe attending her first SOBS meeting:

“I felt as if a weight had been lifted off my shoulders, and it was just that moment of connecting with a complete stranger, with a group of complete strangers, who had gone through what I was going through and what my children were going through.”⁷³

92. A number of stakeholders highlighted the [Help is at hand Cymru](#) resource developed by the National Advisory Group, however we’ve heard worrying evidence that this has not been made routinely available and that further promotion is required.

93. Professor Ann John said that many people were unaware of “Help is at hand” until several months after experiencing a death by suicide, and as people who lose someone through suicide are at risk themselves, she concluded that “postvention is prevention really”. Professor John went on to say she believed resources would be needed should a pathway be put in place for the

⁷² Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 260

⁷³ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 264

“dissemination of “Help is at hand” to ensure that there are people who, as part of their job descriptions, need to be taking these things forward”.⁷⁴

94. Emma Harris told us that there wasn't a consistent approach to bereavement support in Wales. She also stressed the importance of training front-line staff who come into contact with those bereaved by suicide in order to reduce the stigma of talking about it.⁷⁵

95. Susan Francis echoed the importance of training front-line staff to support those bereaved by suicide, and ensuring that the “Help is at Hand” resource is available in multiple formats:

“Again, in my experience of going around, I've spent a lot of time talking to front-line staff and hearing from them the struggles that they're having of not knowing where to signpost people and what to do and how to handle the situation when somebody approaches them. And there's the anxiety that that causes them as well. I think there's a massive impact on our front-line staff and their well-being, and I think there needs to be something put in place. We need to be encouraging more employers to put support in place. So, I think the two things need to be linked. The resource is good, but maybe we need it in different formats, and we certainly need front-line staff to understand it and know how to apply it.”⁷⁶

96. During our meeting with members of the Jacob Abraham Foundation, all participants emphasised the lack of support received following the death by suicide of their family member. Many described how, after the initial visit from the police, they were left alone to deal with the aftermath and pick up the pieces. Participants felt let down; it was highlighted that people receive more support (including from police family liaison officers) when bereaved in other ways, for example as the result of a road traffic accident.

97. None of the participants had received a copy of Help is at Hand Cymru, all said they would have found this a very helpful resource. Nicola Abraham told us that despite attempts, the Foundation was unable to obtain copies from Public Health Wales to give to service users, and has had to rely on the England version which is of more limited benefit to Welsh residents.

⁷⁴ Health, Social Care and Sport Committee, Record of Proceedings, 21 March 2018, paragraph 26

⁷⁵ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 44

⁷⁶ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 51

98. Some participants who had sought help from their GP mentioned being referred for counselling and to Cruse Bereavement Care. The long waiting lists for these services were emphasised, with some individuals still waiting to be seen many months later.

99. The lack of support for those bereaved was echoed by Ged Flynn from Papyrus, as illustrated by an example he cited to us:

“A woman told me that she mislaid her laptop and it became clear that it had been stolen on the tube, and after that event, within three days, she’d received two 90-minute phone calls from victim support. Seven months later, her daughter died by suicide, and she’s still waiting for a phone call from anyone. She had to reach out. I think it’s a powerful story. The Support After Suicide Partnership was set up three or four years ago, across the UK, for individuals and organisations who wanted to coalesce around the belief that it should be a right that you get access to a service having lost someone to suicide. At best, it’s a postcode lottery just now, right across these islands.”⁷⁷

100. Angela Samata also described the importance of **face to face support** for those bereaved through suicide, highlighting that there is only one SoBS support group operating in Wales. She illustrated how, for a relatively small amount of funding, a support group can help a vast range of people who would be at high risk of suicide themselves:

“it costs around £1,000 a year to run a SoBS group. You can be helping up to 30 people every time you meet, and you have 12 meetings a year. That’s an enormous number of people. If you’re looking at around 350 people taking their lives in Wales every year, then, actually, a really, really quick win for those people would be to set up some additional SoBS groups in the areas that you know that we need those groups set up.”⁷⁸

101. Nicola Abraham highlighted the importance of the right kind of support – support groups should be properly facilitated, and should not require people to share more of their experience than they are comfortable doing at any given time.

102. The Cabinet Secretary acknowledged that improvements to bereavement services are needed. On the concerns raised by the Jacob Abraham Foundation regarding the availability of Help is at Hand Cymru, the Cabinet Secretary told us:

⁷⁷ Health, Social Care and Sport Committee, Record of Proceedings, 21 March 2018, paragraph 191

⁷⁸ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 297

“I met both the mothers a couple of years ago and we did talk about ‘Help is at Hand’, and at that point, they described some difficulties and they said that they would’ve found it useful, because they didn’t have access to it at the time. So, I’m really disappointed to hear that there are still families out there that are describing that they don’t have access to it... I think we need to understand from those people who’ve not had the support that is available how we do that and what would’ve mattered to them, because it’s different for different people—but to understand, if you’re looking for support, how do you look for it and then to make sure that people like the Jacob Abraham Foundation have got ready access to hard copies as well as online versions.”⁷⁹

103. The Cabinet Secretary told us that he would be listening to the advice of the National Advisory Group in terms of a postvention pathway for Wales:

“Again, we’re getting advice from the advisory group, but I would be very surprised if the national advisory group did not recommend taking on the learning from England in understanding what we want to do here in Wales. It would be kind of odd if I said, ‘I think we’ve got more to do on bereavement support’ and to then say, ‘but I’m not interested in what’s taking place across our border’. So, yes, I’m interested. I know it’s one of the recommendations and I expect that to come forward from the recommendations not just from this committee but also from the national advisory group as well.”⁸⁰

Our view

104. We were staggered to hear of the lack of support available to those bereaved by the suicide of their loved one. We strongly support calls for a Wales-wide postvention pathway for suicide in order to ensure there is a consistent and structured approach to supporting those bereaved. This should be put in place as a matter of urgency.

105. We know that a person bereaved by suicide is far more likely to attempt or complete suicide themselves. Given the evidence that for every suicide at least six people are significantly affected, although this figure is thought to be much higher, there is a vast proportion of people at risk. It is therefore crucial that

⁷⁹ Health, Social Care and Sport Committee, Record of Proceedings, 27 June 2018, paragraphs 33-35

⁸⁰ Health, Social Care and Sport Committee, Record of Proceedings, 27 June 2018, paragraph 34

appropriate support is available, both in the immediate aftermath of learning of the death of a loved one by suicide and in the proceeding months and years.

106. Frontline staff, particularly the emergency services and medical staff, should be equipped to direct people to appropriate support services as part of their contact with those affected. We know that resources such as Help is at Hand Cymru are available and can offer effective support, but we were appalled to hear of the difficulties experienced by some in accessing this information. Help is at Hand Cymru is a valuable resource, and it should be available to everyone who needs it so that they can access appropriate support when it's needed. We acknowledge that the Cabinet Secretary has committed to taking action to ensure that information on Help is at Hand Cymru is available online, but we believe more should be done to promote the resource so that those bereaved are provided with the information as a matter of course and in the most appropriate format for their needs.

107. Support groups for people bereaved by suicide are inexpensive to run, but can be very effective and can reach a wide range of people. We heard first hand how support groups can help by providing an opportunity for those bereaved by suicide to share their experiences and realise that there are other people in similar situations. Investing a small amount of money in running a support group would be an effective way of ensuring that help is available for those dealing with the complex grief that follows a death by suicide. The support that families / friends receive could go a long way towards maintaining their own mental health and wellbeing, and help prevent suicidal behaviour in this high-risk, vulnerable group.

Recommendation 13. We recommend that the Welsh Government accepts the call made in the mid point review of Talk to me 2 to develop and implement a Wales-wide postvention strategy for suicide, and that this work should be taken forward as an immediate priority. This should include details of follow up support for individuals bereaved by suicide, and in organisational settings. It should incorporate the recommendation in Mind over matter that guidance should be issued to all schools on talking about suicide (and as a priority, to schools where there has been a suicide or suspected suicide). The Welsh Government should ensure that sufficient ring-fenced resource is available to implement this postvention strategy.

Recommendation 14. We recommend that the Welsh Government and Public Health Wales actively promote the availability of the Help is at Hand Cymru resource. This should include proactively engaging with third sector support groups and ensuring that frontline staff, particularly emergency services, who have contact with those bereaved by suicide are not only fully aware of Help is at

Hand Cymru but, crucially, have access to copies of the resource so that this can be distributed to those bereaved at the point of need. As this resource is already available, this should be implemented within 3 months.

Recommendation 15. We recommend that the Welsh Government should, as part of an all-Wales postvention pathway, give active consideration to providing funding for support groups for those bereaved by suicide, so that people across Wales are able to access much-needed support. We believe such groups can play a key role in supporting the mental health and wellbeing of those bereaved through suicide. This could in turn lead to reduced demand for NHS services.

4. 1. Co-production

108. We've heard that harnessing the "lived experience" of those who have been affected by suicide should be a key part of suicide prevention. This includes clinicians for example with relevant professional experience as well as people who are personally bereaved. Angela Samata emphasised the need for a "co-produced" approach:

"I truly believe that everything that we produce now that is to do with suicide prevention, suicide bereavement and suicide awareness should be co-produced. And I really mean that. Co-production with people with lived experience is not always easy. We face our own challenges. However, there is lived experience within the clinical community, there is lived experience within the lay community, and bringing that together is such a powerful thing to do."⁸¹

109. Ged Flynn of Papyrus also emphasised that "lived experience needs to be at the forefront of our strategic thinking and our planning". He told us that progress had been made in Westminster in terms of reaching out to those who have had suicidal thoughts themselves and those bereaved by suicide and involving them in "organising, planning and helping to implement suicide prevention",⁸² but that more could be done in Wales and by the National Advisory Group on suicide prevention:

"the advisory group does some exemplary stuff and challenges you as an Assembly and Government. But one thing we could do better, perhaps, is to reach out further at that table, to include in our leadership team those who have been touched personally by suicide. I

⁸¹ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 281

⁸² Health, Social Care and Sport Committee, Record of Proceedings, 21 March 2018, paragraph 176

represent, at one lens into that, those who have been bereaved, but there are others who have had suicide behaviours and have survived and would have a lot to offer to that.”⁸³

110. We heard that the regional forums were conscious of the importance of people with lived experience being represented. Avril Bracey told us that the Mid and South West Wales group did have people with lived experience on its membership,⁸⁴ Gwenllian Parry said North Wales did not have formal representation by someone bereaved by suicide:

“We’re very, very pleased that we have Caniad, who attend regularly and give a voice for those with lived experience. I am aware that we don’t actually formally have somebody representing those who have been bereaved by suicide, although I’m sure that there are members of the group who actually have been bereaved through suicide.”⁸⁵

111. The Cabinet Secretary acknowledged the benefits of co-production in listening to those effected and harnessing their experiences, and told us how the Welsh Government was adopting this approach:

“Well, that’s one of the things we’ve tried to do more broadly in health and healthcare services: actually listening to the voice of people with direct experience, whether they’re staff, carers or individual people and families affected. So, in terms of taking forward not just the recommendations of the advisory board, we want to think about how we actually make sure that we are listening to people and they’ve got a voice in what we’re saying. Because it isn’t just a one-off, I accept; you can’t just say, ‘I talked to families and I listened to families three years ago, therefore, everything’s okay’. So, it has to be a regular part of what we’re doing. When we talk about continuous engagement, this is one of the things we’re talking about. So, when we review other frameworks as well on mental health generally, on substance misuse, on a range of areas, we want to listen to the voice of carers and users. It will be the same in this area as well.”⁸⁶

⁸³ Health, Social Care and Sport Committee, Record of Proceedings, 21 March 2018, paragraph 182

⁸⁴ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 233

⁸⁵ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 231

⁸⁶ Health, Social Care and Sport Committee, Record of Proceedings, 27 June 2018, paragraph 48

Our view

112. Harnessing the “lived experience” of those bereaved by suicide should be pivotal in developing approaches to suicide prevention, their direct experience should be learnt from to ensure that strategies are as effective as can be. All suicide prevention activity should be “co-produced” with those with lived experience of suicide. This includes clinicians for example with relevant professional experience as well as people who have been personally bereaved through suicide. Importantly, this should also involve those who have themselves experienced suicidal ideation, including survivors of suicide attempts.

113. We believe that involving those with direct experience of suicidal ideation is key to suicide prevention, their perspective will be different to that of professionals, so it is crucial that their voices are heard at the highest level. The National Advisory Group and regional forums should engage with these groups to ensure that all suicide prevention activity is informed by lived experience.

Recommendation 16. We recommend that the National Advisory Group and regional suicide forums should engage with people who have personal experience of suicide ideation, including survivors of suicide attempts and people bereaved by suicide to ensure that all suicide prevention activity is informed by lived experience.

4. 2. Support for emergency staff etc

114. Responding to instances of suicide or attempted suicide is a reality for many front-line staff from a range of professions, particularly the emergency services and those working in the rail industry. We've heard that working with such difficult situations can affect the mental health of those professionals, so it's crucial that they receive the support they need to carry out their work and deal with any impact on their own wellbeing. As Stephen Clarke from the Welsh Ambulance NHS Trust told us:

“there is something about these roles in blue light services that are uniquely stressful and challenging... these are tough jobs and you're seeing some quite extraordinary, some quite out of the ordinary things in your day-to-day work.”⁸⁷

115. Those we heard evidence from told us about the arrangements they have in place to support their staff, including initiatives aimed at supporting the mental

⁸⁷ Health, Social Care and Sport Committee, Record of Proceedings, 7 June 2018, paragraph 318

health and wellbeing of staff through occupational health services, mental health support networks, and MIND's [Blue Light programme](#) for emergency services staff.

116. ACC Jonathan Drake told us that across Wales significant investment had been put into counselling services, and highlighted the Blue Light champions who can offer help and support to staff and peers as good practice.⁸⁸

117. Bleddyn Jones explained that fire and rescue staff receive follow-up from occupational health colleagues following traumatic incidents whereby:

“a trained counsellor will contact all individuals involved to offer them assistance immediately and invite them to seek further support if needed.”⁸⁹

118. Alison Kibblewhite added that across the fire and rescue services, staff are able to access an employee assistance scheme, where they can access confidential support and can be signposted for further counselling if required.⁹⁰

119. We heard that WAST have a TRiM (trauma risk assessment and management) system, which involves TRiM practitioner contacting staff who've experienced a traumatic incident within 72 hours of that taking place, which is then followed-up around four weeks later. Stephen Clarke also referred to other resources available to WAST staff such as online cognitive behavioural therapy, occupational health service and well-being support service.⁹¹

120. We heard from Ian Stevens of Network Rail that around 10 people will be called out to an incident of suicide on the rail network – these include a replacement driver, maintenance engineer, the police and operational staff. He said there would be additional staff, such as depot staff and cleaners who may be affected by the sight of “detritus” on a train. Mr Stevens emphasised the importance placed by the rail industry on managing the impact on staff, he told us:

“each train operator will have some form of counselling service in place and a very robust means by which the individual that's been involved in the event can be debriefed and can be managed through time. Because with trauma and post-traumatic stress disorder, one may lead into other, but it's about the management of that and, hopefully,

⁸⁸ Health, Social Care and Sport Committee, Record of Proceedings, 7 June 2018, paragraph 170

⁸⁹ Health, Social Care and Sport Committee, Record of Proceedings, 7 June 2018, paragraph 172

⁹⁰ Health, Social Care and Sport Committee, Record of Proceedings, 7 June 2018, paragraph 173

⁹¹ Health, Social Care and Sport Committee, Record of Proceedings, 7 June 2018, paragraph 319

bringing that individual back into the workplace where they can best be managed and helped through a potential issue.”⁹²

121. Mr Stevens provided details of “trauma support” training which is provided to rail staff in conjunction with the Samaritans:

“trauma support training, which is for the likes of drivers who may become involved in suicidal events. To a degree, that provides a certain amount of resilience for drivers and other individuals who may be front-line staff who think, ‘I may get involved in these events, and therefore I would just like to know how that might impact upon me’.”⁹³

122. Chief Inspector Mark Cleland from British Transport Police spoke of the training and support available to officers and other BTP staff:

“They get College of Policing training, and we get Samaritans training given to all our officers as well. And then, post incident, we have hot debriefs where we review how our officers and everyone associated—even our partner agencies—have managed that incident and what support they need in the following days after that. We have a thing called TRiM, which is post-incident trauma counselling, which we review 72 hours after the incident, because that’s when we start to find that the issues start, and that ongoing support continues right throughout the organisation—so, not just the officers who attend, but we even consider that, when the form filling continues after that, there’s going to be other impacts. So, admin staff may be privy to seeing some quite detailed reports. There’s an element of support that goes in for those staff as well.”⁹⁴

Our view

123. We recognise that responding to traumatic situations is a routine occurrence for staff working in the emergency services, it is therefore crucial that they receive appropriate and effective support from their employers to deal with such circumstances. We know that dealing with a traumatic incident could have a profound impact on the wellbeing of those staff and could affect their personal lives as well as their ability to undertake such high pressured roles. We acknowledge and welcome the actions taken by all three services, such as the

⁹² Health, Social Care and Sport Committee, Record of Proceedings, 7 June 2018, paragraph 465

⁹³ Health, Social Care and Sport Committee, Record of Proceedings, 7 June 2018, paragraph 501

⁹⁴ Health, Social Care and Sport Committee, Record of Proceedings, 7 June 2018, paragraph 463

Blue Light Programme and TRiM assessments, it is vital that staff are provided with such support so that they are able to cope with difficult situations. Employers should continue to prioritise the availability of support services and ensure appropriate funding is in place to ensure that all staff in need of support can benefit from this.

124. We realise that emergency services staff are not the only people to encounter traumatic situations such as suicide, and we are very grateful to Network Rail for its evidence on the initiatives the rail industry has put in place to support workers affected by incidents of suicide on the rail network. The importance of such initiatives cannot be over emphasised, employers should ensure that support arrangements are in place for staff should they encounter a traumatic incident such as suicide as part of their routine of going to work.

Recommendation 17. We recommend that the Welsh Government works with NHS employers in Wales to ensure that all employees who have dealt with cases of suicide/attempted suicide are able to access appropriate support.

5. Priority people, priority care providers and priority places

125. Talk to me 2 highlights that some people may be at greater risk of suicide, and particular focus is given to the following groups who have been identified as priority people (based on the epidemiology of Wales):

- middle-aged men;
- people over-65 with poor physical and mental health;
- people in prison;
- vulnerable children and young people, especially those who are not in education, employment or training;
- people in the care of mental health services;
- people with a history of self-harm;
- people who are socio-economically deprived;
- people who misuse drugs or alcohol;
- people bereaved or affected by suicide.

126. Sara Mosely of Mind Cymru believed the approach taken in Talk to me 2 of focusing around groups who are most at risk and more likely to take their own lives was the correct approach, saying:

“the general programmes are clearly not reaching those groups—they're not reaching middle-aged men, they're not reaching older people with long-term conditions, and we need to make a very specific and determined effort to be sure that they are not left out by whole-population programmes in order to be effective.”⁹⁵

⁹⁵ Health, Social Care and Sport Committee, Record of Proceedings, 21 March 2018, paragraph 143

5. 1. Priority people

127. We are aware that there are other groups at higher risk of suicide, e.g those with easy access to means, however our evidence has focused on specific groups within those classed as a priority.

Middle-aged men

128. Throughout our evidence gathering we've heard that men, particularly middle-aged men, are at higher risk of suicide. It is a staggering statistic that suicide is the single biggest cause of death among men aged 20–49 years.⁹⁶ It was suggested to us that men are less likely to seek help in traditional ways, Sara Mosely from Mind Cymru told us that it had been “more difficult to engage men in talking about mental health”. She went on to say that having listened to a group of men discussing mental health, the issues preventing them from talking were “linked into insecurity around work, conditions of employment and so on”. She said that their considerations were:

“If I talk about my mental health problem, my work will find out, I'll lose my job, I won't be able to look after my family, and then I'll completely lose my identity’.”⁹⁷

129. The mid-point review of Talk to me 2 recommended that new ways of encouraging men to seek help should be developed. Professor Ann John suggested:

“it might not necessarily be advantageous to brand these things as being about mental health, and maybe we need to go to the places where we know that men are going to be particularly vulnerable, like job centres or citizens advice bureaux, and have things available there.”⁹⁸

130. Professor John went on to say that in the long term, it may be beneficial to review “the evidence base about how best to get men into accessing services”.⁹⁹

⁹⁶ Based on official data (Office for National Statistics, [Deaths registered in England and Wales](#)). The leading underlying causes of death are based on a list developed by the World Health Organization (WHO). This categorises causes using the International Classification of Diseases (ICD).

⁹⁷ Health, Social Care and Sport Committee, Record of Proceedings, 21 March 2018, paragraph 125

⁹⁸ Health, Social Care and Sport Committee, Record of Proceedings, 21 March 2018, paragraph 45

⁹⁹ Health, Social Care and Sport Committee, Record of Proceedings, 21 March 2018, paragraph 46

131. When we met with the founder and service users at the Jacob Abraham Foundation, it was again highlighted that men are at much greater risk of suicide than women, yet are less likely to seek help. It was notable that all participants in the group discussion were women, and all had lost male relatives. A strong message from our discussions was that new approaches are needed to encourage help-seeking behaviour among men, as well as to support those bereaved through suicide.

132. Nicola Abraham described the Foundation's involvement in a Comic Relief-funded project to provide suicide prevention training to tattooists. Tattooists may spend hours with one client and have a relationship of trust, and the project seeks to make the most of that opportunity (in a similar way to the "Trust me I'm your barber" initiative).

133. Alex Cotton from Connecting with People told us about the "It Takes Balls to Talk" initiative which uses sporting themes to encourage people, particularly men, to talk about how they feel. She explained that through the initiative, trained volunteers attended sporting events in the Warwickshire area to offer support and distribute cards with advice on how to seek help.

134. Dr Kathryn Walters from the British Psychological Society also believed that it would be worth "thinking creatively" about how to target communities or groups of people who may not access mental health services, and referred to a previous campaign in Scotland aimed at men by putting information in pubs – on beer mats and posters at the height of urinals.¹⁰⁰

135. The Cabinet Secretary told us that the Welsh Government, along with the third sector had invested money in areas including men's access to mental health, for example a grant for Men's Sheds.¹⁰¹

People with a history of self-harm

136. As identified in the Talk to me 2 strategy and by many of those who gave evidence to this inquiry, people with a history of self-harm have an increased risk of suicide. The written evidence from the National Advisory Group states that:

"over half of those who take their own lives have a history of self-harm."¹⁰²

¹⁰⁰ Health, Social Care and Sport Committee, Record of Proceedings, 17 May 2018, paragraph 41

¹⁰¹ Health, Social Care and Sport Committee, Record of Proceedings, 27 June 2018, paragraph 98

¹⁰² Written evidence, S27, National Advisory Group

137. This is echoed in the written evidence from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH), which highlights that 70% of mental health patients have a history of previous self-harm. It explains that studies have shown that the risk of suicide following self-harm is high, and that specialised psychosocial assessment is key in determining future risk:

“Self-harm is a crucial indicator of risk and should always be taken seriously, even when the physical harm is minor. Services which respond to self-harm are key to suicide prevention.”¹⁰³

138. The written evidence from the NAG also states that:

“many of those who self-harm and present to emergency services have difficult experiences...negative experiences when seeking help impacts on future help-seeking behaviour.”¹⁰⁴

139. Professor Ann John explained to us the importance of tracking people who self-harm when they present at emergency departments in order to improve data collection and better understand the support they receive:

“we know that sometimes people turn up at emergency departments with self-harm, they register, some of them then leave before they're ever seen, and from the research evidence we know that's predominantly young men. It would be useful, I think, to be able to track much more clearly who's coming, who's seen, what happens when they're seen, who gets admitted, who gets offered to return to a crisis service, who does and who doesn't, and then what happens to them.”¹⁰⁵

140. The Talk to me 2 action plan includes a priority action to improve the health care response to self-harm. This is to be achieved by:

- ensuring that NICE guidance on the management of self-harm is implemented in Wales;
- improving the management and recording of self-harm in emergency departments and in primary care;

¹⁰³ Written evidence, S 53, National Confidential Inquiry into Suicide and Safety in Mental Health

¹⁰⁴ Written evidence, S27, National Advisory Group

¹⁰⁵ Health, Social Care and Sport Committee, Record of Proceedings, 21 March 2018, paragraph 9

- ensuring that people who have self-harmed are cared for with compassion and the same respect and dignity as any service user.

141. Dr Alys Cole-King also stressed that people who self-harm are at a much greater risk of suicide, and warned:

“We need to take self-harm more seriously.”¹⁰⁶

142. Emma Harris from the Samaritans told us that better data should be gathered on self-harm attempts and admissions to emergency departments because of it being such a high risk factor for suicide. She said that anyone discharged following a suicide attempt or self-harm should be followed-up within seven days, but often people don't receive that follow-up and a lack of data makes it difficult to understand the extent to which this happens.¹⁰⁷

143. We heard from Dr Gwenllian Parry that an action for the North Wales regional forum is to monitor the number of cases of self-harm presenting at emergency departments and the number of incidents of self-harm on the NHS estate.¹⁰⁸

144. NICE guidance on the short-term management and prevention of self-harm state that everyone who has self-harmed should have a comprehensive assessment of needs and risk (psychosocial assessment). The mid-point review of Talk to me 2 identified the implementation of NICE guidance on self-harm as an immediate priority, and recommended this to the Welsh Government. In the written evidence from Dr Rhiannon Evans of Cardiff University, she said:

“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.”¹⁰⁹

145. In oral evidence, Dr Rhiannon Evans told us:

¹⁰⁶ Health, Social Care and Sport Committee, Record of Proceedings, 21 March 2018, paragraph 147

¹⁰⁷ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 13

¹⁰⁸ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 215

¹⁰⁹ Written evidence, S 44, Dr Rhiannon Evans

“So, obviously there’s NICE guidance about what should happen when an individual presents at hospital with self-harm, and that’s for over-eights, so there should be treatment for medical injuries, a psychosocial assessment. So, there’s a set of pathways, and that is recommended, but studies show that that’s not happening. So, psychosocial assessments are probably only delivered in about 60 per cent of cases.”¹¹⁰

146. Dr Evans went on to tell us about research currently being undertaken with CAMHS crisis liaison teams on “improving the conduct of assessments with children and young people”, she explained:

“I think that was an issue—that they weren’t being necessarily delivered with that population. So, that’s intended to mitigate that risk of them not happening. It should be on-site that they should be delivering those assessments with children and young people when they present to the hospital. We’re trying to explore within that what’s the experience of that: are young people more inclined to take up those assessments? Because there’s a risk that an individual can just leave the hospital of their own volition before these assessments are conducted. So, we’re trying to explore how we increase the uptake of those assessments.”¹¹¹

147. The Cabinet Secretary told us that he did not recognise that situation and queried the robustness of the 60 per cent figure.¹¹²

People who misuse drugs or alcohol

148. Alcohol and substance misuse is another significant risk factor for suicide, as identified in Talk to me 2. Stakeholders described difficulty in referring people appropriately who co-present with mental health and substance misuse issues. The Royal College of GPs for example, described how patients with drug or alcohol problems are often bounced out of mental health services into substance misuse services, and then don’t get the specialised support needed for suicide prevention.¹¹³(315) In written evidence, the National Advisory Group described “a

¹¹⁰ Health, Social Care and Sport Committee, Record of Proceedings, 17 May 2018, paragraph 264

¹¹¹ Health, Social Care and Sport Committee, Record of Proceedings, 17 May 2018, paragraph 267

¹¹² Health, Social Care and Sport Committee, Record of Proceedings, 27 June 2018, paragraph 102

¹¹³ Health, Social Care and Sport Committee, Record of Proceedings, 17 May 2018, paragraph 315

known gap in both provision for, and expertise in, working with individuals presenting with both mental health and substance use".¹¹⁴

149. During our meeting with the Jacob Abraham Foundation, we discussed whether drug use is a contributing factor to suicide. Some participants were aware that their relative had taken drugs in the period leading up to their death by suicide. Cocaine was involved in a number of cases – there was concern that this drug is very easy to obtain, its use is becoming normalised, and that the sleep deprivation associated with taking cocaine may increase the risk of suicide.

150. Nadine Morgan representing Hywel Dda Health Board highlighted to us steps taken by the health board to improve joint working, including the co-location of substance misuse and mental health teams:

“So, in particular areas we have substance misuse teams and mental health teams in the same building, so at least then they can put a face to a name, they can start those conversations, and that leads them to better joint working—joint assessments happening, consultation advice happening formally, but I think it’s about that relationship building as well.”¹¹⁵

151. The Cabinet Secretary told us that a service framework had been developed for people with a co-occurring mental health and substance misuse, and went on to say:

“We need to understand how that’s being implemented as well, because, again, we know that substance misuse is one of the risk factors in this area as well.”¹¹⁶

People who are socio-economically deprived

152. The Samaritans highlighted the link between suicide and poverty and emphasised the importance of building resilience to ensure that communities have infrastructure in place allow people to build support networks:

“you can do things like support work to increase community infrastructure—community centres, groups, things the third sector does that bring people together, things that mitigate the impact of unemployment on individuals. That’s why we’ve called for a poverty

¹¹⁴ Written evidence, S27, National Advisory Group

¹¹⁵ Health, Social Care and Sport Committee, Record of Proceedings, 7 June 2018, paragraph 139

¹¹⁶ Health, Social Care and Sport Committee, Record of Proceedings, 27 June 2018, paragraph 104

strategy, because that's about a coherent approach to reducing the emotional distress and the isolation that economic disadvantage can bring to individuals.”¹¹⁷

153. This was also raised during our recent inquiry into loneliness and isolation, where we noted evidence from the Samaritans that “the increase in library and community centre closures and the ending of Communities First could result in the most vulnerable communities experiencing an increase in loneliness and isolation due to the “subsequent lack of social connection which these centres and schemes provide”.

Our view

154. We know that there some groups of people who are at a higher risk of suicide than others, we believe that it is right for these to have been identified as a priority in Talk to me 2, but alongside that, innovative approaches are needed to focus suicide prevention attempts towards these groups. Nevertheless, targeting high risk groups should not be to the detriment of a whole-population approach.

155. The evidence we heard around suicide being the single biggest cause of death in men was staggering, this should be considered a national emergency. It is evident that men may be reluctant to seek help for mental health issues and that traditional approaches are not working. New approaches are now needed to encourage help-seeking behaviour and improve mental health, wellbeing and resilience among men. We heard of various approaches being used to encourage men to seek help such as the “It takes balls to talk” campaign targeting those attending sporting events in the Coventry area and the project run by Comic Relief to train tattoo artists to discuss mental health issues with clients. Non-clinical approaches such as these can be very effective and should be extended.

156. We wholeheartedly support these innovative approaches, but more still needs to be done to reduce the stigma associated with mental health which prevents people from talking about it. This echoes a conclusion we drew in the report of our inquiry into loneliness and isolation inquiry, that people are too ashamed to admit they are lonely, particularly men who we know present a much higher risk of suicide. The approaches we heard about can make a huge difference but often rely on the commitment of individuals or are unsustainable due to short term funding. Reducing and, ultimately, preventing male suicide needs to be recognised as a national priority for the Welsh Government and

¹¹⁷ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 35

specific resources should be made available to implement sustainable, innovative approaches to reach this group and encourage them to seek help.

157. We heard clear evidence that self-harm is a significant risk factor for suicide, and are concerned by the evidence presented to us that psychological assessments were only carried out in around 60 per cent of the cases of child self-harm presenting at hospitals. Whilst we realise that the Cabinet Secretary said that he did not recognise that figure, we are not convinced that the NICE guidance on self-harm are being fully adhered to, indeed the mid-point review of Talk to me 2 identified the implementation of NICE guidance on self-harm as an immediate priority.

158. We endorse the recommendation of the mid-point view that the implementation of the NICE guidance on self-harm be an immediate priority for the Welsh Government.

159. We acknowledge that the Welsh Government recognises the increased risk of suicide among people with substance misuse issues, and emphasises the importance of strong partnership between substance misuse and mental health services. We are aware that work has begun, but further progress needs to be made in developing integrated care pathways for individuals co-presenting with substance misuse and mental health issues, in order to reduce suicide risk in this group.

160. Evidence presented to this inquiry echoes messages we heard during our inquiry into loneliness and isolation, particularly how cuts to non-statutory services such as libraries, leisure facilities and adult learning and to third sector groups previously funded through Communities First, play an important role in keeping people connected and preventing loneliness. Loneliness and isolation can lead to suicide, and such messages need to be taken seriously when funding decisions are being made and an acknowledgement given of the longer term negative impact of cuts to funding.

Recommendation 18. We recommend that the Welsh Government recognise male suicide as a national priority and allocate appropriate funding to identify and implement new approaches to reducing the stigma associated with mental health to encourage men to talk about and seek help. This should include scope to roll out existing projects more widely.

Recommendation 19. We endorse the recommendation of the mid-point review of Talk to me 2 that the implementation of NICE guidance on self-harm

be a priority for the Welsh Government. This should be implemented within 6 months of the publication of this report.

Recommendation 20. We recommend that the Welsh Government ensures that its forthcoming loneliness strategy reinforces the message that loneliness and isolation should be central considerations when budget and policy decisions are made.

5. 2. Priority Places

161. Priority places, identified in Talk to me 2 as being settings where suicide prevention efforts should be particularly focused, include rural areas, workplaces, schools, further and higher education establishments, and prisons and police custody suites.

Schools, Further and Higher Education establishments

162. In recent years, there has been a steady increase in the number of suicides among the student population. Several universities in the UK have experienced a number of student suicides within a short period of time.

163. In May 2018, Universities UK published new guidance aimed at improving the coordination of care between the NHS and universities in England, to enable all students to access the support needed.¹¹⁸ Written evidence we received from Universities Wales states that work is underway to explore whether this could be replicated in Wales.

164. Samaritans Cymru highlighted that many students who are struggling won't necessarily be in contact with mental health services, and a "whole student population" approach to raising awareness and more effective signposting is needed, Emma Harris told us:

"So, whilst it's vital that there's adequate mental health provision on campus or within the university, we need to assume that a lot of those students are not going to be going for formal support; they're going to be struggling in silence. And that, we think, is closely linked with loneliness and isolation, the stigma around thinking you're the only one having a bad time at university. So, a lot of it is increasing awareness about help seeking and just saying, 'It's okay to feel lonely and it's okay to feel isolated.' So, I think it's working with—. Each university needs clear guidance on how they can help the whole student population,

¹¹⁸ [Minding our future: starting a conversation about the support of student mental health](#)

through awareness campaigns and just better signposting and help seeking from the minute they get there.”¹¹⁹

165. Universities Wales provided details of policies and practices put in place by higher education institutions in Wales to support students.¹²⁰

166. On 23 May, witnesses discussed the need for more portable health records, and suggested this would remove some of the barriers to providing effective care. This issue came up particularly in relation to university students who may need to access health services both at home and while away from home. The Royal College of General Practitioners told us:

“What we really need to get to is a situation where the notes move with the patient because we have so many challenges at the interfaces where the hospitals don't know what's happening in general practice; we don't know what's happening at the hospitals; we don't know what's happening one practice to another. (...) I think we need to have more ambition for our view of medical records. So, we already see maternity patients successfully carrying their notes around with them so that their information is always there. In this day of apps and smart phones, I think we have got a need to give people more ownership of their health data.”¹²¹

167. Health board representatives described this as “the right way to go” but “a huge logistical challenge”.

168. The Cabinet Secretary told us that the Welsh Government was interested in working with the university sector to understand the best way of supporting young people in university. He went on to say that university students are at less risk than the rest of the population of a similar age, and that there was a greater incidence of suicide among those who do not go to university than those who do.

Rural communities

169. Talk to me 2 outlines certain factors which create “risk and stress to people living in rural areas over and above the suicide risk factors affecting general populations”. It states that:

¹¹⁹ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 56

¹²⁰ Health, Social Care and Sport Committee, 27 June 2018, paper 3, Universities Wales

¹²¹ Health, Social Care and Sport Committee, Record of Proceedings, 17 May 2018, paragraph 326

“Local suicide prevention plans should take into account the particular issues for remote and rural areas when selecting types of suicide prevention interventions.”

170. We met with representatives from Tir Dewi, an organisation that provides listening services for farmers to work through their problems and improve their welfare, it told us that many of the over 100 cases it had been involved in since its formation in 2015 were desperate enough to lead to discussions on suicide. We heard that whilst there are no specific statistics available on the number of farmers who had completed suicide, all farmers knew a farmer who had taken their own life. Representatives were unaware of the Talk to me 2 strategy and believe a specific mental health strategy for farmers is needed, produced with input by those who understand the pressures faced by farmers.

171. Representatives were aware that farm inspection teams from the local authority areas covered by Tir Dewi would be receiving mental health training organised by the DPJ Foundation, however they called for mental health training to be undertaken by staff of all those organisations who interact with farmers. We were told that the work of the Welsh Government's farm liaison service was valued, but representatives felt that communication with and across other departments could be improved in order to ease the pressure on farmers.

172. Using a family bereavement as an example, written information provided by Tir Dewi demonstrated how issues such as suicide, bereavement and illness can impact farmers differently to others in society:

“It is not an exaggeration to say that farmers might be working 16 hours a day, 7 days a week already so how can they cope with this loss? The answer is too often that they can't... jobs get missed, the welfare on the farm drops, income reduces and the farmer becomes stressed; all of this on top of the fact that a family member just died.

When a death occurs on a farm, the cows still need to be milked this morning, and this evening and tomorrow.... There is no compassionate leave.”¹²²

Prisons

173. Talk to me 2 identifies prisons and police custody suites as priority places for focussing suicide prevention efforts:

¹²² [Health, Social Care and Sport Committee, 19 July 2018, Paper 12](#)

“People at all stages within the criminal justice system, including people on remand and those recently discharged from custody are at increased risk of suicide (although the greatest risk is during the first week of imprisonment). A high proportion of offenders are young men, already at increased risk for suicide. The vast majority (up to 90%) of all prisoners have a mental health issue and/or substance misuse issues. Prisoners are separated from their family and friends and thus isolated.”

174. According to the most recent Ministry of Justice [Safety in custody statistics](#) for England and Wales (published April 2018):

- In the 12 months to March 2018, there were 69 apparent self-inflicted deaths in prison custody, down 40% from 115 in the previous year (on a rate basis this is 0.8 instances per 1,000 prisoners). Within the female estate, there was 1 self-inflicted death, down from 10 incidents in the previous 12 months. ('Self-inflicted death' means any death of a person who has apparently taken his or her own life irrespective of intent).
- In the 12 months to December 2017, self-harm reached a record high of 44,651 reported incidents (a rate of 521 per 1,000 prisoners), up 11% from the previous year. The number of self-harm incidents requiring hospital attendance increased by 12% to 3,067. (The proportion of incidents that required hospital attendance remained largely unchanged at 6.9%).

175. [2016/17 statistics](#) for England and Wales show that there were 233 self-inflicted deaths of offenders in the community, down 9% from the previous year.

176. Prior to the drop in self-inflicted deaths in custody between 2017-18, there had been a general increasing trend. According to the Howard League for Penal Reform's¹²³ 2016 report [Preventing prison suicide](#), the rise in the number of prison suicides has coincided with cuts to staffing and budgets and a rise in the number of people in prison, resulting in overcrowding.

177. Kenny Brown from HM Prison and Probation Service told us that recent data demonstrated a downward trend in the number of suicides in custody, however there had been an increase in the incidents of self-harm.¹²⁴ Mr Brown did not believe that there was a correlation between staff numbers and self-harm, saying that there was no research to demonstrate it.

¹²³ The Howard League is the national charity working for less crime, safer communities, and fewer people in prison).

¹²⁴ Health, Social Care and Sport Committee, Record of Proceedings, 7 June 2018, paragraph 374

178. Written evidence from HM Prison and Probation Service in Wales highlights the importance of early identification of prisoners at risk of suicide or self-harm:

“Any prisoner identified as at risk of suicide or self-harm must be managed using the Assessment, Care in Custody and Teamwork (ACCT) procedures. ACCT is a prisoner-centred, multi-agency care-planning system which reduces an individual’s risk.”¹²⁵

179. Published in 2013, the National study of self-inflicted death by prisoners (by Manchester University and National Offender Management Service) found that the majority of self-inflicted deaths were not formally assessed as “at risk” and were not on ACCT at their time of death.

180. Additional written evidence submitted by HM Prison and Probation Services demonstrated how many of the self-inflicted deaths among offenders in Wales had been identified as “at risk” and were being managed under ACCT procedures:¹²⁶

| | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 (to March) |
|----------------------|------|------|------|------|------|-----------------|
| Self-inflicted death | 1 | 4 | 2 | 7 | 1 | 1 |
| Of which with ACCT | | 1 | | 4 | | |

181. We heard from Sophie Lozano how HMPP had introduced new suicide and self-harm prevention training, including courses to help staff in identifying risks and triggers.¹²⁷ She went on to say that enhanced mental health training for all staff who become ACCT assessors to engage with people identified as being at risk.¹²⁸

182. We also heard how offenders were trained to offer peer support to each other, with 1,715 active listeners trained by the Samaritans as of 2017.

Our view

183. We welcome the inclusion of priority places in the Talk to me 2 strategy as important in recognising and targeting specific environments where suicide prevention should focus.

¹²⁵ Written evidence, S 19, HM Prison and Probation Service in Wales

¹²⁶ Health, Social Care and Sport Committee, 27 June 2018, Paper 4

¹²⁷ Health, Social Care and Sport Committee, Record of Proceedings, 7 June 2018, paragraph 399

¹²⁸ Health, Social Care and Sport Committee, Record of Proceedings, 7 June 2018, paragraph 443

184. We welcome the identification of schools as a priority place where suicide prevention should be focused, and explore some of the issues relating to children and young people in a subsequent chapter.

185. Leaving home and moving to a new area can be a difficult time for many young people, and we are aware that there have been recent instances of suicide among students. We acknowledge that incidents of suicide among university students are lower than among people of the same age not at university, but we realise that university life can be stressful to some, so we welcome the work being done across universities to ensure that students can access support for coping with stress or mental ill-health.

186. We are aware of a University Mental Health Charter announced in July 2018 and currently in development by Student Minds, which is supported by the UK Government. We realise that the Cabinet Secretary for Education has said that HEFCW are working with universities on a strategic approach and action plan for mental health, but we believe that the Welsh Government should, in partnership with the higher further education sectors, take a lead role in the development of an equivalent to the English charter scheme.

187. Suicide and mental ill-health among farmers and others in rural communities is another particular concern to us. During our meeting with representatives from Tir Dewi, we heard how the burden of various administrative requirements and concerns around money cause significant stress on farmers. This stress, combined with long working hours – often in isolation, easy access to means, and the general reluctance in men to seek help means that farmers are at a high risk of suicide.

188. We acknowledge that Talk to me 2 identifies this risk, but we feel there is more the Welsh Government could do to ensure that when their staff come into contact with farmers who may be experiencing difficulties. It is crucial that staff are compassionate and understand the impact the various pressures can have on farmers' mental health. We heard that some Welsh Government and local authority staff who deal directly with farmers have undertaken suicide awareness training organised by the DPJ Foundation, and would endorse such training being rolled out to other staff who may have contact with farmers.

189. We are particularly concerned by the rise in the number of incidents of self-harm in prisons, it is crucial to get a better understanding of the reasons for this increase and that action is taken address it. Self-harm in itself is a risk factor for suicide, but coupled with the other risk factors of being in the justice system and being male, prisoners are potentially at a higher risk of suicide. We believe that

prison staff must be fully trained to understand the seriousness of self-harm, identify those in danger and signpost them for support.

190. We acknowledge that HM Prison and Probation Service manage prisoners identified as at risk of suicide or self-harm through the Assessment, Care in Custody and Teamwork procedures, however we are concerned with the robustness of these assessments. We note from the figures provided by HMPP that there were 16 self-inflicted deaths in custody in Wales between 2013 – March 2018, and that of those, five of the individuals were being managed through the ACCT process. Our concerns are two-fold, firstly that eleven individuals were not assessed as being at risk yet subsequently took their own lives, and secondly that five individuals took their own lives despite being managed. The process of assessing prisoners at risk must be robust enough to identify all those at risk and the right support must be in place for those who are assessed as being at risk.

Recommendation 21. We recommend that the Welsh Government takes a lead in the current work with HEFCW and for it to expect further and higher education providers in Wales to introduce Student Mental Health Charters. This work should be done in time for the start of the 2019-20 academic year to ensure that students in Wales benefit from the work as soon as possible.

Recommendation 22. We recommend that relevant staff from the Welsh Government and other agencies receive appropriate training, such as the Samaritans' "Working with compassion" kit, to show a greater awareness and understanding of the higher suicide risks associated with rural communities, particularly among farmers and their families. This would enable them to respond compassionately when dealing with bereaved families, and promote a greater understanding of the difficulties families in this situation can face in not only carrying on with their day to day farming business, but also in meeting timescales associated with Welsh Government farming processes. We would encourage relevant Government staff to use their discretion to alleviate further stress on bereaved families, for example by deferring farm inspections in appropriate circumstances.

Recommendation 23. We recommend that the Welsh Government liaises with the Home Office with regard to reviewing the process for assessing and managing prisoners' risk of suicide and self-harm to ensure that it is sufficiently robust to identify those at risk and provides the right support for those who are managed through the process.

5. 3. Priority care providers

191. Talk to me 2 also identifies priority care providers as people who are often the first point of contact for someone with suicidal behaviour or who self-harms. These include police, firefighters and ambulance staff, primary care staff, and emergency department staff.

Emergency services

192. Talk to me 2 identifies the emergency services as priority care providers, stating:

“The police, fire fighters and Welsh Ambulance staff have an important role to play in providing support to, and dealing sympathetically with extremely distressed people, including the families and friends of those who have either attempted suicide or taken their own lives.”

193. Claire Bevan of the Welsh Ambulance Service NHS Trust told us that in 2017, the total number of 999 calls to the service was around half a million, and out of the half a million about 30,000 were coded as mental health/self-harm categories. She added that around 4,500 of the 278,000 calls a year to NHS Direct Wales are linked to self-harm and suicidal ideation. She said:

“So, our staff who are on the telephone triage, as well as our front-line staff, obviously have significant interaction with people who are in the self-harm category, or indeed suicide ideation, or actually attending a suicide end-of-life experience.”¹²⁹

194. Assistant Chief Constable Drake of South Wales Police told us that a risk assessment is undertaken when someone is booked into custody, including indicators around the risk of suicide or self-harm:

“So, we complete a risk assessment for every person who is detained. we’ve looked at every aspect of custody provision, and that includes the designs of cells to remove ligature points—all of that as well. We can put people under constant supervision. We have video monitoring as well. So, basically, whilst people are there, everything that we possibly can do to keep them safe—. When people leave custody, we also ask how they’re feeling—so, when they’re leaving as well.”¹³⁰

¹²⁹ Health, Social Care and Sport Committee, Record of Proceedings, 7 June 2018, paragraph 272

¹³⁰ Health, Social Care and Sport Committee, Record of Proceedings, 7 June 2018, paragraph 212

195. Written evidence from South Wales Fire and Rescue Service's highlights that "Safe and Well" home visits, where fire and rescue services provide advice and safety equipment to reduce fire risk, can provide an opportunity to identify individuals at risk of suicide or self-harm. Alison Kibblewhite told us that each fire and rescue service has a safeguarding officer, who has links to other partners such as health boards and social services. She said that the aim was to train operational staff, when undertaking home visits, to recognise when people may require additional support and identify them to the safeguarding officer.

Armed forces

196. Talk to me 2 identifies armed forces personnel as priority care providers but aside from this, it includes no specific reference to armed forces/veterans. Antony Metcalfe of the Royal British Legion told us he would like to see reference to the wider armed forces community, including veterans and spouses in the Welsh Government's suicide prevention strategy as a specific population in need of support.¹³¹

197. The Royal British Legion highlighted that the overall incidence of suicide and self-harm in the UK armed forces is lower than in the general population, and Combat Stress told us that there is evidence suggesting that the longer an individual stays in the military, the lower the suicide risk. Mr Metcalfe referred to 2009 research (Kapur et al), which found that risk of suicide among veterans was greatest in males, those who had served in the Army, those with a short length of service, and those of lower rank.

198. Paula Berry of Combat Stress told us that, although there were several opportunities within the armed forces to talk about mental health, there is still stigma attached which prevents people from talking. She believed that more should be done to address the stigma by raising awareness that it is ok to come forward and seek help, suggesting that those of more senior ranks should encourage junior ranks.¹³²

199. Ms Berry also told us about the training in place within the armed forces, including training for front line personnel to identify depression, anxiety and traits of trauma-related illnesses among their colleagues.¹³³

¹³¹ Health, Social Care and Sport Committee, Record of Proceedings, 17 May 2018, paragraph 137

¹³² Health, Social Care and Sport Committee, Record of Proceedings, 17 May 2018, paragraph 115

¹³³ Ibid

200. Ms Berry went on to say that more could be done to support veterans during their transition period to adjust to civilian life after leaving the forces, particularly those who leave after a shorter period of service and those who may have experienced difficulties in their lives prior to joining.¹³⁴

201. Mr Metcalfe welcomed some of the initiatives put in place to support veterans, particularly the armed forces liaison officers across local authorities and the veterans gateway service, describing the gateway service as:

“A real example of multiple third sector collaboration, not just from the armed forces charities, but from Shelter, from Mind, from the Samaritans...By phoning the veterans gateway you'll get clear, concise signposting to the relevant organisations.”¹³⁵

Our view

202. We believe that the approach of identifying priority care providers in Talk to me 2 is appropriate in ensuring that the people most likely to be in contact with those in crisis are trained to respond in a compassionate way and can offer or signpost the person to support.

203. We welcome the proactive work being done by the fire and rescue services in building upon the opportunities they get to engage with vulnerable people through their home visits to identify people who may also have other needs. This good practice should be rolled out further, if necessary by training more fire and rescue staff to undertake the visits, in order to reach as many vulnerable people as possible.

204. We recognise the importance of specifying the armed forces as a “priority care provider” in Talk to me 2, however we are disappointed that this is the only reference in the Welsh Government’s strategy. We support the recommendation put to us by the Royal British Legion that reference to the wider armed forces community be included in the suicide prevention strategy to ensure that veterans and their families are also supported.

205. The armed forces have a particular responsibility to ensure that personnel are supported both during and after their careers. We heard that, despite mental health support being available for personnel, many were reluctant to step forward to receive that support due to the stigma attached. We acknowledge that this

¹³⁴ Health, Social Care and Sport Committee, Record of Proceedings, 17 May 2018, paragraph 121

¹³⁵ Health, Social Care and Sport Committee, Record of Proceedings, 17 May 2018, paragraph 152

issue is a priority for the third sector organisations who work with veterans, and we applaud the work they are doing.

206. We heard that more support is needed for service leavers to help them adjust to life outside the forces, and believe that this should be addressed urgently. This is particularly pressing for personnel leaving after a relatively short period of service and those from disadvantaged backgrounds or who experienced difficulties before joining the services. These are groups at a higher risk of suicide, so it's crucial that they are supported to prevent potential negative experiences such as substance misuse.

207. Whilst we applaud initiatives such as the armed forces liaison officers, Veterans NHS Wales and the veterans gateway, we believe better promotion of these is needed to ensure veterans and their families are aware of the range of support available to them.

6. Children and young people

Suicide is one of the leading causes of death among young people aged between 15 and 19 years old. Additionally, young women under 19 years old have the highest prevalence of self-harm.

208. Talk to me 2 identifies a number of different groups of young people as being at high risk of suicide; these are looked after children, care leavers, children and young people in the youth justice system and bullied or victimised children and young people. It also identifies schools and further and higher education establishments as being priority places where suicide prevention efforts should be focussed.

209. Professor Ann John highlighted the extent of the issue and the importance of doing more in schools to address suicide and self-harm:

“With children and young people, suicide is in the top-two causes of death, and the reason for that is partly because that they are not dying of other things that older people would die of, but it means that it’s a really, really important thing for us to tackle for young people.

So, if we’re looking at older adolescents, three people in a class of 30 will be self-harming. So, self-harm is relatively common; suicide is very rare in this age group, even though it is the commonest cause of death. So, most young people who self-harm will not go on to take their own lives, and the reason it’s important to say that is that one of the things that sometimes happens...is that people are scared when young people are self-harming.

So, what will sometimes happen is that schools will exclude people, and some of that is fear-based, and how do we manage people, because it is frightening. I think you can’t underestimate how difficult it is for people who aren’t trained and don’t know when to hand people over. And for that reason, sometimes these young people get excluded, which compounds the risk factors that we know are there. So, I think

within schools as a setting with young people there's a lot of work we can do."¹³⁶

210. Sara Mosely also emphasised the importance of doing more in schools, and referred to a lottery grant for Time to Change to pilot work in being undertaken in schools, however despite its effectiveness, the funding was short term for 18 months.¹³⁷

211. Witnesses emphasised the importance of suicide prevention training and raising awareness across a range of people who children and young people may turn to for help. Stephanie Hoffman of Pro-mo Cymru cited that suicide prevention is an issue for everyone:

“this is a big issue for all of us. It's not just professionals within CAMHS or us as a low threshold, universal service. We all have a part to play, whether that's parents, carers, dinner ladies in school—you know, whoever it is...this is a matter for all of us, and we need to somehow get cleverer, perhaps, in how we get those messages across, particularly because of the stigma and the difficulty that's associated with the issue and being able to talk about it.”¹³⁸

212. Ged Flynn told us:

“In terms of children and young people, I would start with those who most readily come into contact with children and young people. If I were to ask each of you to name two of those, schools would be on everyone's list, but also parents.

Not every lollipop lady needs the same as your local psychiatric liaison officer, but there needs to be some gradation. She [Professor Ann John] and others have given evidence to say, 'This is everyone's business. We can't leave it to people in white coats and people whose vehicles have blue lights. Your child may only have one chance to speak to somebody and that may be you.' We need to translate that message right across the country.”¹³⁹

¹³⁶ Health, Social Care and Sport Committee, Record of Proceedings, 21 March 2018, paragraphs 48-50

¹³⁷ Health, Social Care and Sport Committee, Record of Proceedings, 21 March 2018, paragraph 126

¹³⁸ Health, Social Care and Sport Committee, Record of Proceedings, 21 March 2018, paragraph 167

¹³⁹ Health, Social Care and Sport Committee, Record of Proceedings, 21 March 2018, paragraphs 195-196

213. He went on to say that Papyrus had produced a schools' guide, *Building Suicide-Safer Schools and Colleges – A guide for teachers and staff*, which equips schools to talk about suicide with children.

214. The Children, Young People and Education Committee's recent report on the emotional and mental health of children and young people recommended that guidance should be provided to schools on talking about suicide and self-harm, to dispel the myth that any discussion will lead to "contagion". It recommended that, as a priority, this should be issued to schools where there has been a suicide or suspected suicide. It also recommended that teachers undertake basic mental health training so that all teachers are equipped to talk about suicide.

215. In September 2018, the Welsh Government announced a new focus on a "whole school" approach to mental health and wellbeing for children and young people, including the establishment of a Ministerial Task and Finish Group to help accelerate this approach.

Our view

216. The rates of suicide and self-harm among children and young people are alarming, and it is clear that a concerted effort is needed to ensure that school staff are equipped to provide support to those who need it and to signpost or refer to them to appropriate services. It is crucial that teachers and other staff understand the importance of talking responsibly about suicide, and that talking about it will help and not lead to "contagion".

217. Building resilience in children and young people has the potential to also transform the mental health of adults. Ensuring that people get the support they need at a young age will better equip them to deal with any challenges they may face in adulthood. We wholeheartedly endorse all of the recommendations made by the Children, Young People and Education Committee in its Mind over matter report on the step change needed in emotional and mental health support for children and young people in Wales. We believe that the recommendations made in that report will have a positive impact in improving support for children and young people, and believe that their implementation must be a priority for the Welsh Government.

218. We welcome the Welsh Government's decision, in response to the Mind over matter report, to focus on a "whole school" approach to mental health and wellbeing for children and young people. We believe that this change of approach is crucial to ensure that children and young people get the support they need to improve mental health, well-being and emotional resilience.

Recommendation 24. We recommend that the Welsh Government ensures that the Children, Young People and Education Committee's Mind Over Matter recommendations are implemented in order to improve and protect the mental health and wellbeing of children and young people in Wales. On suicide specifically, we recommend that the Mind Over Matter recommendation on guidance to schools (its recommendation 16) should be taken forward as an immediate priority:

- That the Welsh Government, in relation to suicide specifically, work with expert organisations to:
 - provide, within three months of this report's publication, guidance to schools on talking about suicide and self-harm, to dispel the myth that any discussion will lead to "contagion";
 - work with expert organisations to 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.

7. Reducing access to means

219. Objective 5 of Talk to me 2 relates to reducing access to the means of suicide, stating that “reducing access to certain particularly lethal means of attempting suicide is an effective way to prevent suicide”.

220. We heard from South Wales Fire and Rescue Authority how it had been involved in targeting known suicide locations such as bridges and car parks and had placed in those areas signs promoting the Samaritans' Talk to Us scheme in the hope that it would encourage a person in distress to seek help.¹⁴⁰ Bledwyn Jones from the Authority told us that the signs were relatively inexpensive at £30 each, and that there is evidence that when a person is in crisis, there is a moment where they are open to suggestion:

“There's evidence that says that when an individual is in crisis and is taking that step to take their own life, they say that there's a moment where they're open to suggestion, and that's what safeTALK and Assist is based on, that suicide first aid, that you can suggest an alternative to somebody and they are open to suggestion. So, the hope is that, if they're on their own and there isn't any emergency service presence, that they may see that sign. These signs are around £30. So, they may see that sign and it might just be the prompt that says, 'Okay, yes, I will give them a call.' And I think, for £30, it's definitely worth it; if it saves one life, I think that's worth its weight in gold.”¹⁴¹

221. Mr Jones told us he believed there was a responsibility in the design and planning of new structures, particularly tall building and bridges, to ensure there is reduced access, for example by including a higher barrier that is difficult to climb on to.¹⁴²

222. We also heard how Network Rail was using engineering measures to prevent suicide on the railway network. These included mid-platform fencing to prevent people moving between platforms, platform-end barriers to stop people walking down ramps, and particular types of fencing at areas of high risk.

¹⁴⁰ Health, Social Care and Sport Committee, Record of Proceedings, 7 June 2018, paragraph 210

¹⁴¹ Health, Social Care and Sport Committee, Record of Proceedings, 7 June 2018, paragraph 252

¹⁴² Health, Social Care and Sport Committee, Record of Proceedings, 7 June 2018, paragraph 242

Our view

223. Reducing access to means is an important aspect of suicide prevention, and we commend the proactive work being done in this regard. In particular, the action by South Wales Fire and Rescue Authority in placing signs at locations known for suicide attempts, and would encourage this to be expanded to cover more locations. Such an initiative is inexpensive, but can be effective is a person in crisis sees a signs and seeks help.

224. Making tall structures such as car parks and bridges harder to access for people with suicide ideation is an important step in preventing suicide. We realise that designers will want new structures to look attractive, but safety must be the key consideration. We believe that all new planning applications should consider whether the structure provides a means to suicide and makes adaptations to the design to prevent this.

Recommendation 25. We recommend that the Welsh Government writes to all planning authorities in Wales emphasising the importance of ensuring that all new structures include measures to prevent them being used as a means of suicide.

Recommendation 26. We recommend that the Welsh Government identifies the most appropriate agency to identify known suicide locations and places signage in those areas encouraging people to seek help.

8. Role of the media and social media in suicide prevention

8.1. Media reporting of suicide

Objective 4 of the Welsh Government's strategy is to support the media in responsible reporting and portrayal of suicide and suicidal behaviour.

225. Talk to me 2 sets out that this objective is to be achieved by:

- promoting specific training in responsible suicide and self-harm reporting for journalists trained in Wales;
- in collaboration with the Samaritans and other partners, the National Advisory Group Chair will issue a letter to Wales' media editors in response to incidents of inappropriate reporting of suicide and self-harm behaviours (letters will signpost editors to the Samaritans media reporting guidance).

226. The National Union of Journalists (NUJ) has produced a practical guide for journalists on the responsible reporting on mental health, mental illness and death by suicide, Dr Sallyanne Duncan, a senior lecturer in journalism at Strathclyde University recently revised the professional guidelines. The Samaritans has also produced media guidelines for reporting suicide, which reflect similar points as the NUJ guidelines.

227. The mid-point review of Talk to me 2 described "good progress" as being made against this specific objective, however, in her written evidence to us, Professor Ann John of the National Advisory Group suggested far more could be done, including raising awareness in journalism schools and introducing training sessions on responsible reporting. Professor John told us that there was good work being done in Wales, but that it was important to work with journalists:

"Starting off with the media and print media, I think we do a lot of good work in Wales. The Samaritans have issued guidance, and we've adopted and translated that. I work quite closely with the Samaritans, who run lots of training sessions with local journalists. There is definitely a balance between their needs and our needs, but it is a matter of working together.

The Samaritans review all headlines, but things have to reach a certain level to hit their threshold at a national level. So, in the national advisory group, we do issue letters to editors if we feel there's been a breach. I think it's very important for us to realise that we're working with the media and that they have very different objectives. In my experience, for the most part, people are people and they don't want to do harm."¹⁴³

228. Emma Harris from the Samaritans concurred:

"But I think it's about working with a variety of agencies really. With the media, for every negative story, or just a story covering suicide, there should be a balanced piece that promotes help seeking or how you can improve your mental well-being. That's a really good way of dealing with that, and we've seen some good practice of that here in Wales."¹⁴⁴

229. Sarah Stone also from the Samaritans explained the importance of responsible reporting of suicide:

"One of the things about the portrayals of suicide is there's really good evidence that copycats can be caused by the wrong kind of reporting—by over-detailed reporting of a method, for example. So, we work with the media, usually behind the scenes, to encourage responsible reporting of suicide, which encourages help seeking."¹⁴⁵

230. Written evidence from Dr Sallyanne Duncan Strathclyde referred to numerous scholars having made "a connection between the way journalists report suicide and vulnerable people's susceptibility to repeat the action by taking their own lives". Her paper went on to say:

"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."¹⁴⁶

¹⁴³ Health, Social Care and Sport Committee, Record of Proceedings, 21 March 2018, paragraph 63

¹⁴⁴ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 68

¹⁴⁵ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 75

¹⁴⁶ Written evidence, S 45, Dr Sallyanne Duncan

231. Dr Ann Luce from Bournemouth University told us that she “took issue” with evidence that suggests the more suicide is reported, the more suicides that will actually occur, she told us:

“There’s some evidence around vulnerable people being influenced, but I think we need to be very careful about cause and effect. There’s a correlation, and correlation is not indicative of causation. So, there’s no actual evidence that reporting suicide causes suicide. If that was the case, every time we saw a suicide story, or every time we would see a murder, for instance, then that would mean another murder would go with it.

I think the impact we have on audiences isn’t as strong as you might think or might be right to believe, there’s been no real audience research that’s been done on the impact of suicide stories on the audience. So, we’re, kind of flying blind on that one.”¹⁴⁷

232. Dr Duncan’s paper also refers to another perspective which is “that suicide stories can be in the public interest because they can educate people about broader social and public health deficiencies”. She cites that 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”.¹⁴⁸

233. Dr Luce told us of a study published in the British Journal of Psychiatry in 2017 which examined adherence to the reporting guidelines on suicide. She said that of the 229 samples examined, 199 had failed to comply with at least one of the guidelines, adding that the most common causes of non-compliance were failing to provide details of support services, providing excessive details of the method and speculating on the causes.¹⁴⁹

234. Dr Luce believed that the immediacy of online reporting sometimes ran a greater risk of reporting guidelines not being adhered to:

“What we’re finding is that journalists, in an online environment, probably are not adhering to guidelines as much as they would in a printed product, for the simple fact that it is immediate and it’s to try and get the story first and to get the images out there first. So, there

¹⁴⁷ Health, Social Care and Sport Committee, Record of Proceedings, 17 May 2018, paragraph 185

¹⁴⁸ Written evidence, S 45, Dr Sallyanne Duncan

¹⁴⁹ Health, Social Care and Sport Committee, Record of Proceedings, 17 May 2018, paragraph 194

does seem to be a bit of an issue around online reporting that really needs to be investigated.”¹⁵⁰

235. Dr Duncan believed that this could be a growing problem as “there’ll be more online content than print content in the future”. She suggested that perhaps journalists “need a little bit more vigilance”:

“Instead of tweeting or posting on Facebook, they should stop, think and then act—so, even just building in a few seconds of reflection before they actually do that, and that’s perhaps something that the guidelines should address in the future.”¹⁵¹

236. We heard that Dr Duncan and Dr Luce were undertaking a study where they were asking journalists whether they were aware of the guidelines on reporting suicide, with Dr Luce telling us that “overall there’s low and inconsistent use of guidelines”.¹⁵² In order to overcome the problem, Dr Duncan would be looking into why journalists are not aware of the guidelines and why they weren’t using them to better effect. Dr Luce told us she suspected that there are too many sets of guidelines:

“Just off the top of my head, I could probably name you nine or 10 in the UK alone, and I think that’s probably quite problematic.”¹⁵³

237. Dr Duncan believed there was room for improving the training provided to journalists:

“we need to go right back to the start of journalist education, and from the day they enter into a university or a further education college course, we need to be making them aware of these issues and they need to be responsible reporters, because it’s a very difficult thing for them to deal with on their own.”¹⁵⁴

238. We heard that adherence to guidelines tends not to be monitored in any formal way due to their voluntary nature. Dr Duncan told us there could possibly be a role for the regulators – the Independent Press Standards Organisation (IPSO) and IMPRESS, in monitoring adherence although she noted caution as these are voluntary organisations with limited powers. She went on to say that pointing out

¹⁵⁰ Health, Social Care and Sport Committee, Record of Proceedings, 17 May 2018, paragraph 193

¹⁵¹ Health, Social Care and Sport Committee, Record of Proceedings, 17 May 2018, paragraph 199

¹⁵² Health, Social Care and Sport Committee, Record of Proceedings, 17 May 2018, paragraph 207

¹⁵³ Ibid

¹⁵⁴ Health, Social Care and Sport Committee, Record of Proceedings, 17 May 2018, paragraph 211

bad practice alone could have a negative impact, whereas highlighting examples of good practice would help journalists to see the benefits of responsible reporting.¹⁵⁵

239. Dr Luce referred to “Headline”, a media monitoring unit for suicide, mental health and self-harm in the Republic of Ireland, which points out good and bad practice and provides training to journalists. She pointed to this approach as an example of good practice, and believed such a model could be adopted in Wales.¹⁵⁶

Our View

240. We welcome the guidelines for journalists on responsible reporting of suicide, but are concerned that adherence to these tends not to be monitored in any formal way due to their voluntary nature. We are aware that some stakeholders, notably the Samaritans, do monitor media reporting of suicide and will contact news outlets to challenge their reporting and provide advice. Whilst we commend this action, it would be impossible for all media reporting to be monitored in this way, therefore it is inevitable that some irresponsible reporting will be missed.

241. We believe there is scope to strengthen the current approach to monitoring adherence to reporting guidelines by establishing more formal arrangements either through media watchdogs or a unit such as “Headline” in the Republic of Ireland. This could also help to raise awareness of guidelines and promote compliance.

242. We realise that news reporting is constantly evolving and that outlets are under pressure from the public who expect instantaneous coverage online. We therefore believe the reporting guidelines should be updated to take greater account of online reporting.

243. It is important that journalists understand that there could be consequences to irresponsible reporting of suicide, including the distress that can be caused to the family and friends of the person and the potential contagion effect should too many details be released. This could be achieved by including it in the training provided as part of journalism courses and through continuous professional development.

Recommendation 27. We recommend that the Welsh Government explores what formal arrangements could be put in place to promote and monitor

¹⁵⁵ Health, Social Care and Sport Committee, Record of Proceedings, 17 May 2018, paragraph 221

¹⁵⁶ Health, Social Care and Sport Committee, Record of Proceedings, 17 May 2018, paragraph 223

adherence to the guidelines, given the negative impact that the irresponsible reporting of suicide can have. This should include looking at arrangements in place elsewhere, including the Republic of Ireland.

Recommendation 28. We recommend that the Welsh Government engage with universities, the Samaritans and other relevant parties such as the National Union of Journalists and publishers to explore how training for journalists at university, through continuous professional development or on the job training could include the importance of adhering to the guidelines on reporting suicide and promoting an understanding of the negative impact of irresponsible reporting.

8. 2. Social media

244. In the evidence we received, concerns were voiced about the negative impact the internet and social media can sometimes have on people's mental health and wellbeing (particularly young people), including as a result of cyber-bullying. It was also noted that the internet can be used as a research tool by people who self-harm or attempt suicide, and the existence of websites that "promote" suicide was highlighted.

245. Dr Rhiannon Evans explained the complexities around how information available online can be accessed both to seek help and to cause harm:

"We know from some of the samples and studies that have been done that individuals tend to actually use the internet a little bit more for help-seeking around self-harm and suicide than they do actually for looking at sites that promote it. So, it is used quite a lot in a helpful way, but the issue is that studies show that when individuals are already engaged in self-harming practice, or self-harm with suicidal intent, they tend to use the internet for methods, and in ways that then perpetuate or contribute to those behaviours.

So, it's certainly got a problematic usage for individuals who are already engaged in self-harm. But I think if we take a step back and think about the wider use of it, a lot of people are using it in a positive way, and there's definitely scope for online interventions, both in terms of internet, but also app-based interventions that young people might interact with to try and increase positive help-seeking."¹⁵⁷

¹⁵⁷ Health, Social Care and Sport Committee, Record of Proceedings, 17 May 2018, paragraphs 289 - 290

246. Ged Flynn told us:

“I’ve written to the Attorney General, last week, the week before, to say that Wikipedia still, if you search online, shows you how to kill yourself. I think that’s heinous. The problem for the Attorney General and the Crown Prosecution Service is that it’s very difficult to get a case study. It’s very difficult to demonstrate that this information led to this death.”¹⁵⁸

247. Emma Harris referred to negative videos being allowed to run and link to other damaging videos on channels such as YouTube. She told us that the Samaritans would want to see links to help-seeking videos, acknowledging that would involve targeting social media channels.¹⁵⁹

248. Despite concerns around the negative impact, it was also noted that the internet provides a route for many people to access advice and support, and there may be scope to develop electronic mental health interventions further.

249. We heard from several witnesses that online resources can play an important role in enabling people to feel connected (a strong protective factor in suicide prevention), and can offer immediate access to sources of information and support. Online support is available to everyone when they need to access it, Dr Alys Cole-King told us:

“there is no stigma to accessing good quality, safe information online; we can all do that.”¹⁶⁰

250. Sara Mosely highlighted the importance of information being available to people when they need it, and referred to some of the resources available through Mind, including 24-hour chat:

“1,800 people looked at our support information in Wales over the last three months on suicide. And we also, as do other organisations, run online support groups for people. Elefriends, for instance, you can go on there 24 hours a day and chat to somebody who’s feeling just like you are, and that element of peer support and joint support is really, really important.”¹⁶¹

¹⁵⁸ Health, Social Care and Sport Committee, Record of Proceedings, 21 March 2018, paragraph 233

¹⁵⁹ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 71

¹⁶⁰ Health, Social Care and Sport Committee, Record of Proceedings, 21 March 2018, paragraph 135

¹⁶¹ Health, Social Care and Sport Committee, Record of Proceedings, 21 March 2018, paragraph 138

251. Dr Rebecca Payne referred to resources such as cognitive and behavioral therapies courses that can be delivered online, and believed that increasing the availability of those through the NHS would be helpful to patients when it's not possible to access help in other ways. Dr Kathryn Walters agreed that aspects of social media can be used as support mechanisms for those in need:

“I recommend quite a lot of apps to clients. I work, generally, with adults of working age, but anyone who works with adolescents will know that they're much less likely to perhaps read a book than they would be to look at an app. So, I think there's definitely scope.”¹⁶²

252. Genevieve Smyth from the Royal College of Occupational Therapists told us that social media also has the potential to raise awareness and encourage people to talk about how they feel and seek help:

“I think we can use it more to spread positive messages about asking for help and sharing and talking about how you're thinking and feeling. It's not a shameful thing... but we don't talk about it. And that's what needs to change and social media can do that. There have been some brilliant campaigns about other things—so, for example, other public health issues like skin cancer—and they've been using social media to push messages to people when we know they're moving into risky times or risky transitions. So, we could do that; the technology is there. It's harnessing it.”¹⁶³

253. Angela Samata (SoBS) highlighted the free online resource [Hub of Hope](#):

“It's free; it's an online directory. If you've got a child sitting in front of you in school and they are telling you that they're not feeling okay and you don't know where to signpost them or what to do or what information to give their parents, you can go on the Hub of Hope. It's a free iTunes app now. You can go on your phone, you can put your postcode in for anywhere in Wales, anywhere in the UK, and you can say, 'Find help near me' and it will find it for you.”¹⁶⁴

254. The Cabinet Secretary acknowledged “that there's a potential there to deliver a service that is not just cost-effective, but actually is useful from the citizen's point of view about how they want to access a service as opposed to having to

¹⁶² Health, Social Care and Sport Committee, Record of Proceedings, 17 May 2018, paragraph 83

¹⁶³ Health, Social Care and Sport Committee, Record of Proceedings, 17 May 2018, paragraph 85

¹⁶⁴ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 314

physically attend somewhere". He told us that he was definitely interested in taking proper advantage of online support resources in a consistent way across Wales.¹⁶⁵

255. The official supporting the Cabinet Secretary told us of a pilot in Powys using online therapy for children and young people:

"We have invested in a roll-out of computer internet-based cognitive behaviour therapy for people aged 16 and over with an all-Wales approach, following a pilot in Powys, and we're also scoping ways of looking at what is the best evidence and most reliable and effective programmes for children and young people under the age of 16. So, we're currently working with a number of partners to determine what are the best programmes that are available in terms of online self-help and considering whether a similar approach in Wales, to roll out one or more of those, would be appropriate."¹⁶⁶

Our view

256. We are acutely aware that social media can make both a positive and negative contribution to people's mental wellbeing. We are very concerned by the stories we have heard about cyber-bullying and children and young people accessing material online that is not age-appropriate, and the potential for this to have a long-term, negative impact on their mental health. We are appalled by websites that promote methods of suicide and believe that internet providers and social media companies are in a position to take action to protect children and young people from the harms that can be caused by such websites and other negative online experiences. We are aware that in April 2018, Jeremy Hunt MP the then UK Secretary for Health, wrote to social media companies to put pressure on them to take steps to cut underage usage, prevent cyber bullying and promote healthy screen time and that in May 2018, the UK Government published its Internet Safety Strategy Green Paper. We encourage the Welsh and UK Governments to work together to take actions to protect children and young people online.

257. Despite the potential negative impact, we also realise that there is huge scope for online resources to be used for good, and we are pleased that these are being developed and utilised especially for people who may not engage with traditional therapy. We know that there is a wealth of support resources available

¹⁶⁵ Health, Social Care and Sport Committee, Record of Proceedings, 27 June 2018, paragraph 112

¹⁶⁶ Health, Social Care and Sport Committee, Record of Proceedings, 27 June 2018, paragraph 115

online, including the “Hub of Hope” which Angela Samata referred to, promoting these resources is an ideal way of letting people know that help is available and can be accessed whenever is convenient rather than physically attending an appointment.

258. Online support and therapies can also provide a stop-gap before formal therapy is available. We know that there are long waiting lists for psychological therapies, and whilst online tools should not replace that, they could help people in the interim. We believe that technological advances should be used for good, so it is important to continue to develop online tools and make best use of technology to offer innovative solutions. Using the internet and technology to access information is now the norm for most people, especially children and young people, so it is important this method is available.

259. Given the general reluctance among men to seek help in traditional ways, we believe that online support targeted at men would be an effective way of reaching out and promoting the support that is available.

260. As technology constantly evolves, it will be crucial for online information to be updated regularly to ensure the most up to date information is available, and as new apps and tools are developed, the online support methods will need to keep up with these trends.

Recommendation 29. We recommend that the Welsh Government engages with the UK Government on its Internet Safety Strategy Green Paper to ensure that action is taken to protect children and young people online. Additionally, we are keen to see the potential for social media to have a positive impact on people’s mental health and wellbeing maximised. We believe that all opportunities to promote good mental health through social media/internet sites should be explored, for example through more active promotion of sources of support.

9. Implementation of Talk to me 2

Talk to me 2 states that the overall aims of the strategy are to reduce the suicide and self-harm rates in the general population in Wales and promote, co-ordinate and support plans and programmes for the prevention of suicidal behaviours and self-harm at national, regional and local levels.

261. The strategy sets out six key strategic objectives:

- Further improve awareness, knowledge and understanding of suicide and self-harm amongst the public, individuals who frequently come in to contact with people at risk of suicide and self-harm and professionals in Wales;
- To deliver appropriate responses to personal crises, early intervention and management of suicide and self-harm;
- Information and support for those bereaved or affected by suicide and self-harm. (The National Advisory Group has produced [Help is at hand Cymru](#) - a resource for people bereaved through suicide);
- Support the media in responsible reporting and portrayal of suicide and suicidal behaviour.
- Reduce access to the means of suicide;
- Continue to promote and support learning, information and monitoring systems and research to improve our understanding of suicide and self-harm in Wales and guide action.

A “cross-governmental, cross-sectoral and collaborative” approach

262. Suicide and self-harm are largely preventable, the strategy says, if risk factors at individual, group or population level are effectively addressed. This requires effective collaboration and joint-working between government departments, health boards and local authorities, the third sector, and staff and service users in multiple settings.

263. Talk to me 2 emphasises the need for local ownership and implementation of suicide prevention activity, supported by national leadership and action. It states that the varied social, cultural and geographical landscape of Wales means that local areas need to adapt and develop strategies according to local circumstances. The national strategy provides the supportive and co-ordinated framework that makes such regional variation possible and describes the following key roles/structures:

- The Welsh Government provides national leadership and oversight of the implementation and evaluation of the strategy, and facilitates “high level engagement” at health board and local authority level. Where actions involve non-devolved matters, the Welsh Government will engage with the relevant UK Government Departments;
- The National Advisory Group (NAG) on suicide and self-harm prevention, chaired by Public Health Wales, reports annually on progress to the Welsh Government. As well as informing national policy, the NAG provides guidance to support local action and the development of local suicide prevention plans;
- Regional suicide prevention forums report to the National Advisory Group. These multi-agency forums (covering north Wales, south east Wales, and south west Wales) aim to improve joint-working across all sectors and to oversee local implementation of the strategy.

264. The mid-point review of Talk to me 2 found that while much progress had been made in recent years, continued high-level engagement and sustainable resourcing will be needed for progress to continue. The review highlighted some specific issues including that some health boards place the governance of suicide prevention under the umbrella of “mental health”, which may limit wider partnership, engagement and planning.

265. We heard from the Chairs of the Mid and South West Wales Regional Forum and the North Wales Suicide and Self-harm Working Group that the progress made in developing local suicide plans varied between the regions. Whilst a plan had been agreed for North Wales, we were told that a draft plan for Mid and South West Wales was due to be launched in July, with a view to publishing the plan in autumn 2018.¹⁶⁷

¹⁶⁷ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 207

266. Concerns were raised during our evidence gathering about the sustainability of the regional forums in previous years, in part due to an over-reliance on the commitment of individuals. Avril Bracey, Chair of the Mid and South West Wales Regional Forum explained the situation in that area:

“It’s fair to say that our region has been inactive for a while. I took over as chair last November, so it’s about six months that I’ve been chairing the group. Prior to that, the group hadn’t met that often, and, really, that was because of some committed and inspired individuals who moved on to different positions.”¹⁶⁸

267. The Chairs of both regional forums described to us inconsistencies in the make-up and operation of the forums across Wales. In terms of the differing reporting structures in their areas, Dr Gwenllian Parry explained that in North Wales:

“we report to the regional delivery group, which, in turn, reports back then to the ‘Together for Mental Health’ partnership board. And it’s the local implementation teams who then put the ‘Together for Mental Health’ strategy, or the mental health strategy for north Wales—they implement that strategy.”¹⁶⁹

268. Avril Bracey went on to tell us that in Mid and South West Wales:

“In terms of reporting, I think that is also a little complicated, because we have the regional group, we report quarterly into the national advisory group, but we have slightly different reporting mechanisms as a region. So, we have a sub-regional delivery group in the west—Pembrokeshire, Ceredigion and Carmarthen. We report into the Together for Mental Health partnership, but that’s not the same in other local authorities.”¹⁷⁰

269. We also heard that the groups were structured differently and that, whilst representation on the groups had improved, there was still room for further progress in this area, Dr Gwenllian Parry told us:

“We do have very good representation, and, with the new guidance, we’ve increased the membership of the group as well. We’re very, very pleased that we have Caniad, who attend regularly and give a voice for

¹⁶⁸ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 188

¹⁶⁹ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 182

¹⁷⁰ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 190

those with lived experience. I am aware that we don't actually formally have somebody representing those who have been bereaved by suicide, although I'm sure that there are members of the group who actually have been bereaved through suicide. I think we could do better in some areas. For example, with youth justice and probation services, I think we need to invite them into our services, and other services as well. We're very pleased that recently we've had representation from the perinatal mental health service, as well as the coroner—the coroner now joins us—and chronic health difficulties as well.”¹⁷¹

270. In terms of the membership of the Mid and South West Wales group, Avril Bracey said:

“I don't think we're quite there yet. That's a priority for us this year. As I said, I think local authority representation has improved, and if I look even where we were six months ago, we are getting more representation. We have probation, we have the Samaritans as vice-chair of the group, and so we have third sector, we have people with lived experience on the group. We have health boards. So, I think we do definitely need to extend that representation, and that's a priority for us.”¹⁷²

271. Written evidence received from the South East Wales Regional Multi-Agency Suicide Prevention Forum states that “the regional group provides leadership, influence and support to ensure successful regional and local delivery of the strategy and the action plan”. It goes on to describe the structure and reporting arrangements for that group:

“The South East Wales Group took the decision for the Chair of the group to be rotated. In this way, each health board area takes turns to Chair the regional meeting and also be responsible for reporting to the following NAG meeting on behalf of the Region. This was felt to be a more efficient use of resources, given the time pressures on members of the regional group, who are also responsible for leading suicide prevention work locally.

Local groups are responsible for the development and implementation of action plans which are based on the national objectives set out in

¹⁷¹ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 231

¹⁷² Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 233

Talk to Me 2, taking into account local evidence, needs and priorities. As well as reporting to their regional group and to the NAG, local groups are also accountable to the Mental Health Partnership Board in their area. Local Partnership Boards are responsible for reporting to Welsh Government on progress with local suicide and self-harm actions via the monitoring for Together for Mental Health.”¹⁷³

272. Dr Gwenllian Parry called for a greater “central steer” from the Welsh Government and the National Advisory Group in relation to membership and reporting structures.¹⁷⁴

273. Professor Ann John, Chair of the National Advisory Group provided some reassurance that the position had improved:

“I think there’s been real progress in the last year and a half. So, I think there were issues. The way it’s been set up is that there are three regional fora, and although they were working very well and they were multi-sectoral there were no statutory reporting responsibilities. And, because of that, enthusiastic, interested individuals working within organisations kept those going, but, every time someone retired or there was sickness, the sustainability of the regional fora was very problematic. On the national group, we stepped in quite a lot. I think, in the last year and a half, with the issuing of the local planning guidance, the issuing of a letter from Welsh Government saying that plans had to be developed by the end of February, the regional fora have developed local formal reporting structures.

I think there has been a huge change. And, because of those local formal arrangements, I think that change is going to be sustainable, whereas two years ago I would have been saying something very different.”¹⁷⁵

274. Sarah Stone, Executive Director for Samaritans in Wales, provided a similar picture of how the regional forums were now making better progress following a slow start:

¹⁷³ Written evidence, S 43, South East Wales Regional Forum

¹⁷⁴ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraphs 193 - 196

¹⁷⁵ Health, Social Care and Sport Committee, Record of Proceedings, 21 March 2018, paragraphs 20 - 22

“There’s quite a dependence on key individuals who are enthusiastic. When they’re not there anymore then the impetus can fall a bit. So, I think that progress has been a bit slow. I think that it’s happening now and I think that the fact this inquiry is happening and the fact that guidance has been issued by the national advisory group has galvanised people locally. So, it’s not a bleak picture, progress is being made, but the engagement of local agencies in an energetic way is absolutely critical.”¹⁷⁶

275. Emma Harris from the Samaritans went on to stress the importance of representation on the forums:

“we’ve had meetings with fire and rescue and police where they’re doing great work on suicide prevention in their local area but they don’t necessarily sit on the suicide prevention group, and that’s because of a lack of resource in promoting it and holding it regularly and just getting some information out there about it.”¹⁷⁷

276. In response to the call for a greater steer from the Welsh Government on a more consistent approach by the regional forums, the Cabinet Secretary told us that it was necessary to balance the need for a local approach appropriate to local need with working within a national framework. However, he went on to say:

“But I’m interested in what the advisory group have to say about greater consistency and the engagement and involvement of different people who should be in the same room at the same time.”¹⁷⁸

277. In his subsequent letter of 23 July 2018, the Cabinet Secretary wrote that whilst local variation based on local need is to be expected, he had asked his officials to raise the concerns at a future meeting of the NAG.¹⁷⁹

278. The mid-point review of Talk to me 2 found that continued high-level engagement and sustainable resourcing will be needed for progress to continue. It recommended that consideration should be given to making resources available both centrally and locally for implementation of the strategy.

¹⁷⁶ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 18

¹⁷⁷ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 24

¹⁷⁸ Health, Social Care and Sport Committee, Record of Proceedings, 27 June 2018, paragraph 93

¹⁷⁹ [Letter from the Cabinet Secretary for Health and Social Services, 23 July 2018](#)

279. Sarah Stone from the Samaritans told us she believed that additional resources should be allocated to achieving the aims of Talk to me 2, saying:

“there are some very specific, achievable aims in there, which need to be supported better, in order for us to really make progress, nationally and locally.”¹⁸⁰

280. The lack of specific funding for suicide prevention was also highlighted to us by the regional forum representatives, Dr Gwenllian Parry told us:

“In terms of resources, we don't have any specific resources, and I think that we could do more if we did have those resources.”¹⁸¹

Avril Bracey concurred, saying:

“Resource is always helpful. So, I think some central and local resource would help us, because even the smallest projects that we're starting in communities need a resource. So, in all honesty, some resource would help us deliver on this agenda, for sure.”¹⁸²

281. The National Advisory Group's evidence paper suggests there may be a need for further resources to ensure the strategy is effectively implemented across Wales, highlighting that in other countries suicide prevention is supported by specific funding or dedicated national posts. Professor Ann John also told us that the lack of specific funding for suicide prevention remains a big issue:

“I think to progress from now, we do need to adequately resource, either at an area level or at an intervention-pathway level. And some of that funding may need to be cross-sectoral. So, to enable people to work together, the funding needs to be available, say, for police and health to work together.”¹⁸³

Our View

282. We were encouraged to hear that, following a slow start by some, progress is being made across the regional forums, spurred by the issuing of local planning guidance by the National Advisory Group. Ensuring that the right people are members of the regional forums is key to their success, so many different

¹⁸⁰ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 81

¹⁸¹ Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 194

¹⁸² Health, Social Care and Sport Committee, Record of Proceedings, 23 May 2018, paragraph 203

¹⁸³ Health, Social Care and Sport Committee, Record of Proceedings, 21 March 2018, paragraph 24

agencies have a role in suicide prevention and it's crucial that they contribute to local plans and approaches. We believe that the membership of the forums should not be left to chance, the right people need to be involved and this should be replicated across Wales.

283. We acknowledge the importance of ensuring that the regional forums have the flexibility to design and tailor their suicide prevention plans to best meet the needs of their local areas, however the call for a greater steer from the Welsh Government or the National Advisory Group around the forums' structures and reporting arrangements was made by the forums themselves. We note that the Cabinet Secretary has asked the NAG to consider the concerns raised with us, and urge this be done at the earliest opportunity to ensure that the momentum gathered in developing and implementing the local plans continues to progress further.

284. We were concerned to hear that there is no dedicated funding for suicide prevention and believe this should be addressed as a matter of urgency. Whilst good progress is being made by the regional forums, we believe that they should be adequately resourced if they're to going to implement the multi-agency approach that's needed to deliver significant change. We are aware that in May 2018, the Department for Health and Social Care, Public Health England and NHS England announced the start of a 3-year programme worth £25 million to reduce suicides in England by 10% by 2021 and will support the zero suicide ambition. We believe that suicide prevention in Wales should also receive specific funding.

285. We heard that the forums sometimes rely on the commitment of individuals, and whilst we applaud their dedication, there is a limit to what can be achieved through commitment alone. We believe that specific funding for suicide prevention would make a big difference to the ability of the regional forums to bring all of the necessary people together to make real progress in reducing the number of deaths by suicide. We know that, despite being preventable, suicide is a leading cause of death among people under the age of 35, and a leading cause of death in men under 50, it is therefore crucial that specific funding is available to tackle this worrying statistic.

286. We are aware that the UK Government has recently appointed a Minister for Suicide Prevention for England and additional funding for the Samaritans to run its helpline. We feel that suicide prevention in England seems to have gained more momentum, and it's crucial that initiatives in Wales keeps apace with elsewhere in the UK.

Recommendation 30. We recommend that the Welsh Government / National Advisory Group provides a clear steer to the regional forums to ensure a consistent approach to their membership, structure and reporting arrangements. The Welsh Government should monitor the effectiveness of the regional forums to ensure that they deliver sustainable and consistent outcomes across Wales, and provide regular updates to the Committee.

Recommendation 31. We recommend that the Welsh Government / other public bodies (LHBs / LAs) make specific funding available for suicide prevention to ensure that it is sustainable in the long term. The Welsh Government should work with the National Advisory Group to ascertain how much funding is needed to ensure this sustainability, and ringfence the appropriate amount.