Agenda - Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

Lleoliad:
Ystafell Bwyllgora 2 - Y Senedd
Dyddiad: Dydd Iau, 7 Mehefin 2018
Amser: 09.15

I gael rhagor o wybodaeth cysylltwch a:
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Rhag-gyfarfod anffurfiol (09.15 - 09.30)

1 Cyflwyniad, ymddiheuriadau, dirprwyon a datgan buddiannau

(09.30)

2 Atal hunanladdiad: Sesiwn dystiolaeth â chynrychiolwyr Byrddau Iechyd Lleol a Iechyd Cyhoeddus Cymru

(09.30 - 10.30) (Tudalennau 1 - 90)

Nadine Morgan, Pennaeth Nyrsio Dros Dro, Bwrdd Iechyd Prifysgol Hywel Dda

Rhiannon Jones, Cyfarwyddwr Gwasanaethau Cymunedol ac Iechyd Meddwl, Bwrdd Iechyd Addysgu Powys

Will Beer, Meddyg Ymgynghorol ym maes Iechyd Cyhoeddus, Bwrdd Iechyd Prifysgol Aneurin Bevan

Su Mably, Meddyg Ymgynghorol ym maes Iechyd Cyhoeddus, Iechyd Cyhoeddus Cymru

Briff Ymchwil

Papur 1 - Conffederasiwn GIG Cymru

Papur 2 - Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Papur 3 - Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg

Papur 4 - Bwrdd Iechyd Prifysgol Betsi Cadwaladr

Papur 5 - Bwrdd Iechyd Prifysgol Aneurin Bevan

Papur 6 - Bwrdd Iechyd Prifysgol Hywel Dda

Papur 7 – Bwrdd Iechyd Prifysgol Cwm Taf

Papur 8 – Partneriaeth Cynllunio a Datblygu Iechyd Meddwl Powys a Phartneriaeth Plant a Phobl Ifanc Powys

Egwyl (10.30 - 10.35)

3 Atal hunanladdiad: Sesiwn dystiolaeth gyda chynrychiolwyr y gwasanaethau brys

(10.35 - 11.10) (Tudalennau 91 - 124)

Y Prif Gwnstabl Cynorthwyol Jonathan Drake (Heddlu De Cymru), Prif Swyddog Arweiniol Cymru ym maes Iechyd Meddwl, Grŵp Prif Swyddogion Cymru

Alison Kibblewhite, Pennaeth Lleihau Risg, Gwasanaeth Tân ac Achub De Cymru

Bleddyn Jones, Pennaeth Gorsaf, Gwasanaeth Tân ac Achub De Cymru

Papur 9 – Uned Cyswllt yr Heddlu

Papur 10 – Heddlu De Cymru - Trafnidiaeth

Papur 11 – Gwasanaeth Tân ac Achub Gogledd Cymru

Papur 12 – Gwasanaeth Tân ac Achub De Cymru

Papur 13 – Gwasanaeth Tân ac Achub Canolbarth a Gorllewin Cymru

Egwyl (11.10 - 11.15)

4 Atal hunanladdiad: Sesiwn dystiolaeth ag Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru

(11.15 - 12.00) (Tudalennau 125 - 139)

Claire Bevan, Cyfarwyddwr Ansawdd, Diogelwch, Profiad Cleifion a Nyrsio, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru

Stephen Clarke, Pennaeth Iechyd Meddwl, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru

Nigel Rees, Pennaeth Ymchwil ac Arloesedd, Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru

Papur 14

Egwyl cinio (12.00 - 12.45)

5 Atal hunanladdiad: Sesiwn dystiolaeth â Gwasanaeth Carchardai a Gwasanaeth Prawf EM

(12.45 - 13.25) (Tudalennau 140 - 142)

Kenny Brown, Cyfarwyddwr Carchardai Sector Cyhoeddus yn Ne Cymru, Gwasanaeth Carchardai a Phrofiannaeth EM

Sophie Lozano, Arweinydd Diogelwch Grŵp Carchardai, Gwasanaeth Carchardai a Phrofiannaeth EM

Papur 15

Egwyl (13.25 - 13.30)

6 Atal hunanladdiad: Sesiwn dystiolaeth â Network Rail

(13.30 - 14.10) (Tudalennau 143 - 150)

Ian Stevens, Rheolwr Rhaglen - Atal Hunanladdiad, Network Rail

Yr Uwch-arolygydd Mark Cleland, Heddlu Trafnidiaeth Prydain

Papur 16

7 Cynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o weddill y cyfarfod hwn

(14.10)

8 Atal hunanladdiad: trafod y dystiolaeth

(14.10 - 14.20)

Mae cyfyngiadau ar y ddogfen hon

	The Welsh NHS Confederation response to the Health, Social Care and Sport Committee's inquiry into suicide prevention in Wales.
Contact:	Callum Hughes, Policy and Research Officer, Welsh NHS Confederation. [redacted] Tel: [redacted]
Date created:	15th December 2017

Introduction

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

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

Overview

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

d. Innovative approaches to suicide prevention;

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

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

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

Conclusion

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

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

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

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

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

December 2017

THE WELSH NHS CONFEDERATION
CONFFEDERASIWN GIG CYMRU

Key actions to increase the effectiveness of suicide prevention in Wales

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

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

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

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

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

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

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

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

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

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

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

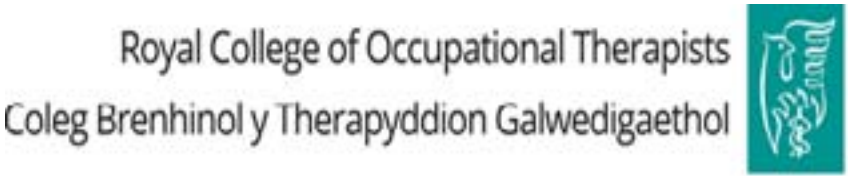
8. Provide better information and support to those bereaved or affected by suicide: The response provided to bereavement is key. The impact of suicide on the survivors, such as spouses, parents, children, family, carers, friends, co-workers, and peers who are left behind, is significant, both immediately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

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

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

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

This document is endorsed by:



GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

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

EVIDENCE FROM CARDIFF AND VALE UHB

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

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

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

3. Suicides are highest in middle aged men in Wales and the causal factors for this are complex, but certainly material disadvantage has a role to play. The report researched and written by the Samaritans: *Men, Suicide and Society*, explains the

[1] OECD (2017), *Health at a Glance 2017: OECD Indicators*, OECD Publishing, Paris. http://dx.doi.org/10.1787/health_glance-2017-en [accessed 29 November 2017].
[2] ONS (2017), Suicides in Great Britain: 2016 registrations, https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2016registration#great-britain [accessed 6 November 2017].
[3] PHWO (2017), Public Health Outcomes Framework, https://public.tableau.com/profile/publichealthwalesobservatory#!/vizhome/PHOF2017Characteristics-Individual/Individual?:iid&:tabs=no , [accessed 6 November 2017].

key causes for suicides in this population[4]. Explanations include: personality traits, masculinity, relationship breakdowns, challenges of mid-life, emotional illiteracy and socio-economic factors. The Welsh Government Strategy, *Talk to me 2,* also highlights the high risk groups for suicide, which include: male sex, low socio-economic status, low educational attainment, previous suicide attempts, mental disorder, chronic illness and alcohol/substance misuse amongst others[5].

The social and economic impact of suicide

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

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

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

6. Welsh Government launched their suicide and self-harm prevention strategy *Talk to Me 2* in 2015. Locally this has provided a useful framework by which to prioritise suicide prevention activities across Cardiff and the Vale of Glamorgan. Across Cardiff and the Vale of Glamorgan we have formed a Suicide and Self-harm Prevention Steering Group, with a multi-agency membership. Based on audit findings of where the partnership was against the action plan of *Talk to Me 2*, we created a local Suicide and Self-harm Prevention Strategy and action plan. There are three priority workstreams falling out from this work: training and development (focusing on the development of a local database and sharing of good practice); prisons (learning from other areas as to how best to prevent suicide a
7. nd self-harm in prisons); and geographical suicide hotspots (collecting data to inform us where hotspots might be, and to prevent any future suicides at these sites). Therefore, the national strategy has provided structure and function to suicide prevention on a local level. There was also a regional network for South

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

East Wales, comprising of Cardiff and Vale, Cwm Taf and Aneurin Bevan Health Boards which progressed some shared learning; however, this has not met for a while.

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

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

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

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

11. People aged 18 and over are managed by appropriately trained specialists in Community Mental Health Teams for Adults and for Older People. Other options include Crisis Resolution Home Treatment teams and the inpatient setting. Mental Health workers are trained in WARRN risk assessment. Mental health workers also provide a limited level of training for school teachers, third sector and other agencies.

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

The contribution of local communities and civil society to suicide prevention

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

Other relevant Welsh Government strategies and initiatives

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

Innovative approaches to suicide prevention

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

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

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

Sentinel Incident Review Group

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

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

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

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

Single Point of Access

A single point of access for all referrals was adopted in Old Age Psychiatry in Bridgend in 2003. The model was published in 2007 (Colgate R and Jones S). Further collaboration with academic nursing colleagues from Melbourne Australia led to the United Kingdom mental health triage scale in 2015 which was quickly adopted by General Adult Psychiatry services in Bridgend and more recently in Swansea.

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

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

Mental Health Crisis Services

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

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

Early and Effective Intervention within the Inpatient setting

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

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

Initiatives around Psychiatric Liaison

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

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

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

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

Morriston Hospital bereavement group

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

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

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

Dechrau Newydd

Dechrau Newydd is a community-based complex needs team providing specialist therapy to secondary care clients, with a presentation indicative of a personality disorder. The team offer Dialectical Behaviour Therapy (DBT) to clients who have a recent history (last six months) of self-harm and/or suicidal behaviour. DBT consists of a weekly group in which clients learn skills in four

domains: mindfulness, distress tolerance, emotional regulation and interpersonal effectiveness. Clients also attend a weekly one to one session with a therapist, and have access to a coaching line Monday- Friday 9-5pm.

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

Initiatives around Primary Care

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

Preventing Suicide in Public Places

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

Improving Community Resilience and Social Connectedness

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

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

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

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

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

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

Figure 1: BCUHB and Wales

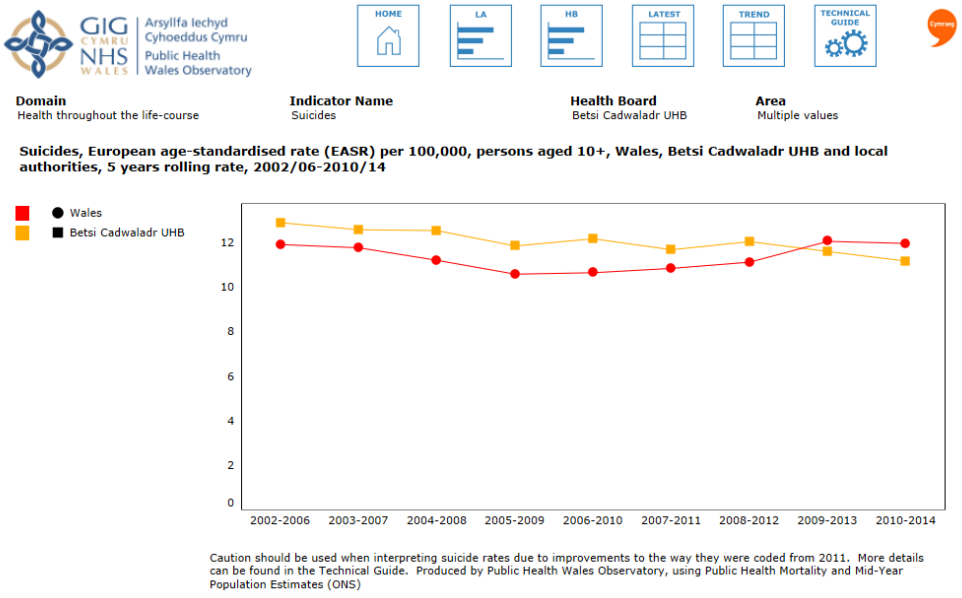


Figure 2 shows the rate of suicide in BCUHB in recent years (the five calendar years 2010-14) is not statistically significantly different from the Wales rate as a whole. In terms of the individual Unitary Authorities (UAs), Figure 3 shows that none of the North Wales UAs are statistically significantly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

Figure 2:

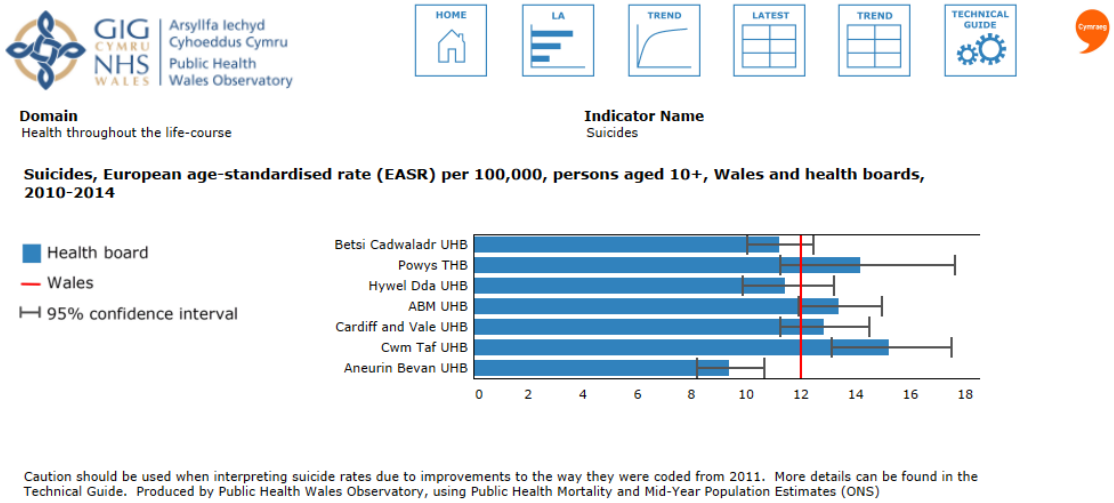
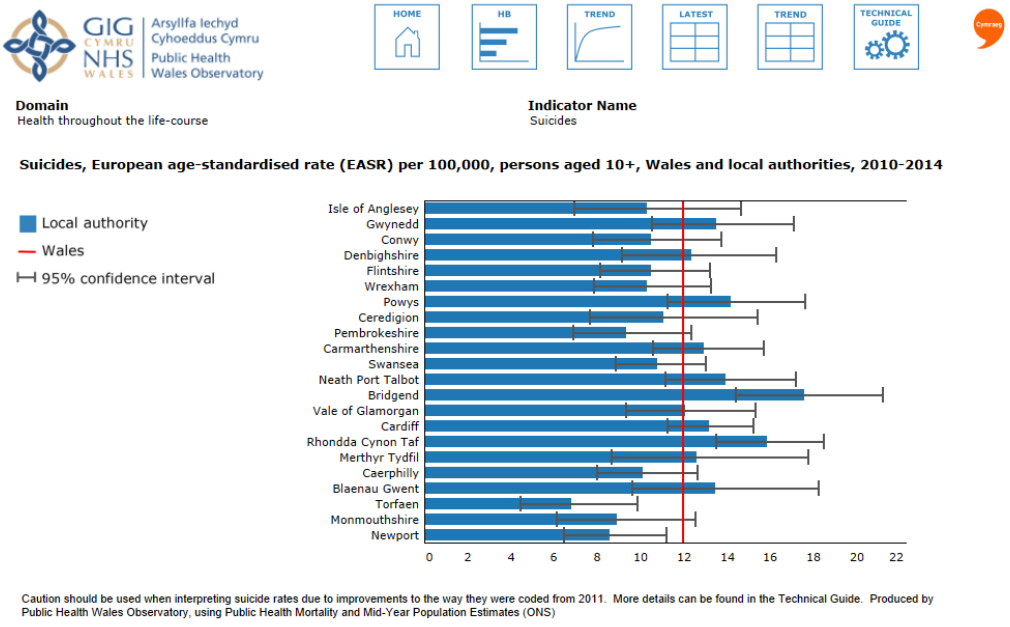


Figure 3:



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

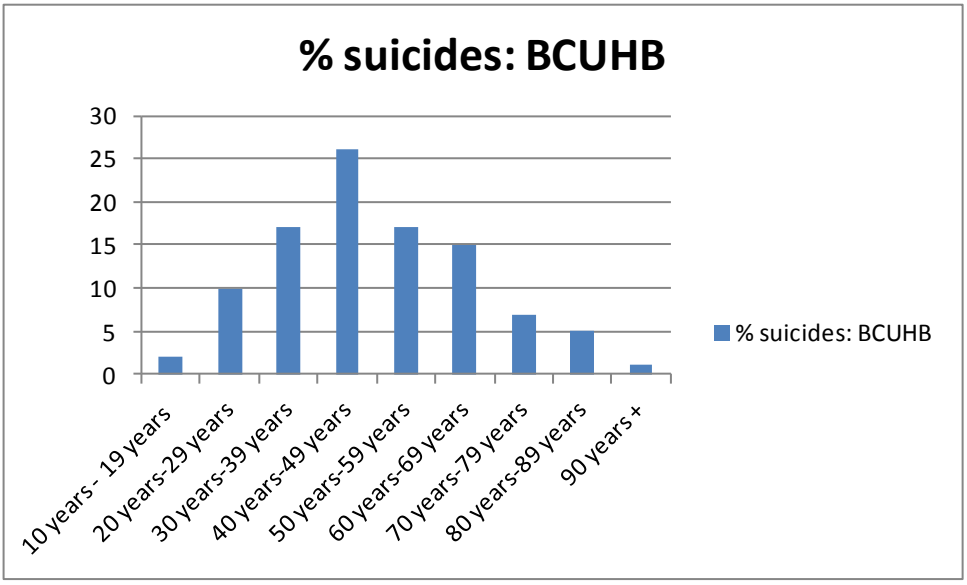
been considerably higher than female suicides since the 1860s, with the male to female ratio fluctuating from 4:1 in the 1880s to 1.5:1 in the 1960s (Thomas & Gunnell, 2010).

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

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

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

Figure 4:

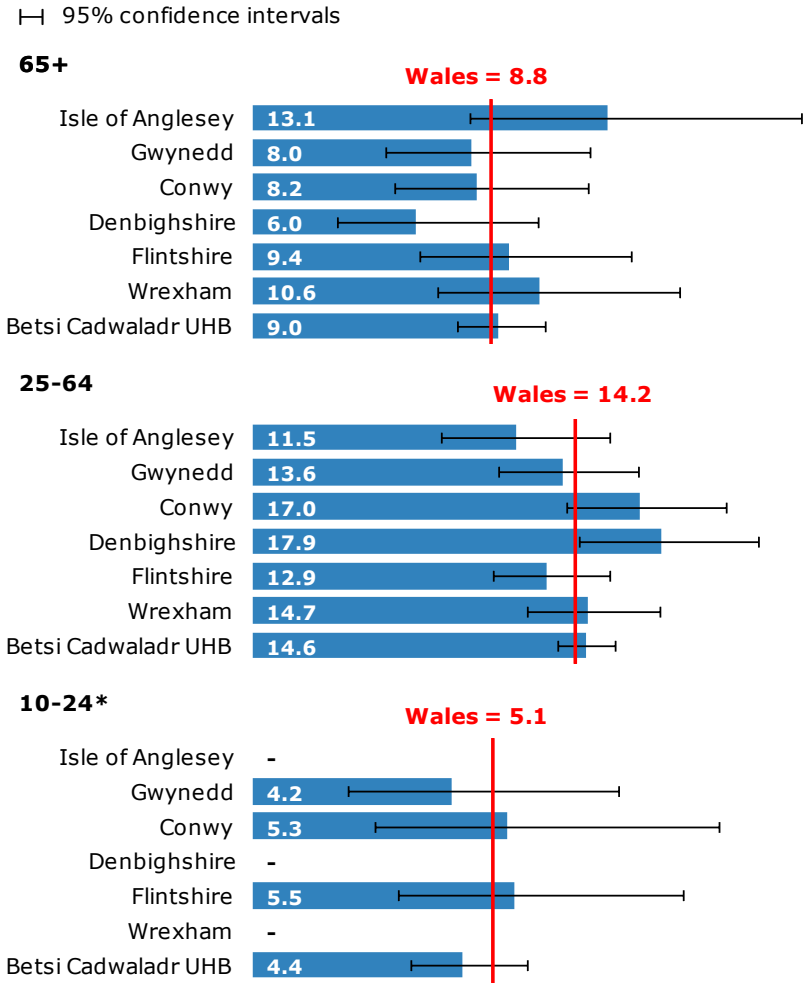


Source: ONS

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

Figure 5

Suicides, age-specific rate per 100,000, persons aged 10 & over, Betsi Cadwaladr UHB and Wales, 2005-14
Produced by Public Health Wales Observatory, using PHM & MYE (ONS)



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2/ The social and economic impact of suicide.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7/ Innovative approaches to suicide prevention.

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

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

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

The evidence map covers:

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

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Aneurin Bevan University Health Board Response

Health, Social Care and Sport Committee
Consultation on Suicide Prevention

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

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

2. The social and economic impact of suicide.

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

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

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

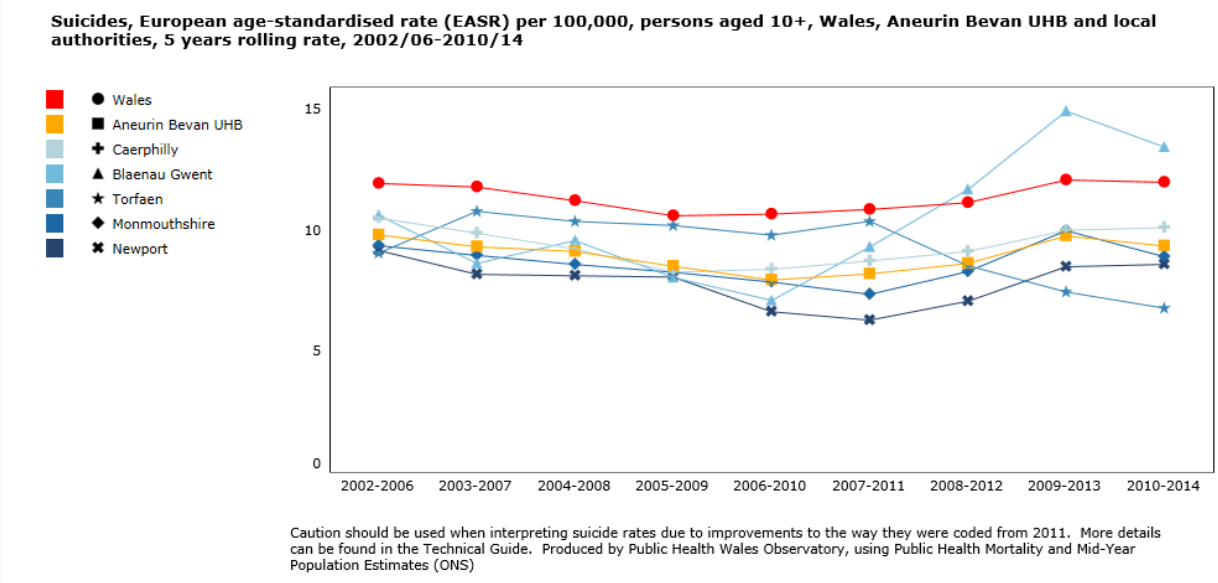
6. Other relevant Welsh Government strategies and initiatives - for example Together for Mental Health, data collection, policies relating to community resilience and safety.

7. Innovative approaches to suicide prevention.

1. The extent of the problem of suicide

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

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



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

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

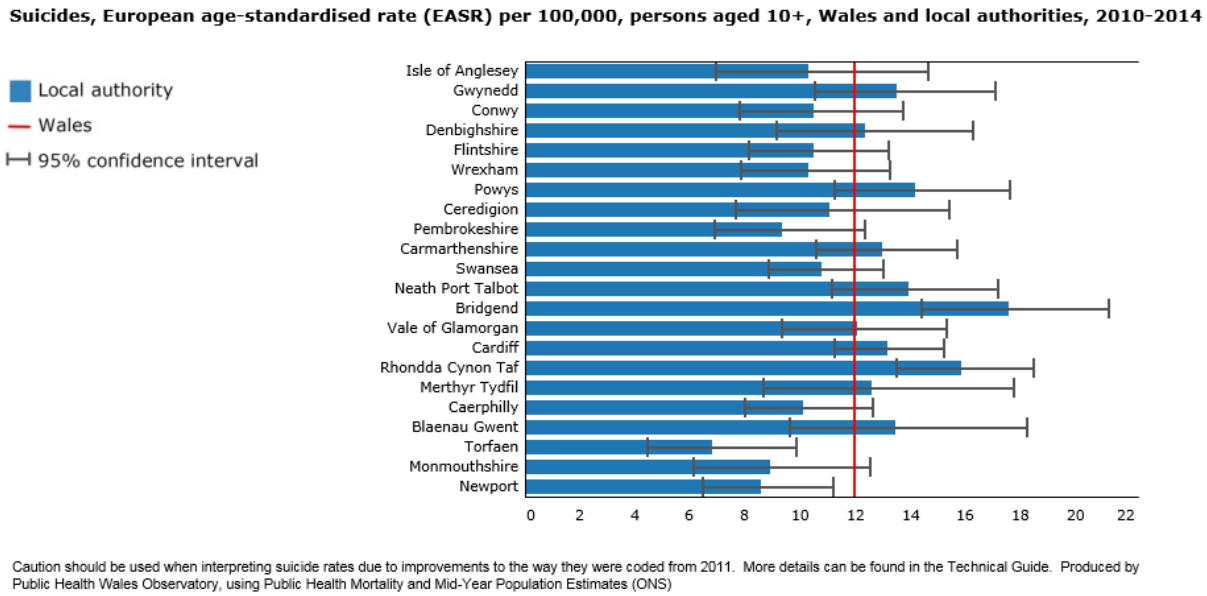


Figure 3 – Comparison of Suicide Mortality, persons aged 15 to 24, 2002-2011 (Public Health Wales, 2013)

Suicide mortality rates per 100,000 population, persons aged 15-24, 2002-2011
Produced by Public Health Wales Observatory, using MYE & ADDE (ONS)

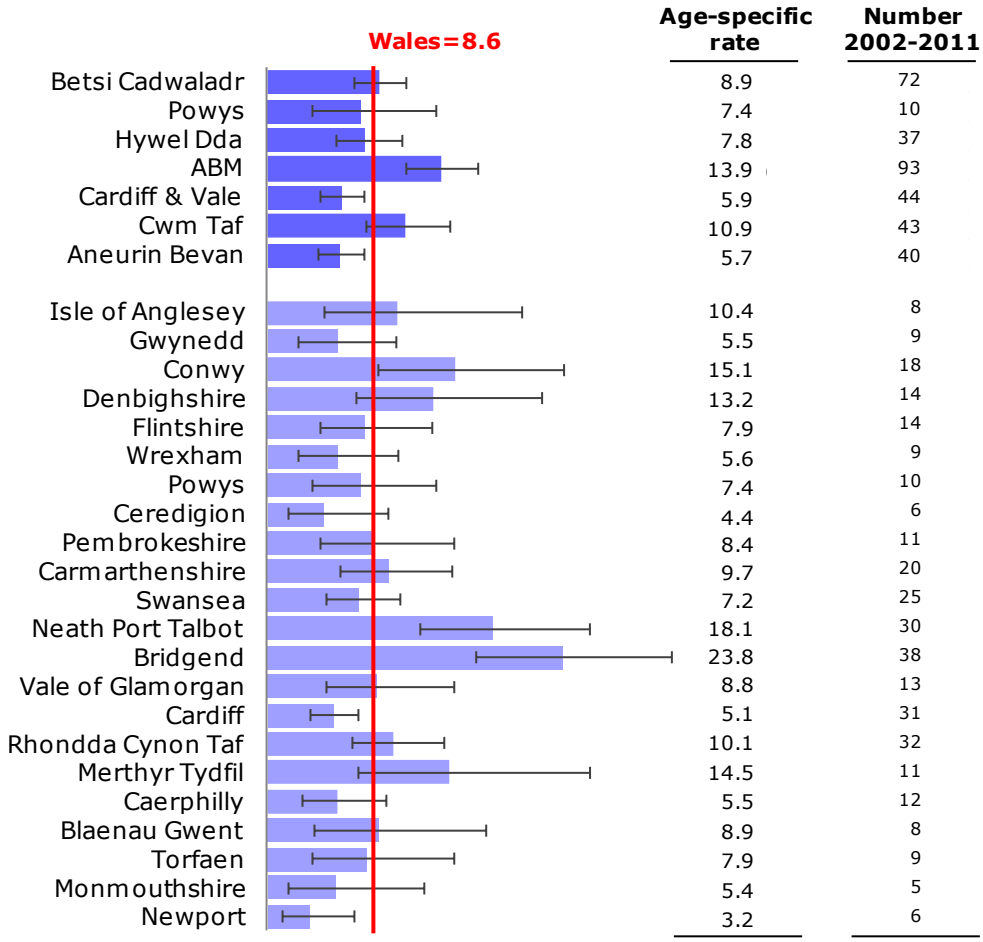


Figure 3 compares the suicide rates of young people aged 15-24 for 2002-2011 across Wales. The average age specific rate for Gwent is 5.7 which is significantly lower than the Wales average of 8.6. None of the Gwent local authorities have significantly higher rates than the Wales average.

Vulnerability of particular groups

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

Priority People	**Priority Places**	**Priority Care Providers**
Men in mid life Older people over 65 with depression and co-morbid physical illness Adult Prisoners	Hospitals Prisons Police custody suites Workplaces	People who are first point of contact or first responders, including: Police Fire fighters

Children and young people with a background of vulnerability People in the care of mental health services including inpatients People with a history of self harm	Schools, Further and Higher Education establishments Primary care facilities Emergency departments Rural areas Deprived areas	Welsh Ambulance staff Primary care staff Emergency department staff

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

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

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

Risk factors

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

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

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

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

2. The social and economic impact of suicide

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

3. The effectiveness of the Welsh Government's approach

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

4. The contribution of the range of public services

The Local Public Health Team are members of the South East Wales **Regional** Suicide Prevention Forum with representatives from Cardiff and Vale and Cwm Taf University Health Boards who are leading suicide prevention work in these areas. The group are able to share information and engage national and regional-level agencies such as Network Rail and South Wales Fire & Rescue Service.

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

However, we recognise that a lack of resources to complete work centrally sometimes limits the capacity of the NAG to progress planned pieces of work, and this has hindered the progress of the local action plan. For example, there was a delay in the production of local planning guidance as well as a national dedicated website which would allow timely access to

information and resources (e.g. an up-to-date list of quality assured training courses to support the national training framework). We note that in other nations these pieces of work are either commisioned separately or a funded post supports work undertaken nationally.

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

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

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

Local progress since 2015 includes:

<u>Promoting Mental Well-being and Resilience</u>

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

- Integrated well-being networks developing on an NCN footprint. Work is on-going to strengthen the network that exists to ensure Foundation tier services form an integral part of a holistic approach to community well-being, reducing silo working.
- Mental well-being 'Foundation Tier' provision has been developed by the Primary Care Mental Health Support Service (PCMHSS) through the Road to Well-being programme www.wales.nhs.uk/roadtowellbeing

- A new multi-agency model for Children and Families PCMHSS is being piloted in Newport with plans to roll out across Gwent
- Four of the 12 NCNs have prioritised the National Clinical Priority - Early Intervention CAMHS (Newport North, Newport East, Caerphilly South and Blaenau Gwent West)

Interim Gwent Suicide Prevention Action Plan

Specific suicide prevention actions undertaken 2015-2017 include:

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

5. The contribution of local communities and civil society

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

6. Other relevant Welsh Government strategies and initiatives

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

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

7. Innovative approaches to suicide prevention.

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

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

Summary

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

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Mental Health and Learning Disabilities Directorate

Quality Assurance and Practice Development Team

Clinical Governance Framework including learning from untoward incidents.

The Mental Health and Learning Disabilities Directorate within Hywel Dda University Health Board (MHLD HDUHB) have carried out a thematic review of all the Untoward Incidents (UI) reported and investigated within the Directorate from April 2016 to the current date. The themes identified have informed a work plan for the Quality Assurance and Practice Development Team (QAPDT). The QAPDT was formed in January 2017 with a remit of service improvement, learning from events with a robust mechanism for assurance of implementation of the lessons learned and sharing of good practice across all teams.

The team have led on benchmarking the incidents as described above against the National Confidential Inquiry Suicide Homicide 2016 20 year review which provided Quality/Safety Standards for organisations. These standards were set with an evidence base that demonstrated through adopting these standards organisations reduced the levels of suicide within their organisation. The QAPDT has benchmarked their local findings against these standards and generated an action plan to address areas for improvement in service provision/standards as well as share good practice across teams.

The mechanism for engaging staff at all levels of the organisation has been established and is being rolled out in a phased approach across the directorate. This includes Quality Assurance and Practice Development workshop sessions/clinical governance meetings which are attended by local team leader and clinicians on a monthly basis. The teams are engaged in contributing to improvements within services such as written control documents, audit development and compliance, spot checks and developing clinical excellence in line with NICE guidance and local and national lessons learned.

The QAPDT focussed upon managing the investigations in line with the welsh government expectations in relation to timeliness of completion (60 days) as well as the improved quality of the investigation process and final report. In house training has been delivered to investigators and the approach to investigations has proactively engaged staff from all disciplines and levels as well as carers and families as appropriate.

Further information relating to the development of this process is noted below as it is noted within the quality/safety standards of the NCISH 2016 that those Trusts/Health Boards who implement a robust way of managing UI’s have reduced incidents of suicides due to the learning effect.

The implementation of learning and assurance associated with this has identified a gap in data collection and resource available to analyse the themes of the audits. This is being taken forward as a business proposal to the Senior Management Team.

The regional fora for suicide and self harm prevention is being actively attended by the Head of Nursing for MH&LD and the fora has been tasked with providing welsh government with a regional action plan to Welsh Government as to how the Suicide and Self harm Strategy will be implemented in early 2018. Following this a local forum co chaired by Health (Head of Nursing MHLD) and Local Authority (Head of Service) leaders is being established within the HDUHB area. This will create an action plan at a local level which will include key stakeholders including carers, service user representatives and 'first responders' in order to address local priorities such as identifying and reducing the means to suicide locally such as bridges, railways, multi storey buildings. This will be linked in with the partnership groups already in operation.

Themes for learning

Action plans from investigations closed since April **2016** have been reviewed and actions are underway and monitored through the local quality assurance meetings which have been set up as part of the clinical governance structure. The themes which have emerged are as follows:

1. **Carer involvement** at assessment and risk management planning;
2. Q**uality risk assessment and contingency planning** (issues around accuracy of risk assessment, no or insufficient contingency planning, actions taken by teams (i.e. discharge) do not correlate with risk identified)
3. **Documentation** (rationale for decision making and MDT discussions, accuracy and timelines of CTP etc)
4. **Clinical interventions** and access to psychological therapies (little or no evidence of interventions by staff teams, pathway unclear/waiting lists etc)
5. **Discharge**/DNA/engagement process (unclear **rationale** for discharge, opt in letters and DNA following with immediate discharge even though significant risk identified).

Carer involvement at assessment and risk management planning;

Investors in Carers Workshops continue to be held with excellent uptake from teams. All inpatient wards are on track to achieve their Bronze award by January 2018. Some wards are working towards their Silver award.
Community teams are making progress with achieving the Bronze award and some have already achieved this.
The Triangle of Care is currently being piloted in a Crisis Team and an Older Adult Inpatient Unit to be rolled out after review of the pilot during April 2018. This includes assessment of carer needs and identifying a 'care plan' for the carer themselves. Joint work with non statutory provider is in place.

The 15 Steps Challenge is being rolled out with the first challenges having taken place on acute mental health wards. An engagement event is taking place in early December to encourage more carer and service user representatives to sign up and join the challenge team from across MH and LD services. This event is being supported by local non statutory providers although led by HDUHB. The 15 steps challenge is part of the governance framework adopted from NHS England as good practice. The challenge has derived from a carer's experience of walking into a ward and 'sensing what kind of care her daughter would receive within 15 steps of walking into the ward'. This experience has been translated into a toolkit which prompts questions of the

challenge team which is made up of service user/carer representatives and senior staff from the organisation with a view to provide constructive feedback from a service user/carer perspective.

This event is being organised by QAPDT and will form part of the governance arrangements around service user and carer representatives visiting wards. Further dates for 15 steps will be set after this training is completed.

An Audit tool for documentation review has been developed (further detail under 'documentation' and begun roll out in September 2017 which captures carer involvement in Care and Treatment Planning (CTP) process.

Consent to share and confidentiality processes workshop is required to provide clarity and improve confidence of staff in this area.

Quality risk assessment and contingency
WARRN Training – There has been an increased promotion of risk management training with an assessment of need for priority areas to take this training. There has been 100% increase in WARRN training of clinical staff across teams with a plan to roll out further over the coming two years.

Training and support is offered on a team by team or individual basis when in relation to the use of care partner where requested.

STORM training is available to staff which is prioritised for crisis team staff and trainers require an update in the training they are delivering in line with the latest version of STORM.

Documentation, CTP and Care partner
Training/workshops have been carried out for teams in relation to CTP and Care Partner.
In response to lessons learned from incidents, audits and inspections and in agreement with managers through QA forums, the monthly audit for case records has been agreed to be reinstated.
The monthly audit has been updated to reflect timeliness as well as quality of documentation standards against the Delivery Unit, Health Inspectorate Wales and MHA Measure (2010), lesson learned, service user, carer and staff feedback. A workshop session has been delivered to operational managers to ensure clarity of standards within the audit and consistency in their individual assessments.
This has been rolled out across Adult MH community teams since October 2017 with the remainder of the directorate being rolled out in a phased approach. Quality assurance meetings will monitor compliance, performance and improvement plans.
This audit will be carried out monthly and provides immediate results to the team leader.
The audit auto populates graphs and charts for prompt analysis and review in conjunction with Audit department.
The workload that this is generating will require review and additional corporate team support.

Clinical interventions
One CRHT in a rural setting has carried out a focussed piece of work in order to raise awareness and confidence of staff in the use of clinical interventions such as emotional coping skills and crisis management and seen a marked reduction in the number of referrals made to TDS. There is agreed consultation advice and support being provided by TDS. This will be rolled out across all teams and needs analysis for skill development is required.
Training needs analysis required and the Head of Nursing is in process of re-evaluating the mandatory training requirements of staff groups and roles as well as the reporting and monitoring structures of said training.

National Confidential Inquiry for Suicide & Homicide
The learning from the investigations has been benchmarked against quality/safety indicators recommended within the 20 year review. An action plan has been formulated and presented to QSEASC in September 2017. This is a high priority piece of work. Local teams are being made aware of common themes and actions required through QAPD meetings and some pro active work has already been rolled out in Ceredigion and Llanelli. All work streams carried out by the QAPD Teams are informed by lessons learned and pro active improvement.

There are a number of work streams underway in relation to learning from events:

<u>Investigation process</u>
The process for managing the investigation process has been refined with significantly shorter turnaround on investigations than there has been historically. The investigation process now includes clinical teams, carers and implementation of lessons learned. The quality of the investigations has improved with recommendations and actions being embedded into practice.
The clinical governance structure now in place across adult mental health services sets the framework for review and implementation of the actions.

Immediate assurance/improvement actions have begun to be taken as a result of incidents occurring. The immediate actions during quarter 1 consisted of:

- Circulation of relevant policies and procedures to teams with a request for assurance that all team members had read and understood;
- posters displayed in relevant clinical areas;
- training arranged as required; and
- spot checks following the awareness raising.

Spot checks are being carried out in responses to lessons learned and a planned audit and spot check cycle is now in development.

Investigation training
There has been a request for additional training in RCA and investigation process for staff as there is a limited number of staff formally trained.

An in-house training programme was provided during September. Positive feedback has indicated further date is in the diary. With the staff trained, a rota system for completing investigations is being adopted for allocation and support from operational service leads. This has increased the pool of investigators for Serious Incident investigations. The team has developed a toolkit for all involved in the investigation process and actively engages the clinical teams to contribute to and engage in the lessons learned.

Training/workshops – delivered

Investigation workshop – delivered to Medical staffing as part of the post grad session. This provided update on investigation process as well as a workshop session where medics scrutinised the documentation for current serious incidents investigations. This valuable continuation has been fed back to investigators of the cases. This is encouraging medical staff to be more involved in the management of investigations, understanding the lessons learned and implementing the action plans as well as role modelling good practice. Medics are engaged in developing the process further and supporting teams to improve standards within practice.

Quality Assurance meetings/workshops

The Quality Assurance meetings are underway for Adult Services with positive feedback from teams. These meetings are being rolled out across the rest of the directorate over the coming year. These forums provide an opportunity for communication and discussions relating to clinical issues which have a direct impact upon the quality of the services being delivered and received.
During 2017 all localities have unscheduled care provision on a 24/7 basis. This provides an opportunity to prompt assessment and treatment in line with NSISH standard.

The police triage team is in place over a 4 day period currently with a view to progressing this further.

Joint working with general health colleagues has been agreed in order to develop a training package for general health nurses.

Joint working with general health colleagues in order to develop pathways and formal communication between services as well as transfer documentation. Risk assessment when there is a change of clinical environment and observation and engagement of patients on general wards to have an identified risk of suicide/self harm.

Roll out of co occurring substance misuse and mental health training is on schedule to be completed by April 2018.

The quality assurance meetings are part of a wider governance structure/framework which has been introduced across the directorate during 2017. The structure includes a clinical incident review group, a written control document group, a patient experience, carer experience, a safeguarding and medication optimisation group.

Communications are shared through these groups and into the Health Board channels.

Talk To Me 2: Suicide and Self-Harm Prevention Strategy 2015-2020

In Hywel Dda we have made good progress towards the Talk To Me 2: Suicide and Self-Harm Prevention Strategy 2015-2020 (T2M2).

We have:

- Met the requirement to attend the Regional forum over the last 3 years
- A plan to develop a job description and person specification for a Talk to Me 2 Coordinator to drive the work required from delivering the T2M2 strategy. Resources for this post are already being committed
- Committed to a delivery group on suicide and self-harm prevention in the early days of the LMHPB

Our challenge now going forward is to:

- Engage with the Regional Partnership Board and the Health Board, and possibly the local health and well-being boards, to ensure high level commitment to drive the strategy and action plan
- Make sure those driving this work have the passion and resources to prioritise it and are able to bring the right people to the table to make the decisions required
- Local Mental Health Partnership Boards are responsible to report on action plans, supported by Regional T2M2 groups.

The Contact Detail for the Mid & South West Wales Chair: Robert Goodwin, [redacted] (PA). The National Advisory Group on suicide and Self-harm monitors progress, and produces an annual report. The Welsh Government monitors statistics on suicide and self harm rates, admissions to hospital and population mental health well-being scores. We can all work together to improve wellbeing. The strategy and action plan can be found at: http://gov.wales/topics/health/publications/health/reports/talk2

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

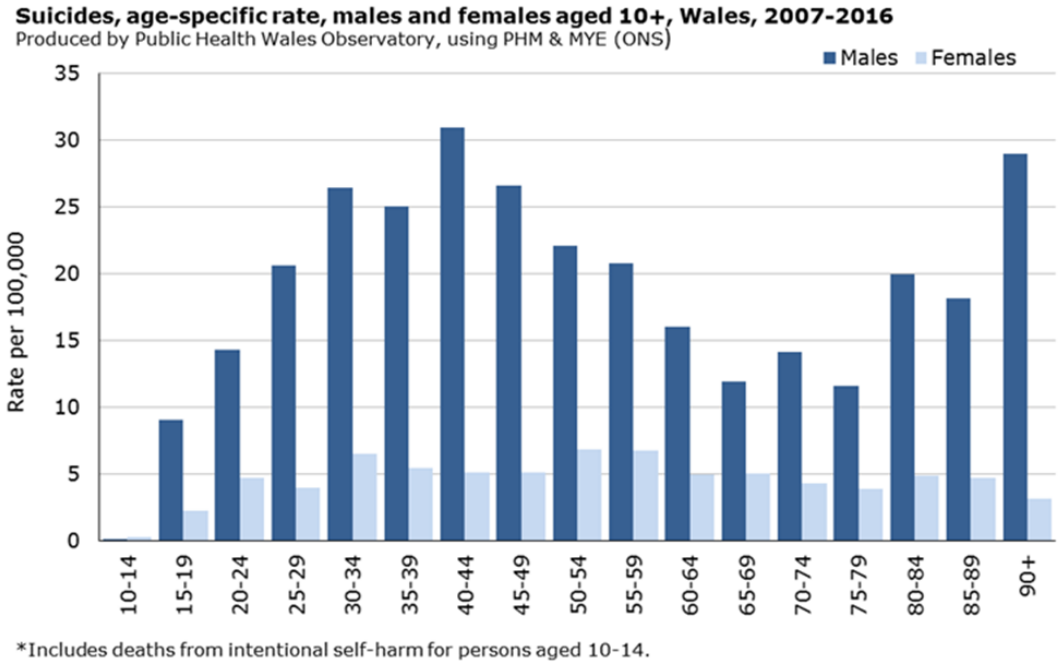
EVIDENCE FROM CWM TAF UHB

Cwm Taf Health Board was established in October 2009 and achieved 'University' status in July 2013. It provides primary, community, hospital and mental health services to almost 300,000 people living in Merthyr Tydfil and Rhondda Cynon Taf. The University Health Board is also responsible for the provision of child and adolescent mental health services for South Wales. The Health Board is the second largest employer in the area, employing almost 8,000 people, a significant number of whom also live in the local area.

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

Suicide is quite rare but suicide, self-harm and thoughts of suicide are a cause of distress for many people - the individual, family, friends, and the wider community. There is no single reason why someone may take their own life or harm themselves. It is usually in response to a complex series of factors that are both personal and related to wider social and community factors.

Suicide rates across Wales are four times higher in men than in women. Half of all the suicides in men occur in the 30-50 age range, with the highest amount (13%) happening in men aged 40-44. Suicide rates fall in late middle age, but there is a further increase after the age of 80.



The social and economic impact of suicide

There were 332 deaths from suicide registered in Wales in 2016 (Source: ONS), and for every person who dies at least 10 people are directly affected[1]. The economic cost of each death by suicide of someone of working age is estimated to be £1.67 million. This covers the direct costs of care, indirect costs relating to loss of productivity and earnings, and the intangible costs associated with pain, grief and suffering[2].

Suicide and inequalities

Increased suicide rates are associated with unemployment, less education, low income or material standard of living, in addition to poor physical health and adverse life events.

Evidence shows that the strongest negative effect of economic downturn is on mental health and that economic recessions are linked to increases in suicide rates[3]. In addition, Cwm Taf has also been especially hard hit by

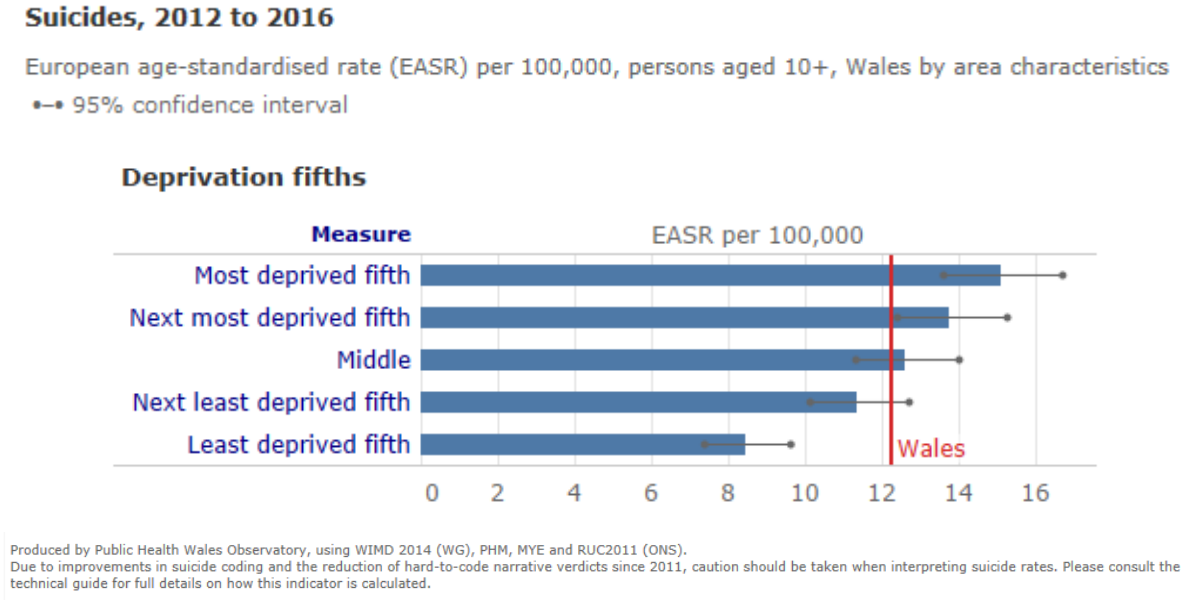
[1] Pitman A, Krysinska K, Osborn D, King M. Suicide in young men. *Lancet*. 2012 Jun 23;379 9834:2383 –2392.

[2] McDaid D, Park A, Bonin E-M. Population level suicide awareness training and intervention. In Knapp D, McDaid D, Parsonage M, editors. Mental health promotion and prevention: the economic case. London: Department of Health; 2011. p.26-28

[3] Winters, L., McAteer, S., Alex Scott-Samuel, A. (2012) *Assessing the Impact of the Economic Downturn on Health and Wellbeing*. Liverpool: Liverpool Public Health Observatory

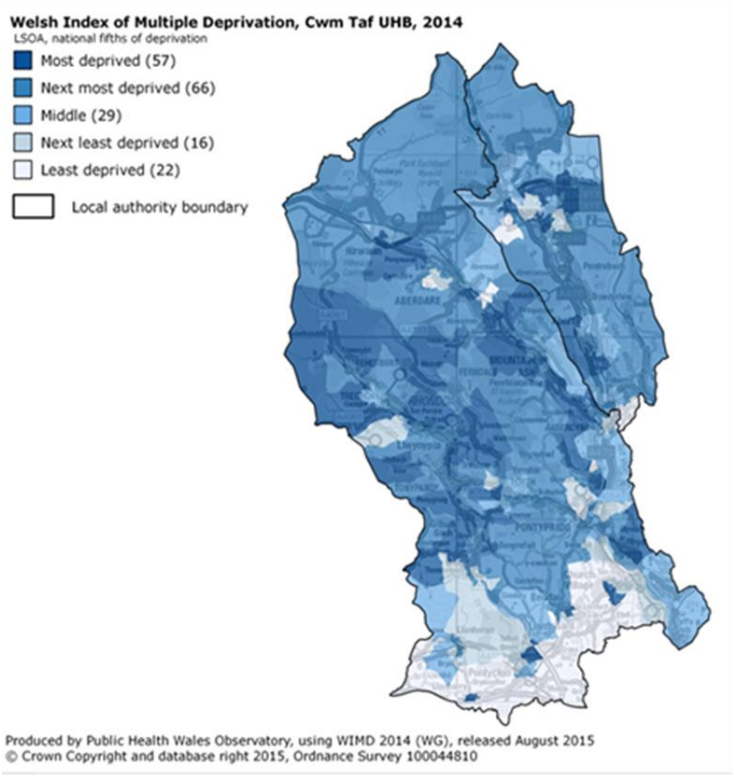
recent austerity measures and welfare reforms; A recent study[4] has shown the South Wales valleys are among the areas most adversely affected by welfare reforms. For example, in Maerdy, Pen-y-Waun (Rhondda Cynon Taf) and Gurnos (Merthyr Tydfil), the estimated loss is expected to average more than £1,000 a year per adult of working age and this may lead to increased inequalities.

The Welsh Index of Multiple Deprivation (WIMD) categorises data by fifths of deprivation. Suicide rates are two to three times higher in the most deprived neighbourhoods compared with the most affluent.



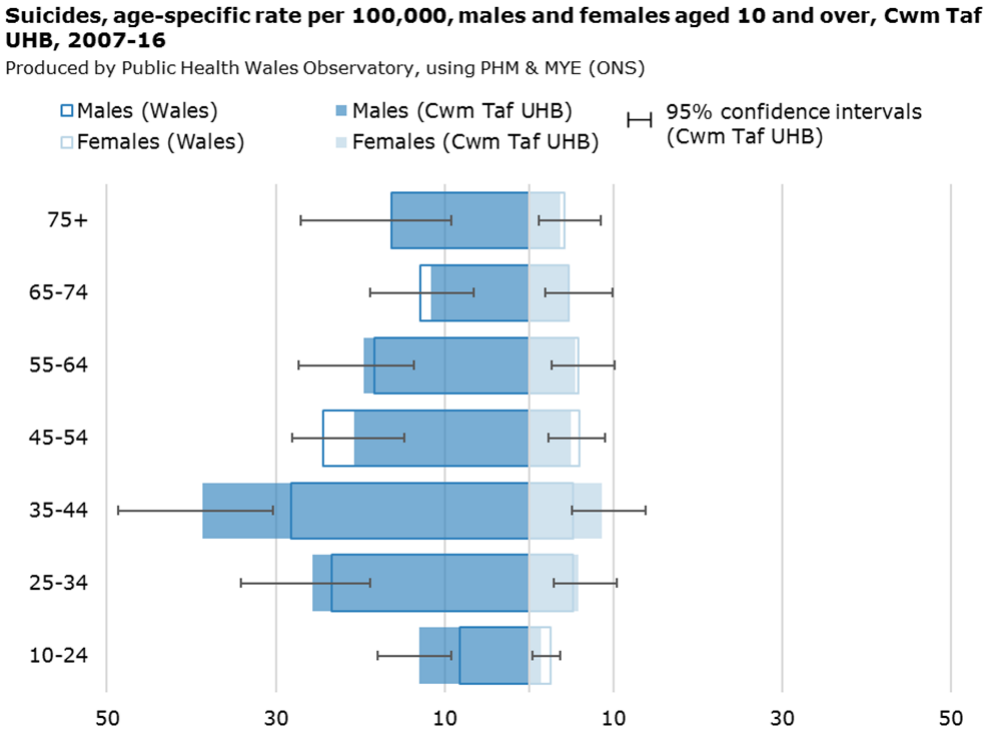
The following map shows that 65% of the neighbourhoods in Cwm Taf fall into the bottom two fifths of deprivation.

[4] Beatty C, and Fothergill F, (2014) *The impact of welfare reforms on the valleys*, Sheffield Hallam University/ Industrial Communities Alliance (Wales)



The size of populations needs to be considered when looking at suicide rates. There is more variance in rates at a Local Authority level, due in part to the relatively small numbers involved, and so there is a need to exercise caution in the interpretation of suicide data. The limitations of the data presents challenges for planning suicide prevention and responding to community needs.

The latest data from Public Health Wales Observatory shows that in Cwm Taf, the highest rate for suicides is in men aged 35-44, and this is statistically significantly higher than Wales.



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

The Talk to Me 2 Strategy and Action Plan has provided a structure and guidance for the development of local suicide prevention planning. In Cwm Taf we have a multi-agency Suicide and Self Harm Prevention Group and we are currently in the process of developing our 2018-2020 action plan.

Suicide has an effect on the frontline staff from a range of agencies (Police, Fire & Rescue, Ambulance, A& E staff and others) who have to respond to an incident. It is important that these staff are trained and supported to deal with this. It would be helpful if resources could be made available for this.

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

The mental well-being of children and young people is supported by a range of educational programmes and the school-based counselling service. The Child and Adolescent Mental Health Service (CAMHS) supports those with more severe mental health problems. CAMHS Services are provided through a regional NHS network, hosted by Cwm Taf UHB to children and

adolescents for the University Health Board areas of: Cwm Taf, Abertawe Bro Morgannwg and Cardiff and the Vale.

Valleys Steps offers free, open access, self-help courses in Stress Control and Mindfulness to help people better understand and manage their feelings in order to improve their wellbeing. Courses are available throughout Rhondda Cynon Taf and Merthyr Tydfil.
http://www.valleyssteps.org/ [Accessed 26.05.18]

The Health Board's Primary Care Mental Health Support Services are aimed at individuals of all ages who are experiencing mild to moderate, or stable, severe and enduring mental health problems. These services are based in four locations – Rhondda, Taff Ely, Cynon and Merthyr.

Crisis services are available 24/7 for people with an urgent mental health issue and many who use this service are experiencing suicidal feelings so urgent support plans are put in place.

There is a high risk of suicide in people admitted to adult mental health wards.

Managing environmental risks are only effective when done in conjunction with individual clinical risk assessment so ongoing staff training is essential to ensure a whole system approach. This is an essential part of mandatory and developmental training for all staff and will remain high on the agenda within the drive towards achieving the best quality of care for patients.

Cwm Taf's Safeguarding Board has developed a Protocol for the Immediate Response to Critical Incidents to manage the consequences of critical incidents (including suicide) in Cwm Taf in order to ensure that those who are affected, including friends, family, professionals and the wider community, are effectively supported.
http://www.cwmtafsafeguarding.org/media/1461/immediate-response-protocol-endorsed-december-2016-version-5.pdf [Accessed 26.05.18]

The contribution of local communities and civil society to suicide prevention

South Wales Valleys Samaritans support the suicide prevention agenda through a number of local initiatives:

- Awareness raising and promotion of help-seeking behaviour.

- Teacher training on the use of DEAL resources – Developing Emotional Awareness and Listening
- Emotional support is delivered in a variety of outreach venues e.g. Feet on the Streets, in town centres, Police custody suites, hospitals, pharmacies, job centres.

These activities will increase as the volunteer base expands.

Cwm Taf Mental Health Forum is a syndicate of health board, statutory and voluntary sector mental health organisations working in Rhondda Cynon Taf and Merthyr Tydfil to enhance partnership working across the mental health sector.

The Director of Merthyr and the Valleys Mind is the current Chair of the Cwm Taf Suicide & Self-harm Prevention group.

A number of voluntary and community organisations support population well-being in Cwm Taf.

Other relevant Welsh Government strategies and initiatives

The Together for Mental Health Strategy is overseen by Cwm Taf's Mental Health Partnership Board.

The Well-being of Future Generations (Wales) Act 2015 provides a unique opportunity for all public services to work differently together, involving communities in shaping their long term future and improving well-being for all. Tackling loneliness and isolation is the cross-cutting objective of Cwm Taf's Well-being plan; loneliness and isolation are risk factors for suicidal behaviour. Conversely, social connectedness through family and community support is a protective factor. One of the other objectives in the plan is to promote safe, confident, strong, and thriving communities improving the well-being of residents and visitors and building on our community assets. The actions being developed under these objectives will aim to improve community resilience and complement Talk to Me 2.

Innovative approaches to suicide prevention

Merthyr and the Valleys Mind are in collaboration with Welsh Rugby to take forward the **#ItTakesBallsToTalk** Campaign. This will reach out to 2500 men aged 18 – 50 via local rugby clubs and 'pop-up' awareness sessions across the Cwm Taf community, sharing events via Twitter to spread the word and offering free Talking Treatments as follow up support. The campaign has secured funding from Big Lottery and will run from September 2018 – August 2019.

Dear Sir/Madam

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

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

Powys Position statement

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

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

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

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

The Welsh Government's approach to suicide prevention, most specifically the suicide prevention strategy Talk to Me 2 has focussed local activity in terms of multi-agency approaches to suicide prevention; public awareness campaigns; reducing access to the means of suicide is delivered locally through the Powys Hearts and Minds: Together for Mental Health Delivery Plan ensuring a cross sector approach. Guidance associated with the strategy became available in October 2017 which has supported development of a local plan which is due for submission to the Regional fora in Wales in February 2018. The Mental Health Planning and Development Partnership will be monitoring the effectiveness of this important work stream at a local level.

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

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

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

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

Yours faithfully

Louisa Kerr
Mental Health Partnership Manager

Police Liaison Unit Welsh Government, Cathays Park	
Protective Marking:	**NOT PROTECTIVELY MARKED**
Author:	**DI Dave Rees**
Title:	**Suicide and Self Harm Evidence**
Version:	
Summary:	**Pan Wales Response**
Authorised by:	**ACC Drake**
Date sent:	**25th April 2018**

Terms of Reference

To examine the extent of the problem of suicide in Wales and what can be done to address it. To include;

- 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 Governments 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.

The Committee would like to discuss how, as priority care providers identified in *Talk to Me 2* are trained and supported to deal with incidents of suicide, the Committee will wish to explore how the police identify people at risk of suicide and their role in helping them get the support they need. The Committee would also like to discuss the training for staff and support for those who have dealt with distressing situations.

The extent of the problem

I am aware that the Office for National Statistics (ONS) provides data on the number of suicides by Local Authority for England and Wales and that this data is informed by the Coroner's Office. In recent years the ONS have only provided suicide data for those 15 years and over, but in recent years have revised their data to include deaths of persons aged 10 and over. There have also been changes in the classification of deaths in line with the new coding rules of the World Health Organisation (WHO).
The police are called to investigate all cases of sudden and unexpected death however, it is HM Coroner who will ascertain the cause of death through an inquest process and who may determine, taking into account all the information gathered as part of the inquiry, that a person has taken their own life. As a result, the HM Coroner cohort across Wales is best placed to report on numbers, trends and patterns regarding the incidence of suicide.
As a police service, we are able to contribute to the inquiry through a review of our custody records. Later in my evidence, I will explain the processes and procedures that we use to assess persons brought into custody who are at risk of suicide or self-harm.

The social and economic impact

There are numerous social and economic impacts as a result of increased suicide. The four Welsh Force policing areas consists of many close knit communities, the impact of suicide on family members and wider communities is lasting and wide ranging with some of those affected needing support of police and wider partner agencies.

Within a policing context the impact of a death following police contact can have a significant impact on public confidence. Nationally there are numerous examples of public campaigns for changes in policy and legislation following such incidents particularly those related to mental health.

I have included a custody section in my presentation that highlights the type of circumstances that could be a contributory factor.

The North Wales Suicide and Self-Harm Prevention Strategic Plan estimates that the economic cost to North Wales from suicide is approximately £90m per annum. There is an evidence base that suggests that public mental health interventions deliver large economic savings and benefits which lead to reduced spending in criminal justice.

Data for North Wales suggests that the 5 year averages between 2002 and 2012 suicide rates were higher than in the Welsh average. The five year average for 2009 to 2013 fell below the Welsh average.

The effectiveness of the Welsh Governments Approach to Suicide Prevention

The Police Liaison Unit (PLU) based in Welsh Government have a representative that sits on the Nationally Advisory Group for Wales on Suicide and Self Harm on behalf of the Welsh Chief Officer Group.

Talk to Me 2 highlights a very important point, and I agree that we all can play our part in reducing stigma, improving awareness and understanding of suicidal behaviours.

This is something that we recognise in the police service and the important role that we play in providing support to, and dealing sympathetically with people in crisis and also the families and friends of those who have either attempted suicide or have taken their own lives.

Talk to Me 2 lists police custody suites as a priority place where suicide prevention efforts 'should be focussed' and I will provide detail in my presentation as to how we manage this.

Gwent Police and South Wales Police (SWP) have formed an invaluable partnership with the Samaritans providing support to detainees in Merthyr custody suite. Persons coming into custody are offered a call to the Samaritans whilst in detention. As well as a telephone service, Samaritans volunteers attend custody suites and provide support to individuals who may be experiencing emotional distress.

In addition, when a person leaves custody, they provided with Samaritans contact details and are offered a call from the Samaritans within 24 hours.

Samaritans have delivered training to custody staff, raising their awareness of their work and how they can help and further awareness training is planned, along with the roll out of the telephone service to all custody suites in the future.

By April 2018, the full service was available in Merthyr and Swansea with the telephone service available in Bridgend.

With regard to public awareness, SWP promote partners and the support that they can provide through social media channels on a regular basis, to signpost people to appropriate agencies and organisations. SWP currently have 100,000+ followers to their social media and this number continues to grow.
SWP do this at times when they know people can be particularly vulnerable such as at Christmas and New Year and at these times, colleagues from Samaritans have located themselves in SWP control room who can speak to people directly when calls are received.
This has included calls from people who are vulnerable - but where contact is not a policing matter.
As well as Samaritans there are numerous other organisations that the four Welsh Forces work with, such as:-

- Childline
- Welsh Women's Aid
- Respect UK
- Mind Charity
- Age UK
- NHS Direct Wales
- Victim Support

Dyfed Powys Police (DPP) works closely with partners in order to deliver the *Talk to me 2* strategy. As part of the Mid and West Wales region the force has contributed to the creation of the draft Suicide Prevention Strategy which is to be delivered locally via the regional suicide harm prevention group and local mental health partnership delivery boards. These boards include statutory and non-statutory partners, and service users.

DPP is keen to focus on Suicide prevention and is currently working with local authority partners to identify key risk sites across Pembrokeshire in order to implement additional signage and support messages.

The force is currently piloting an Integrated Risk & Intervention Service – (IRIS) to support those who come into regular contact with police and other agencies when in crisis to identify support and interventions to prevent further harm.

Dyfed Powys are actively engaged in supporting delivery of the Crisis Care Concordat local action plans in conjunction with local authority and health partners. In support of this work the force has fully embedded scrutiny mechanisms for the use of S135 & S136 powers, and a fast time partnership

review process to quickly identify any service delivery learning or issues that require strategic escalation.

North Wales Police (NWP) have worked collaboratively with partners to create a regional Suicide and Self-Harm Prevention Strategic Plan. The objectives of the plan follow the national objectives of Talk to Me 2 and are as follows:

1: 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 North Wales

2: Deliver appropriate responses to personal crises, early intervention and management of suicide and self-harm

3: Information and support for those bereaved or affected by suicide and self -harm

4: Support the media in responsible reporting and portrayal of suicide and suicidal behaviour.

5: Reduce access to the means of suicide

6: Continue to promote and support learning, information and monitoring systems and research to improve our understanding of suicide and self-harm in North Wales and guide action

The regional approach has considered national learning, but also builds on practice, experience and expertise within North Wales. Not only is improving people's mental health a priority for the Together for Mental Health Partnership Board, but it also has a mission to support the whole population's mental wellbeing.

Gwent Police participated in the development of the Suicide and Self-Harm action plan with Public Health Wales and attend the annual Gwent suicide and self-harm prevention workshops and meetings.

Gwent WASPI (an information sharing protocol) has been developed that enables data sharing between the Police, Health Board and Social Services specifically for mental health crisis.

This has been evidenced by a pilot of a Community Psychiatric Nurse (CPN) in Gwent Police control room. This has now become permanent and is

commissioned by Police and Crime Commissioner. A CPN is now employed on every shift in the Force Control Room providing 24/7 cover.

Contribution of public services to suicide prevention

I have previously explained how we work with specific partners to prevent suicide and provide support to those at risk of suicide and self-harm.
As a police service we work collaboratively with a number of agencies through both our operational arrangements and partnership arrangements.
SWP have a joint Public Service Centre with the South Wales Fire and Rescue Service and Wales Ambulance Service Trust and work with both public and private sector partners in their Multi-Agency Safeguarding Hubs and in doing so, have made significant improvements in providing support and services to our most vulnerable at the earliest possible opportunity.

Gwent and South Wales Police are firmly engaged with the Early Intervention (ACES) programme and have dedicated staff to move forward with this piece of work. It is anticipated that, amongst the variety of other ACE type issues, our engagement with the programme may assist in the early identification and signposting for individuals at risk of suicide or self-harm.

It is vital that the Welsh Forces have an ability to be able to access information at first point of contact from our partners in Health Care either through direct access to information or through our partnership arrangements with Health Care Professionals. This will make a significant difference to the right and timely support to persons in crisis and those at risk of suicide and self-harm.

The four Welsh Forces work with their Statutory and Third Sector partners to deliver the aims of the Welsh Mental Health Crisis Care Concordat (MHCCC) this work has a direct link to Suicide Prevention. The MHCC is a shared commitment, endorsed by senior leaders from the organisations most heavily involved in responding to mental health crisis in a specific context. It covers what needs to happen when people in mental health crisis, often in a public place require attention from the Police. The MHCC is designed to support policy making; investment in services; in anticipating and preventing crisis; and in making sure effective emergency response systems operate in localities when a serious crisis occurs.

The MHCC is structured around:

- Access to support before crisis point.

- Urgent and emergency access to crisis care, (whilst using the least restrictive options) by both face-to-face and 'hear and treat' services.
- Quality treatment and care when in crisis.
- Recovery from crisis and staying well in the future.

NWP is a standing member of the North Wales Suicide Prevention Group chaired by Dr Gwenllian Parry. The Suicide Prevention Group recently published its strategic suicide and self-harm plan for the next 3 years. It sets out the partnership commitment and action to reduce suicide and self-harm.

The work completed by North Wales Police to reduce the incidents of suicide and self-harm are concentrated in three key areas. (1) The crisis pathway available to the person in crisis to ensure that they receive the support they require at point of contact, (2) the treatment of detainees whilst in police custody and (3) the mental health support available to staff within the organisation.

North Wales Police and Betsi Cadwalader University Health Board (BCUHB) piloted a street triage team (police officer and mental health practitioner) for eighteen months to respond to all police incidents that involved a person with mental health needs. This approach reduced use of s.136 by 69%, whilst ensuring the immediate needs of the individual were met. This approach is popular in large densely populated towns and cities demonstrating greater cost efficiency. The majority of individuals (67%) were currently or previously known to specialist community services from within the Mental Health and Learning Disability Division.

North Wales Police and BCUHB have trialled locating a mental health practitioner in the police control room for eight hours a night over a few days in the month of December to provide tactical advice and support when police respond to a person with mental disorder. Whilst a limited trial, initial evaluation demonstrated the benefit that could come from a telephone triage service for individuals in crisis. The intention is that this becomes a permanent feature within the North Wales Control Room.

BCUHB and North Wales Police are working together to provide police officers with opportunity to consult prior to detention under s.136, in accordance with the Policing and Crime Act 2017.

Gwent Police has the ability to access information at first point of contact from their partners in Health Care either through direct access to information or through their partnership arrangements with Health Care Professionals. This makes a significant difference to the right and timely support to persons in crisis and those at risk of suicide and self-harm.

Dyfed Powys Police have implemented a mental health triage unit based in their Force Communication Centre which comprises of police constables and a mental health practitioner. The team assists front line officers when dealing with persons suffering mental health crisis, ensure that vulnerable members of the community have access to the most appropriate services.

The triage unit have access to both police and health care information enabling a collaborative approach in response to calls for service, ensuring that individuals exhibiting signs of mental illness or those with a history of engagement with mental health services are signposted to the most appropriate support/intervention at the earliest opportunity. In addition the unit are able to offer telephone advice and guidance to officers dealing with mental health incidents.

This service was initially available 4 days per week, however coverage has recently been increased to 7 days per covering times of key demand (1600 – 0020) in order to enhance this service.

Arrest and Custody

When an officer makes an arrest, they are personally responsible for the risk assessment and welfare of the detained person. This responsibility continues until the suspect is handed over to the custody officer for a decision regarding detention. The custody officer is then responsible for documenting and recording the risk assessment for every detainee in the custody record.

Where there is a high risk of self-harm, the custody officer has a number of options available to consider that includes referring the arrestee to police custody healthcare professional and they are kept under close proximity supervision. Officers have access to the forces directly employed mental health liaison officers; NHS employed healthcare professionals as well as FME/doctor for advice and/or assessment.

Any action taken is dependent on the outcome of any assessment and there are a number of factors which may not be obvious but which are considered indicators of an increased risk. These include.

- Mental ill health including depression, personality disorder, anorexia and schizophrenia
- It is the first time a person has been arrested and detained
- Drug, alcohol or substance abuse or withdrawal
- Breakdown of social support and isolation (military service veterans, students, prisoners, homeless people, immigrants, older people and refugees are at particular risk)
- Being unemployed
- Previous episodes of deliberate self-harm, especially if occurring within a custodial environment.
- people in certain professions who have easy access to a means of suicide, e.g., poisons, drugs or guns, have higher rates of suicide than the general population
- chronic disabling pain or illness
- family history of suicide and/or mental ill health
- recent loss such as bereavement, divorce, separation, redundancy
- adverse childhood experiences
- People arrested in relation to violent or sexual offences, especially where they involve children, a close friend or family.

Young people may be more at risk of suicide or self-harm when the following factors are present:

- Impaired parent-child relationships (including poor family communication styles and extremes of high and low parental expectations and control)
- Parental separation or divorce
- Mental ill health in parents (e.g., depression)
- History of parental substance use disorders and antisocial behaviour.

<u>Self-harm</u>

Increased vulnerability to self-harm may arise:

- After interview
- On being charged with an offence
- After arrest for further offences
- Following a visit by family, friends or others who have taken an interest in their welfare
- After refusal of bail
- While on bail

Officers and staff will personally speak to a detainee prior to release and decide what action if any, is appropriate to support a vulnerable person upon release. Depending on the circumstances, where an individual has come into custody in respect of sexual offending against a child or offences in relation to Indecent Images of Children, The Police also ensures that the individual is supplied with literature from the Lucy Faithfull Foundation Stop It Now campaign which provides advice, guidance and a confidential number to assist with issues post arrest.

Warning markers and flags

The Welsh forces will use warning markers/flags on their respective record management systems for Suicide and Self-harm.

Markers are added during initial questioning by custody staff about a person's circumstances, health, medical condition and general wellbeing.

Self-harm is a signal that is used where information suggest that a person may self-harm, but that the harm is not considered to be a suicide attempt.

Suicidal is where a person has a previous history, indicates or threats that they may make a determined effort to commit suicide.

In both incidences the methods used or likely to be used is recorded on the person's record. This is not restricted to any attempts whilst in custody.

The process of checking a person's circumstances, health, medical condition and general wellbeing is repeated every time they attend at custody and warning markers are updated. If the information provided by a person at risk of suicide i.e. by what method has been or is likely to be attempted changes, then additional warning markers with information is added e.g. attempt suicide by way of ligature, cutting, drugs, swallowing items.

Contribution of local communities and other groups to suicide prevention

The police service work with many groups and partners, some of which are highlighted in this report. Wherever possible, The Police will signpost individuals to the services provided locally to assist them.

Other Welsh Government strategies and initiatives

The four Welsh Forces support the Welsh Governments delivery plan 'Together for Mental Health' and actively participate in the development and adoption of the Mental Health Concordat.

Training

All four Welsh Forces have embraced and invested in upskilling their staff in line with the Approved Professional Practices (APP) published by the College of Policing on mental health, suicide and self-harm.

At SWP, Suicide awareness is included as part of the forces mental health awareness training. Between May 2017 to December 2017, 1,000 response officers received new mental health training to include changes to the Police and Crime Act (2017) which made changes to police powers under the Mental Health Act (1983).
Day 1 – Suicide Awareness
Day 2 – Practical Guide to Procedure S.135 and S.136
Police training is based on the College of Policing modular inputs and is supplemented by podcasts from;

- A service users experience of being detained under S.136
- Dr Gaynor Jones on mental capacity to include fitness to detain and fitness to interview
- The Force Advisor on Mental Health provides a cradle to grave guide on S.136 procedure for officers
- Negotiator input on the do's and don'ts at first point of contact, when someone is in crisis and at risk of immediate harm or suicide.

Gwent Police MH training has been provided for 1000 front line police officers alongside Health and Local Authority staff mainly Approved Mental Health Practitioners (AMHP) Jan-March 2017. The training covered the law and criminal justice around MH (Sec 135/136; Mental capacity; missing people where MH is a factor) and how to interact with people with MH conditions or learning disabilities and Suicide Intervention.

In May/ June 2018, MIND will be delivering a training package to all Gwent Force Control Room staff around taking calls from people in MH crisis (which is likely to include but not be exclusive to those who are suicidal). Presently, MIND Newport are writing the training package. This will be to assist call handlers with first identifying that someone may have a MH problem and then how to talk to them and signpost where appropriate.

Custody Officers and Detention Officers, receive training in dealing with MH crisis on their initial courses. This training is supported and developed through bespoke annual custody refresher training.

In Dyfed, the force provides training in the form of two mental health awareness training days; the training is delivered to officers and front facing staff in order to provide them with the knowledge and tools to deal with a wide range of mental health related incidents and life events.

The training is a culmination of legislative inputs in respect of the Mental Health Act 1983, Mental Capacity Act 2005, guidance and protocols to follow as well as general awareness of mental illnesses and their associated symptoms. The training also highlights the role and involvement of a range of health care providers in the event that intervention is required and specifically where section 135 or section 136 powers are invoked. Furthermore the force has delivered bespoke dementia and autism awareness to front line staff.

This training is reinforced to supervisors and forms part of the newly promoted sergeants and Inspector's course content. This is in addition to the training/awareness provided as part of the initial joiner's course, which constitutes practitioner inputs and placement within mental health facilities to engage with patients and staff.

At the time of writing 865 members of staff have received the mental health awareness training; this equates to 89% of officers and front facing staff.

Several of the force Mental health Triage Team and some force trained negotiators have also received Applied Suicide Intervention Skills Training to enhance their ability to identify persons who may have suicidal thoughts and create plans to support on-going well being.

In addition to mandated training the force supports continuous professional development events. For example, in March 2018 and in conjunction with the office of the Police Crime Commissioner, Dyfed Powys Police hosted a mental health conference. Attendees included strategic leads and practitioners across police and mental health services nationwide across Wales, with presentations from academics, partners and service users.

The force employs a full time mental health officer, whose responsibility is to provide specialist advice and guidance to all staff in relation to the service provided to those with mental health needs both internal and external to the organisation. The role is supported by a Chief Superintendent as strategic lead.

North Wales Police have similar training arrangements for their front facing and supervisory officers.

Officers in regular contact with Children and Young People through the All Wales Schools Liaison Core Programme

This is a national Pan Wales programme, which the four Welsh Forces are actively engaged with.

Suicide and self-harm amongst children and young people is also something that we recognise.

We have specialist officers who work with the All Wales Schools Liaison Core Programme that have two bespoke training days delivered by the Charlie Weller Trust on mental health, depression, suicide and self-harm. This better equips them to understand young people in distress.

It is important to note that advice from educational research is that discussing the issue of suicide – even in a controlled and sensitive fashion – can have a detrimental effect and in fact *can* encourage young people to attempt suicide. Therefore, we have established that officers do not speak about it.

They have been trained however, to respond to direct questions from children and young people regarding the topic, by accepting the question and offering to answer on a one to one basis after the class or group session has finished – with a school member of staff present.

With regard to self-harm – the schools programme is not a 'health' programme. There are no deliveries on self-harming behaviour such as cutting or scarring. The evidence is similar to that of suicide in that a child or young person needs one to one counselling and support.

The schoolbeat.org website does contain a guide for parents regarding self-harm in their children and other information and guides.
What the programme does offer is a wealth of harm reduction messages and these can be found in all of the schools topic areas such as drugs and substance misuse (including alcohol), healthy relationships, internet safety and bullying and sexting and other areas that can affect a young person's mental wellbeing.

Police Officer & Staff Wellbeing & Counselling
There is a provision within all four Welsh Forces for welfare services for police officers and staff to be referred to confidential counselling. The service

supports individuals through trauma and difficulties to restore their psychological wellbeing.
Qualified counsellor's work with the individual in a confidential and safe environment, and in doing so, enables the staff to explore any anxiety and difficult feelings from a traumatic or distressing event or situation.
Where there is a need for ongoing counselling or support, or where the requirement is greater than that which is provided, then referrals maybe made with directly employed counselling and trauma advisors.

Health and Wellbeing.

South Wales Police continues to invest heavily in the environment and facilities for its staff. This is also reflected in the three other Welsh Forces. In SWP A programme of refurbishment and improvement is underway across the force with funds being made available to improve canteen and rest area facilities as well as expand and improve facilities for physical training and fitness. Various initiatives have been undertaken including mental health and well-being, bureaucracy reduction, time to train, etc which are all seen as a means of improving general well-being, physical and mental health and positivity. Similar schemes are operating in the other three Welsh Forces

In 2017 Dyfed Powys Police Chief Officer team launched the force 'Calon' strategy which focuses on leadership and wellbeing across the force. This has resulted in the creation of wellbeing committees across the force who delivers well-being information and initiatives.

The force has an active occupational health unit that provides confidential counselling for staff. In addition all staff involved in traumatic incidents are given the offer of specific support in addition to welfare support from line management.

The force participates in the national Mental Health Awareness week and World Mental Health Day to raise awareness both internally and externally.

North Wales Police are working towards the College of Policing Oscar Kilo Blue Light Health & Wellbeing Framework – the police services first dedicated framework in health and wellbeing which includes the areas of mental health, leadership, resilience, managing the environment, and managing attendance.

North Wales Police provide an internal Occupational Health service provision, which includes access to qualified physiotherapy and welfare and counselling

services. Where there is a requirement for further psychological support this is assessed on an individual basis.

Gwent Police has an active Mental Health Support Network with 60+ members. This group continues to grow with new members joining on a regular basis. The group meet quarterly and run the interactive Whats App group as a peer support mechanism. Group members plan social activities throughout the year as another means of offering peer support to colleagues living with MH conditions. The network members also contribute to campaigns throughout the year such as World MH day and submit blogs and stories about their lived experience

Mind Blue Light Programme.

South Wales Police have reached a key Blue Light Programme objective in establishing a large number of Blue Light Champions within their organisation. A Blue Light Champion is an employee or volunteer in the emergency services, who takes action in the workplace to raise awareness of mental health problems and challenge mental health stigma. This role acts as a signpost service to those who require support related to mental health.

We all have mental health just as we have physical health. We know that one in four people in the UK will experience a mental health problem in any given year. But independent research shows that the estimated quarter of a million people who work and volunteer in our emergency services are at an ever greater risk of experiencing a mental health problem than the general population, but are less likely to get support.

Last year South Wales Police formally signed the "Blue Light Pledge". The pledge challenges organisations to meet a series of objectives:

1. Tackling mental health stigma
2. Improving workplace wellbeing
3. Building resilience
4. Improving access to information
5. Improving pathways to support.

Since launching the Blue Light Programme, across the UK over 1,700 blue light staff and volunteers have become Blue Light Champions. To meet one of the key milestones linked to the pledge, South Wales Police is providing mental health awareness training for managers and supervisors.

The training will:

- increase awareness of mental health issues
- ensure own resilience and the resilience of those under management
- improve management styles of those affected by mental health

• better equip those manage their own mental health and the mental health of those under their supervision
• address stigma and discrimination

Dyfed Powys Police are active participants within the Blue Light Programme and have a number of volunteers Blue Light Champions within the force. These volunteers work to raise awareness and address the stigma of mental health throughout the organisation.

In addition to these volunteers the force has facilitated two mental health awareness for managers training days, and is in the process of reviewing the force mental health training packages to ensure they are 'business as usual' within the annual force training plans going forward.

North Wales Police have begun implementing a Mental Health Peer Support Network in 2017 and successfully obtained a grant from the Police Dependents Trust. Supporters are being trained to enable them to support staff in times of need, and sign post them appropriately to more specialist interventions if necessary. Additionally, North Wales Police have trained thirty staff as MIND Blue Light Champions.

Gwent Police have reached a key Blue Light Programme objective in establishing and training 60 Blue Light Champions within their organisation. A Blue Light Champion is an employee or volunteer in the emergency services, who takes action in the workplace to raise awareness of mental health problems and challenge mental health stigma. This role acts as a signpost service to those who require support related to mental health.

Transport related Suicide prevention

Over the last 12 months research carried out in Sweden has highlighted the misclassification of transport related suicide. The research carried out by Anna-Lena Andersson (Special Adviser, PhD Swedish Transport) challenged the official statistics of 6% of fatalities on the transport network being suicide. Her team concluded that this figure is 4 or 5% higher, highlighting that the problem is significantly greater than first thought.

In Wales collaboratively we are working with key stakeholders to strategically plan ahead to reduce the risks on our network. Over the next few months the first All Wales Fatal review board will meet and one of the terms of reference will be to identify collisions that are caused by suicide. The Fatal review Board is a first of its kind for the UK, it function is to bring all emergency services, local authorities, NHS, coroners and 3 sector partners together to review all fatal collisions in Wales. This will allow all parties to learn from good/bad practices, identify common themes and collectively make really changes throughout Wales to save lives.

Wales Government Transport department has set up a working group with the Police to identify opportunities to prevent transport related suicide. The group have identified that there must be a multi-agency approach share date of bridges, buildings, costal area that members of our community are using to attempt/commit suicide. Upon identify these locations in Wales we could take a collaborative approach to put preventative measures in place to reduce the risk. This could be for example an engineering solution, signage signposting individuals to charities and so on.

In Wales we have started to work with our partners in British Transport Police to learn from the outstanding work their doing to reduce suicide on the rail network. BTP and partners have taken a 9 point approach to reducing suicides on the network, these are the 9 points -

1. Leadership and resources:

a. Working in partnership and allocating resources appropriately across the railway industry such as tasking local officers and embedding officers within route teams.

2. Identifying 'priority/at risk' locations:

a. Employing geographical and temporal analysis to identify locations, regions or routes with proportionally higher numbers of incidents.

b. Compiling a list of National Priority Locations based on incident numbers and disruption. c. Introduction of the Escalation Process to address locations that have seen three or more suspected suicides and/or injurious attempts within a 12 month period.

d. Engaging with local authorities to address suicidal activity and enhance the support for those in mental health crisis.

3. Physical mitigation measures:

a. Restricting access to the means by methods such as; securing bridges, lineside fencing, mid platform fencing and restricting access to unused platforms.

b. Introduction of more CCTV cameras, security lighting, platform hatchings and enhancing security and patrols at high risk locations.

4. Promoting life-saving interventions:

a. Promoting and supporting life-saving interventions using suicide prevention materials and the BTP Suicide Prevention Hotline.

5. Training staff to intervene in suicide events:

a. Introduction of the Managing Suicidal Contacts (MSC) course for frontline staff and the related Learning Tool DVD.

6. Promoting help seeking behaviour:

a. Using campaign material such as Samaritans posters to promote help seeking behaviour and introducing crisis signs at high risk locations.

b. Raising awareness of suicide both nationally and locally and using third-party referrals for potentially vulnerable individuals.

7. Trauma management support and resilience.

8. Trauma support training.

9. Emotional support.

In Wales our goal is to introduce a similar approach to the road network, together with the fatal review board we believe that Wales make a significant step towards reducing suicides in Wales.

Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Health, Social Care and Sport Committee
HSCS(5)-17-18 Papur 11 / Paper 11

SUICIDE PREVENTION BRIEFING NOTE FOR WELSH GOVERNMENT

Kevin Roberts

18 May 2018

Gwasanaeth Tân ac Achub
Fire and Rescue Service

Contents

Aim

This briefing note provides information on two areas regarding suicide and suicide prevention. The provisions provided both internally for NWFRS employees and externally in terms of operational response and partnership working.

Internally, the briefing note provides an overview of how NWFRS responds to its own staff where a risk that an individual may attempt death by suicide is recognised.

Externally, the briefing note shows how the Service has responded to suicide related incidents and is involved with partner agencies, it will provide data amounting to the number of times NWFRS has initiated an operationally response and how this response is mobilised to an attempt to death by suicide and a death by suicide.

Internal Provisions for Suicide Prevention and Awareness

There is a NWFRS Health and Wellbeing Guidance document available to employees which covers mental health and the supporting mechanisms available.

Health and Wellbeing Guidance.pdf

SafeTALK

Suicide awareness training has been undertaken by Human Resources (HR) staff and Colleague Supporters including members of Control. The course involved alertness training to prepare to become 'suicide-alert helpers'. The training assists in recognising particular behaviours and to take appropriate action by connecting individuals with life-saving interventions, such as:

- Notice and respond to situations where suicide thoughts might be present
- Recognise that invitations for help are often overlooked
- Move beyond the common tendency to miss, dismiss, and avoid suicide
- Apply the TALK steps: Tell, Ask, Listen, and KeepSafe
- Know community resources and how to connect someone with thoughts of suicide to them for further help.

Previous training undertaken by Colleague Supporters and the HR team include the Mental Health First Aid course which also involved suicide awareness training.

Supporting Mental Health

NWFRS has a range of internal support mechanisms which complement SafeTALK to promote mental health at work and support staff who are experiencing difficulties.

Health and Wellbeing is embedded in the All Wales HR National Issues Committee objectives and in the All Wales People and Organisational Development Strategy 2018-2021. Mental health is listed in the key collaborative project plans for HR Departments in the Welsh Fire and Rescue Services for implementing a mental health strategy and also planned action in the NWFRS HR budget and business objectives (progress is reported to Principal Officers on a quarterly basis). The Equality Plan also refers to promoting mental health at work through initiatives to support employees as one of the key objectives.

NWFRS has signed up to the MIND Blue Light Programme in order to provide further mental health support for employees. The Service has a team of seventeen fully trained Blue Light Champions within the organisation who take action to raise awareness of mental health problems and challenge mental health stigma within the workplace. All Senior HR team members are being provided with mental health awareness training in 2018 to assist managers in supporting employees experiencing difficulties. This knowledge and awareness will be cascaded to all employees. A Health and Wellbeing day took place in April 2018 which included mental health as a key topic and included mindfulness courses. The Service is a chartered signatory with Mindful Employer which focuses on increasing awareness of mental health, the Service has also signed the Time to Change Wales pledge, this is the first national campaign to end the stigma and discrimination faced by people with mental health problems.

Standardisation meetings are held within the HR team to ensure that Senior HR Advisers provide the same level of support to Line Managers across the Service in a consistent manner. The Attendance Management policy and Line Manager Guide provides detailed information in respect of signposting staff for assistance and referral procedures. There are posters at all locations within the Service advertising the Employee Assistance Programme, Colleague Support and Critical Incident Debriefing schemes to staff. The Colleague Supporters are able to signpost and attend regular training events to update them on initiatives. The Service also has a Critical Incident Debrief team for employees who may have had a particular distressing experience or incident with an opportunity to discuss and review thoughts and feelings arising from the event. This service is open to any employee in NWFRS.

Monitoring of Health and Wellbeing

Any employee who cites a mental health concern to the Service is immediately referred to Occupational Health (OH) for an appointment with the OH Physician. Employees can also access a 24/7 Employee Assistance Programme with offers counselling such as Cognitive Behavioural Therapy etc.

Non-operational employees are asked to complete a medical questionnaire every year from the Service's Occupational Health service provider to establish if there have been any changes in their health. Appointments to see a Physician will be arranged as appropriate based on the responses in the completed questionnaire. Periodic medicals for operational employees are undertaken on a three yearly basis to ensure fitness for duty (both physical and mental). Those employees who undertake a Critical Incident Debriefing, Colleague Support or Family Liaison Officer role are required to complete an annual questionnaire to ensure they are not experiencing any mental health related issues associated with undertaking the welfare role.

Recognised Incidents

During a 13 year period there has been one employee death due to suicide, and three other incidents whereby suicidal thoughts have been cited by employees but not acted upon.

External response to Suicide Prevention and Awareness

Statistics and Data

Data provided by the NWFRS Corporate Planning Department shows that over the last five years up to 2016/17, NWFRS have received requests for assistance to eighty two suicide related incidents. Fifty five of these incidents were attended by NWFRS. The data-search was carried out from narrative included in the NWFRS Control call takers' documented information where there was a reference to suicide or the police believed an act was deliberate, which could be deemed suicide or attempted suicide, and includes special service calls.

40 of these calls were special service calls, 10 calls related to deliberate fire incidents, 2 were related to accidental fires and 3 were false alarms.

The specific incident type is broken down in the table below:

Total of Suicide related incidents	**82**
Suicide related incidents – attended	55
Suicide related incidents – not attended	27

Total Number of Special Service Calls (SSCs)	**40**
SSCs -Assist other agencies	3
SSCs – Making Safe -Remove/retrieval of a body (not RTC)	7
SSC - Release of person RTC	1
SSCs - other	5
Attempt/threat of suicide	24

The requests for assistance at suicide related incidents which resulted in an operational response is evenly spread across the six local Authority areas, as shown in the table below:

Ynys Mon	8
Conwy	6
Denbighshire	10
Flintshire	8
Gwynedd	7
Wrexham	16

Multi Agency Involvement

The Deputy Head of Community Safety attends and liaises with the North Wales Suicide and Self-Harm Prevention Steering Group. This multi- agency work stream has produced the North Wales Suicide and Self-Harm Prevention Strategic Plan 2018-2021.

Missing From Home (MFH)

All stations in NWFRS have now been trained in search techniques to support Missing From Home (MFH) to support North Wales Police (NWP) to conduct systematic searches for vulnerable people who have been reported missing. NWP request the availability of resources via Control and then coordinate the search through the Police Search Advisor (PolSa). NWFRS crews search agreed areas whist remaining on call for fire incidents. This training was been rolled out initially to all whole time duty stations and more recently to all remaining retained Duty Stations.

Since its implementation in April 2017, there has been forty-three recorded MFH incidents recorded on NWFRS CADView including when NWFRS crews have been deployed.

NWFRS crews who were mobilised on two separate occasions have successfully found the individuals who were deemed at high risk and vulnerable, one in Wrexham and one in Prestatyn.

Stations which have been utilised to date are Wrexham, Rhyl, Deeside, Colwyn Bay, St Asaph, Ruthin, Conwy, Prestatyn, Holywell and most recently Llangefni.

Training

Information provided by the Training Department highlights that training and awareness that has been provided to NWFRS employees regarding suicide prevention:-

- Speaking up/Speaking Out – delivered by MIND
- Safe Talk Suicide Awareness
- Mental health First Aid
- Violence Against Women, Domestic Abuse
- Critical Incident Debriefing – awareness on the impact of traumatic events
- Colleague Support
- Mindfulness
- ICE – to Control Room Staff and Hazardous Material and Environmental Protection Officer (HMEPOs)
- Make every Contact Count (MECC)

Referrals

Where it is considered that any individual is at risk, an Incident Commander can make an immediate referral to the Welsh Ambulance Trust and North Wales Police. Referrals are made through the Services vulnerable person referral system via the Control system.

Future Work

All NWFRS who deliver Safe and Well Checks have had training in Making Every Contact Count (MECC). The ethos of MECC is to take the opportunity to provide pathways to the occupier for them to take to improve their wellbeing.

It is proposed that in the event that someone sharing that they were suffering from depression or were down, that a card with a contact for the Samaritans would be left.

South Wales Fire and Rescue Service

Gwasanaeth Tân ac Achub De Cymru

Suicide and Self Harm Prevention Briefing Paper for Welsh Government

Compiled by

Bleddyn Jones

Station Commander

South Wales Fire & Rescue Service

Suicide and Self Harm in Wales

In the ten year period between 1996 and 2006 there were three hundred recorded deaths related to suicide in Wales. Since 2007 this figure has risen in Wales and in 2015 there were 350 recorded suicides. This data indicates that suicide is the main cause of death for young people in Wales with the highest rate in the 30 – 34 year age group. The extent of the problem is not localised but spread across the country and reaches into many different socio-economic groups.

In 2009 the national action plan to reduce suicide and self-harm, called 'Talk to Me' was launched to provide an overarching strategy for the forthcoming five year period. The aim of the policy was to work together to save lives by developing a collaboration between Welsh Government, NHS Wales, local authorities, justice agencies, voluntary organisations, employers, education and community groups.

In this first iteration the Fire & Rescue Service (FRS) were not identified as a 'Primary Care Giver'. This may have been due to a lack of awareness of the expanding role of the FRS across Wales.

Talk to Me 2

As a FRS we felt it was important for our role as a care provider to be identified and recognised, we were keen to contribute positively to the excellent work that was ongoing across Wales.

We worked with the leads of the National and Regional groups to provide detail on the vital role we could play in both the mitigation and supporting potential 'Persons in Distress'. This work has led to us being included and identified within the second version of the National Strategy, Talk to me 2

Statistics and Data

Data provided by SWFRS Statistics Department shows that over the last three years up to 2017/18, SWFRS have received requests for assistance to thirty two suicide related incidents. Of these 32 incidents, 18 resulted in suicide. Of the 32 incidents 66% were male (21) and 10 of these males were in the age range of 25-40. These figures have seen a steady but small decrease over the last three years. However, this could be due to not being requested to attend by other agencies.

There have also been 97 water rescue incidents since 2015 and SWFRS can only confirm two of these incidents being the result of suicide. There is an issue across the

UK as to how some of these incidents are recorded using differing terminology is used across many different organisations.

Fire & Rescue Priorities

Objective 1: 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.

FRS personnel enjoy a privileged position in terms of the access we have to the communities that we serve. Through our day to day risk reduction activities we may come into contact with individuals who we identify as being at risk of suicide or self-harm. As part of our Safe & Well (visits to people homes to provide advice and equipment to reduce fires, smoking cessation, security & scams, carbon monoxide)visit our highly trained staff can identify individuals at risk during discussions relating to health and well-being. We have a robust referral process in place which is managed by our Safeguarding officer, in conjunction with the children and adult services teams within our ten constituent Local Authorities.

FRS personnel may come into contact with a 'person in distress' who is either threatening to harm themselves or to take their own life. This can often be seen in scenarios where an individual has placed themselves on a bridge or other elevated position and is threatening to harm themselves by jumping off. Our staff often found themselves 'negotiating' with these individuals or feeling lost for words when they assisted them from a watercourse or bridge.

In order to support them in widening their knowledge we embarked on training our staff in suicide first aid. We trained 109 staff in Newport across South Wales in Safe Talk and Applied Suicide Intervention Skills as a high proportion of calls to these type of events occur in Newport. This training was kindly supported by Aneurin Bevan Health Board and Public Health Wales. This has given our staff far greater confidence in talking to potential victims and also identifying people in distress both in the community and the workplace. We often rely on electronic training systems and encourage our staff to engage in self-study, but we felt that it was important to create an opportunity for face to face training and engagement in role play to enhance the experience.

We are very proud that the British Medical Association endorse this approach as opposed to the reliance on e-learning. The BMA also go on to highlight the importance of the development of skills in CPR. (Response from BMA Cymru Wales, March 2015).

All front line FRS personnel across Wales are trained and certified to carry out CPR as part of their IEC Trauma qualification.

The suicide first aid training has been put to great use both externally and internally and is reflected across the three services in Wales. We see it as an important part of the suite of options we deliver to maintain the health and wellbeing of our staff across Wales. Our operational staff can sometimes be expected to deal with situations that may have a lasting effect on their mental health. In order to mitigate the effects we deliver an immediate response from our specialist team within our Occupational Health Unit (OHU).

Post incident we implement the critical support process whereby individuals can seek specialist support. This ranges from an informal discussion with a trained practitioner to access to full psychological assessment. If individuals to not wish to notify the OHU they can access counselling and support through our Employee Assistance Programme through self-referral. Individuals can seek support from specialist colleagues who operate within our peer support function, the Colleague support Team. We are also proud of the support provided by our Service Chaplain who can provide not only spiritual guidance but emotional support when required.

All three FRS' in Wales are proud supporters of the Blue Light Programme delivered by the mental health charity Mind. We have trained 'champions' across all levels of our organisation who are striving to remove the stigma of mental health by provoking discussion and supporting colleagues to be aware of their own mental health and wellbeing.

We are proud supporters of the Firefighters charity who continue to provide our personnel with access to state of the art rehabilitation services. Individuals can seek physical rehabilitation and psychological support via self-referral and attend one of the treatment centres across the UK.

Objective 4: Support the media in responsible reporting and portrayal of suicide and suicidal behaviour

As a FRS we recognise that we cannot fully control the way the media report on the incidents we attend. We also recognise that if the right information is shared with the media we can attempt to have some influence on the way the message is delivered.

In order to achieve this we have delivered media training to all of our Tactical Officer cadre to enable them to report on incidents more positively and use the correct language. It is important to consider the likelihood of copycat incidents and the effect any negative commentary may have on the relatives of the deceased.

We are also in the process of changing the way we categorise incidents involving potential suicide and self-harm. We are now tagging and categorizing these incidents as 'Person in Distress' rather than a more generic term of 'Rescue from Height' or 'Person in Precarious Position'. We believe that by clearing up the way these incidents are categorised will allow us to provide the appropriate emergency response, report the outcome appropriately in the media and create cleaner more accurate data which will support the identification of trends and hot-spots in the future. This improved data sharing will support future funding provision for more preventative work and clearly identify the scale of the issue and the extent of emergency service involvement.

Objective 5: Reduce the* means *of access to suicide

Within South Wales the FRS has led on a project to reduce the means of access to suicide by working with partners to implement mitigation measures. One such project is in Newport where we have led on the delivery and erection of signs on 'hot-spot' locations along the River Usk in Newport. The River Usk is somewhat of a special risk in that it has the world's highest tidal range of any City River and it can be easily accessed by a series of bridges and walkways.

The options for the types of mitigation measures used by agencies like Network Rail are limited as almost all of the bridges are listed, therefore major restructure works cannot take place. Supported financially by the Newport SIP board we have erected signs on all bridges along the River Usk which have been provided by The Samaritans. Evidence suggests that when a person is in distress there is a moment where they are open to an alternative route and we hope the signs will provide a vital lifeline and save lives. The signs simply offer an individual the opportunity to 'Talk To Us' on the Samaritans free phone number. These signs are widely used by Network Rail across the rail network and stations.

We have also gained agreement from NCP Car Parks in Newport to join the scheme along with the signs being placed in the council operated multi storey car park in the town centre.

The next phase of this project is to affix stickered signs in all public access elevators where members of the public can gain access to roofs and ledges at high level.

Future Project Work

- Currently in discussion with South Wales Trunk Road Agent (SWTRA) to identify their own high risk areas, erect signs and consider mitigation measures.

- Establish ‘Person In Distress’ as a recognised call type across all emergency services. This will create better data and better outcomes for the individuals involved.
- Expansion of signs across all tall buildings in Wales to remove the stigma and promote acceptance of the issue and the potential for the person standing next to you in the lift to need this support.
- Increased training provision for all staff across the FRS in Wales.

Gwasanaeth Tân Ac Achub
Canolbarth a Gorllewin Cymru

Mid and West Wales
Fire and Rescue Service

Suicide involvement - Briefing Note

1. Introduction

Mid and West Wales Fire and Rescue Service have a holistic approach to intervention. This includes promoting partner health and safety messages and being proactive in identifying vulnerable individuals and applying safeguarding principles to help protect those who are at risk of self-harm. The Service is also a champion for positive mental health attitudes and greater awareness of mental health and provides a network of support to staff. This briefing note provides an insight into how the Service responds to the subject of suicide within its Communities.

2. Impact upon our Operational Response staff

Operational Crews and Officers are often exposed to traumatic incidents and the Service is mindful of the impact that this can have on them. This has led to a team of staff being specially trained so that they can be deployed for Critical Diffusion debriefing and Trauma Risk Management (TRiM) and this allows these Diffusion Officers to identify where they can provide support. This support can be as immediate as discussing the traumatic event or where appropriate referring individuals or teams for more specialist support.

An employee Stress Awareness Programme is being rolled out to all staff ensuring that all staff have received a level of awareness and that there are a number of roles who have received more intensive and detailed training. This allows for trained staff to be available across the Service area.

At Executive Team level, the Corporate Head of Prevention & Protection is the strategic lead for Mental Health within the Service.

3. Staff awareness and Staff support through Corporate Health

Raising awareness on mental health and supporting staff with training and awareness is co-ordinated through the Service Human Resource and Corporate Risk Departments who are proactive in improving responses and attitudes to mental health.

Strategies are in place such as the Occupational Stress Management Procedure to set out clearly the Service's commitment to supporting positive mental health and identifying and managing stress with an action plan for mental health promotion.

There is a wide range of comprehensive information on the Service's intranet and messages are also communicated via e-mails, posters and social media, using our corporate communication methods team to reach as wide an audience as possible.

Mid and West Wales Fire and Rescue Service is proactive in promoting campaigns, both national and international that raise awareness on mental health and our objective is to support the removal of the stigma that is often associated with mental health and encourage people to discuss the subject openly and support each other.

The provision of occupational health options has been significantly developed and this allows for individuals to be referred to a wide range of mental health specialists and counsellors, including priority support during times of employee crisis or following traumatic incidents. Employees can be directed to external resources such as Mind Blue Light, CRUSE counselling and Samaritans as necessary.

The Service promotes fitness and health, which includes mental health at Wellbeing Days across the Service. This encourages awareness and engagement and allows the staff to share any concerns.

The Service has an Employee Assistance Programme provided by 'Care First', a free telephone facility for staff to discuss any concerns they have with a qualified, independent counsellor who can advise them on a wide range of issues that may be causing them anxiety or unhappiness both within and outside of the workplace. An on-line resource is also available to support self-run health and mindfulness advice and exercises and the Service constantly reviews emerging supplementary therapies.

4. Our role within the Community

Mid and West Wales Fire and Rescue Service has an essential role within the Community both in response and preventative measures. However, for matters of Suicide Prevention, this is limited to attending emergency incidents where we can assist in preventing an individual from harm and this includes self-harm such as when fire is used as a means of self-harm. Such activity can include the use of high reach appliances and the use of our Drone technology. Sadly, the Service also attends to assist other Services following suicide events to include matters of body recovery.

Since 2012/13, Mid and West Wales Fire and Rescue Service has attended 236 incidents that are suicide related.

Mid and West Wales Fire and Rescue Service employees are trained to identify Safeguarding risks and will refer any concerns to the Safeguarding Office who will assess, advise and refer as appropriate. This Safeguarding includes where concerns are identified regarding mental health or self-harm. During 2017/18, there were 11 cases of concern regarding attempts of suicide and these were dealt with through signposting to key Partners and multi-agency working.

5. Multi-agency working

Our Service Safeguarding staff attend regular meetings with Local Authority Mental Health Teams and this allows Partners to share critical information with us in a secure and limited way where fire is used as a means of self-harm.

6. Public Service Boards

Mid and West Wales Fire and Rescue Service has a statutory role on Public Service Boards and in the development of their Well-being plans and these focus on the collaborative responsibility of raising awareness and supporting well-being, including the mental well-being of everyone within our Communities.

Eitem 4

Welsh Ambulance Services NHS Trust

Submission: Health, Social Care and Sport Committee: Inquiry into Suicide Prevention

1. The Welsh Ambulance Services NHS Trust welcomes the opportunity to submit evidence to Committee on this important topic.

2. This evidence comprises two elements: a general summary of the organisation's work in the broad realm of mental health and suicide more particularly, coupled with a detailed submission based on research by the Welsh Ambulance Service's Head of Research and Innovation, and Advanced Paramedic Practitioner, Nigel Rees.

3. Sadly, it is not uncommon for ambulance service staff to attend incidents of suicide. It is similarly the case that attendances to patients experiencing mental distress are also rising.

4. Caring for patients with a mental health problem demands a particular set of skills which can be quite different from those required for more what might be considered as more traditional types of emergency care, for example trauma.

5. Additionally, working collaboratively with other emergency services, notably the police, and the wider NHS system is crucial in ensuring that patients receive the right service for them, and that the voices of this vulnerable group of patients are heard.

6. Importantly, the mental well-being of ambulance service staff cannot be overlooked and, as an organisation, we are committed to developing support services for colleagues in order that they have access to any support required, regardless of whether that need is the result of distress experienced as a function of their professional experiences or because of matters outside work.

7. In the interests of brevity, included with this submission is a copy of the Welsh Ambulance Service's Mental Health Improvement Plan 2017-2019 which outlines the organisation's approach to developing both the way we care for patients with mental ill health and also support our staff and the wider system as we adapt our services to cope with this increasing demand.

8. Detailed below is a detailed submission written by the Welsh Ambulance Service's Head of Research and Innovation, Nigel Rees, who has discrete knowledge of, and academic interest in mental health and self-harm paramedic care.

9. It is hoped that the information included in this submission is helpful to Committee and that it will help inform both questioning at the forthcoming oral evidence session and the outcome of the inquiry.

EVH/April 2018

Summary

The Health, Social Care and Sport Committee is currently undertaking an inquiry into suicide prevention in Wales. This paper serves as the detailed response to this inquiry from the Welsh Ambulance Services NHS Trust (WAST). The response has been prepared by Nigel Rees, who is an Advanced Practitioner and Head of Research & Innovation for WAST. Nigel has been exploring paramedics' perceptions of care for people who self-harm as part of his PhD in Medical and Health Studies at Swansea University. The paper is informed by unpublished work from this PhD and the most up-to-date available research evidence in this area, including three peer reviewed publications which constitute the only published research on paramedic care for people who self-harm.

The paper presents the following findings and recommendations, along with more detailed information underpinning the recommendations:

Findings

- At approximately 5% of all calls to emergency ambulance services, self-harm far exceeds calls for major trauma and cardiac arrest combined.
- Duncan et al (2017) found that 4% of people who self-harm died within the year of their 999 ambulance service contact, and that 35% of these were recorded as suicide. Also, up to four times more people die in Wales by suicide than in road traffic collisions (ONS 2014 a, 2014 b).
- People who self-harm are up to 100 times more likely than the general population to die by suicide, and it has been found that one person in every 100 appearing in hospital following self-harm dies by suicide within a year, and five per cent in the following decade. One study found 4% of people who self-harm presenting to one ambulance service died within the year of their 999 ambulance service contact, and that 35% of these were recorded as suicide.
- The quality of care and attitudes from health care staff towards people who self-harm or die by suicide have previously been reported as being unsatisfactory
- Studies have revealed how patients avoid services for fear of being detained under the Mental Health Act (1983).
- Ambulance staff and police face difficult legal and ethical challenges when caring for people who self-harm or have thoughts of suicide.

- Research has demonstrated that invalidated suicide risk prediction scores are commonly used in emergency care. Such scales perform no better, and sometimes worse, than clinician or patient ratings of risk. The limited clinical utility of such risk scores may be leading to a waste in valuable resources.
- Assessment in which the patients' views are taken seriously, participation in decisions about their care and treatment, and provision of clear explanations for decisions are highly rated
- Policy and guidelines recognise the role ambulance staff must play in the care of people who self-harm and in suicide prevention. The role of ambulance staff needs to be supported by greater support, referral pathways and advice from a wide range of professionals and groups.
- A range of initiatives have been introduced to UK Ambulance Services to support staff in caring for people who self-harm or have thoughts of suicide. These include local pathways, telephone advice from mental health professionals and joint police/mental health responses. Despite this, there is limited published evidence of the effectiveness of such initiatives, and what does exist suggests more progress and research is needed.
- Significant challenges and variations exist in terms of availability of pathways, support for ambulance staff, and consistent approaches for people who present after having consumed alcohol. Resourcing the development, delivery and maintenance of these new ways of working is also challenging.
- Finally, there appears to be limited consistency of audit and reporting processes across Wales to assess the effect of any such new ways of working or interventions.

Recommendations

- Guidelines and policy should continue to acknowledge the role of ambulance staff in caring for people who self-harm and preventing suicide. Greater emphasis should be placed on avoiding variation in support for ambulance staff, and a consistent, national approach should be considered for allocation of appropriate resources, for improved care, reporting and audit.
- Mental health literacy should be considered key to improving ambulance service care for people who self-harm or have thoughts of suicide. Whilst this should include educating patients and carers in how to respond during crisis, it should also include ambulance staff education for greater understanding of self-harm.

- Scales to predict risk of suicide should not be used to determine patient management or to predict suicide.
- Tailored, context specific and multi professional education and training should be developed for ambulance staff in order to give greater understanding of self-harm, suicide prevention and improve competence and confidence. This must include appropriately interpreting and applying mental health legislation.
- Support mechanisms for ambulance staff caring for people who self-harm and suicide prevention, such as the referral pathways, and the emerging street/mental health models, are to be welcomed; however, they need to be rigorously evaluated.
- Future development of legislation around self-harm and suicide prevention should consider the role of ambulance staff and the complexity of paramedic care for people who self-harm.
- High quality research is urgently needed on the ambulance service role in suicide prevention and the care of people who self-harm.

Introduction

Scale of Self-Harm presenting to ambulance services

Self-harm is one of the five top causes of acute hospital admissions in the United Kingdom (U.K.) (RCP 2010), and is increasing by 10% every three years (NHS information Centre 2011, HSCIC 2015) with 98.8% being emergency admissions (HSCIC 2015). Duncan et al (2017) conducted a retrospective cohort study of patients attended by the Scottish Ambulance Service in 2011, and found 9014 calls to be with ambulance clinician attendance codes relating to 'psychiatric emergency' or 'self-harm', and of these, almost half (n=3238, 48%) made at least one repeat call. These figures may, however, under-represent the scale of self-harm calls to the ambulance service, as another UK study led from Wales scrutinised narrative sections of ambulance clinical records, and found that up to 10.7% of 999 calls to ambulance services relate to mental health problems, and of these 53% are related to self-harm (INVENT 2013). Therefore, at approximately 5% of calls to emergency ambulance services, self-harm far exceeds calls for major trauma and cardiac arrest combined; indeed, up to four times more people now die in Wales by suicide than in road traffic collisions (ONS 2014 a, 2014 b). These figures do not, however, reflect the true scale of self-harm, as only 10-20% of those who engage in self-harm present to hospital (Pages et al. 2004, Ystgaard et al. 2003, Doyle et al 2015), leading to suggestions that there is a hidden population of distressed individuals, who may benefit from access to mental health services (Ystgaard, et al 2003). The true scale is estimated to be 1 in 130 people, as many make efforts to avoid A&E because of the unsympathetic response they expect there (MIND 2004).

One person in every 100 appearing in hospital following self-harm dies by suicide within a year, and five per cent in the following decade (Hawton & Fag 1998). Self-harm elevates risk of suicide 50 to 100-fold within the year following self-harm (Chan et al, 2016), and those who self-harm are also 100 times more likely than the general population to die by suicide (NICE 2004). Duncan et al (2017) found that 4% of people who self-harm died within the year of their 999 ambulance service contact, and that 35% of these were recorded as suicide.

What do patients think of care?

The quality of care and attitudes from health care staff have previously been reported as being unsatisfactory (NICE 2004, MIND 2004, Warm, Murray, & Fox 2002), and patients have also reported negative and hostile reactions from ambulance staff (Mental Health Foundation 2006). Studies have revealed how patients avoid services for fear of being detained under the Mental Health Act (1983), as the person's actions may bring them to the attention of the police and to a place of safety (NCCMH 2004). However, assessment in which the patients' views are taken seriously, participation in decisions about their care and treatment, and provision of clear explanations for decisions are highly rated (Taylor et al, 2009).

Challenges with Self-Harm and Suicide presentations to ambulance services

Risk of further harm or death of a patient by suicide is of concern to paramedics, but sometimes such care is refused by people who self-harm (Rees et al 2016). RCP (2008) advises if a person refuses care and is mentally capable of making the decision, it must be respected, even if refusal risks injury to health or premature death (unless the Mental Health Act 1983 can be applied). When considering application of the MHA (1983) ambulance staff need support of professionals with statutory responsibilities within this act such as the police, medical personnel and approved social workers.

Section 136 of the MHA (1983) is sometimes applied in scenarios involving self-harm or concerns of suicide (Rees et al 2016). However, there have been challenges over improper application of section 136 of MHA (1983) in such circumstances (Webley v St George 2014, Seal v Chief Constable of South Wales Police 2007, Rees et al 2016). The England and Wales Independent Police Complaints Commission (2015) found examples of unlawful section 136 detentions, with people being detained in private premises; interviewees talked about individuals who had been 'enticed' outside then detained under section 136. It was stated that this was generally done because officers were either: concerned about the welfare of the individual; did not feel they had time to wait for a warrant to be obtained under section 135 of the MHA (1983) in order to lawfully detain someone in a private premise; or did not feel they had any alternative options for detaining the individual. Such scenarios challenge ambulance staff who feel they lack the support to provide effective care for people who self-harm and refuse to accept help (Rees et al 2016).

Ambulance staff are often the first health professionals contacted following self-harm or suicide (Rees et al 2014), and whilst paramedic clinical practice guidance (JRCALC 2016) covers aspects of self-harm care, there are limited paramedic specific education or training programs focussing on self-harm and suicide prevention. Calls have been made for qualitative research focusing on occupational groups such as paramedics to better understand care delivered to those who self-harm (NICE 2004, RCP 2010. Warm, Murray, & Fox 2002). The author of the document has conducted previous metasyntheses and systematic reviews of the literature (Rees et al 2014, 2015), which have highlighted the challenges and opportunities which exist in paramedic care for people who self-harm, but also the limited nature of published evidence and lack of tailored education and support for paramedics in caring for people who self-harm.

Assessing risk of suicide

Risk scores for use in predicting suicide are common in emergency care. Quinlivan et al (2014) found a wide range of invalidated tools in use, and advises that such tools were not intended to replace clinical assessments or face-to-face communication. The Royal College of Psychiatrists (RCP 2010) also holds that prediction of suicide risk is virtually impossible, and that 'tick box' assessment: "*removes staff from people, devalues engagement and impairs empathy… empathic listening and talking have key therapeutic benefits*" (RCP 2010 p79). This was recently emphasised by Quinlivan et al (2017) who found that such scales performed no better, and sometimes worse, than clinician or patient ratings of risk, and recognised their limited clinical utility, leading to a waste in valuable resources. In line with guidelines (RCP 2010), Quinlivan et al (2017) advised that risk scales should not be used to determine patient management or to predict suicide. It is, therefore, argued that such scales should not be relied upon by ambulance services, rather targeted education is key to understanding and managing such clinical complexity in caring for people who self-harm, along with developing empathetic understandings.

Policy context

A raft of policy and guidelines recognises the role ambulance staff must play in the care of people who Self-Harm or those who die by suicide (RCP 2006, NICE 2004, Mental Health Crisis Care Concordat 201, Talk to me 2 2015). Such guidelines call for Ambulance services to work with other organisations to develop care pathways, including service users being taken directly to mental health units, primary care, crisis intervention teams or to social services. They suggest that ambulance trusts, emergency departments and mental health trusts

should develop locally agreed protocols for alternative care pathways for people who have self-harmed. These policies also call for ambulance staff to have access to telephone advice from crisis resolution teams, from approved doctors and social workers, regarding the assessment of mental capacity and the possible use of the Mental Health Act. Policy also advocates involving patients in decisions over care, and offering alternatives to the Emergency Department, but despite this it is reported that this is not happening (Rees et al 2016), which is backed up research which indicates conveyance rates to hospital [usually the Emergency Department] for self-harm to be between 89 and 95%, even when a paramedic has not recorded suicidal intention (Duncan et al 2017, INVENT 2013). Challenges exist in patients who have consumed alcohol with reports of mental health services refusing referral of patients who have consumed alcohol (Rees et al 2016). This is problematic, as there is strong association with suicidal behaviour and alcohol, with up to 46.1% of SH patients having consumed alcohol within six hours of their self-harm incident (Haw et al 2005).

The Welsh Ambulance Services NHS Trust has worked collaboratively to develop alternative ways of working in caring for people who self-harm or have thoughts of suicide. Despite this, significant challenges and variations exist in terms of availability of pathways, support for ambulance staff, clear and consistent approaches for people who present after having consumed alcohol and resources to develop, deliver and maintain these new ways of working. Finally, there appears to be limited consistency of audit and reporting processes across Wales to assess the effect of any interventions.

Opportunities to improve care for people who Self-Harm

Improving care for people who self-harm or have thoughts of suicide must recognise the influence of ambulance service staff on opportunity for intervention. Help-seeking intentions decrease with increasing suicidal ideation (so-called help-negation) (Rickwood et al 2005), and embarrassment or shame felt by individual or family members and friends, who might help the at-risk individual may also result in fewer opportunities for intervention (Ahmedani 2011, 2013). Individuals are said to seek mental health services in stages, first for problem recognition, then deciding to seek help, and finally, service selection, and these stages can be influenced by factors such as attitudes and beliefs about suicide, health literacy, internal and external barriers, and perceived need for treatment (Gould 2004, 2006). Stigma, both self and induced by others, is believed to reduce likelihood an individual will seek help to resolve a suicidal crisis (Batterham et al 2013, Ben-Zeev et al 2012). Calear et al (2014) highlighted importance of mental health literacy (knowledge of the symptoms, causes and treatment of a

disorder) and stigma (negative attitudes towards individuals with a disorder) in the help-seeking process in suicide prevention. High suicide literacy and low suicide stigma, however, are significantly associated with more positive help seeking attitudes and greater intentions to seek help (Caleara, et al 2014). This is supported elsewhere in community-based research, where low mental health literacy and high stigma were found to be associated with an unwillingness to accept help from mental health professionals, a lack of treatment adherence and a tendency towards inappropriate service use (Reynders et al. 2014).

Ambulance staff therefore need support to care for, and signpost at risk individuals to appropriate support care; these people may otherwise avoid services. Some countries have developed legislative powers for paramedic involuntary detention of people with self-harm and mental health problems. The Australian Mental Health Act (2000) section 33-35 (p.47-49) authorises police officers and ambulance officers to make emergency examination orders and detain patients in mental illness and an imminent risk of significant physical harm to the person or someone else. Despite this, there is confusion over its enactment (Shaban et al 2005). Extending legislative powers to UK paramedics may address some of these issues, but will require careful consideration. Any such changes to mental health legislation or policy should consider the challenges ambulance staff face in caring for people who self-harm and in suicide prevention. Mental Health literacy should therefore be considered key to improving ambulance services care for people who self-harm. Whilst this should include educating patients and carers in how to respond during crisis, it should also include paramedic education for greater understanding of self-harm to reduce stigma.

Joint mental health and police mobile response units have been implemented in a small number of other countries, including Canada (Forchuk et al. 2010; Kisely et al. 2010), and the US (Lamb et al. 2002; Scott 2000; Zealberg et al. 1992). In Australia, a joint police-mental health response unit referred to as a Police and Clinical Early Response (Huppert 2015) was introduced. Suicide was the largest patient group faced by PACER at 33%. Introduction of PACER resulted in reducing the time to assessment for patients with mental health problems, was less costly than standard care, and resulted in fewer patients being transported to hospital ED for care (19% of cases with PACER; 82% of cases with usual care). In the U.K., street triage schemes have been introduced due to the increased involvement of police forces with individuals suffering from poor mental health. They involve dedicated mental health professionals collaboratively working with police officers, attending scenes and offering more tailored interventions, in order to ensure individuals receive the most appropriate care.

Initiatives such as these involving the police, paramedics and mental health workers in improving care for people who self-harm report varying degrees of success, yet there is little published research reporting on their effectiveness (Lee et al 2015, NIHR 2016), and there is a need for further research into this.

Limitations:

This paper has been informed by the best available evidence relating to self-harm and suicide prevention in an ambulance service context. It is recognised that pre-hospital and ambulance services care has a limited evidence base, and therefore studies in this response were often conducted in a non-ambulance service context. Those studies which have explored self-harm within pre-hospital and ambulance care context are of low quality, with small samples. It is therefore strongly recommended that more high quality research is needed to explore these issues further.

Conclusion

Ambulance services respond to significant numbers of people who self-harm or have thoughts of suicide, and are therefore key to improving care and preventing suicide. Policy and guidelines recognise this role, and recommend that ambulance services should be supported by a range of stakeholders and organisations to deliver care. Patients have reported that attitudes from staff and care provided is unsatisfactory, and therefore avoid care, whilst ambulance staff have reported limited support and education in caring for people who self-harm or have thoughts of suicide. Despite significant collaboration and progress being made in recent years, more work is required to support ambulance staff in their care for self-harm and in suicide prevention.

The Welsh Ambulance Services NHS Trust welcomes the opportunity to contribute to the important work of the Health, Social Care and Sport Committee inquiry into Suicide Prevention in Wales. It is hoped that the findings and recommendations in this response will be well received by the committee and considered in its work in preventing suicides in Wales.

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Eitem 5

To: SeneddHealth@assembly.wales
Dai Lloyd AM, Chair
Health and Social Care and Sport Committee
National Assembly for Wales
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Cc: [redacted]
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Date: 8th December 2017

Annwyl / Dear Dai,

Re: Suicide Prevention

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Yn gywir / Yours sincerely

Amy Rees

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

Health, Social Care and Sport Committee's inquiry into Suicide Prevention

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

1. Introduction

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

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

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

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

2. Key facts and figures

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

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

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

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

3. Impact of suicide

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

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

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

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

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

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

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

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

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

4. Network Rail and the industry role in suicide prevention

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

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

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

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

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

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

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

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

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

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

5. Suicide Prevention Strategy

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

Prevention measures

5.1 Physical and technological measures

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

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

5.2 'Hard' prevention measures

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

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

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

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

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

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

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

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

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

IX. Platform hatching/yellow box markings - yellow cross hatching on platforms is a psychological measure. Many grow up knowing that a yellow box painted on the road indicates the need to keep the carriageway clear. Their use on platforms is to promote this thinking. Vulnerable people subsequently have to deal with the dilemma of stepping into this area to gain access to the running line, whilst at the same time potentially exposing themselves to increased surveillance from rail staff and passengers amongst others.

5.3 'Soft' prevention measures

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

5.4 Third party cooperation

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

i. Organisational and procedural measures - These are strategic, collaborative, enforcement and process related measures which seek to define the suicide problem in particular areas and develop strategies with third parties to help address them. The benefit of these measures is that they have the potential to influence the attitude and/or activities of a vulnerable individual who may be considering taking their life prior to them accessing the railway or even thinking about it as a means of lethality. Collaborating with third parties is critical to the success of these measures not only to prevent suicides on the railway but in the wider community as a whole.
ii. Public awareness and educational measures - Such measures seek to improve the knowledge or skills of various groups of people who have the potential to influence those at risk of suicide. They comprise of communications campaigns, signage, education, media guidelines and work with third parties.

5.5 Training

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

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

II. Provide basic guidance on talking to a vulnerable person; how and where to seek support and safely resolve the situation
III. Increase awareness of trauma, how it can affect people and the warning signs
IV. Provide basic guidance on talking to someone who may be suffering from trauma and how and where to seek further support

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

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

5.6 Intervening in suicide attempts

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

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

5.7 Trauma support

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

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

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

5.8 Partnership Approach

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

5.9 Innovative measures

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

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

6 Conclusions

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

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

However, we recognise the part we have to play in reducing not only suicides on the railway, but in the communities we are part of as a whole and the stigma that surrounds them. To conclude, as well as discharging our legal responsibilities in this area as an industry of 'Duty Holders' (be it of franchises or railway operations); we

seek to work with any organisation and share our knowledge and materials with those that can help achieve that end for the greater good of society.