Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Health, Social Care and Sport Committee
HSCS(5)-16-18 Papur 2 / Paper 2

Health, Social Care & Sports Committee Inquiry into suicide prevention

The Royal College of Psychiatrists is the professional medical body responsible for supporting psychiatrists throughout their careers, from training through to retirement, and in setting and raising standards of psychiatry in the United Kingdom.

The College aims to improve the outcomes of people with mental illness, and the mental health of individuals, their families and communities. In order to achieve this, the College sets standards and promotes excellence in psychiatry; leads, represents and supports psychiatrists; improves the scientific understanding of mental illness; works with and advocates for patients, carers and their organisations. Nationally and internationally, the College has a vital role in representing the expertise of the psychiatric profession to governments and other agencies.

RCPsych in Wales is an arm of the Central College, representing over 550 Consultant and Trainee Psychiatrists working in Wales.

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The Royal College of Psychiatrists in pleased to respond to the Health, Social Care and Sports Committee on their inquiry into suicide prevention. Suicide is preventable if we are given the right training and support, but rates are still high, particularly in certain parts of the population, and growing in others. The Committee recognised through evidence gathered during the inquiry into loneliness and isolation, that these are contributing factor to suicide. We welcome the Committee's in-depth look into this particular area as more can and must be done to prevent deaths and the impact that suicide has on the community.

Main points:

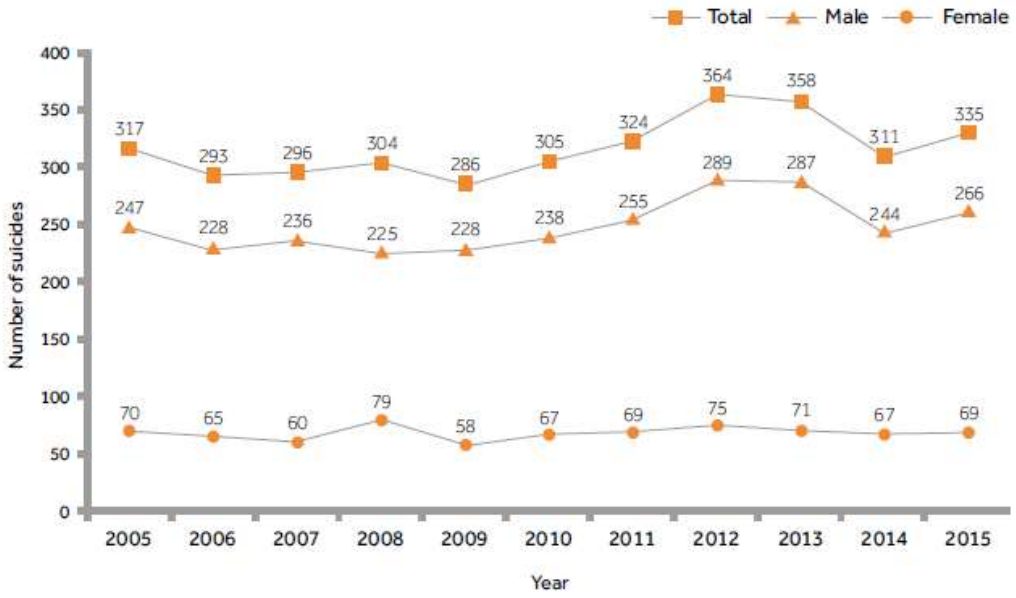
- Suicidal ideation is not a serious mental illness but it is related to poor mental health
- Suicide has a devastating impact on society and is a major public health concern.
- There is still a stigma around suicide and a lack of understanding of, and sometimes willingness to prevent it.
- Most suicides are preventable, so every effort should be made to save lives.
- Once a patient experiences suicidal ideation it is imperative that they are referred to the appropriate services, either in the NHS or third sector, as soon as possible.
- Professionals who are likely to encounter people with suicidal ideation must have training and support.
- Parity of esteem includes staff treating people in distress with respect.
- There must be quicker access to the appropriate psychological therapies, particularly for those in secondary care services.
- Improved liaison services in A&E departments would be able to better manage and care for those who present having self-harmed. These aren't problem people but people with problems who deserve to be treated with respect and dignity.

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.

<u>Statistics</u>

1. Figures published by the Office for National Statistics in 2017 show that the number of completed suicides in Great Britain fell by 3.4% from 5,870 in 2015 to 5,668 in 2016, which is 10.1 per 100,000 population. Approximately three quarters of all suicides are male with the highest rate amongst the 40 – 44 year age group at 15.1 per 100,000. The age group with the highest rate for women is 50 – 54 at 8.1 per 100,000.
2. Every year, approximately 300 people in Wales die from suicide. This figure peaked to 364 in 2012.

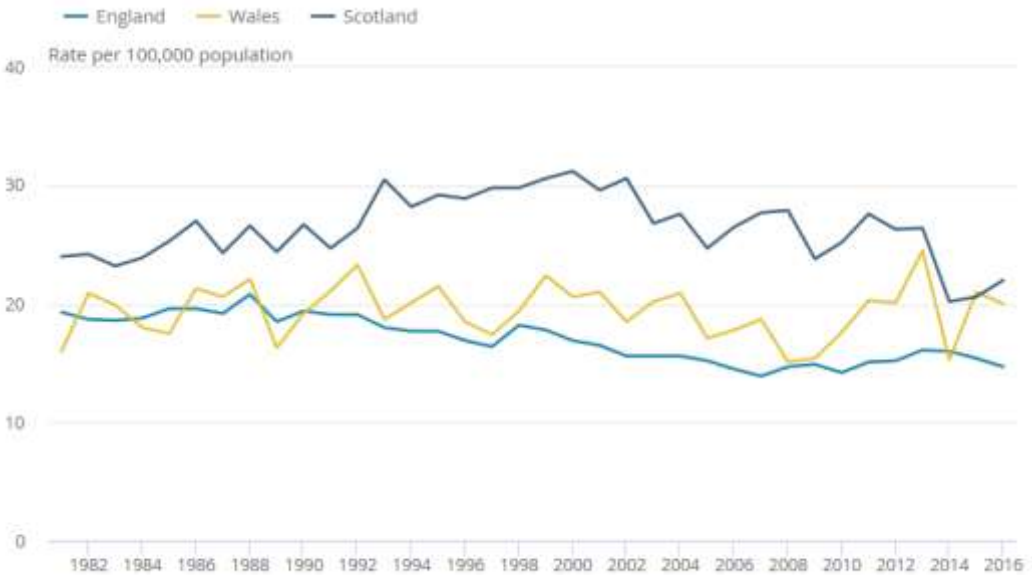
Graph 1: The number of completed suicides in Wales, by male and female



Source: The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

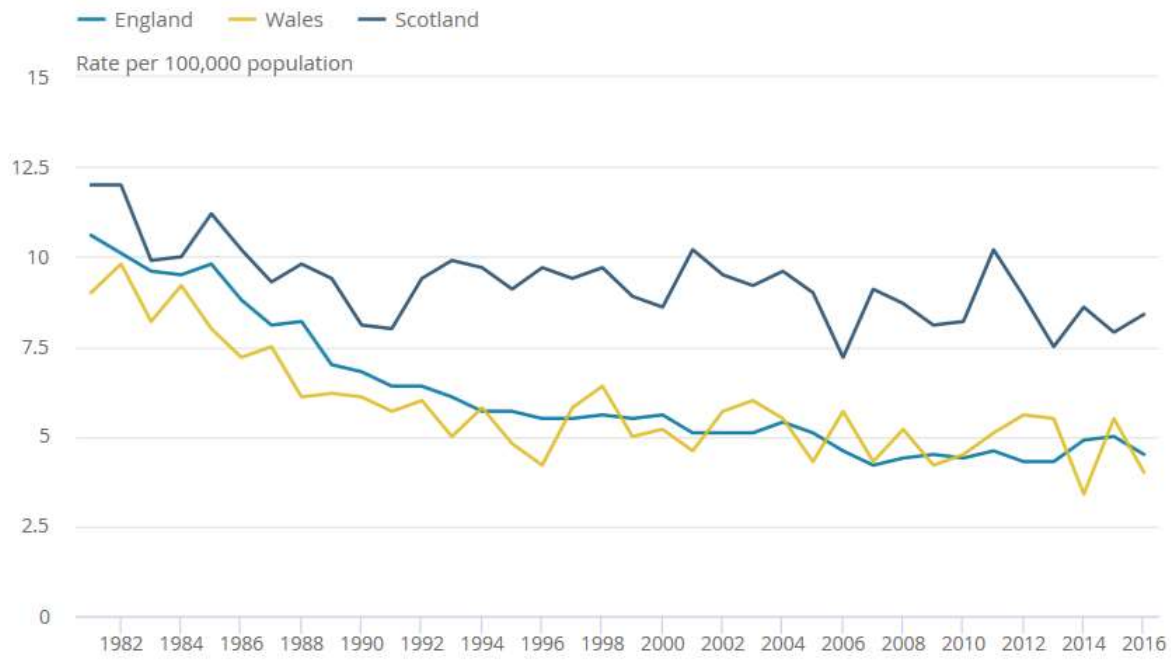
3. The overall rate of suicides has fallen in Wales from 13.0 in 2015 to 11.8 per 100,000 people in 2016; however, this is still higher that the GB average. The lowest rate for Welsh males was in 2008 at 15.1 and the highest was in 2013 at 24.3 suicides per 100,000 males. The figures appear more erratic for Wales and Scotland due to the population size.

Graph 2: The rate of completed suicides in Wales, Scotland and England 1982 – 2016 in men



Source: Office for National Statistics, National Records of Scotland

Graph 3: The rate of completed suicides in Wales, Scotland and England 1982 – 2016 in women



Source: Office for National Statistics, National Records of Scotland

4. During 2005-2015, 28% of suicides in the UK general population were mental health patients, although this figure is slightly higher in Scotland and slightly lower in Wales.[i] This trend has fallen since 2005 and continues to fall but the longstanding downward trend has slowed.
5. Although there is no hard evidence yet to show, there are indications that there could be a rise in completed suicide amongst women between the ages 16 – 34 as they are using more violent means.

Risk Factors

6. There are many reasons why people intentionally take their own lives. Ultimately, suicidal thoughts are triggered by a number of factors that are dependent on an individual's circumstances. However, there are certain factors that increase the risk of attempting or completing suicide.
7. Men are three times more likely than women to complete suicide. This could be attributed to a reluctance to seek help or talk openly about problems that they are experiencing. People suffering from substance and alcohol misuse are much more likely to complete suicide compared with the general population, as are those with psychiatric disorders, particularly those who have recently been discharged from psychiatric inpatient services. (Details of these and other risk factors can be found at Annex A.)
8. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness includes data this year on the less common diagnoses where there is a high prevalence for suicide. These include eating disorders, autism and dementia – all showing a recent rise in rates.

The social and economic impact of suicide.

Social impact

9. Suicide is devastating to those it affects and the impact can be long lasting. Because it is most often preventable, those who are affected by the death of someone through suicide often blame themselves for not having intervened. Their relationship with the suicidal person, their emotional investment in the relationship, often makes it difficult to detect or accept common signs of suicidal behavior.[ii] This impact will resonate within the family and their wider networks, often impacting closer, smaller communities more profoundly. The role of the family in suicide prevention is therefore crucial, albeit very complex.

Economic Impact

10. Suicide has an economic impact as well as a social impact. Depression, which is a major risk factor of suicide, has been identified by the World Health Organisation through the global burden of disease study as one of the leading causes of ill health and economic cost in the developed world. Depression is ranked by WHO as the single largest contributor to global disability (7.5% of all years lived with disability in 2015); anxiety disorders are ranked 6th (3.4%).[iii] The same measures to combat depression will impact on suicide rates.
11. It is important to note that a common factor of suicide is social deprivation. You are at tow to three times increased risk of suicide if unemployed than not. Men in the lowest social class, living in the most deprived areas, are 10 times at greater risk of suicide.[iv]

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.

Welsh Government

12. Suicide is a major policy issue for Welsh Government in their *Together for Mental Health* strategy, and mental health is one of the five key areas in the Welsh Government's national strategy *Prosperity for All*. There are constructive outcomes in the *Delivery Plan for Together for Mental Health*; however, we would advocate that all individuals discharged from inpatient care to have a first follow up within **three** and not five working days of discharge, given the significant risk of suicide to this group (see Annex A).
13. The Welsh Government has produced guidance on suicide prevention, *Talk to me 2* which uses evidence-based research on suicide prevention, relying on a collaboration of local partnerships. All regions in Wales have developed multi agency suicide prevention forums with agreed local reporting structures, and these report to the National Advisory Group.
14. The College is very supportive of Talk to Me 2 but we are yet to see a strong commitment by some local implementation groups. These groups must take ownership of the Welsh Government's commitment to preventing suicide and it is on the Welsh Government to implement their recommendations, to ensure that local implementation groups are effective.

Public Awareness Campaigns

15. Time to Change Wales has made real strides in reducing the stigma around mental health. We would hope that Phase 3 is continued to be supported particularly as there is a focus on men, the workplace, and developing community hubs across Wales.

Reducing Access to Suicide Means

16. There has been a concerted effort by some organisations to reduce access to suicide means and there are good examples of joint working. The Samaritans have worked with Network Rail on a suicide prevention programme that began in 2010. Since then, they have seen a reduction in the number of suicides to 237, the lowest since the programme began. According the Network Rail 16,000 railway employees have received training to intervene in suicide attempts and in 2016/17 rail employees, the police and public intervened in more than 1,593 suicide attempts on the railway. [v] They, and others, have also put up fencing to reduce access to dangerous areas, such as bridges, and there is the use of the signage with contact details.

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

17. Public services have been slow to respond to suicide prevention. Parity of esteem for mental health implies that services treat suicide and the conditions that are predisposed to it with the same attention as they do physical illnesses. Yet we continue to see that some people in distress, who self-harm or threaten suicide can be considered as a nuisance or time and money wasters. What perpetuates this is a lack of understanding around suicide and the stigma that is attached to it. Many, even those working in public services, do not see caring for people in distress as their responsibility.
18. Liaison and mental health crisis services are best equipped to deal with people presenting with suicidal ideation in hospitals and in the community, but these services are not always available. We are pleased that the Welsh Government has invested in liaison psychiatry services across Wales and have developed these in all District General Hospitals, and that the College's Psychiatric Liaison Accreditation Network (PLAN) was adopted in all Emergency Departments. In addition, the College, and others, have signed up to the Crisis Care Concordat to ensure that all public bodies responding to people in crisis work together in the best interest of the individual. Although this is good on paper, we still need to see a commitment from some health boards and more investment in health-based places of safety. We are pleased that the Task and Finish Group that oversees the implementation of local plans will continue to meet and is now an Assurance group.
19. A series of high-profile cases have put suicide on the political agenda and brought it to the forefront of the public's consciousness, which is further helped by a general increase in understanding of mental health and wellbeing.

Education

20. In schools, teachers, counselors, and school nurses should be able to spot early the signs of suicidal ideation. The Samaritans run the DEAL project in schools, providing emotional health lessons in school to increase resilience and improve an individual's ability to cope with difficult situations. We are pleased that it is

now a statutory duty for all secondary schools to have a school counseling service. We are also encouraged that Welsh Government has invested £1.4m in a pilot project in three Health Board Areas to provide dedicated Child and Adolescent Mental Health Support in schools. We would like to see the Donaldson's recommendations taken forward as there is potential for the new curriculum to impact on reducing the risk of suicide in young people and give them the skills that they can take with them into adulthood.

Police

21. The police will come into contact with many people experiencing a mental health crisis requiring immediate support. Although police officers are not mental health professionals per se, in a time of crisis, it may be that the police are the best placed to control a certain situation, in particular where an individual may be violent, aggressive, and a danger to themselves or to others. In other instances, police involvement is unnecessary or even detrimental. The Crisis Care Concordat for Wales was signed by the Local Health Boards and the police to ensure that through collaboration, the use of police cells as a place of safety was reduced. We are concerned that collaboration has not been wholly successful throughout Wales. We also worry that there are no improvements in the provision of health-based places of safety to be used under Section 135 and 136 of the Mental Health Act.

END

Annex A

Factor	Estimated increased risk
Male gender	X 3
Current or ex psychiatric patients	X 10
4 weeks following discharge from psychiatric hospital	X100-200
Prisoners (male and female)	X 5-10
Being a male rather than a female prisoner	X 2
Being married	X 1.5
Accommodated in a single cell	X 9
Life sentence	X 4
Suicidal ideation	X 15
Current psychiatric diagnosis	X 6
Psychotropic medication	X 4
Alcohol misuse	X 3
Self-harm	X 30
In first year following self harm	X 66
Aged over 60 with a more than one episode of self harm requiring hospital treatment	X 49
Those aged over 60	
who have experienced bereavement in the last year	X 3.5
who have life problems associated with accommodation (for example impending move into residential care)	X 5
Socioeconomic deprivation	Not known
Substance misuse	
Drug misuse	X 20
Heroin	X 14
Alcohol	X 6
Prescription drugs	X 20
Prescription drugs and alcohol	X 16
Prescription and illicit drugs	X 44
Schizophrenia	
Previous depressive disorder	X 3
Previous suicide attempts	X 4
Drug misuse	X 3
Agitation or motor restlessness	X 2.5
Fear of mental disintegration	X 12
Poor adherence to treatment	X 4
Recent loss	X 4
Bipolar disorder	X 15
Dysthymia	X 15
Anorexia nervosa	X 23
Anxiety disorders	X 6 -10
Personality disorder	X 7
Physical illness	
Cancer	X1.5 – 4
Neurological disorders	Not known
Renal disease	Not known
Chronic pain	Not known
For men being divorced or separated	X 2
Unemployment	X 2 -3
Family history of suicide	Not known

Source: Public Health Wales (2010) Suicide Prevention – update on the summary of evidence

[i] The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Annual Report: England, Northern Ireland, Scotland and Wales. October 2017. University of Manchester.
[ii] Owens, C. et. al (2011) Recognising and responding to suicidal crisis within family and social networks: qualitative study2011;343:d5801
[iii] WHO (2017) Depression and other common mental disorders: Global health estimates.
[iv] Samaritans (2017), Dying by Inequality: Socioeconomic disadvantage and suicidal behaviour, summary report.
[v] https://www.networkrail.co.uk/communities/safety-in-the-community/suicide-prevention-railway/