HOUSE OF COMMONS

Health Committee

Oral evidence: Suicide prevention, HC 300

Tuesday 1 November 2016

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Watch the meeting

Members present: Dr Sarah Wollaston (Chair); Heidi Alexander; Luciana Berger; Mr Ben Bradshaw; Dr James Davies; Andrea Jenkyns; Andrew Selous; Maggie Throup; Helen Whately; and Dr Philippa Whitford.

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Witnesses

I: Ruth Sutherland, Chief Executive, Samaritans, Sophie Corlett, Director of External Relations, Mind, and Dr Ann John, Associate Professor, Swansea University Medical School.

II: Saffron Cordery, Director of Policy and Strategy, NHS Providers, Dr Liz England, Royal College of General Practitioners, and Dr Peter Aitken, Chair of the Faculty of Liaison Psychiatry, Royal College of Psychiatrists.

Written evidence from witnesses:

Samaritans

Mind

UK Faculty of Public Health

NHS Providers

Royal College of General Practitioners

Royal College of Psychiatrists

Examination of witnesses

Witnesses: Ruth Sutherland, Sophie Corlett and Dr Ann John.

Q1 **Chair:** Good afternoon. Thank you for coming today. I want to make an opening statement on behalf of the Committee. We recognise that suicide is an issue that has deeply affected the lives of many people in this room and outside, and it has lasting consequences for individuals, families, friends, communities and witnesses. We would like to say as a Committee that we will hold that very clearly in everything that we talk about over the coming weeks. I want to say for anyone who is following this inquiry that there is always help available. We have links on our website to Samaritans and others who will be able to provide support for anybody who feels they need help as a result of any of the issues we discuss over the course of the inquiry. We are deeply grateful to all the many families and individuals who have contributed to this inquiry, both in responses to Mind—our thanks to Mind for doing that—and in detailed submissions to this inquiry. They have all been immensely important to us, so thank you very much.

I thank the panel members for coming this afternoon. I would like you to introduce yourselves to those following from outside this room, starting with Ann John.

Dr John: I am Dr Ann John. I was formerly a GP but I then became a consultant in public health. I chair the national advisory group for suicide and self-harm prevention in Wales and work as a clinical academic in this area. I am here representing the UK Faculty of Public Health.

Ruth Sutherland: I am Ruth Sutherland, chief executive of Samaritans.

Sophie Corlett: I am Sophie Corlett, director of external relations at Mind, which has services across England and Wales as well as running some national services and information services.

Chair: Andrea Jenkyns has to leave early today so she will start the questioning.

Q2 **Andrea Jenkyns:** Thank you very much, Chair. First, we especially need to praise the voluntary organisations and thank them for the work they do. I have a family member who was a Samaritan for several years and I know how much work you put in, so thank you.

Why is suicide prevention a public health issue and what sort of agencies do you think need to be involved? Can we start with Ruth, please?

Ruth Sutherland: Suicide is very complex. There are a number of background factors, which could be life events, a mental health problem, a biological factor or a psychological factor. Then life gets in the way—all the things that life throws at you that you have to deal with. That can lead to a situation of unbearable pain, which can lead to thoughts of suicide and plans of suicide. In the unbearable pain bit and the drivers for that, there are bereavement, debt, relationship problems and financial

problems, all the things that life throws at you. No one single organisation or individual is going to be able to be responsible for any of those things and no one factor is going to be responsible. We need a multi-agency approach, because it is much bigger. We know that only 28% of people who die by suicide have been in contact with mental health services within the last 12 months. The bigger issue is the public health issue; it is all those people who do not have contact. Samaritans takes 5.4 million contacts a year. We will have dealt with 14,000 contacts today: every six seconds, someone rings the Samaritans. What they talk about is a whole array of difficulties in their life, and it would take more than one agency to support that.

Q3 **Andrea Jenkyns:** From the public health perspective, what is your view?

Dr John: I completely agree with Ruth. The idea that there is no single cause so there is no single organisation means that you want to involve the police or fire services—the front-line services that people in distress come into contact with. Collaboration is very much a public health collaboration across sectors and services. The other issue to raise, in terms of public health, is that public health has always been about addressing inequalities and inequities. It is undeniable that anyone can be affected by suicide, but it is much more common among our more deprived communities. That is why you also require a public health approach. Public health has often been an advocate for more vulnerable members of our society and communities. As well as those from deprived areas, there are certain high-risk groups, such those from the LGBT community, prisoners and looked-after children, who are also at higher risk. It is very important that we take that sort of wide-ranging approach, addressing inequalities.

Q4 **Andrea Jenkyns:** I will bring Sophie in on the second part of the question, as it is about the voluntary sector. How large a role do you think voluntary organisations, such as yourself and the Samaritans, play in suicide prevention, and is there a case for increased financial support for organisations such as yours, given the roles that you play?

Sophie Corlett: Obviously the answer to the second part of that question is yes. We play quite a big role. Samaritans play a role and we can see exactly what they are there to do. Mind is not really about suicide—it is about mental health—but we are increasingly dealing with callers who are suicidal, not because we have set up and advertise to be that, but because people who come to us with mental health problems are increasingly at that crisis and suicidal point. For instance, through our information service we give information and signpost people—it is a very simple service in some ways—but when callers are actively suicidal and we can identify that they have a plan and that it is a real plan for them, we will, if they give us permission or indicate that that is what they want us to do, escalate that and call the ambulance service. We have had a 64% increase in the number of escalations, as we call them, over two years. We are increasingly having to deal with people who are at that point.

Q5 **Andrea Jenkyns:** Ruth, can we have your perspective as well?

Ruth Sutherland: On the role of the community voluntary sector in public health, volunteering is good for you: it is good for you physically and mentally; it reduces isolation and enhances connectedness, and those are protective factors. A vibrant community voluntary sector is necessary to mitigate some of those problems. We can also cut through. We often find at a local level, with local area action plans, that we can be the glue. We do not get sucked into the politics of who is talking to who or whatever; we just want the job to be done, and we can provide the glue. We are a good partner. We do not have much in the way of pound notes, but we have a lot of commitment and resolve, and we are a good partner.

Q6 **Andrea Jenkyns:** I guess you agree with Sophie on the extra funding.

Ruth Sutherland: Yes, please.

Sophie Corlett: At a local level we are involved in a number of initiatives. Cambridgeshire and Peterborough Mind and Bristol Mind have a STOP Suicide campaign, so there are a number of ways at a local level that we can be part of a local suicide prevention programme.

Dr John: Two other things to think about are protective factors, thinking about wellbeing and suicide prevention across the life course. A public health approach would be very much about thinking how we build resilience in our young people so that they go on to be adults who can problem-solve.

Q7 **Chair:** Can I ask a two-part question? We know the Government are due to publish an updated suicide prevention strategy, so the question in two parts is: first, what do you feel is missing from the strategy as it stands; and secondly, what three things do you think should definitely be in the updated strategy? Could you set them out?

Dr John: About five days ago Public Health England published a large document, which I was involved in developing, about how to develop local suicide action plans. There is something about ensuring that national strategies that can co-ordinate the areas that we highlighted that we need to address are implemented locally. The suicide prevention APPG highlighted local suicide prevention plans and action plans as well. There is something about supporting organisations locally, to have these sorts of multi-agency forums operating at local authority level so that people get to know each other on this agenda, and start working together.

Then there is understanding your local data; we produce and the ONS produces lots of national data, but we need to understand particular populations locally, where you can address and build services, whatever sorts of services they are, that highlight the issues, for example services in particularly deprived communities where you can encourage men to be helped to see it. There is something about making sure that people have access to local data, that there are suicide prevention forums working

locally and then working towards local suicide audits, which is about data, but it is also working with local coroners and people in the area, to make the data accessible to public health teams and those working locally. People are brought together much better when they think about local implementation.

Ruth Sutherland: We have had the existing strategy. There is nothing wrong with the existing strategy. It is a good, comprehensive, public health approach. The six priority areas still stand, with the emphasis on middle-aged men and bereaved people. We have had good progress in developing the tools, just as you described—the Public Health England guidance. We have had annual reports, which list every year activities that are all good activities, but the problem is implementation: we do not know how we are doing. All the activities listed in the annual report are good, but what are they leading to and what is the impact? If I was to pick out four things—I am putting an extra one in—

Chair: That is fine; we will let you.

Ruth Sutherland: Leadership is absolutely key. Leadership within the health body is not clear in the current strategy, where the leadership lies between Public Health England, the Department of Health and NHS England; it is about getting that right. There is getting leadership right cross-Government. I have worked in and alongside the health service for 35 years and we have talked about cross-Government things for all of that time. Let this be the model. Let this be the time when we actually ignite the enthusiasm of the Departments for Transport, Work and Pensions and Education—all of those people. All those Government Departments are spending money on things that impact suicide prevention. Dial up suicide prevention in all your work, whether it is on education policy or whatever. Where is the leadership going to come from across Government to make that happen?

Then, of course, we need leadership at local level. We have some outstanding examples of local area action plans, but they are a handful. The 2014 APPG did a survey and found that 30% of local authorities in England do not have a plan, and 40% of local authorities in England do not have a multi-agency prevention group. If you have not done an audit, you cannot do a plan. If you do not have a group, you cannot deliver the plan. Samaritans are involved in a number of those plans, and we think from all our work locally that the situation is worse than in 2014, but the fact is we do not know. There is no monitoring to know what is happening at local level. My fear is that resources are under stretch. Public health money has diminished, and that is putting huge strain on that area. They should be the people who can take leadership at local level and they are overburdened and cannot do it. We have had reports from Samaritan branches of meetings being cancelled, that they are being told that there is not enough resource to do anything, so we think there is a deteriorating situation from 2014, but we welcome Public Health England

now saying they are going to survey it, and we will know soon what the activity is.

To go back to my four areas, there is leadership at local and national level and resource. The money made available through the mental health taskforce is to be welcomed, but £25 million is too little, too late. It is not commensurate with the cost—£1.67 million is the economic and social cost of one life lost—to think that we are going to help by investing £25 million. The money will be allocated to the CCGs, and certainly the CCGs need the money, but how are we going to stimulate the activity that needs to happen across the sector? To go back to the resource point, Samaritans plays its role and we do what we can, but our total turnover is £14 million; Macmillan's is £230 million. We are the biggest player in the suicide prevention charity world. The investment is not commensurate with the size of the problem. In resource, I would also count research, data, awareness, skills and training. Those are all resources that we need.

The third area is integration. This is not a stand-alone policy strand. Alcohol has as much a part to play as anything else. If we could integrate all our policy initiatives—as I say, dial up suicide prevention across the policy gambit—we would make huge progress. Parenting and education are examples.

The last area is accountability. We have no visibility of what is happening. There is no oversight, so how do we know what the impact is and what more we need to do? How do we know we are learning anything? That is the research point. We were pleased to be engaged with the refresh and we have put all these views forward and hope they come out the other end; what we really want are properly resourced, co-ordinated and multi-agency sectoral plans in every area, with national overview. If we could achieve that one thing, we could move mountains.

Q8 **Chair:** Thank you. That is really comprehensive, Ruth. Can I take you back to one point you made? You said you think the situation is getting worse, but you do not know. What are you basing that on?

Ruth Sutherland: Reports from our local Samaritans branches that are involved in local area plans. They report back to us. We have a list of areas, but I never like to—

Q9 **Chair:** It might be helpful if you could send a note to the Committee on that. That would be useful. Finally, Sophie, is there anything you want to add?

Sophie Corlett: I could help with that. In our efforts to get information about the public health spend on mental health, we have had to do Freedom of Information Act requests. I have it here somewhere and can send it to you, but I think the spending has gone down from about 1.4% to 1%. We are waiting on the results of the next one, but the trend seems to be down. That is the public health budget.

Q10 **Chair:** If you get it before the end of these hearings, it would be very helpful to have your formal note on that. Is there anything you want to add to what Ruth said?

Sophie Corlett: Ruth seems to have covered almost everything.

Chair: Yes, it's terrible being the last of the panel.

Sophie Corlett: There are a couple of things I want to add. There is a national leadership issue. We have had a really interesting experience in a slightly different forum, around mental health crisis care—the Mental Health Crisis Care Concordat—where there has been national leadership, and an expectation that that is replicated locally cross-sector. That has worked very well, the national partners have taken action to make sure that things happen at local level as well, and then at local level partners have got together to indicate what they can do, what they can bring to the party and work on together. If that was replicated on suicide, it would be very powerful, because I feel that people are not bringing what they can to what is happening at local level. We know what many of the triggers are for suicide—debt, inability to get health services, a whole string of things—so all the different parties need to make sure that debt advice is easily available and that you can get crisis care when you need it. That means that people not only have to do their bit, but have to be able to refer people on to the other bits as required. That leadership is of two parts.

The other thing would be to listen to local people. The exercise we did, getting information in and asking people what their experience was of suicide—a friend or relation's suicide—was very powerful in indicating how very variable people's experiences are, and each local area needs to know what the experience is locally. The third thing would be around stigma and discrimination, and efforts that can be made locally to make it more possible for people to talk, and to train people who work on the frontline—education, police, youth services, employers, colleagues—so that people feel much more open to talk about suicide.

Chair: We will talk about that in more detail later on. Luciana has a supplementary question and then we are going to go to Maggie.

Q11 **Luciana Berger:** Ruth, in your contribution you talked about national leadership and joined-up thinking across Government Departments. I do not know if any of you have historical knowledge about what happened before 2010, but there used to be a sub-committee of the Cabinet Office that co-ordinated across Government to think about how we kept people well. Do you know whether that included suicide prevention? Whether it did or it didn't, is it something that could make a difference, to bring all those different Departments together to make an impact?

Ruth Sutherland: I do not think it was on suicide prevention itself. I think it might have been cross-Government on mental health, or maybe on public health, but certainly it would be a good idea. More co-ordination across Government Departments would make a huge difference, but it

needs to be the same at local level as well. I perhaps forgot to mention, but maybe I will get another chance, the role of the private sector.

Q12 **Mr Bradshaw:** The need for effective cross-Government and cross-departmental action could apply equally to obesity. I think the point Luciana was making is that, without high-level leadership on that, you are not going to get it. You gave us a very good solution to put in our report.

Q13 **Chair:** I think you were just being asked whether you feel it is important.

Ruth Sutherland: Yes.

Q14 **Chair:** Does anybody else want to reply to Luciana's point?

Sophie Corlett: It was a good point.

Q15 **Maggie Throup:** Ann and Ruth, you have already mentioned the all-party group report from 2014, and Ruth, I think you mentioned that 30% of local authorities did not have a suicide prevention plan in place. What proportion of local authorities do you think now have a plan in place?

Ruth Sutherland: As I said, we do not know. My sense is that it is a deteriorating position, but we have had reports of some new ones coming on. The real answer is that we do not know and the fact that we do not know means, "How do we add it?" Anecdotally, we hear from some local areas that they think that they do not have a problem. Therefore, they are not going to prioritise it. But if you have not done an audit, how do you know whether or not you have a problem?

Maggie Throup: If you have not measured it, yes.

Ruth Sutherland: My worry, and it is linked to the stigma point, is ignorance—that people somehow believe that suicide is inevitable when all the evidence shows us that suicide is preventable. If you think it is inevitable and you think it is not your problem, because you do not think you have a problem, in a pressured environment where every pound note is haggled over, you can see why we are in the situation that we are in. If we do the repeat and we know, then we need to start monitoring it. We need to start learning from good practice what works and for whom, and do more of that.

Q16 **Maggie Throup:** Why do you think some will have dropped off their plan? If they already had a plan in place, why do you think numbers have gone down?

Ruth Sutherland: It is just hard-pressed resource, with meetings poorly attended and not the right people. Again, it is short-sighted not to engage the wider community. Of course, public services are hard pressed, but I want to highlight the Network Rail work. The role of the private sector is important. What could Government do to incentivise and promote activity from the private sector and get other people involved? Samaritans have been involved in a seven-year partnership with Network Rail, and they have seen a 13% reduction in suicides in the last year. We

have trained more than 10,000 railway men—they are mostly men—and, great, they are mostly men in the middle-aged group; they are men who would probably have no access to knowledge of mental health and all those kinds of things, in any other walk of life. They have families, they have communities and they start to influence people. There have been more than 1,000 interventions by rail staff in the last year, which has contributed to that reduction. All of that work has been taken on their own initiative. Yes, it was a huge cost to them, but this is a huge cost to the country. They understood the huge cost to their business, and have invested in a commensurate way and got the results. They have lots of data that they would happily share with a local authority, but no local authorities are asking them—a few are.

Q17 **Maggie Throup:** Ann, do you want to add to that?

Dr John: There is an opportunity. The guidance for local authorities on how to develop plans was sparse before; if there were people with interest in an area, they would develop a plan, but if you do not have someone with a specialist interest, if there is no clear leadership or ownership in an area, it would appear to be quite a daunting task to gather all those different people together and create a plan. There is an opportunity with the production of the guidance, which is very comprehensive. If you can recommend handing over some ownership, accountability and leadership to local areas, they have sufficient pointers in the guidance produced by Public Health England to develop plans now, possibly without having specialist expertise in the area. It is very comprehensive.

Q18 **Maggie Throup:** Do you think the guidance will now make sure that local authorities prioritise their prevention plans?

Dr John: The problem with issuing guidance is that only the people who are interested know that the guidance has been issued. There is definitely a lot of work to be done, first, to raise awareness and, secondly, on accountability locally. In the past, people have not been keen to make it mandatory to have plans and action plans in this area, but if you do that the guidance is there for it to be developed. Otherwise, you preach to the converted.

Q19 **Maggie Throup:** Ruth, you have already mentioned the £25 million that is coming on stream and said it is too little too late, but you also share a concern about its being targeted at CCGs rather than local authorities. Where should it be targeted?

Ruth Sutherland: Everybody needs some. We have to welcome the £25 million. There has never been this level of investment before, so we have to welcome it, but if the strategy is talking about public health, singling out the additional money for the health part seems to run counter to the strategy. I would like it if the £25 million was going to CCGs, and the Department for Communities and Local Government could match it and put that money into the local authority, and everybody else could put

their bit in. Then we would have a reasonable pot. But it is £23,000 per CCG and over the course of the three years it will amount to about £66,000. It will start next year with £5 million, the year after £10 million and the year after £10 million. In the scheme of all the pressures there are for CCGs, primary care and everything else, what is £23,000 going to do?

Q20 **Maggie Throup:** If local authorities have the responsibility, what is the rationale behind it going to the CCGs?

Ruth Sutherland: It was money from the Department of Health, so that is where it came from.

Q21 **Maggie Throup:** Ann, do you want to add to that?

Dr John: I agree. If you have proper leadership to bring those different people together—we see it in Wales—it is about someone taking ownership of the local groups. Money goes to all those different places, and in some ways that is part of the problem. If you do not have someone in a CCG or a local authority taking ownership, being accountable and taking a lead role in suicide prevention, you get piecemeal interventions happening in areas. What you want is for someone to take ownership of the agenda to bring all the sectors and funding together. Lots of different services are doing bits and pieces in this area.

Q22 **Andrew Selous:** Ruth, earlier you talked about bereavement, debt and relationships being three key issues leading people to take their own life. Who is working on looking across the local community to see where the gaps are in the voluntary groups, in the community groups—the clubs, the lunch clubs—that would provide some of the support that we know could be a key protective factor? I absolutely get the role of the CCGs and the local authorities, but quite a lot of this is third sector, if I am hearing you correctly. Who is looking across that and trying to stimulate it? You mentioned debt. The Salvation Army in my area and CAP—Christians Against Poverty—has just increased its debt counselling services, which is brilliant, so I know that is one tick in my local area, but I probably have gaps in one or two others. Who is looking at that piece overall?

Ruth Sutherland: The whole ambition that a local area is a good place to live lies with the local authority, but it is about their interface with the community and the voluntary sector and the co-ordination of that. Certainly the community and voluntary sectors could do better at co-ordinating organisations. Again, suicide prevention offers an opportunity. Citizens Advice have been very active around the debt area and are the backbone but are quite overwhelmed with volume. The National Trust has been doing great work on improving physical areas, and guidance in public places. Even the Wildlife Trusts have been doing things in that area. The numbers of people who are members of the National Trust are greater than for any political party, and in the

voluntary sector there are a lot of people who are engaged at local level, but I agree with Ann, and on other points that we have made, that it is about the co-ordination of all that. Having a good place to live must be the ambition of the local authority.

Q23 **Heidi Alexander:** Ann, I would like to follow up on one of the things you said in passing before I put some questions to Ruth about co-ordination of different suicide prevention initiatives. Ann, you talked about resistance in the past to making suicide prevention plans mandatory. Do you think they should be mandatory and, if not, why not?

Dr John: They should be mandatory. I work a lot on suicide prevention in Wales and sit on the national advisory group. We have established three regional forums across Wales that meet regularly. It was very hard work to do, and I have noticed over the years that, when within a community or a certain sector there is an issue with suicide, everyone looks around for advice and how to co-ordinate, and suddenly everyone is focused. What you really want is that those relationships are already there, so that you can highlight the issues early, and you can be doing work quietly in the background, co-ordinating all the efforts in a community. Lots of people are doing work on this agenda, often without realising it, but until there is an issue people tend not to focus on it, because there are so many other pressures, particularly within the public sector and the voluntary sector. If you make things mandatory, you are building a foundation, so that when there are issues in areas, those relationships are already there. Some of those relationships should be very standard between all the services. As regards others, I have found myself in a room with the architects of a bridge talking about parapet heights. That is completely outside my experience, but it shows the breadth of relationships that need to happen locally for suicide prevention. Yes, they should be mandatory.

Q24 **Heidi Alexander:** Ruth, I would be interested to know whether you agree with that. More broadly, in your written evidence you refer to some concerns about co-ordination between CCG-led initiatives, such as the zero suicide pilots and local authority-led work on suicide prevention. It would be helpful if you could articulate your concerns around that co-ordination and what would need to change to tackle it.

Ruth Sutherland: We certainly welcome the zero suicide pilots. We have three; they are all different and we have yet to see any evaluation. They are about service improvement and, therefore, about mental health services. They are a really important part of the jigsaw, but the local authority area plans should be more comprehensive. There is no reason why a zero suicide initiative could not fit nicely into a local area plan. We were signalling that if we learn from the zero suicide pilots that they improve services, and what works and all of that, let's make sure, if we are rolling them out, that we do so in an integrated way, and we do not end up with duplication.

The general point about co-ordination we have made quite a lot, but I highlight for you that in Scotland, in the earlier phase—the 2006 to 2008 Choose Life strategy—a co-ordinator for each local authority was part of the funding package, and it made great strides. There was also a national implementation support team. The next phase is not quite as developed, and in a way it has gone a little bit backwards, but there is a lot we could learn from the 2006-2008 period about co-ordination. Scotland had a really co-ordinated effort at the whole thing and it paid off. They had some of the highest rates and they saw a decline. That is what we need—consistency and a concerted approach.

Q25 **Luciana Berger:** Sophie, our thanks to Mind for the survey you did of your members. It was very significant that we had 1,600 responses—or you had 1,600 responses to that and shared the results with us. The Committee separately had 40 individual responses, and it has helped to have that body of response you co-ordinated as well, so thank you for that. I was reflecting on the word clouds that you shared with us that brought together the responses you had. My assessment, from looking at the word clouds, is that the thing that comes through most strongly from your members is access to services, in answer to the questions that relate to our terms of reference around why people believe there has been an increase in suicide, what the barriers are to tackling the increased suicide rate and what measures need to be put in place. Could you confirm that my interpretation of your word clouds reflects the views of your members?

Sophie Corlett: Yes. It is worth saying that the group we sent that out to was a group of people who campaign with us, so they are very possibly people who are more interested in services. People for whom there might be other issues might not have been on our campaigners' database, so there may be a bit of self-selection. What came up over and over again—it was my key takeaway from this as well—was that people wanted to get access to services when they felt they really needed them, as opposed to being, they felt, often turned away as not suicidal enough. The repeat concern we got from people was that they were being asked to go right up to the edge. In another survey that we did a couple of years ago, I remember one quote really strongly; someone said they felt they had to have one foot off the bridge before the service was going to take them seriously. Suicidal feelings are not being taken seriously.

The second thing is how people are treated when they get access to services. One of the things that comes through very strongly is people feeling belittled by services—one person used that phrase—feelings that they are time-wasting or to do with their weakness, that suicide is "something that you should not be coming to us with," and that you are lesser for those feelings. People feel belittled. Of course both those things in themselves are hugely damaging if there is a likelihood of somebody in future taking their life, quite apart from the absence of a decent service.

Q26 **Luciana Berger:** Thank you. Do you have one or two other key messages, or perhaps the most important messages, in addition to services, from your members who responded to that survey that you think the inquiry should take into account?

Sophie Corlett: Ruth has already alluded to the social issues. One person called it the impact of austerity, people feeling that they had reached the end of the line and the sensible option was suicide, effectively. They had difficulties with benefits; people mentioned the bedroom tax and falling into debt. If you add things that can roll on from that, such as losing their home, job or relationship, becoming isolated and just feeling that they did not know where to turn—obviously the services that might support them are becoming harder to find as well—that would be the second thing.

The third thing is stigma, which I mentioned before; people feeling that suicide is not something you talk about. Even if you have had contact with mental health services, suicide is difficult enough to raise, but if you have never had any contact with the services before, suicide is not something that you even know the language to raise and many people do not know how to respond. Being able to talk about suicide, suicidal feelings or feelings of despair much more openly within society would make a huge difference. That goes for front-line workers, people whose job it might be to spot that sort of thing—a teacher, a youth worker, a line manager—but also for colleagues and family members.

Q27 **Dr Whitford:** Looking at suicide prevention training, Ruth, you were talking about the different approach in Scotland. That started back in 2002 when they set themselves a target to get a 20% reduction by 2013 and got that down by 19%, which is quite a big impact, although we started at a much higher level in Scotland. Looking at some of the things that had been done there, they set a target for suicide prevention training of getting 50% of front-line staff trained. How useful do you think suicide prevention training is?

Ruth Sutherland: Absolutely, it is important, and a 50% ambition for the gatekeepers, the front-line workers, would be really good. We have a number of different models of training at the moment, and it would be helpful to understand the strengths and weaknesses of each approach, so that we can make sure that we invest in the right approach. It is definitely important that front-line workers are part of it, and that will help everything else, because once people understand the issue they will want to work on it, but we should not underplay the importance of general training—public awareness and skills training. Mental health first aid is an evidence-based model. The component on suicide prevention could do with a bit more enhancement, but generally it is a good model. As I say, it is evidence based. If we could have as many people mental health first-aid trained as we have people who can do CPR, we would be in a different place.

Q28 **Dr Whitford:** That is something I was going to ask about. We try to get

defibrillators and try to do CPR training and so on in schools, and I wondered what you thought about giving people those skills at that level. I have written down, "Pupils in schools." Do you think that is something that could be handled and could be used to open discussion with pupils around the whole topic?

Ruth Sutherland: Certainly in schools, mental health awareness and suicide prevention are well placed to be part of the curriculum, to work with teachers as front-line workers. Samaritans runs a programme called Step by Step; when there has been a suicide in a school the school can call Samaritans and we go in to help and support. Many people, when we go into schools in that way, wished that they knew more about it. They think they do not need to know until the terrible thing happens. That is equipping schools, but as regards general awareness among the general public—I talked about the example with Network Rail—a huge amount could be done if public awareness and skills were higher. Business in the Community have done some great initiatives with their mental health toolkit, and there is another one coming on suicide prevention that is targeting small and medium-sized enterprises. Again, that is a great initiative, but we need to understand what works in training and make sure that training is evidence based before we roll it all out.

Q29 **Dr Whitford:** There is a need to change the dialogue. I often think we give people the five things they need to do for their physical health, from fags, drugs, weight and what-not, but actually we do not teach people anything about how to look after their mental health. We tend even to use the phrase "mental health" to mean mental health issues, so we mean mental illness rather than how to be healthy mentally. How do we change that dialogue? It is not just front-line workers in a medical sense; it is people who are in public services, people who interact.

Ruth Sutherland: It is emotional literacy generally, I think. I can speak as a former chief executive of Relate. Of the top four reasons why people ring Samaritans, relationship breakdown is the No. 1 thing. How prepared are we for the pain and disaster of relationship breakdown? Who supports us when those relationships go wrong? Where does that come from? Most people do not discover any of that until they are in the pain. What is it like to be—

Q30 **Dr Whitford:** We started at a worse level in Scotland, but it has come down considerably, and in England at the moment it is going up. Why do you think there is that difference? Do you think it is to do with policy or do the other social factors drive it?

Ruth Sutherland: If you were making a comparison between Scotland and England, you would have to point to the concerted effort and consistency—a concerted plan to reduce suicide. As to the social factors, they are much higher in parts of Scotland than in parts of England. Again, that is good learning.

Q31 **Dr Whitford:** Can I bring you in, Ann, on the public health side of what

Ruth is saying, taking this much further upstream? I will come back to you in a minute, Sophie.

Dr John: I remember going up to Scotland for the launch of their second strategy, and what was obvious to me when all the local suicide prevention officers stood up in the afternoon was that they were a huge resource, very available locally, which showed both commitment at all levels, from the top to the bottom, and resource for the agenda. Different levels of training are appropriate. There is the general public awareness training, and there are people who will come into contact with people who are distressed. It is thinking about everyone who works in a setting, for example the YMCA, from the porters to the cleaners to the youth workers. Then there are the front-line services that we are talking about.

Several issues have come up. One is the evidence base. The evidence base is beginning to emerge for different sorts of training, to ensure among all the providers out there that people have access to information about how much the training costs and in which medium it is delivered. For some people an online self-directed resource is much more likely to happen than a two-day course that lots of front-line workers in the public sector cannot commit to. There is something about not being entirely prescriptive but making sure that the training that is delivered is appropriate to the setting. I completely agree about the different areas, such as school-based settings, where people should be trained. Training not only improves people's own literacy in talking about these things but allows them to respond to other people. It is not just that they will talk more but they will respond better.

There is lots of evidence that people's experiences within society, in terms of shame and stigma about these issues, and in contact with services, can be negative. That impacts on how they seek help and interact with services down the line, but sometimes people do that because they feel uncomfortable themselves. The discomfort that people feel talking about these issues completely impacts on people's ability to respond appropriately. When people are not responding appropriately, they think things like, "You are attention seeking." There is something very important about understanding that training is as much about improving your own mental health, for want of a phrase, as about ensuring that as a society we respond appropriately to people in distress.

The evidence is emerging. There was a huge randomised controlled trial done across, I think, 35 countries in Europe, looking at school-based training and awareness with teachers and students. It showed a clear reduction in suicidal behaviours among young people. It was called the SEYLE study.

Q32 **Dr Whitford:** Was that submitted to the Committee? It would probably be a great resource for us to see.

Dr John: I am not sure, but I can send you a copy of the paper. These things work.

Q33 **Dr Whitford:** It is empowerment and confidence—the number of times people in any situation think, "Should I stop? Should I help?"; you need to have the confidence that you are not going to make it worse and you definitely know what you are going to do. The more we spread that, the better. One interesting thing, looking at the data—we will talk about gathering data later—is that often, when we did public health, everything we did helped everybody, but the difference between deprived communities and the well-off never went away, whereas in Scotland it has helped the deprived more, and the change in women and the change in richer groups is not there. The effort seems to have gone to the worst bits, which is unusual. We do not usually manage to pull that off.

Dr John: That is important, because a lot of things that we do—the same with smoking cessation—can sometimes work to increase inequalities. It is important to be mindful of the impact on inequalities in anything that is recommended.

Q34 **Dr Whitford:** Sophie, can I bring you in? You wanted to comment. Before you do, I will fling in my last question: how should it be funded? I am not sure how helpful a question that is, but I will put it out there.

Sophie Corlett: Thanks for giving me that one. On the rise in suicide in England, my understanding is that the rise at the moment is in women, and I do not think we really understand quite why that is. We have put a lot of focus on men, as three times as many men as women take their lives, and there is a real problem that we need to address, but potentially, while we have not had our focus on women, those numbers have started to creep up. It is fair to say that we do not understand as much as we might about suicide and there is a lot more that we could do. We need to look more at the data and talk more to people, including at local level. Where people are in touch with health services, there is lots more information in those circumstances to track exactly what happened and what opportunities were missed. That is the first thing.

On training, in Wales we have been involved in a big trainers' programme for ASIST, which is one of the suicide prevention training programmes. Our experience is that, once you start offering training, people really want it. As Ruth was saying, they immediately recognise how useful it will be and the opportunities that they have missed in the past, and people start to use it almost immediately. We had very quick feedback from people saying they used it within a week with somebody on the bus, or whatever. It is very powerful.

There are a lot of other sorts of opportunities to intervene. We run a pretty popular online community for people with mental health problems. Suicide comes up quite a lot and we have become—increasingly, in fact—much more adept at knowing how to intervene, when to intervene and how to do that appropriately; when to bring people off the site and have a direct conversation with them. We have been approached by a lot of people who run online communities not about mental health, because they have identified increasing suicidality among the users of their online

communities. We are training them and offering them tools and support. You would not necessarily think of that, but there are all sorts of ways in which organisations are interacting with people where their potential desperation in certain circumstances is surfacing and there is a real opportunity to intervene.

Q35 **Andrew Selous:** I am really interested in following up the point about schools and teachers and so on. Is any part of teacher training focused on wellbeing and positive mental health, and is that an area where you think more should be done? Maybe that is not an area you are an expert on.

Dr John: I cannot answer on the specifics. I would be very surprised if they do not do something on it, but often when people say there is a component of suicide prevention and training, we go and have a look at it and it is tiny. It is about making sure that the bits that are there are of appropriate depth, so that people can understand the complexities of the issue. The other side is that you do not want it to be so long that nobody does it.

Q36 **Mr Bradshaw:** I have a couple of questions about how the media deal with suicide, but first I want to ask this. One reason we decided to have this inquiry is that suicide rates in England had been falling consistently for more than 30 years, and in the last few years they have been going up again. What is your explanation for that?

Ruth Sutherland: We are clear that it is to do with recession. The suicide rates track economic prosperity. Economic recessions come and go in waves, but social recession is longer and deeper, and although we might start to see economic recovery, we will see the social impacts for longer. There was a shock in 2007-08, and that is when rates started to increase. The point about the female increase this year—the first time—is certainly something to look at. The economic factors are that it is 10 times more likely for middle-aged men in the 40 to 49 age group if they are low income, and it is the same for women. It is still to do with low income.

Q37 **Mr Bradshaw:** We know there is a relationship between absolute low income and suicide rates, but is there a relationship between inequality and suicide rates if you look at international figures?

Ruth Sutherland: I do not know at the ends of my fingers.

Q38 **Mr Bradshaw:** Do you know, Ann, if there is a relationship? We know there is a relationship between socio—

Dr John: You mean globally.

Q39 **Mr Bradshaw:** Are less equal societies more prone to suicide? We know more equal societies are healthier, but are they also less prone to high suicide levels? Is there any evidence to suggest that?

Dr John: The difficulty when you start looking at rates globally is that the ways things get counted are very different. Even between the four nations of the UK, some of the counting is quite different. When you are looking at rates globally, there are certain nations that consistently have high rates, but in the countries that you are talking about we may not always have very reliable counting, so it is very difficult to say.

Q40 **Mr Bradshaw:** Going on to the media, what is your assessment of how the media treat suicide? There are guidelines. Are you happy with them and that the press stick to them? Do you have any examples of really bad practice or good practice? What can be done in this area?

Ruth Sutherland: Yes. There have been huge strides made on the media guidance. It is something that Samaritans monitor and we have had good improvements, with the Editors' Code of Practice. With the print media, there is regulated activity, so it is easier. Obviously, there are sometimes glitches and that is why you monitor it, and when you monitor you can go to talk to them. The bigger challenge is around online, and we are going to have to adjust to new approaches. Where you have a regulated activity, you set the code of practice and, if people do not adhere to it, you can follow it up. We would like even that to be strengthened, but with the online approach you have inappropriate content often emanating from abroad where laws will be difficult. The genie is out of the bottle. The approach that Samaritans is trying to adopt is that we need to work with online providers to get them to understand the impact of what they are doing. Clearly, it is their responsibility what they do with that information. We have had good success working with Google, Twitter and Facebook. If you are trying to type "ways to kill yourself," when you get to "ways to" it used to auto-fill "to kill yourself" and we have worked with them to change that, so it is now "ways to weed your garden"—anything else, but not that. Also, if you manually type it in, a pop-up will come up on Google now saying, "Do you want to talk to Samaritans?"

Q41 **Mr Bradshaw:** This is all voluntary.

Ruth Sutherland: It is still all voluntary. Wikipedia is the thing that comes up first on the search engines and will give you very graphic content. Everything that we know in research is telling us that this is not a good thing, but we still have to work with them to try. We also want to increase online support. We have to accept that people are going to be online. We know from recent Bristol University research about online behaviour just how high are the numbers of people intending suicide who research it first online. If that is where suicidal people are, we have to be there to help. You want to try to work with providers to improve content, but you want to improve opportunities to get help. We have a huge amount of work to do there and, again, it is an under-resourced area. We have drama as well. I don't know if anybody watched "The Fall" last Friday; there was a complete breach of guidance—disappointing—but we are following it up.

Q42 **Mr Bradshaw:** Have you made a formal complaint about that?

Ruth Sutherland: We are in the process of doing it.

Q43 **Mr Bradshaw:** Luciana will ask a bit more about social media, but before she does, can I ask you about methods? There are striking statistics that the professions that have the highest levels of suicide are doctors, nurses, vets and farm workers because of easy access to methods. How important do you think method restriction is in this whole area?

Ruth Sutherland: Ann will probably have more to say, but restricting methods when it is part of your job is quite difficult. It is about really paying attention to the support of those professions. The farming community has done a lot of good work about supporting farmers. You look to the professional bodies, you look to the support organisations and their needs. We must not forget the front-line staff who are affected by suicide; for Network Rail, we offer a comprehensive service to drivers who have experiences, and that needs to be the same for all professions, for doctors or nurses. Anyone affected by suicide needs help and support.

Q44 **Mr Bradshaw:** Ann, do you have anything to add to that?

Dr John: I completely agree with that. There are some methods where means restriction works, such as restricting how much paracetamol people can buy, medication in different packaging and putting parapets on bridges, but when you are talking about certain occupations, it is very difficult. That is when you come back to mental health and suicide awareness in the workplace, so that people in those professions know where help is available and they are not too ashamed to seek it.

Q45 **Chair:** Thank you. Ruth, can I follow up the point you made about "The Fall"? What kind of response do you get from organisations when you subsequently challenge them? Do you find that they are receptive to accepting there has been a breach? How are you working with organisations in the media to challenge them when you see bad practice?

Ruth Sutherland: The best thing is to try to get in before they do it, so it is about having relationships. All the soap operas regularly consult us, and I know they do the same with Mind.

Sophie Corlett: Yes, we do a huge amount with them. We put them in touch with somebody who has experience of the difficulty, who has attempted suicide, to help them to make sure that the way it is portrayed is not overly sensationalist, and to make sure they put out trigger warnings and information at the end of the programme. The soaps in particular are really to be commended; they have been very serious and responsible in how they have dealt with that. It is much more difficult with one-off dramas that may not know to come to seek help and may be looking for something more sensationalist anyway.

Q46 **Mr Bradshaw:** For those who did not see "The Fall," what exactly were you upset about, unless that would be unhelpful?

Ruth Sutherland: It was graphic content on method.

Chair: That is disappointing.

Q47 **Luciana Berger:** To follow up some questions that Ben asked specifically about online material and the internet and social media, you were very specific that progress has been made and you mentioned some areas. You did not mention Facebook. Obviously, that is a significant social media platform, and I wonder if you can reflect on your experiences of Facebook. In addition to Wikipedia, are there any other significant online platforms that we should be aware of that are doing things you would like to see changed?

Ruth Sutherland: Facebook, I have to say, has been very proactive and the good thing is that it caters for an older age group, so if we are trying to target a middle-aged group, it is quite a good place to go. It has set up an internal system, which we helped to advise it on, where when it sees distressing content it will flag, "Are you having a bad day? Maybe you want to do this," so it puts people in contact with us. We have worked on different models with it on that.

There is a difficulty around data. If people are referred to us online, some of the companies want to own the data. If somebody is referred to Samaritans, there is a front door and you leave them at the front door, because we have to assure confidentiality. But if Facebook wants to be the data controller this side of the door, we cannot have that. Control of data has been a stumbling block. It would be better for the user of the service if they could click through online, because it would be more direct and more immediate. You do not really want to have to come off what you are doing and then ring up or contact by email or something, so it is not really around the experience of the person. That's it on Facebook.

All the search engines are really the target. We started with the biggest and we are working down all of them. Usually, when they become aware of their responsibility they are very enthusiastic to do something. Certainly with Twitter, just to finish off, if there are celebrity-driven difficulties online, they would be the first to consult and say, "What do we do about this?" That is good.

Dr John: With young people, one thing to be aware of is that it will be very difficult for organisations and services to keep up with the way that they use social media and the internet, and which medium is the thing to use at the moment. As well as working with the big social media organisations, we need to think about working with children in schools on things like digital citizenship, how they behave online and how they respond to each other. We are doing some work on that at the moment and there is evidence that kids are increasingly signposting their distress online, so it is about how we respond to that. There is something about teaching them to respond to each other appropriately and about peer support, and working with the organisations where those things are being posted. With particularly vulnerable young people, if they access services,

if they see their GP or other people, people should ask them about their social media use or their digital histories.

Another important aspect in this area is the translation of face-to-face traditional bullying and cyber-bullying. Those sorts of issues are where we need to teach children how to relate to each other online. That is a really important part of the agenda that needs to be brought into schools and other places that work with young people.

Sophie Corlett: One thing that came up quite strongly in the responses that we had was the nature of social media, the "always being on" thing about social media, particularly for younger people, and the pressure that people felt from social media. This was not specific to bullying, trolling or anything like that, although that did come up. It was just the nature of it, the expectations that it seemed to drive of the perfect life and needing always to be on top of what was happening and what was new. I do not want to be too, "The world is all going to hell in a handcart," but we need to adapt to how people live now and, if that is to be the new normal, the not online aspects of people's lives—education and whatever—need to give them the resilience to manage that different way of living. I do not think we have really got to that point. People are entering this new world without the resilience to manage it.

Dr John: One last thing is to be aware that online communities can be quite supportive as well. It is not all bad, particularly for vulnerable groups like young people from LGBT communities, to be able to express these thoughts but then be encouraged to seek help. It can be a positive thing. Those are the things we need to access. For certain communities, particularly of young people, this can be the one place they can go to express those thoughts and find help. There is always very much a focus on the negative, but I think it can be a positive.

Sophie Corlett: Yes, we run a very popular and supportive online community.

Q48 **Luciana Berger:** Are there any other carrots or sticks that you think we should be considering in this space that would make a difference in reducing levels of suicide?

Ruth Sutherland: On providing more online support, we have a text service and an email service, and we are piloting instant messaging. One thing that has fuelled that is how the channel can make a difference to how people communicate. We know from Norway that people who text get to suicidal ideation—thoughts of suicide—quicker on text than they do verbally. You can have a long conversation with someone on the phone or face to face and it is really hard to tease out the issue. Particularly with middle-aged men, we find that it is easier to text than it is to talk. The channel can influence the ability to access to help. We need more research and more development in help-seeking in the online space.

Sophie Corlett: I agree with that. The work that we have done with other organisations that run online communities has been really interesting—people who are running online communities about other health conditions, or about anything really. They are finding that things surface in that environment, because people feel quite confident online to share things that they might not share face to face, but we need to make sure that the moderators of those communities, or the organisation that is moderating, know how to respond and how and where to signpost.

Another key part about all the training on mental health, suicide and supporting people to open conversations is helping people to know what their boundaries are and to not take responsibility. Sometimes that is forgotten when we talk about it, particularly for moderators in online communities, where people may think they have to deal with something and actually they do not; they can refer people on. What happens is not necessarily anything that they need to take any responsibility for. That is quite important.

Q49 **Chair:** Thank you. It is a very interesting point about texting being an easier way to talk about suicidal ideation more quickly. Could you possibly send us a link to that paper as well, Ruth?

Ruth Sutherland: Yes.

Chair: That would be very helpful. Our final question today is from Philippa.

Q50 **Dr Whitford:** Ruth and Ann, you both talked particularly about the need to evaluate what works, what does not work and the need for data. Obviously, in Scotland we have the Scottish Suicide Information Database, where information has been collected quite systematically, but you also talked about the difference in how things are connected and the definitions. Ours changed to come into line with the WHO international statistics definition around 2010, which changed poisoning, so that an overdose related to using drugs may now look more like a suicide, whereas obviously in England there seems to be an issue around the narrative verdicts with coroners, and there may be quite a big underestimation. What are your thoughts on how we can change that? What would you want changed about the actual certification, the analysis, the collection of data, to know what is going on in the first place?

Dr John: There are two issues. On the narrative verdict, the ONS issued a lot of training, and that has gone some way to addressing the issue in the last couple of years. There are two issues in terms of the data. There are the long-term trends. ONS data, when we get it, is usually from the year before. It relies on coroners' conclusions. Sometimes, those conclusions may be about 4% and it takes about a year to come through. However, we know that that is very reliable data for England. There is something else about timeliness of data, so that you have reliable data for long-term trends to see how things change. When I first worked in this area, we were worried about young men. Now those men have aged

and possibly that has an effect; we are looking at middle-aged men. There is also something about having timely data so that you can respond very quickly. The way to collect that data is much more complicated.

Dr Whitford: That is the real-time surveillance, looking for clusters.

Chair: I am afraid we have a Division in the House, so I have to suspend the sitting for a moment. Apologies for that. I know we are very near the end, but you have not quite finished your questions, Philippa, and Helen has a short supplementary, so if you could, bear with us while we zip across the way and back. Apologies to the second panel and thank you for being very patient.

Sitting suspended for a Division in the House.

On resuming—

Q51 **Dr Whitford:** There are two different aspects to the data. One is exactly how you definine it to make what you are collecting crisp. In Scotland, because the fiscal has to use the international statistics definition, there is a crisp definition that the person sadly died by action of suicide, whereas here, because things are much more open to the coroner, there is much greater use of narrative verdicts without making that kind of commitment to what you think it was. How big a role do you think that plays, because it could be underreporting the figures that you are actually dealing with?

Dr John: There are definitely issues around narrative verdicts and the way they are coded. For those of you who do not know, narrative verdicts are where the coroner talks about the circumstances around the death as opposed to saying specifically what the cause of death was. In some ways, that reflects the complexities we were talking about, but both the training that ONS gave and, for the future, being much more definite in guidance about how things should be counted will give us much more accurate figures. When we are doing research on this, we look at where the death was classed as intentional and suicide, and where the intention was undetermined we count those as probable suicides; and then there are possible suicides, which might be single-vehicle accidents, accidental hangings or poisonings. In research terms, you have different ways of counting, but improving the accuracy would be very important. I think for learning and directing where we need to do interventions, it would be important.

Q52 **Dr Whitford:** Do you think there would be consideration of using the international standards? Obviously it would make inter-UK comparisons easier, and it then becomes easier internationally to compare. Do you think that is likely to come?

Dr John: There is lots of work to be done with the Chief Coroner. It is a really good thing that we now have a Chief Coroner and we can unify our work with coroners, so yes.

Q53 **Dr Whitford:** What about the system actually to collect that data and then tie it back to things? In Scotland, one key thing was deprivation, which used to show four times the rate of suicide; it is now three times the rate of people who are not suffering deprivation. Another thing is contacts with services in the previous year, three months and so on, which let us see if we have missed opportunities. Where are you with having a system to bring that data together, outwith research, in a systematic routine way?

Dr John: There is the ONS data. Linking across access to different services happens differently in all four nations, and when you throw in the slightly different definitions, it can make comparisons quite difficult. There are research databases available that can do it across the four nations in a comparative way, but determination to have systematic collection across the four nations would also mean that we can co-ordinate what is going on across the UK.

Q54 **Dr Whitford:** But even if not between the four nations, are you comfortable that you are getting systematic data collection all across England that lets you know what is happening where? That brings you back to Ruth's point about evaluating, "In this area they are doing this and, look, they are getting a result."

Dr John: There are certain things that get counted systematically, but possibly not in a timely way, like the actual deaths. In terms of knowing what is happening locally, there is a push towards doing local suicide audits. Going back to the conversations we had at the beginning of this session, that requires currently a resource to pool the data, and that resource does not always exist locally. Some of the ways that it could be made easier would be if coroners provided data in a more amenable format, possibly electronically, to local public health teams so that they know their own—

Q55 **Dr Whitford:** It is not on a database, in essence, at the moment. You still require someone to do it as a project.

Dr John: Yes.

Q56 **Dr Whitford:** That is the difference. Ours has been on a database for quite a long time, which then means, when you analyse it on a rolling basis, that you see whether you are getting better or worse.

Dr John: That is really important.

Sophie Corlett: There is quite a lot that can and should be done regardless of databases, collection or waiting for coroners' reports. When people are in touch with services there is no reason why there should not be some learning almost immediately, making sure that that learning is shared and making sure that people are in contact with relatives and the bereaved, or indeed in touch with people who have attempted suicide, and supporting them and helping their families. There is much more that could be done now to learn from what is known locally. Some of that we

are now beginning to know nationally. We now know that for people who are in contact with and in the care of crisis resolution and home treatment teams, which are supposed to provide intensive support to people in crisis, including people who are suicidal, there is an increase in suicide among that group. That would have been known locally before it was known nationally. What is happening locally to make sure that those services are being improved?

Q57 **Dr Whitford:** But it still also requires a feedback loop—a general practitioner, or anyone who might have interacted with someone—whereby they hear that, and they may or may not get that information.

Sophie Corlett: If they are under the care of the crisis resolution and home treatment team in the same way as if they are an in-patient, that information is known within the system.

Q58 **Dr Whitford:** But that is a relatively small proportion in that two thirds of them are not in the care of anyone in psychological terms.

Sophie Corlett: It is a small but disturbing number, because it is increasing, and because that service is supposed to be there specifically to support that group and it is not working at the moment, for reasons that are known—they are not operating in fidelity to the model, which has an evidence base.

Q59 **Dr Whitford:** That is an internal service learning that could go ahead, but equally, as the evidence we have been sent shows that two thirds of people are not in touch with any kind of mental health services yet may have visited their GP about something else, this is where the talk comes in about screening and other approaches. It is trying to make sure that the information is coming back. What about the issue that was raised earlier—the real-time surveillance? Is work going ahead on trying to create that?

Ruth Sutherland: There are pilots at the moment, and it looks as though there are benefits and some negatives. Again, it needs to be evaluated. I agree with all the points made and would add that if there is a huge time lag, certainly for bereaved people, you are preventing those people from getting services. The services that are now available for people bereaved by suicide are much improved, but what happens if you do not get them because you do not have an outcome? The second point is about sharing of data. If you do the local audit, you have to share. Some coroners are really helpful and give access to data for local areas; other coroners do not want to share any data.

Q60 **Dr Whitford:** It is left totally up to them.

Ruth Sutherland: Yes. The basis of what we need from data is that it is systematic, timely and accurate.

Q61 **Dr Whitford:** In much health data, we have, if you like, rough versions that get an annual tidy-up later on. I do not see that real-time needs to

undermine having long-term data.

Ruth Sutherland: No. We welcome the real-time.

Chair: We have one final tiny supplementary from Helen.

Q62 **Helen Whately:** This is a short supplementary to Sophie. You made, I think, a very important point before we went away to vote, which was that, given that social media is always on, there is a need for young people to develop a resilience to manage that fact of life, the "always on-ness." Do you have a view on how that resilience can be developed? As yet, do we know what works or is that work to be done?

Sophie Corlett: I do not know if we know what works, but I can find out whether there are models that work. I know that there are many opportunities for people to be supported to do that. Parents, teachers and peers are in a good position. Therefore, anything that people go to online and online sites are also in a good position. We have already talked about the possibility of online sites and providers checking content, but helping people to build resilience in their use of social media is helpful. I do not mean unrealistic things like saying, "You are not allowed to go on social media and that is a punishment"-type approaches, because I do not think that is realistic, but helping people to understand the difference between real life and what goes on in social media, or what appears to go on in social media, would be very helpful.

Helen Whately: Thank you.

Q63 **Chair:** Thank you very much for really helpful answers to these questions today. We appreciate what you are doing.

Ruth Sutherland: Could I make one last plea about making this really good Committee count? I look around the table and see this as a really big opportunity. We have never had a Select Committee on this topic before and it is a good opportunity, so I really hope from the Samaritans, Mind and everyone else that you make it count.

Chair: Thank you. Our ask to the Government is that they take account of what is said to this Committee before they publish their next strategy. Thank you.

Mr Bradshaw: It is worth putting on the record that the suggestion came from Emma Reynolds, who has now sadly left the Committee and has gone to the Brexit Committee, so thanks should be extended to her as well.

Chair: Thank you.

Examination of witnesses

Witnesses: Saffron Cordery, Dr Liz England and Dr Peter Aitken.

Q64 **Chair:** Welcome to our second panel. I am very sorry to have kept you

waiting. Thank you for your patience. For the record, as we are hearing from the Royal College of Psychiatrists as well this afternoon, I declare a personal interest in that I am married to a registrar of the Royal College of Psychiatrists, who is also a full-time forensic psychiatrist and has in the past been involved with suicide prevention strategies in the south-west. Moving on from there, could I ask each member of the panel to introduce themselves?

Dr England: Hello. I am Dr Liz England, a practising GP in Aston, Birmingham. I am here representing the Royal College of General Practitioners as their mental health and whole-person care lead. I am also, incidentally, a Sandwell and West Birmingham CCG mental health and clinical commissioner.

Dr Aitken: Hello. I am Dr Peter Aitken. I am a consultant psychiatrist in Devon Partnership Trust. I work mainly in Exeter. I am also chair of the faculty of liaison psychiatry at the Royal College of Psychiatrists. The panel may also find me on the medical committee at the Royal National Lifeboat Institution. My history is that in 2008 I was the co-author with Christabel Owens of the action to be taken at suicide hotspots guidance, which was part of the original NIMHE approach to suicide prevention. That is my experience.

Saffron Cordery: I am Saffron Cordery. I am director of policy and strategy at NHS Providers. We are the membership association for mental health trusts, acute trusts, community services trusts and ambulance trusts in England.

Q65 **Chair:** Thank you. Could I start with the same question that I asked the first panel? It touched on the fact that the Government are going to publish a refresh to the suicide prevention strategy. It would be interesting to hear the views of each member of the panel about what is missing or perhaps even wrong with the current strategy and what are your three key asks—even four if you would like to expand it to four—that you would like to see in the next document.

Dr England: From the primary care perspective, I echo what the previous witnesses said: it is an extremely complex area. It is also quite rare, and I think there is a statistic by Williams that suggests it takes eight to 10 years for a GP with a list of 1,000 patients to have a consultation that will end with somebody dying by suicide. From that perspective, it is challenging when you are looking at training, day-to-day management of patients, screening and so forth. We know, though, that many people who die by suicide pass through primary care in some way, but again the challenge is that those people often do not present in any way with a mental health problem and it may not even arise as part of the consultation. The assessment of patients and risk management is very challenging, but it needs greater focus, and people need to look at perhaps targeted screening as a possibility, with investment to do that in primary care to pick up some of the people we are not necessarily seeing immediately.

Q66 **Chair:** Targeted screening is one of your asks for the strategy.

Dr England: Targeted screening is, but from the perspective that at the moment I realise there is a limited evidence base for it. I am picking up something that Louis Appleby wrote in his last paper when he was looking at suicides and homicides in primary care. He picked up that there are a number of risk factors that possibly could be used as a screening tool to identify some of the very high-risk people. The ask I would then have is: what do you do with these people once you have identified them? That would mean that we would need rapid access to a mental health professional to be able to help these people.

I wrote down my four asks, although it went to five actually. There is not one part of the system that can do it on its own. It has to be an integrated, systematic approach. Each part of the system has to talk to the other to provide that level of continuity of care, and we need secondary care to work with us in primary care, with psychiatric liaison coming into primary care and primary care going out to psychiatric liaison. There needs to be that communication. We were hoping that the 3,000 mental health workers who are coming would be part of that and that there would possibly be a liaison role within that or a link role.

The other area I would really like is information data sharing, from a number of perspectives. The first is that we all use different systems and do not communicate, so people fall between the gaps. The second is training about information, and consensus around information sharing for people who express suicidal thoughts. I do not think we use that enough to share information with family and with other healthcare professionals. That needs to be built into whatever training we can develop. The third area is training. At the college, we are still very hopeful of the four-year training programme, which would include extra training in psychiatry, or elements of mental health and paediatrics. That would contribute towards the mental health sensitivity that was talked about by the previous witnesses. If you have done some mental health training, you are sensitised more to what is going on around you generally, which may help pick up some of the people who are not expressing suicidal thoughts directly. I think we could put the training into a safeguarding perspective. At the moment, when we do safeguarding, we look at how we protect vulnerable adults from harm, so it would be a reasonable thing to look at how you protect adults from suicide as the same thing. Those are my asks.

Q67 **Chair:** Thank you. Peter.

Dr Aitken: Thank you, Chair. There is some real strength, as the previous witnesses offered, in relation to the suicide strategy that was set and some really good progress made in some areas towards delivering it. I would completely sustain that and, given that we know that suicide is preventable and that we know that many of the things we ought to be doing are not being done, the biggest plea would be for a robust

methodology around implementation. That is the thing that we all, I think, can agree on.

When it comes to the specialist mental health component, we have a contribution to make in terms of the effectiveness of the models of mental health care that we articulate to commissioners. We need to be, as a college, standing up for model fidelity in relation to crisis response and home treatment. We need to make sure that when IAPT—improving access to psychological therapies—is implemented, it is effective in managing depression. We need to make sure that the national service framework services for psychosis that were set up over a decade have not been eroded, stretched or strained to the point that they become ineffective for the evidence base they were set up on. Our concern as a college would be that in fact all those things are the current issue of the day.

We have the five year forward view, which is extremely helpful in terms of pointing the way to what we ought to do next, but the real risk is that we have a very limited mental health workforce in nursing, psychiatry and psychology, never mind the other disciplines that work in and around us. It is a precious expertise, and it is extremely difficult to know where best to place it. What is clear is that it is being stretched. Crisis response and home treatment is being stretched away from a focus on people with severe and enduring mental illness, or the major psychoses, to try to respond to all kinds of social crises, all kinds of upset, all kinds of relational breakdown and other things that seem to lead to the two thirds or three quarters of suicides that happen outside the purview of specialist mental health services.

That comes to the second ask, which is that we do not give up on the notion of a whole-community or a whole-system response to the problem of suicide. My 14-year-old son, who talks about these things at school, pointed out something to me when I said, "Do you know what, I am being asked to describe the haystacks within which we will find some needles, and many of those lie far away from my few haystacks, which are populated by so-called high-risk people and in fact most of the deaths will occur in haystacks that are sparsely populated and elsewhere. How am I to find them?" He said, "It's worse than that, Dad. These needles are invisible. You can't see suicide and you don't prick your finger on them." We have the problem that the suicides we are looking for, which are so devastating in our communities and affect 10 other people dramatically for the rest of their lives and for several generations to come, are distributed in places that it is hard for psychiatry to get to, never mind mental health services. It is certainly hard for general practice to get to, for all the reasons of general practice. I think we heard from the previous witnesses about how we have to try to engage and work with people in the community to do rather better.

Unfortunately, there is also something rather difficult to say in terms of screening and risk assessment. Recent editorials in *The British Journal of*

Psychiatry and the *British Medical Journal* tell us that the risk assessment tools that we have are largely useless for the purpose we hoped was intended. Suicide is just too rare: 4,500 cases of something in a population of 60 million people is really difficult to find. We make more errors with our risk-assessment tools than we find cases, so let's hold that in mind.

We have heard a lot about data sharing and inter-agency co-operation. The things for me that have made the most difference in my clinical practice are twofold. One is the voice of the service user. I cannot think of another area of my clinical practice where my views have been so significantly altered than in interviewing high-lethality survivors and hearing their stories, and how eight out of 10 profoundly regretted their impulse the moment they left the edge of the station platform or the bridge. It gives us hope that, if we could only get in the way of that impulse, we might make a huge difference, which brings me to my second point.

I have been looking back through the history of psychiatry and mental health. Recently, I had the pleasure of looking through the 1907 Lunacy Commission report into the performance of the asylums, which we found in the skip at work. We decided to have a look at it to see what learning we could take from it. It tells us that in 1907 the solution was to build another 2,000 beds per annum for the remainder of the asylum-building programme, so stretched were services, to try to make good on demand, out-of-area treatments and lack of beds. All the kind of things we wrestle for today have been in the past.

How are we going to organise ourselves and our communities to make sure that the interventions we need in the community space are there in the first hour of care? The first hour of care is missing in psychiatry, in that there is no standing army of ambulances nine minutes away from a psychiatric emergency as there is for a cardiac emergency. We are missing a skillset. If I were to suggest anything in the new strategy, it would be that we think a bit about how we bring mental health expertise to bear and support those who are involved at the point of need and in the first hour of care.

Saffron Cordery: Obviously, I do not disagree with anything my colleagues have said. The current suicide prevention strategy was written in 2012 and, if nothing else, it is ripe for a refresh because we are in very different times. The Health and Social Care Act and all those changes are now in place and it is very important that any refreshed strategy reflects them. Also, it was written at a time when financial constraint was anticipated but probably not quite to the degree, particularly in the NHS, that has actually come to bear. It is very important that it is refreshed on those lines. I echo what Peter says: this is about implementation now, and it is very important.

The five, I am afraid, very quick points I am going to make are these. We must see implementation supported by sufficient funding reaching the frontline. I know it is something that we at NHS Providers have said a lot, but it is absolutely fundamental. We need whole-system support in mental health if we are to prevent suicide.

The second thing is around accountability of commissioning. There is a lot of work to be done in commissioning to make our services run more effectively and efficiently.

The third thing is better quality service provision in secondary care, which is about ensuring that we continue to support crisis care—we continue to support people in crisis—so that we do not have a situation that ends in someone dying through suicide. It is supporting that crisis-care approach.

The fourth point is around workforce, which Peter touched on a bit. It is absolutely fundamental. Across the NHS and across public services, we are reaching crisis point in workforce, and we need sufficient staffing in mental health secondary care services, particularly around suicide prevention and all the services that contribute to preventing suicide.

Finally, on the point about integrated care, we need better services to reduce demand on secondary care and other bits of care. We need to make sure that things like the sustainability and transformation plans are really focusing on their mental health elements as well as other elements, so that we can help to prevent suicide. It is really about bringing the strategy up to date and making sure that the strategy is there to implement the direction of travel we have at the moment.

Chair: Thank you for that point.

Q68 **Luciana Berger:** Saffron, if I may, I will ask you to expand the points included in your evidence specifically on the funding of mental health. We know it is not just about resources, but resources are vitally important to be able to deliver everything we want. Could you expand two points you made in your written evidence, if that would be okay? One is that in your submission you said that promised moneys had not reached the frontline and there remained significant variation in quality and provision of services. In the context of this inquiry, could you expand that a bit?

Saffron Cordery: Of course. Mental health funding and funding reaching the frontline is absolutely fundamental. I was very pleased to sit through the earlier session; it was interesting to listen to different perspectives from across other sectors about how mental health services are perceived. Fundamentally, the five year forward view demands a 10% reduction in suicides, and that is really important, but the funding that is there for that is very small: £25 million over three years. We have to bear in mind that all other mental health initiatives should have, at their heart, preventing suicide and promoting mental health and wellbeing.

How we make funding more accountable and reach the frontline is a complex issue, so I will try to break it down so that it does not get too techie, because NHS funding is pretty techie. The answer lies in being able to follow the money. We know that £3.97 billion has been pledged for additional services for mental health, but it has gone into the clinical commissioning group baseline budgets. Currently, we have a series of national programmes; they are being phased out and it is going into clinical commissioning group baseline budgets. This means that, if a clinical commissioning group is, for example, in deficit, it will not necessarily pass on the full amount to commissioning mental health services.

Also, the way that mental health services are commissioned and paid for is different from the way that acute services are paid for. Often acute services are paid for on a volume basis, so it is a payment per episode, which can often lead to those services being commissioned first, because we need to look at the volume. Then other services that are paid for en bloc, which is basically just an amount of money no matter what the demand is, will be commissioned afterwards. What you are seeing is structural lack of parity in the way that services are commissioned.

As to money not actually reaching the frontline, we did a survey of our members earlier this year and asked them whether they were confident that the money that was meant to be committed by commissioners to commissioning their services would reach the frontline, and only 25% of them were confident that that money would reach them. The King's Fund has recently done an analysis of last year's mental health budgets, and it shows that only 40% of trusts received the additional funding that they should receive. Our own analysis said only 50%. We are in a situation where that money is not reaching the frontline at the moment. We need to look at ways of commissioning and paying for services differently.

Q69 **Luciana Berger:** Thank you. One other point you made in your submission was that one in five suicides happen during the post-discharge period, after someone had been in in-patient care, anything from two weeks to a three-month period afterwards. What do you think the reasons for that are? Do you think it has a connection with resource and people being discharged too early?

Saffron Cordery: There are a number of issues around this. The week after discharge from acute in-patient psychiatric care is one of the riskiest points for anyone being discharged, so it needs greater levels of support, engagement of families, friends and all support services. Often, if people are sent out of area for their treatment, they do not have that link to their home base and that level of support, so it can be a very difficult time for them. Therefore, if people are out of area, they are much more likely to be at risk of suicide than those who are treated in their own area. Also, it is about the availability of the support services to follow up once someone has been discharged from an acute in-patient setting.

Q70 **Luciana Berger:** I have one question for Dr England. In your

submission, you made a reference in point 10 about funding as well, specifically about the five year forward view for GPs, and your concerns about whether investment will come forward to ensure that there will be the extra staff and extra GPs that you believe should be delivered. Do you want to expand on that?

Dr England: I do not think we have seen it yet. That is the bottom line. The challenge is that, unless the funding comes through, we are not able to develop anything else in the service, and, as we have heard, everybody is short staffed and GPs are short staffed as well. Obviously, if the funding comes through to the trusts and the teams, there is a different way of funding for general practice, so you have to combine the two and then it is complex. The part of the funding that is really critical relates to the 3,000 mental health workers; it would be great if we knew what was happening, how they were going to be implemented and what they were going to do, so that we could see some real investment in general practice.

Q71 **Helen Whately:** I have a question for Saffron Cordery on mental health funding not reaching the frontline. Do you have a suggestion about what needs to change for that mental health funding to reach the frontline?

Saffron Cordery: Some of it is in train but it is going to take a little while to come through. What we need is greater transparency on what is being spent. Within the commissioning process and system, we need to be able to hold commissioners to account for what they are spending, and we know that at the moment the way that mental health services are commissioned and budgeted for is quite blunt compared with other parts of NHS provision and commissioning. We need to see much more detailed budgeting. We need to see commissioners being held more closely to account for what they are committing to spend. We are seeing it coming on stream a bit; we have the mental health dashboard, which has just been produced, and the first performance ratings of CCGs, so we are starting to see greater transparency, but we need to see that pushed through as speedily as possible so that everyone is clear about what is being spent.

At the heart of this is lack of data, and I know that everyone will say this over and over again, but it really does exist; the data that is collected is not always as useful as it could be. We need to invest in data, intelligence and analysis, and make sure that we are using it properly. That is across the piece—commissioners and providers. At the moment, NHS benchmarking is the only service providing effective and useful data on mental health. Data is fundamental, but then we need more granular information on what is being allocated to mental health spend, and greater expertise among commissioners of mental health commissioning. That is not to the detriment of commissioners in the room; essentially, it is that we need to invest more in our understanding of mental health and how we commission it.

Q72 **Helen Whately:** You talked about the difference between how physical

health services are commissioned on an activity tariff basis and mental health being much more frequently a block contract. There was work going on to change that in the past, but do you have a view on whether mental health services need to be commissioned in a more sophisticated way and, if so, a view on what that way should be?

Saffron Cordery: Yes. If nothing else, the five year forward view for mental health, the taskforce on mental health, sets out a very comprehensive programme. It has 57 recommendations. It has a whole set of access standards and a whole tranche of activity around things like liaison psychiatry. There is a whole host of complex work coming on stream that needs to be effectively commissioned and delivered. It has to move quickly. NHS England is currently piloting an approach where providers are also involved in the commissioning of some specialised services, because commissioning is very fragmented at the moment; some of it is commissioned locally, some is commissioned nationally and the split between the two is not helpful for those receiving the services, nor is it helpful for those delivering the services. We are seeing providers now being involved in the commissioning and we think that is going to lead to some very fruitful outcomes.

Q73 **Dr Davies:** Dr England, you have already mentioned that many of those who attempt suicide have already seen their GP beforehand. For those who are identified as being at risk by their GP, can you explain what difficulties can be faced in accessing secondary care referrals?

Dr England: Some of it comes down to the presentation of the person. A person who does not present with suicidal ideation—a male, 45 years old with leg pain, or something like that—is the person we do not pick up. The people who present are often distressed rather than actively suicidal, and it is that distress that is really difficult to deal with because it is not necessarily a mental health problem on its own. It is also that their housing has failed, they have relationship problems and a lot of the time it is not necessarily appropriate for us to refer them to home treatment or crisis resolution, but we do not have anywhere else to refer them to. That is then a problem, and we get referrals sent back to us, "This isn't appropriate. This person isn't suicidal. This person doesn't need acute care in that way," but we still have that person. There almost needs to be an intermediate level of care where we can send someone who is distressed to get support, but not necessarily specialist mental health care.

Q74 **Dr Davies:** Where this is an identified immediate need, are there barriers that you can identify?

Dr England: It depends where you are looking. Locally, we have developed a single point of access and it is working brilliantly. It is very smooth; you refer people through and it is great. I have heard from other colleagues that it is very difficult to get hold of a consultant or it is very difficult to get people seen, and then they present in A&E, for example, or present at a later stage somewhere else. It is variable and, again, that

comes down to the commissioning of services. It depends who is commissioning what and how.

I want to add a quick thing in terms of the commissioning, if that is okay. Geraldine Strathdee did a fantastic programme for clinical commissioners, over a year, which was designed to try to upskill us in this area, because it is an area that people do not know much about. It worked really well, but it has now finished. That was a promising way of increasing commissioning knowledge and experience.

Q75 **Dr Davies:** Could I bring in Dr Aitken and Saffron Cordery on my previous question about access to secondary care? Do you have any perspectives that you would like to share?

Dr Aitken: It is variable, and it is down to the complex arrangements around commissioning for services to the biomedical, the psychological and the social. There are some very elegant intersecting circle diagrams that are difficult to draw, never mind interpret, that show how something that is specialist commissioning has to relate to something that is CCG commissioning that has to relate to the local authority and how they are commissioning and that might relate to separate roles for drug and alcohol, which are key to the puzzle, separate arrangements for general practice and how general practice works. That is key to the puzzle. The reason that these interfaces are so problematic is to do, in part, with the way things are commissioned, but even in the best areas, where things are well commissioned, there is a statistical problem.

If you take a county the size of Devon, which has a population of approximately 1 million people, and you take data that suggests the point prevalence of depression and anxiety that meets the diagnostic threshold could be as high as 135,000 to 150,000 people, and you look at mental health specialist provision, including IAPT, for the county being maybe 50,000 care opportunities, that still leaves around 100,000 people in that rather dispersed haystack going to general practice and anticipating that general practice will meet the stress, distress, worry, social dysfunction or whatever it is that has walked through the door. That is why we see pressures at the various interfaces. There is huge pressure in primary care, huge pressure from primary care on specialist mental health services and huge pressures within specialist mental health services to balance early intervention in psychosis with crisis response and home treatment. Then there is inequity for children and young people. I will leave it there and pass over to Saffron.

Dr Davies: I will be asking for the answers in a minute.

Saffron Cordery: You have handed the baton perfectly, because I was going to talk about children and adolescent mental health services. We have not heard, certainly in today's session, much about them. One fundamental issue around access is also about availability of workforce, and we know we are facing a workforce crisis in the NHS, which probably is set to get worse. I have a statistic here that says that between

2013-14 and 2014-15 referral rates for CAMH services increased five times faster than the available CAMHS workforce. That tells you instantly about some of the blockages and pressures in accessing services. We know that at the moment there are currently 1,000 vacancies among the CAMHS clinical workforce in a total workforce of 11,000. That is 9%. They are very striking and compelling statistics, when you are thinking about access to these services.

Overall, the implementation of the taskforce for mental health is going to require a significant increase in the workforce, probably of around somewhere between 35% and 40%. In workforce terms, we are really facing some fundamental challenges. What we need to see is the Government bringing forward a single strategic workforce planning document, which we have not seen at the moment. It needs to encompass all elements of health and social care provision, because right now demand needs workforce as well as good commissioning and the money to pay for it.

Q76 **Dr Davies:** Yes. Workforce is clearly a major hurdle, as are commissioning models, but are there any specific models you wish to raise that you think would improve access that we should be calling for?

Dr England: In my area we have something called the Esteem team, which works really well in the sense that it picks up people who need the increased level of care that IAPT services would not be able to provide, but they do not reach the level of severity for secondary care. That is a model that is being commissioned, but it works really well as an intermediate level of care and reduces referrals to secondary care.

Q77 **Chair:** It would help for those following from the outside if you explain what IAPT is.

Dr England: I am sorry. It is improving access to psychological therapies, which the Government invested in across the whole country. It is access to CBT-based psychological therapies for people with common mental health problems.

Chair: That is cognitive behavioural therapy, just for the record. Ben, you had a supplementary, or do you want to finish your question first, James?

Dr Davies: I will come back in a minute.

Q78 **Mr Bradshaw:** A moment or two ago, Dr Aitken, you used the wonderful analogy with emergency services for physical illness of being within nine minutes of a response, and that is not possible for someone in a crisis situation. It strikes me that often the people who tend to arrive at that situation first are the police, the fire service or another emergency service. Because we are well aware of the kind of stand-off between the police and our own mental health services in Devon on this whole area, can you elaborate on the kind of model that, in your view, would work? Is it better training for police and fire services? Is it some sort of formal

arrangement? What would it look like?

Dr Aitken: Magical thinking would suggest that all our police officers would be well equipped with mental health skills, as would all our GPs and nurses. We heard on the radio this morning that maybe three out of four general nurses have had no mental health training. We know that only a third to half of GPs have had mental health training in their piece. The police, through the College of Policing, are beginning to become aware of some of the gaps in their training and so are paramedics, but it is a gap. Because of the limited numbers of experts in mental health practice across all disciplines, the best we can hope to do at present is to gather around points of urgency, so within an hour of ask I think we can bring physical face-to-face contact from good crisis response and home treatment teams or liaison psychiatry services, to A&E or places of safety. If we can agree as communities where the points of contact or urgency are, we can organise and get there within the hour.

What we cannot do, though, in big cities and across dispersed counties like Devon, is to be everywhere at the point of need. We need to find some way to bring that expertise to the point of need. There are three ways of doing it. One, if you have enough work, is to be in the police car alongside, so I liken that to the intel inside your computer. You need to put mental health expertise in and alongside the other agencies for a good number of months and years until they see what we do and learn how to do it, or else we get ourselves there using telemedicine or some remote way of communicating ourselves. We can do that quite well, with ambulances particularly, because they have the technology to support that. We could be available in call centres—NHS 111 and 999 call centres—so you add expertise to the call handling and that element of it.

It is quite clear to me that if we want to reduce pressure on the crisis response element of crisis response and home treatment teams, so that those teams can get back to home treatment and look after the gap in aftercare when people come out of hospitals, and look after the mental health bed stock, we have to find something in the hour of care before the crisis teams people are pulled away. Our crisis teams are so stretched, even in a county like Devon, that after 9 o'clock we have one member of the crisis team on a telephone offering advice in that kind of space that I feel we have been drawn out into. It is simply us trying to make the best use of the limited resource, because we recognise that at the point of need we have police, fire and rescue, general practitioners and ordinary citizens uncertain of what to do.

Q79 **Mr Bradshaw:** You mentioned a figure a moment or two ago, in answer to another question: you said that within a population of 1 million in Devon there would be 150,000 people suffering from anxiety or mental illness. Is that a real figure?

Dr Aitken: Yes. The Sainsbury Centre came and made that estimation in about 2003. They looked at the population and, based on their work,

around 135,000 to 150,000 people were likely to make the diagnostic threshold for depression and anxiety.

Q80 **Dr Davies:** Does the Royal College of GPs have any view as to the precise role of mental health therapists and how they could best be deployed?

Dr England: In our submission, we were hopeful that they would be deployed in practices, and we have worked up a plan such that 3,000 of them could be divided appropriately. There is evidence that we can submit to you, if you would like, about how we would like to use those mental health workers. There are lots of models that have happened before that we can learn from as well. In 2007 we had some primary care mental health workers, who were graduate psychologists generally. There were lots of lessons to learn from that, and I think that would be of benefit in deciding where these workers go and how they link with the secondary care services and other services as well.

Chair: If you could send us that, it will be useful.

Dr England: I will, yes.

Dr Davies: My other question has been covered.

Q81 **Andrew Selous:** What do you think is the most effective way to train GPs and other primary care staff? Perhaps we could split that into initial/medical school training and then maybe refresher, continuing professional development-type training.

Dr England: The College obviously wants a four-year training programme, which would include a six-month post in psychiatry. There is debate around the best place for GPs in training to actually do that psychiatry placement, because in-hospital training is not necessarily the best thing for what our job will be in the future. We have to start right at the beginning of medical school to introduce mental health alongside the physical health aspects.

Q82 **Andrew Selous:** How long is the training in medical health in medical school at the moment?

Dr England: At the moment, it is five or six years for medical students.

Q83 **Andrew Selous:** How much of that time is spent on mental health typically at the moment?

Dr England: When I did it, it was probably about eight to 12 weeks.

Q84 **Andrew Selous:** Pretty small.

Dr England: It was pretty poor and very much in a silo. You did all the other subjects and then you did mental health, which is not how it works. Mental health is part of everything, particularly long-term conditions. I would suggest that we need a vertical training programme that includes mental health throughout. You then become a specialist, and you go

down your pathways. Most specialists will not do any more mental health either. If you decide to become a cardiologist, there is a distinct amount of mental health involved in cardiology, but there is no training. At the moment, GPs do their rotations, which tend to be two years of different topics, but it is not mandatory to do any psychiatry or mental health within that.

Q85 **Andrew Selous:** Presumably you feel it should be mandatory.

Dr England: In order to raise mental health awareness, there needs to be some mandatory mental health training within it, but I appreciate that it is very difficult to actually do that. When you look at the practicalities of it, there are not enough placements and things like that, and the trainees are often in hospitals and they provide the workforce for the hospitals, so you have to somehow get round taking a whole workforce away to do it.

Q86 **Andrew Selous:** Just so I understand, how far away is the General Medical Council from rescheduling medical school training so that we get the better scenario that you have just described?

Dr England: I do not think it will. I do not think it is looking at it now. It was looked at and put on hold for various reasons.

Q87 **Andrew Selous:** But you disagree with that and presumably think it should be looked at again.

Dr England: The college want the four years' training extended because that is the best model, but I think there are financial implications.

Q88 **Andrew Selous:** Can I go on to another area? I was talking with a former Cabinet Minister last night who spent some time sitting in her local GP surgery in her constituency, and she described a situation where it was either prescribing medicines or referring to a consultant. She was asking about social prescribing, particularly for the lower-level mental health issues that could develop towards a potential suicide risk. What would you say about the whole social prescribing area?

Dr England: I think it is great.

Q89 **Andrew Selous:** I have heard Dr Clare Gerada talk about the need for more of this in the future, but it does not seem to be happening and GPs seem to be quite wary of going down this route.

Dr England: Part of the problem is that there are so many different organisations. Locally, if I was going to prescribe exercise and going to a certain third sector organisation, it is about knowing which organisation it is. That is very complex, because they change all the time and there is not a list of them, and so on.

Q90 **Andrew Selous:** Wouldn't that be easy to sort? Shouldn't the local authority have a role in providing GPs with an up-to-date list of what is of a reasonable standard and available?

Dr England: They did. Unfortunately, our local authority has now cut 50% of everything, so we do not have the capacity. We cannot refer into it now because it is not there. That is happening in many areas. We had an organisation supporting people and 50% of their resources were cut.

Q91 **Andrew Selous:** Dr Aitken, do you want to add to that?

Dr Aitken: I do, because in my practice of liaison psychiatry, which is psychiatry in general hospital and general health settings, one luxury we have in the eyes of our admirers is time. The mean length of an assessment for me is 90 minutes on a range of 15 minutes to three hours. My colleagues in general practice would be highly envious of that, given that I was a GP before, on a sort of 8-minute turnaround.

When you start to unpick the complexity of a person's life over 90 minutes, a number of interesting things can happen. First, you can give the impression that you are listening; people who are suicidal have said consistently that being listened to and validated is an incredibly important part of the interaction. There is something in mental health practice about having the time to listen, to be seen to listen and to make sense of people's lives. People's lives, in our world, break down into their biomedicine, their plumbing and wiring, the pills and potions, their psychology and the cognitive behavioural therapy and the other things they need from psychology, but the vast majority of what we need to influence is basic food and shelter, meaningful occupation, their social worlds.

For that we have the least evidence and the least reliable up-to-date cookbook of things that we might want to try. We have great evidence around the pills, fantastic evidence around the psychotherapy and almost nothing that tells us what we ought to prescribe or use in the social care space. Our observation would be very similar to that of my colleague. Citizens advice bureaux and the next-day housing accommodation officer used to be two of the mainstays of practice in the mid-1990s. You would have somewhere to send people who were in debt and somewhere to send people who needed re-homing urgently. That is not available any longer. That is putting a terrific pressure on health services to try to find ways to support basic life before you can do any medicine. I would appeal to the Committee to hear that and think about what we can do in that third sector and local authority space.

Q92 **Andrew Selous:** That is helpful. Do you want to come in on that?

Saffron Cordery: Yes. I want to pick up on the local authority point. It is not so much social prescribing but thinking within the context of healthcare and then about the broader services that are provided by local authorities. We know that commissioning of things such as drug and alcohol services has moved over to local authorities and comes within the public health domain, and that has decreased substantially over the last few years. That definitely has a major contribution to play in how people are presenting at A&E, for example, with an alcohol or drug-related

incident, and then we know that people with mental health conditions often have a dual diagnosis of a drug or alcohol problem as well. This, I think, is contributing to the acuity of the situation in which they find themselves. People are not being presented into services as early as they used to be. Therefore, they are turning up at places such as A&E in more of a crisis than they were previously.

There is something very important about the services that surround mental health support, and I echo also around supported housing and housing provision. In things as simple—or not as simple but as basic—as the flow of patients through in-patient settings and being supported in crisis resolution home treatment settings, housing is absolutely fundamental in that, and that lack of provision is causing problems.

Q93 **Andrew Selous:** Dr Aitken, do you want to add to that?

Dr Aitken: Yes. I want to come back on the point on why the suicide rate might leap on discharge from hospital. If one thinks about it at the most basic of levels, you take away all the safety work that has been done in mental health wards to reduce access to lethal means, work on ligature points and so on and so forth; you immediately take somebody who is not well from their psychosis and you place them in all the risk that the rest of society has to deal with, such as bed and breakfasts, hostel accommodation and the wicked world out there.

Let us remind ourselves that particularly the major psychoses have not changed in their character since 1907. In fact, they have not changed in their character at all, so people are very psychotic now when they leave hospital, still very ill. In my day, length of stay was somewhere around the six-month mark in a mental health bed. Then it was 28 days. Now the pressure is on to turn around in 14 to 21 days. We are letting ourselves do some rather imaginative thinking if we reckon we are not passing risk out into the community setting.

Q94 **Chair:** Following up on that point, is there evidence that there has been an increase in the rate of suicides in people in the seven days or fortnight after discharge since the number of beds have been cut in mental health?

Dr Aitken: It is hinted at. It is a concern. Medical people are incredibly risk averse; we are incredibly well motivated towards the safety of the people we look after. Because the numbers are so small and the signals in the data so difficult to interpret, you are kind of left with, "Well, it doesn't make statistical significance yet, does it?" But for those of us who look at these things, wondering whether we are doing the right thing by reducing the number of beds in the way we have done, because we know that rehabilitation is so much easier if you rehabilitate people in their natural community—we do these things for all the best reasons in the world—there is a growing sense of unease, particularly around the Crisp commission and the beds commission, that we have pushed it a little bit too far. We need to try to rediscover that purpose.

Q95 **Chair:** It is certainly something we reflected on in our predecessor Committee in our review of the Mental Health Act. Could I ask Saffron and then Dr England?

Saffron Cordery: Coming in on that point around the crisis resolution, or treating people in the community, it is important that we pick up on this issue around managing risk, because it is not perhaps just due to post-discharge that that risk goes up; it is also if there is not the availability of beds and so people are then treated in the community in that crisis-resolution setting. However, they probably would be better placed in an in-patient setting.

The aspiration over the course of the five year forward view is to have a blanket provision of crisis resolution home treatment services—and that is absolutely right—but we have to resource them to manage all the risk that they will then encounter. Very fine judgments need to be made as to whether that is a suitable setting for someone to be treated in. It is very tempting in lots of circumstances, if you have in-patient beds capacity running at over 100%, which is possible in a mental health setting, that someone will be treated in a setting that is not as appropriate as an in-patient setting. So it is not just on discharge; it can be prior to someone who should have been admitted.

Q96 **Chair:** On that point about occupancy rates, are you also measuring occupancy at midnight, which we have been hearing about in other sectors in mental health, or are you measuring occupancy during the day when you say you are running at over 100%?

Saffron Cordery: We are taking the figures that are fed back. I am not sure about the basis of those. I can follow up on that for you.

Q97 **Chair:** The reason it matters is that we have been hearing that during the day occupancy is over 100%—there is a cross-over—but, because of the way, technically, bed occupancy is measured, it can appear to be lower. When you are talking about occupancy rates, is that daytime occupancy? Do you measure daytime or midnight occupancy in psychiatry? It is just a point that has been made.

Saffron Cordery: Yes, I understand the point you are making. I am basing that on feedback that we have heard from our member trusts that will say they are even using beds when people are on home leave, so they are using those beds, which pushes it over.

Q98 **Chair:** Thank you for clarifying. Dr Aitken, you want to come back on this and then we will go to Liz.

Dr Aitken: On that point, if we are operating in that way—most of us are—and you put somebody on home leave by way of testing whether they are ready to be looked after in the community, and then somebody else comes in to their bed in Exeter, they could very well find themselves coming home to Newcastle because there is no longer a bed in Exeter for them. That is presenting huge risk to the system.

In answer to your earlier point, it has been more common than not in recent months in Devon that there have been people who have been assessed by people like me, working on the section 12 rotas out of hours, as medically needing admission for assessment under section 2 of the Mental Health Act, who cannot have that completed because the approved mental health practitioner cannot find a bed anywhere in the country, not just in Devon, to which to admit them. You end up with this rather risky situation where some of the sickest people in our communities are in a waiting place for mental health beds to become cleared so that they can be admitted. The analysis of that, I am afraid, points to a lack of step-down, a lack of community alternatives and a lack of social care support to allow people to come out at the other end.

Q99 **Mr Bradshaw:** Where is that waiting place?

Dr Aitken: The waiting place will be where they are. They will be at home.

Q100 **Mr Bradshaw:** So not in A&E.

Dr Aitken: Not in A&E, or not necessarily in A&E. Some will wait in A&E if they have been lucky enough to get there.

Q101 **Chair:** On that point, it came out from our last inquiry into this subject that we were hearing evidence that people were being sectioned under the Mental Health Act simply to get them into a bed, because otherwise there would not be a bed made available. Is that something that remains a concern?

Dr Aitken: We are now attempting to section people under the Mental Health Act and cannot find them a bed, so I would suggest that the situation is more perverse than the position that you are articulating.

Q102 **Chair:** Thank you. Liz, you wanted to come in.

Dr England: I just want to echo the fact that, by treating people in the least restrictive way, the drive to reduce beds has ended up with taking beds away, particularly with the strategic plans we have at the moment, but then, because of the way it is funded, the money is not diverted to the next service. It does not go into home treatment, crisis care or step-down; it disappears into a saving, basically. That is the worry; we are reducing beds left, right and centre to least restrictive care for people, but it is to save money.

Q103 **Andrew Selous:** This is a final question from me on funding, going back to follow up on some of the earlier questions, and probably one for you, Saffron. Is it the case that we know that money has gone from the Department of Health to clinical commissioning groups, and in some cases not come out of clinical groups to mental health trusts? I am trying to see if there is an audit trail and then hopefully we could shine a bit of light on that.

Saffron Cordery: Yes. Simply put, that is the case. It comes from the Department of Health to NHS England, which then allocates the money to clinical commissioning groups. They are free to choose how they then allocate that money. There is planning guidance, but it is simply guidance; it is not statutorily enforceable. The idea is that they pass on an uplift of funding to mental health services to help implement all the additional funding that has been made available. However, there is not a guarantee at the moment that that will be passed on. If a CCG is in deficit, then it is going to be in a situation where it needs to look at its deficit and manage how it distributes its funding across the piece. Although the guidance says that that money should be passed on, it does not have to be passed on.

Dr England: As a commissioner, I have seen that the money will suddenly appear and you will have three months to spend it. So, although the money was intended for a particular project, you end up just trying to spend money without it ever reaching the right service—

Saffron Cordery: I am sorry to cut across you. That is a very inefficient way, of course, of passing on money. We are not talking about contributing to long-term programmes, but people trying to find ways of spending that money because it has come to them.

Q104 **Andrew Selous:** Is it a Treasury rule that it has to be spent within the three months, by the end of the financial period? Where does this edict come from that it is not leading to an optimal outcome?

Dr England: If we do not spend it, it goes back into the budget and goes towards QIPP savings, which are the quality, innovation, productivity and prevention savings; we all have these savings to make. We have this rush to try to find a service or to try to do something with the money. Also, it has quite a lot of limitations on what you can do with it. You cannot even give it to a service to get an extra person, because a lot of the time it is non-recurrent funding. A lot of money gets wasted that way.

Chair: You had a quick question and then we are going to come on to Helen.

Q105 **Mr Bradshaw:** On the startling evidence that Dr Aitken just gave us about the growing problem of wanting to section people but there not being a single bed available for them anywhere in the country, can you quantify the extent of this problem in terms of numbers?

Dr Aitken: We can certainly measure it, and we have worked very closely with our commissioners and the provider base in Devon to get a handle on this. We have local data on that. It is quite difficult to know the national position because it is quite difficult to find the national bed position. We spend a lot of time phoning around, phoning independent providers and other providers, trying to work out just where we could put people. There is something perhaps in the future organisation of our system where it would be really handy if there was a national bed

bureau. I would say that for specialist services, but I would certainly say it for community beds as well.

Q106 **Mr Bradshaw:** Have there been any examples of people having taken their lives as a result of you not being able to find beds for them in time?

Dr Aitken: I cannot think of one in our local area. I have seen all services going the extra mile to try to make good, which has included us bringing ourselves at risk with the Care Quality Commission for using lounges and other areas of our buildings to have people so that the rain does not fall on them, around which we then staff up to look after them.

Q107 **Mr Bradshaw:** Lounges where—what lounges?

Dr Aitken: Residents' lounges on the ward areas.

Q108 **Chair:** Is it the opinion of all the panel that we are running just too hot, which was the consensus last time?

Dr Aitken: Yes.

Q109 **Helen Whately:** I have some questions about liaison psychiatry, but perhaps for those following the inquiry, could you, Dr Aitken, describe briefly what liaison psychiatry is?

Dr Aitken: Certainly. It is the psychiatry of general health pathways. It is mainly received as the psychiatry of general hospitals and the conditions that bring people into general hospitals, but it is increasingly becoming the psychiatry of general practice, long-term conditions and symptoms unexplained by medicine.

There are two elements of it. There is the urgent and emergency care piece, which is well understood, which is how we support A&E, and anything that emerges in a general hospital that is unplanned. If people become mentally unwell, people bring delirium tremens and all sorts of things into general hospitals with them, we will respond within the hour and try to sort the work out, enable physicians and surgeons to do their jobs, and we will try to make sure that the person's mental health needs are looked after as well as the surgical and medical task. We are now trying to work out ways in which we can do that to support general practice.

Q110 **Helen Whately:** Could you tell us what role liaison psychiatry plays in suicide prevention?

Dr Aitken: The most important contribution we make is being able to respond in an urgent way. We can turn up within an hour to an A&E department and get the work done usually within three hours. If people come to an A&E department with a primary mental health problem, we are in a position to make an assessment. The assessment is biopsychosocial, so it adds value and it complies with NICE guidance. It means we are looking at the psychology and the sociology of the presenting problem. We are particularly skilled in two things: first, in

finding hopelessness in people's mental states. Since back in the late 1960s—this is pretty robust—hopelessness is the single biggest predictor of suicide. Secondly, we are very good at assessing for cognitive intent. What was it that the person meant by whatever it was that brought them to A&E? If they have self-harmed, for example, do we understand the motivation and the reasons for it? Around those two things—hopelessness and cognitive intent—we can intervene.

Some of the evidence—certainly from the services that have this evaluation—would suggest that we are doing something that impacts on subsequent suicide in the following period. I will qualify that. In Devon, we are very fortunate to have a wonderful relationship with the coroners. They are able to tell us pretty much over the antecedent period what has happened to people we have seen. We did a piece of work on this looking at what we anticipated the suicide rate ought to be. Even taking the fairly low estimate of likely suicide in the following calendar year of 1%, we reckoned that, if we were going to have 100 people intend, one of those 100 would kill themselves in the following year. How are we going to know who they are? Our whole service was predicated on trying to find that one.

If I tell you that we have 2,000 to 3,000 attendances at A&E departments typically, of which at least two thirds will have a self-harm component, it gives you some idea that we are looking for suicide in 200 or 300 people. We can estimate what is expected and we can see that in many of these services, over a five-year period, we had 30, 40 or 50 suicides fewer in the economy than seems to be the case. The inference is that liaison psychiatry services are making an impact purely because people are getting decent biopsychosocial assessments, which is what the NICE guidance suggests ought to happen. Again, with low numbers, it is extraordinarily difficult to say it is cause and effect; it is an association.

Q111 **Helen Whately:** It is difficult to say, but there is an indication that liaison psychiatry is saving lives and preventing suicide.

Dr Aitken: Yes.

Q112 **Helen Whately:** Could you indicate the current level of liaison psychiatry across our health system—for instance, what proportion of hospitals have a liaison psychiatry team and the hours that they are covering?

Dr Aitken: I can supply the Committee with a very useful survey. We almost have census-level data from Dr William Lee at the University of Plymouth. He has conducted the census that supports the NHS England team working on this. When we started, it was clear that not every English hospital—because we started in England—with an A&E department reported having a liaison psychiatry service. That was three years ago. Part of that was that people did not know what a liaison psychiatry service was. It could not be found through finance, CCGs or whatever.

Having worked out what these things were, we very quickly got to a place where most hospitals recognised that something was happening from a mental health or self-harm perspective in their A&E departments or in their hospitals. So we set the context of what an adequate service ought to look like. In the last two series of the survey, we have managed to get to a place where we realise that adequate services are a rarity and most services would not be regarded as adequate. It is partly skill mix and partly hours of operation. What we are looking for is a reasonably average A&E department busyness. We would expect to see a 24-hour, seven-day-a-week service where one-hour response times would be the norm and there would be a multiprofessional mixed audience of psychiatrists, psychologists and mental health nurses available to do the work. Probably less than 10% of hospitals have that as we stand.

Saffron Cordery: My stats say 7%.

Dr Aitken: That would be slightly less than 10%. I was being generous.

Q113 **Helen Whately:** Would it be true to say that in the vast majority of hospitals—over 90%—there is not that 24/7 liaison psychiatry service? I know, for instance, in some hospitals in my area in Kent that the services tend to be limited to daytime hours, but people are turning up at A&E with mental health needs particularly outside those daytime hours, because the time that they particularly seek and cannot find help anywhere else is in the evenings and the middle of the night. Would that be the case, from your experience?

Dr Aitken: My sense is that the NHS England team have embraced this and understand it. In policy terms, every English hospital with an A&E department will have at least an old-age service in place by the end of the five year forward view. We have said that 50% of English hospitals with an A&E department ought to have a core 24 adult liaison service in place by the end of the five year forward view, and we think that is achievable because of the limits in workforce; but we have to work with what we have.

The current puzzle for me is how we extend that to children and young people, particularly given that self-harm starts younger and younger, and many of the interventions for 14-year-olds would apply to 24-year-olds. There is something very important about transitions, models of care and how we work in that space.

Then there is the desperately sad situation of the RAID model at Birmingham City Hospital, which was set up and taught us all what good looked like. They had an alcohol and addictions component in that service. They had three components: old age, general adult and addictions. We have all lost touch with the addictions component.

Q114 **Helen Whately:** Can I pick up on that, because you were talking at a pace there, to check I understood right? Your view is that the ambition in the five year forward view for mental health to have a core 24 service in

50% of hospitals at least is achievable? Do you think that we are on track to do that?

Dr Aitken: I think we can see that that is realistic. If we had said 100%, we would have struggled simply because we can see that at the moment we only have half the consultant workforce and half the nursing workforce that we need. Our psychology colleagues are going to be taxed with improving access to psychological therapies for physical presentation. We have had a look at the workforce in the round and we have had a look at what is practically achievable. We conceded that, while magical thinking would be great, the reality is that, if we got to 50% and we targeted it into the right hospitals, it would make a great deal of difference.

Q115 **Helen Whately:** Do you believe it will be targeted at the right hospitals?

Dr Aitken: If I come back to some of the discussion we have had about the variation in behaviour from CCGs, I spend most of my time as chair of my faculty taking calls from distressed people around the country saying that their CCG does not understand and that the CCG is going to spend the money differently. The opportunity around the sustainability and transformation plans, at least in England, is that we need to find a way through the STPs to bring the commitment from NHS England to life. I would expect, wouldn't I—I am a psychiatrist—to see every STP with a very clear articulation of how it is going to deliver the five year forward view for mental health? In that, the icing on the cake would be a clear suicide plan, as discussed by previous people. At the moment, to go back to my earlier point, the complexity of commissioning arrangements around mental health is bad enough. Try doing that for liaison psychiatry, which nobody understands, in an acute care environment, and it is a life's work.

Saffron Cordery: Could I come in on that point about a clear suicide plan and the STPs? It is worth saying that the exhortation that mental health should be a core element within an STP came after STPs were originally announced. So there is a little element there on which we are having to play catch-up. It is also worth saying that the compulsion that all CCGs will have a suicide prevention plan in place by 2017 must surely be integrated into the STPs, because the CCGs are a core part of the STP process. There are some real opportunities out there, not just for suicide prevention at the sharp end but suicide prevention in terms of crisis prevention as well and bringing all those wider agencies together. We heard a lot of it in the previous session from Samaritans and Mind, but it is fundamental that we also look at promoting mental health and wellbeing within this context because it is about preventing crisis, not just about preventing suicide.

Q116 **Helen Whately:** Dr Aitken, in your written evidence you told us about a clear link between self-harm and suicide. Could you tell us what could be done better to look after people who have carried out self-harm so that we can try to break that link?

Dr Aitken: The first thing to say is that it is an arena where qualitative evidence and talking to people with an experience of self-harm has been transformational. What is in the literature and what we know is that people self-harm for a number of reasons. For teenagers, it may be being part of the group. The service-user groups that we spoke to—the young people—talked about it being a cool thing to do. Cutting can be cool. There is also a substantial literature on self-harm as a maladaptive coping mechanism. It is a bit like using alcohol unwisely or gambling unwisely. Self-harm is just another maladaptive behaviour to enable people to get through their working day. If you take it away, it may make their suicide risk go up. We have understood that, again, from speaking to people who use self-harm as a method of coping. A bit like alcohol and drugs, it can get out of hand, and when it does it becomes more of a burden than a solution.

Finally, there is this very small group of people whose self-harm is part of a pathway to, ultimately, taking their own life, and it is incredibly difficult to spot. Without the psychosocial assessment that looks for hopelessness and cognitive intent, you cannot pick it up, and there are not risk tools and structured assessments and things that you can do that particularly help.

First, I would say that everybody with self-harm has to be seen and afforded a psychosocial assessment. That is NICE guidance and it makes complete sense. Secondly, the people making that assessment ought to have time to listen and some skills, and the skills can vary from problem-solving interventions to dialectical behaviour therapy, depending on the nature of the underlying problem. If the person has intractable character or personality pathologies that make them relate to the world around them in a way that the ordinary citizen would regard as strange, you are talking about a dialectical behaviour therapy intervention. If, on the other hand, it is somebody who is in a crisis because they cannot tell their parents something that is unbearable to them and they need a way to work through a problem list, then they need a problem-solving intervention.

Could I make a plea to the Committee that we all commit today not to regard mental health, mental illness or mental problems as a single entity but, rather, that we understand the complexity of the underlying conditions in pathologies that lead to a common rash or three or four common rashes—psychosis, depression and strange behaviour? The reality is that the underlying processes are quite sophisticated and different, which is why psychology, psychiatry and mental health nursing exist. It is not an easy answer, but it opens up something of the complexity of what we do.

Q117 **Luciana Berger:** I have a quick supplementary on the self-harm element. Another group that is affected by self-harm is prisoners. The figures have just come out for the past year that there has been an increase of over 30% in the last year in the levels of self-harm, and the

level of suicide in our prisons now is the highest it has ever been in 25 years. It was over 107 in the past year. I do not know if you could reflect on that for us in terms of—

Dr Aitken: If any of us has ever been imprisoned or had our independence or freedom taken away from us, it is an incredibly constraining thing on your ability to operate adaptive coping mechanisms. You cannot adapt to prison life in that you can walk away or walk out of the cell or the building; you just cannot do it, so the propensity to maladaptive behaviour in prison is greater. You will do maladaptive things such as cutting and harming, and the motivations will be different—getting to the sick bay, getting time out, being re-celled, or whatever. But there is no doubt that the vulnerability of the people who go into prison in the first place already accentuates the risk, and it is clear that self-harm in prisoners has a much higher correlation with ultimate suicide than it does for the general population of young women. You will see in my report that there is a piece of maths that has always disturbed me, which says suicide is predicted by self-harm, but yet there are more suicides in males, who have a much lower frequency of self-harm than women. So the maths does not quite work. This is much more complex than it appears at face value.

Q118 **Helen Whately:** Earlier you said that the crisis and resolution home treatment teams are very stretched. Could you talk some more about that? What is the situation with crisis teams and what can be done to try to improve the situation?

Dr Aitken: The situation is that crisis response and home treatment work takes a certain kind of mindset. It is probably the most risky form of psychiatry I know because you are dealing with real-world people in real-world settings and you are trying to draw a skillset around them that was largely grown out of experience in the old mental hospitals and the old world of our work.

It is exciting work, but it is difficult to recruit people into and burn-out rates are high. Because of the stretch on teams, practitioners often lose the team feeling and start to work very much as lone practitioners. Joint working would be the ideal because of the risks associated with visiting certain houses on certain estates. The reality is often that rotas will not sustain that, and in the desperate urge to be there 24/7 there simply would not be enough people in a crisis response and home treatment team to staff up a person's flat or a person's hostel so that they could manage all the risk that a ward team could manage. So it is simply the stretch and being pulled thin that creates the vulnerability in the model.

Q119 **Helen Whately:** The problem here is particularly workforce and gaps.

Dr Aitken: Commissioning the workforce.

Helen Whately: It is commissioning of the teams as well.

Dr Aitken: A certain amount of money, a certain number of people being pulled hither—

Dr England: And lack of alternatives, I think.

Q120 **Helen Whately:** Is there enough transparency for it to be clear where the problems are so that effort can be focused on improving the crisis team capacity in areas where there is a shortage—any of you?

Saffron Cordery: I am not sure that this is about a lack of transparency. I think it is slightly more complex than that. If you take together the lack of available workforce, an insufficiency in commissioning of services and put a growing demand into that pot as well, it is very difficult in any context not to see crisis resolution home treatment teams as a way of dealing with any kind of crisis rather than the specific crisis that they want to treat, which is to keep people out of in-patient care. It is an alternative to in-patient care, whereas I think it is being treated as a generic crisis resolution response. It is not staffed as a generic crisis resolution response. It is staffed as a crisis resolution home treatment team, which is different. It is hard to say that it is a lack of transparency, because it is a very complex issue.

Q121 **Helen Whately:** What is the connection between the problems with the crisis resolution home treatment teams and the pressure on the in-patient beds that we have heard about?

Saffron Cordery: I will think that one through before I get to—

Helen Whately: My hypothesis, from what we are hearing, is that if the crisis teams are impossibly stretched and they are there in part to help keep people out of hospital, if they are not managing to do that work, we will see more people either going into in-patient beds than might be needed or people unable to be discharged. Is there a clear connection there?

Saffron Cordery: It is the other way round. When there are not in-patient beds available for people who should be in an in-patient setting to keep them safe, they are then treated in a crisis resolution home treatment team, which would not be the best setting for them. I am not a clinician, so I do not know all the criteria around that.

Dr Aitken: You are right. I am sure each system will find its own hotspot. The one we have looked at very closely is if, on paper at least, we have the right amount of beds for the population—and we do; we benchmark right on the mean for the number of beds we ought to have. Where is the problem? The problem in part is front-end pressure. We have managed that pretty well. The issue is really that we cannot move people on. When we sit and look with our acute trust colleagues, we discover we have more in common than we have in part. We cannot move people out of our beds into step-down. If we do move people out of our beds, they end up in Newcastle. We hang on to our people because we do not want to break their care. We want to connect to community

step-down at an appropriate point and all the rest of it, but it slows down the process.

The other thing we find, of course, is that everybody is thinking very carefully about the resource, so we might have a mental health panel that has a look at the mental health bed allocation and use, but there will also be a social care panel that will take a view on the use of other places where people might live and be cared for. Very often those panels are not together, so you end up going through sequential panels, which again delays discharge from wards.

We have this rather clunky set of decision systems, which is fundamentally about, "Please do not come to my space because I do not have very much and it is going to cost a lot of money," which we then have to spend a tremendous amount of clinical, managerial and leadership time trying to negotiate our way through.

Our conclusion is that the bed situation is well designed and would be optimum if we had the step-down and the links into community care that we thought. We all would say that, if we had a set of outreach teams, early intervention and psychosis teams working well with people who are known to have the major psychotic illnesses, we would see less relapse and less use of the front end of the system. Then the crisis response element would be there to try to pick up those people who do not particularly engage well with the outreach, early intervention or ordinary community mental health care. They are there to mop up the rest. The home treatment element was to try to prevent people coming into hospital if it was at all possible that they could be managed at home, but recognising there is a substantial number of people with severe enduring mental illness who find keeping a piece of accommodation really difficult. What else do they have? It is a hospital bed.

Chair: We have one quick supplementary from Andrew and then we will move on to the final few questions because I know we are testing your patience; thank you for bearing with us.

Q122 **Andrew Selous:** I am curious on hearing references to Newcastle, because I had a constituent who was also moved to a mental health bed in Newcastle. Is it the case that somehow Newcastle has been very clever and managed to secure better funding than Devon or Bedfordshire?

Dr Aitken: It is just the furthest place away in England I could think of, if I am honest. Newcastle and Sutherland appear to have achieved a certain amount of success about what I would call a balanced commission. They have reasonably well-resourced, well-planned systems, which we, from elsewhere in the country, are encouraged to go to have a look at and ask questions as to how they might have achieved that. Dr Brown and consultant nurse Kate Chartres are with me today in the liaison faculty and we have been talking through how they have managed to achieve, with their commissioners, what they have. I have been up there and experienced it. They have wonderful commissioners.

Q123 **Chair:** Could I ask you, Peter, to set out the relationship between drugs and alcohol and suicide?

Dr Aitken: It is quite clear that the older you get, the more drug and alcohol misuse, strangely enough, seems to be involved in suicidal deaths. If you look at the evidence from the Faculty of Old Age Psychiatry, they talk about as many as 50% of the deaths in our seniors, people over 75, having an alcohol and loneliness component to the figures. The trouble we have is that the world of addictions and the problems associated with them are now so separate from the world of mental health and the problems associated with that, that time and time again in inquests and inquiries you see two well-intentioned groups of agencies working hard with the same individual but not working out who is in charge, or they cannot. I think some of the re-provision of drug and alcohol services has helped: for the people who are helped, they are helped well. The trouble is the really difficult people who are hard to help are perhaps not helped so well.

Q124 **Chair:** So that is around dual diagnosis.

Dr Aitken: Dual diagnosis I think has been ill served by this split. If I look at liaison psychiatry, we have been ill served by this split in that we are the only agency now back in general hospitals that makes an initial assessment of people with unplanned emergent drug and alcohol use disorders in people that we are asked to see. We can then try, if we can, to engage the interest of community-based treatment services to come in, but something has been lost at the front end; something has been lost about the complex assessment.

Q125 **Chair:** You would like to see that brought back in.

Dr Aitken: We would like to see that brought back in.

Q126 **Chair:** There has been a very significant increase, as I understand it, in the death rate of drug users. Is that something you feel that has a component of suicide or do you think that is more to do with the abstinence policy? Would you like to comment on the increase in that death rate?

Dr Aitken: All those things are worth thinking about. Abstinence is beyond many, and certainly in the most complex it is unachievable. Harm avoidance and harm minimisation—those kinds of strategies—seem to me to be easier for both the person with the experience and agencies gathering around to deal with them. It is not easy work, but at least a relationship would be established, and in a relationship it is possible then to make some assessment of the mental health component. I mean that in the narrowest and most useless purest sense. In somebody who is using heroin, cocaine or amphetamine, can we make some estimation of how their mood, their psychosis or whatever impacts on their wider set of social behaviours? It is not easy work. Most antidepressants and antipsychotics struggle in the face of much more attractive street drugs.

Amphetamine is a much more potent agent than any of our antipsychotics, so it is a different world of work.

I find it unhelpful that, often, our colleagues working in addiction services have to ask us in mental health services to help them with suicide risk assessment. They feel unable, often, to make a suicide risk assessment even though they work with one of the groups of people most vulnerable to dying in unexpected circumstances.

Q127 **Chair:** Why is that?

Dr Aitken: It is because they are not trained in mental health per se and they do not see it as their job to assess suicide risk; they see it as their job to make an assessment of the use and misuse of the substance, the level of dependency and the kind of strategies that might be brought to bear to mitigate those strategies, and, with the policy of abstinence in mind there, their goal is to get people to abstinence. My responsibility is to come into mucky lives where nothing is easy and to try to find a way to help people stay alive long enough that perhaps the addiction strategy can take effect, circumstances will change or people will just grow older. There are all sorts of reasons why people change their substance misuse behaviour.

There is no doubt about it, but we really do miss our addiction expert colleagues. There are 50% fewer psychiatrists in the specialty of addictions now than five years ago. There is markedly reduced interest in training in addiction psychiatry. We are aware of the jobs and there are very few addiction psychiatrists left to do the training because of the vintage we all were. I had addictions training. Many of the addictions psychiatrists that are left are coming into liaison psychiatry, and I do think there is an opportunity there. Well, I would, wouldn't I? I am a liaison psychiatrist so maybe it is unfair, but if they want to come to work in liaison psychiatry services, the RAID model told me it was a very good place to have them.

Q128 **Chair:** If your recommendation is that it comes back into the service—

Dr Aitken: Yes, we have to reintegrate it.

Chair: —should it come formally into liaison psychiatry, in your view? Would that be the best home for it?

Dr Aitken: Some of it needs to come there. The problem with the addictions pathway is it is cross-community, is it not? It runs from hospitals where our dilemma will be that this person has pancreatitis or a liver that is failing, and we have to make a judgment about returning them to life and use of medical intensive care and all of the rest of it. We do that because of the medical imperative, but our addictions expert would tell us that there is limited evidence that those interventions in the physical domain are going to lead to anything other than a cycle of continuing insult, because we have not set up the kind of onward

treatment plan for their addiction that led to the pancreatitis or the hepatitis in the first place.

Q129 **Chair:** Right at the beginning of the session I asked you what your key asks would be for the strategy refresh. Would that be something you would want to see added to those asks specifically?

Dr Aitken: To see the world of drugs and alcohol brought more closely together, yes, absolutely.

Chair: Thank you.

Q130 **Mr Bradshaw:** How far is the task of harm reduction or harm avoidance helped or hindered by the fact that we treat drugs, as a society, as a criminal justice rather than a health issue?

Dr Aitken: I think we live in a world of stigma generally in mental health, and it is just another issue that gets in the way of an open and transparent conversation. We have to be very careful about the way we set the scene for people with addictions so that they can come and have a confidential conversation with us and take it in the round. It would be fair for the panel to know that I have often had conversations with people face to face with bipolar disorder who are high functioners and work in good jobs, and, as they trust me on the third session, they will tell me that it is their cocaine and amphetamine use that is getting the better of them.

Talking to doctors about drug and alcohol use and use disorders is not without risk to the patient. It is a matter of trust, building relationships and taking time that eventually will get to the truth or the truer picture of why a person's mental state is up the creek. But you are so right: if a person thinks I am going to shop them to the authorities, they are not going to talk to me about it.

Q131 **Chair:** Are there any final questions at all? Is there anything you feel you would have liked to have said today that you have not been asked before you leave?

Dr England: Leading on from what was said about addictions and things like that and suicide in professionals—for example, doctors, which was mentioned earlier—there is a service that has been set up for GPs, but there are a lot of concerns because NHS England is running the service, or developing it, but it is also the body that is our appraisal and revalidation organisation. I think people would have significant concerns about being open and transparent when they know that.

Q132 **Chair:** If you would like to write us a note about that, we would be interested. Thank you.

Dr Aitken: A last thought: please do not overlook gambling as one of the significant addictions of our day. Our high streets are a disgrace. The gambling and payday loans are something that the Committee ought to look at because they figure very much in the stories that our patients tell

us as part of the reason why they are in debt and they are feeling vulnerable.

Q133 **Chair:** Thank you. That is a very important point.

Saffron Cordery: A final point from me is that the "zero suicide" approaches that are being adopted by many areas up and down the country are worthy of looking at. Mersey Care is one of them that is really leading the way.

Q134 **Chair:** We will be going to look at their suicide project and hear more about it as we go round. We have heard people say that they need to be more joined up with local authorities. Would that be your view as well?

Saffron Cordery: Yes, absolutely.

Chair: Thank you very much for your time and patience, and for staying on so much longer than we expected.