

# Health Committee

## Oral evidence: Suicide prevention, HC 300

Tuesday 8 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.

Questions 135 – 244

### Witnesses

**I:** Ian Stevens, Suicide Prevention Programme Manager, Network Rail, and Melanie Hide, Head of Corporate Affairs, Royal National Lifeboat Institution.

**II:** Marie Ash, Devon Suicide Prevention Alliance, Shirley Smith, If U Care Share Foundation, Clare Milford Haven, The James Wentworth-Stanley Memorial Fund, Hamish Elvidge, The Matthew Elvidge Trust, Steve Mallen, The MindEd Trust, Dr Marc Bush, Chief Policy Adviser, YoungMinds, and Joy Hibbins, Suicide Crisis.

Written evidence from witnesses:

- [Network Rail](#)
- [Royal National Lifeboat Institution](#)
- [Devon Suicide Prevention Alliance](#)
- [If U Care Share Foundation](#)
- [The Matthew Elvidge Trust](#)
- [Steve Mallen, The MindEd Trust](#)
- [YoungMinds](#)
- [Suicide Crisis](#)



## Examination of witnesses

Witnesses: Ian Stevens and Melanie Hide.

Q135 **Chair:** Good afternoon and thank you very much for coming to this afternoon's hearing on preventing suicide. As I said last week, we acknowledge as a Committee that suicide is an issue that has profoundly touched the lives of many people in this room and outside, and we are very mindful of that in everything that we are hearing in trying to advise about what should be in the Government's refreshed suicide prevention strategy. We are also very grateful to Samaritans, and we have links on our website for anybody who needs to have sources of help and support over the coming weeks and months.

We are going to start with our first panel. Thank you very much to Melanie Hide and Ian Stevens for coming along. Could you introduce yourselves to those following from outside this room, starting with you, Melanie?

**Melanie Hide:** I am Mel Hide. I am head of corporate affairs for the Royal National Lifeboat Institution—the RNLI.

**Ian Stevens:** Good afternoon. My name is Ian Stevens. I work for Network Rail. I have been in the rail industry for 30 years, mainly on safety-related activity, and for the last four years I have had the privilege of running the suicide prevention programme on behalf of Network Rail and the rail industry as a whole.

Q136 **Maggie Throup:** Can we start by each of you explaining why your organisation has decided to develop a suicide prevention strategy?

**Melanie Hide:** First, the RNLI has not developed a suicide prevention strategy, but it is something that we are looking at in the future. One reason why we are interested in suicide is that we are first responders to rescues, and the casualties that we are involved with quite often are water-related self-harm. We are starting to see that about 11% of our activity is in relation to suicide. It is something that we want to understand more so that we can understand the role that we could play with others in the future, because we are not experts in this field in any shape or form. It is very much about working alongside people such as Ian to understand their learning in the work that they have done.

Q137 **Maggie Throup:** You mentioned 11%. Have you seen an increase? Is that what has made you decide?

**Melanie Hide:** No. Interestingly, over the last five years, we have not seen an increase. It is around 9% or 10%, but it is quite a significant piece of work that we do overall, and, interestingly, when you look at regions such as London, it equates to 44% of the activity that we do on the Thames. It is something that we cannot ignore, but we need to understand what role we could play in that chain.



## HOUSE OF COMMONS

**Ian Stevens:** The rail industry's programme started in 2010. Network Rail leads that on behalf of the rail industry, but the programme is a rail industry programme.

The objectives are set out around reducing the risk of suicide on the rail network, which has an impact upon the reduction of trauma to our staff. We have, on average, 256 suicides on the rail. That is about 4.5% of the national total population who take their lives. Therefore, that is 256 drivers who are directly affected. Most suicides on the rail are people who are struck by trains. Then there is a whole group of ancillary staff who are affected by that, which we estimate at about 10 or so people for each suicide on the network. We have a duty of care to our staff across all parts of the network, be they train operators or Network Rail staff who are involved.

The third element of the programme is around improving the passenger experience. There are issues about delays on the networks. A core aspect of the reason why we have a programme is that suicide causes delay to the network, which, on average, is about 2,000 minutes per incident. Some of our incidents will be as much as 15,000 minutes' delay per event, so that has quite an impact on our customers. Also, the cost of each of those incidents is a financial drain on the rail industry. It is not our primary aim for the programme but it has an impact upon the industry as a whole.

Then there are some of the more social aims. We recognise that we have a massive footprint across the country as a whole, and our contribution to plans that others may have is fairly significant. We have up-to-the-moment data so that we can inform about resource allocation for key areas. We know where our high-risk locations are and we can protect appropriately against them.

We recognise the social cost of suicide as well, because if our staff and customers are drawing down on services from the NHS that is depriving other people from doing so.

There were a number of issues that brought the industry together in 2010 that said we needed to do something about this issue. Since that date, we have extended our portfolio. In 2010, it was very much around the work that Peter Aitken—I know you saw Peter last week—had brought out of the Devon Partnership Trust. Our programme is very much based around that and the work that Samaritans do; Ruth was here last week and has explained some of that.

Our programme is focused around there being a cost to our people in terms of trauma, an economic cost, and a cost and an inconvenience to our customers. That drove our programme in the first instance.

Q138 **Dr Whitford:** Could I ask both of you what measures you have put in place? Ian, you talk about doing suicide prevention work. Could we come to you first and then get comments from the RNLI?



**Ian Stevens:** Traditionally, most people think of fences as a means to stop access. That does not necessarily work on the rail network. We have many stations and level crossings that are open access. If you look at the physical measures and softer measures, that may be fencing that prevents access to the running line. It may be fencing at railway stations with disused platforms; we do not allow members of the public on to those platforms. On platforms where trains run, we try to segregate at key locations stopping services and passengers getting on to those from being able to cross on to the adjacent platform, where they may be able to step out in front of a running fast-train service. We call that mid-platform fencing.

We also have psychological measures. We put yellow hatching on platform edges. We are not sure of the impact of those, but there is a psychological issue around people not liking to be seen in exposed places. We know from some of the research we have done that the greater the chance of an individual who comes to the railway being intervened in their attempt to take their lives, the more it puts people off doing so.

I should stress here, though, that our programme is not about stopping people taking their lives on the railway and them finding somewhere else to go. It is very much about stopping people taking their lives on the railway and trying to help those within the community as a whole, hence our relationship with Samaritans, where they are able to support the community, and hence the work in terms of the softer measures that we are doing around working with local authorities, trying to understand the mechanisms that they have in place for suicide prevention, be they the audits or the plans that they should be doing. It is about how we then support those communities and the work we can do within those communities to support those activities that prevent suicide there.

We have moved away in the last six years from a "Let's just protect the railway" approach to a much more rounded approach of, "What influence can a large industry have on the population as a whole, of which it is very much a part?"

Q139 **Dr Whitford:** Would you tend to have railway staff on platforms more? I know on the underground, perhaps for totally different reasons, instead of being upstairs in a booth, the staff are down on the platform. Is that something that you have on Network Rail as well that allows there to be a person there who is aware of what is going on?

**Ian Stevens:** We have a very comprehensive training regime for staff, not just for Network Rail but for train operators. Train operators have staff on most of the infrastructure because of the stations. We have trained around 13,000 staff, be they Network Rail, train operators or the British Transport Police—or local communities, come to that. Where we know we have particular high-risk locations, we will train the local community to look out for those who are vulnerable to suicide.



## HOUSE OF COMMONS

That has worked very successfully for us, we believe. We saw a 12% reduction in suicides last year, which we believe is because we have ramped up the training. As well as the 13,000 people who have been on a day-long training course, we have an excellent video package, which a further 14,000 people have seen, which is around giving them a very basic understanding of how they might intervene in a suicide and how they might get support and help. But we cannot be everywhere all of the time, which means our staff cannot intervene all of the time, which means we look for other bodies to assist us. We will look to train contractors who work for Network Rail, and they take those skills, just as our staff do, back into the community. That then has a ripple effect on their intervention on suicide in the community as a whole and not just on Network Rail.

**Q140 Dr Whitford:** You mentioned that the suicide rate had fallen 12% on the railway. Does that come from an evaluation to look at what you think is working or was that stats being provided elsewhere rather than through your organisation?

**Ian Stevens:** The difficulty with understanding how mitigation measures work is that we do not employ just one; we employ a multitude of mitigation measures at any one location, particularly high-risk locations. We do not have statistics that say, "The fact that you have trained 13,000 people has led to that decline." Indeed, there are many other organisations—and we are very thankful to be with them and supported by them—that do similar work to our own. They may be having an impact on the individuals who come to the railway so that they do not actually come to the railway.

The position of Network Rail and the rail industry is that, if we were not doing what we are doing, we would be in a far worse place than we are. I think Ruth Sutherland last week spoke about the 1,100 people where interventions had been made on the rail network so they had not taken their lives. That is a significant number, particularly given the impact that those individuals could have on the network. We are working on a correlation between more training and more interventions. All railways around the world have the same problem about suicide. We are net exporters of our knowledge to those railways and all railways suffer from the fact they do not collect data very well.

Suicide prevention has tended to be a knee-jerk reaction to a particular issue and, therefore, we think about what implementation measures can be put in to mitigate against it. But when you are trying to put some science behind what works, and where you have limited resources, that is what you need to try to do to understand what works.

We know that mid-platform fencing works. We have seen a decline, certainly along the Thames Valley corridor, between London and Reading, where mid-platform fencing has been put in to stop people moving on to fast-line platforms, and we are seeing the same impact on our London-



north east route coming out of King's Cross, where we are putting the same forms of platform fencing in.

Q141 **Dr Whitford:** You are doing some evaluation.

**Ian Stevens:** Absolutely. We have just engaged with Nottingham University as well to put an evaluation package together so that when we introduce any new methods, or any new technologies at any location, we have a fairly rudimentary way of measuring the impact of that. The other issue we have is that it is such small numbers: 256 is a small number. We accept it has a massive impact, but when you are only looking at that small number it is very difficult to make something statistically relevant. Certainly, we do try to understand the correlation between these events.

Q142 **Dr Whitford:** Can I come to you, Melanie? You said you do not have specific prevention measures, but what kind of changes in policy are you having? Is that more preparing staff to deal with what might happen?

**Melanie Hide:** To put it into a wider perspective, our role is to end preventable loss of life at sea, so we are looking at what constitutes the different incidents within the drowning chain—what leads to somebody losing their life through drowning.

There is evidence that in 2015 we attended 867 incidents of water-related self-harm. That, for us, as I said, is about 11% of our overall activity, but we would like to understand, for example, whether the measures that Ian has talked about could have any relevance in a water environment. We are absolutely clear from the work that we have done that your exposure to risk and your exposure to areas of isolation or access to places where there may be a greater hazard is certainly one element of taking you towards potentially losing your life from drowning. Are there interventions that we could learn from that that you could apply in a water environment, whether that be signage or barriers? Very much coming up from a local level, we have had interventions that our community teams, through collaboration with the council and police, have started to consider on a small level. If you tested some of these, would it make a difference?

The difficulty we have is that the data do not necessarily talk to each other. One area to which we have contributed as part of the UK's drowning prevention strategy is to better understand water-related self-harm. We have commissioned an independent piece of work to look at the current data and what is out there, and see how they talk to each other. They do not in reality, so there are some gaps in the knowledge. Anecdotally, we know from the Exmouth project that, from a behavioural point of view, we have increased awareness and confidence in our crew and members of the community to be able to go and ask somebody if they are okay, something as simple as that, but also to consider when someone is at risk. Very anecdotally, the difficulty is the return of service—that is our data—does not necessarily correlate with any change in the numbers of suicides. At the moment, there are gaps within the



datasets because they all have different requirements. That is something that we would like to look at in future.

**Q143 Dr Whitford:** I suppose for yourselves the hard measures that Ian talked about—the physical measures—are much more difficult. We cannot really fence the coast and, therefore, the soft measures—training, signage and public awareness—are more important. Are you doing any active campaigns on that, such as public education?

**Melanie Hide:** No, not yet. This is the next phase for us. We have a five-year business plan; we are three years within that business plan, and suicide-related self-harm is not part of that strategic objective. What we are very keen to understand is what role we can play. The sharing of data, the involvement at a community level and being part of a multi-agency group is certainly something that we would consider, but it is absolutely about working in partnership, and the small local projects that we have been involved in have been absolutely that. I know we have mentioned Peter Aitken already today, but we are very fortunate that he is a helm who was involved in the Exmouth project, and his academic background and understanding of suicide added some real weight and value to the work that was done.

We have some good anecdotal evidence that we could explore further, but at the moment it is early days for the RNLI to understand the role it plays. We know there is resonance in what we do in the bigger picture of suicide. In terms of numbers, water-related self-harm is 5% of suicide overall. It is a relatively small impact, but it is a third of drowning in the UK, so it is quite a significant piece of work that needs to be considered for the future.

**Ian Stevens:** Could I add to the public issue that you raised there? After six years, we are beginning to realise in the rail industry that part of how we can meet the challenge is to use the general public—our customers—to work with us. We run a campaign with Samaritans, which is around trying to get individuals who may be at risk of suicide to seek some help from Samaritans. That is our primary port of call and we advertise that very strongly at railway stations. It is not about suicide; it is about: “If you have issues that you need to discuss, call Samaritans.” So, we very much promote that campaign. We also use that collateral or ask others to use that collateral; it does not have to be railway-related. They can take that and use it elsewhere. You would have seen it this year at Lord’s cricket ground and at rugby league, because that is our population. Eighty per cent of our fatalities on the railway are men of 30 to 55. So, we are trying to target them through other means.

Most recently, we have done some research work around how to engage directly with customers to work with us to identify potential individuals at risk without saying, “Individuals may be suicidal,” because we worry about the contagion if we start talking about suicide on the railway. We have a project at the moment called Rail505, which is a smartphone app where our customers can send a message if they are concerned about



somebody. We know from research that our customers are willing to get involved; they do not necessarily want to put their copy of the newspaper down and intervene themselves, but they are very willing to look up and occasionally get involved in an event, and think they have done their civic duty by letting us know that. We are very responsive to those sorts of messages. In terms of informing the public and that bystander campaign, it is very important for us as the next step in what we do to drive that forward.

**Q144 Dr Whitford:** What help would you say both of you need? Is it finances to take things further, or is it more about getting involved with people of other expertise who are outwith RNLi and Network Rail?

**Melanie Hide:** Certainly, from our perspective, because this is a relatively embryonic piece of work for us, it is about talking to experts, both at a national and a local level. I would also say the conversation regarding the public and societal view of suicide is interesting, because we are a charity that absolutely relies on public donation, and there are many myths and strong perceptions around suicide. If more was done to understand the trauma of the person who is thinking of taking their own life—that it is not a selfish act—that greater understanding would be helpful for other charities like ourselves that may be at the front end of helping a person who finds themselves in such a crisis situation. So, that is societal awareness.

At Exmouth, we tested a leaflet about whether it was safe to talk. Again, it was looking at increasing confidence but also removing some of the myths that surround “selfish act,” for example, which is something that we quite often hear. Resource is always a challenge, but this is where collaboration and working with others who might have expertise in other areas comes in, and having a way in which to find out where that expertise is, potentially led through a central or a national lead, would be valuable.

**Q145 Dr Whitford:** We equip young people in many schools with Heartstart and other things like that. Do you think taking some of this—“Is it safe to talk?” and “How do you speak to someone?”—into schools might both help the young person to be resilient but give us, as we get older, these kinds of skills?

**Melanie Hide:** Yes. As a mother, I am very conscious of the work that schools are now doing to build resilience with children—for example, on internet-related abuse—which can lead to feelings of less worth. It is really important that we engage at all levels of the community, young and old, and build that resilience.

The other thing I did not mention is that, internally, we are using TRiM, which is effectively looking at skills-based competency and allowing our own staff and volunteers to understand the importance of their own self-protection. The health and wellbeing of our volunteers is really important. Essentially, as an organisation that is 95%—





Q146 **Dr Whitford:** We will come on to that. Ian, was there anything you wanted to add on this?

**Ian Stevens:** Yes. We have four key asks within the industry, one of which you have already touched on about making our young people more resilient. We see suicide prevention very much as a long-term issue and, therefore, our young people being able to cope with the journey that they take through life is exceedingly important. So, we would look to promote that.

The others would be around research. Network Rail, the rail industry, funds its own research. You could argue, "Well, it should do," but the rail industry is not the only transport industry that suffers from suicides. If you look at Highways England—not themselves, of course—they have an equal problem. We need to understand suicide and why people choose to take their lives on the railway or across a transport network, which is a very traumatic way to take your life. Some body that could help inform and direct resources is a key issue for us.

Also, we are very supportive of the introduction of suicide-awareness training, and I know Ruth Sutherland touched on this last week. We have seen it work, we believe, in our own industry, and we believe this is a part of being able to drive the issue upstream before people come to take their lives, be it on the railway or at any other location.

Again, Ruth touched on this, but we would ask that local authorities be mandated to undertake suicide prevention planning and audits, because we have found through the work that we do with 14 councils or local authorities with which we are directly involved that there is a complete spectrum of how those authorities treat suicide prevention. We would look to see those requirements mandated.

Q147 **Helen Whately:** I have a question for Ian to follow up on something that Philippa touched on a moment ago. Are there any particular steps you are taking to prevent suicide at unmanned stations?

**Ian Stevens:** You asked about what measures we have to prevent suicide. There is CCTV, of course; we use that. That often requires somebody to be able to man and respond to an incident. Physically, at stations themselves we may employ CCTV or motion-detection systems, which may play a message that says, "Please step away from the platform end. If you need assistance, please go and speak to..." But because there are so many unmanned stations, the issue about trying to move the problem upstream is critical for us, because we cannot be everywhere all the time. To work in a multi-agency environment that starts to address the core issues of suicide rather than wait for the individual to come to the station or to stand beside the infrastructure is critical for us. Even if we had every station manned, it does not mean that the individual at that station would be able to prevent a suicide, because if they are dealing with another member of the public and turn away, then you have a suicide, potentially, on your hands. We see that



## HOUSE OF COMMONS

even at manned stations. For us, it is very much an issue of how we stop the individual coming to the railway or taking their lives in any way and how we support that activity.

Q148 **Andrew Selous:** Ian, I have a brief question. I do not know if you are aware of which of your stations you have the most serious problems with.

**Ian Stevens:** I am very aware of which they are.

Q149 **Andrew Selous:** Perhaps I will not ask you to say, but I am pleased that you are. Do you take additional measures at those particular stations to try to deal with the issue?

**Ian Stevens:** Absolutely, we do. We have what we call 32 priority locations. Those are the ones that present the highest risk to the rail industry, be it with repeat suicides or, if there was a suicide, it would bring the network potentially to a standstill. All the mitigation measures that we know of are in place at those stations, at those locations. Unfortunately, people still come to those stations to take their lives, so it is always incumbent upon us to find new ways of trying to meet that challenge.

Of late, we have started to employ anthropologists and ethnographers, so that we can start to understand the society that sits around those locations and whether that is driving people to the railway to take their lives. We know, for example, that most people will not travel more than four and a half miles to take their lives. That is a very tight little cluster of the population who seek to use the railway.

An example was Berwick-upon-Tweed where we had two people take their lives in very quick succession of one another and we were able to pinpoint the exact location from where those individuals came. To the credit of the local authority there, they were very quick to respond to that and drive health and wellbeing training into a small industrial estate from where those two individuals had come.

We are very fortunate that we can monitor our data on a daily basis—or minute by minute, actually—and therefore understand exactly where we need to prioritise and allocate our resources. That, again, is one thing we try to work with local authorities to do. Where we have suicide clusters, we will get in touch with local authorities, try to understand what intervention measures they have in place, and then seek to work with them and share the information that we have. At the moment, we have 14 locations where we are working with local authorities to try to see what more we can do: whether we can employ Samaritans more in the local environment; whether we need to put in some bespoke fencing; or whatever measures we can take.

**Andrew Selous:** That is a good answer; thank you.

Q150 **Chair:** How closely do you work with London Underground, because there are some London Underground stations that have a complete physical



## HOUSE OF COMMONS

barrier? Was that primarily a response to trying to prevent suicide or for other reasons, and are you aware of any data that they have had since installing them?

**Ian Stevens:** When you say “barriers,” are you specifically referring to platform-edge doors?

**Chair:** Yes.

**Ian Stevens:** If I take that point first, platform-edge doors are a great way of stopping people taking their lives at platforms. They are very expensive and the technology requires that you run a fixed set of rolling stock that fits the exact pattern of the door. Because of the way the infrastructure and the rolling stock exists on the overground network, that is not possible. There are changing technologies in barriers, so we are looking at that. The Japanese are keen exponents of that. Certainly in terms of station design and station planning, they are a consideration. A lot of work we do at the moment is about station design and station planning, so on the new HS2 facilities at Old Oak Common we are very much involved in thinking how you design suicide out of that station.

As to our relationship with London Underground, there is a governance programme within the rail industry, which is overseen by members of the Rail Delivery Group, which is around making sure we get the input from all groups. Part of that architecture is to involve London Underground—they have key roles within their organisation for suicide prevention—so that we will learn from them and they will learn from us. A lot of what we do is about sharing that learning.

Network Rail and the rail industry in this country leads the world in its prevention of suicide in open spaces, and we export an awful lot of our knowledge abroad. I have been fortunate enough to go and give my colleagues abroad the insight into what we do. A lot of the programmes that are run abroad are based upon what we do here, but the relationship between operators, be they overground, underground or the train operator and the infrastructure controller that I work for, is very close. This is a national issue for us all and has a huge impact, which we take very seriously. We could not do that alone. Therefore, we do need to work with all those other agencies.

Q151 **Luciana Berger:** I have a very short supplementary. You mentioned those key areas where unfortunately there have been higher rates of suicide. Are you involved at a local level? Beyond your work with the local authorities in that area, are you represented in either the local suicide prevention plans for those areas or the multi-agency prevention groups in those areas?

**Ian Stevens:** We are where we have or perceive them to be priority locations, yes. As you can imagine, there are lots of locations and not a huge amount of staff to be able to be part of all of those groups. We have contributed an awful lot to Public Health England’s work, and a lot of the work in the latest publication has come from us about the need to involve



Network Rail and the rail industry in multi-agency groups at that level because of what we can bring to them. We can bring data and a better understanding of how you prioritise resources at those locations. We have certain facilities, through the use of Samaritans volunteers, to be able to help within the wider community to try to destigmatise suicide in that community. Where they are a key risk for that community for the rail organisation, we will have somebody as part of that group. I should also say what a great job the British Transport Police does on the industry's behalf, and, if Network Rail or the rail operator are not represented on that group, British Transport Police will be. There is always a link into the rail industry.

**Q152 Andrea Jenkyns:** I know some of my colleagues have touched on this, but we wanted to do a section on partnership approaches. You have both spoken a lot about the importance of working with other stakeholders and collaborative working. First, what challenges do you face in identifying, developing and maintaining effective partnerships in coalitions? Secondly, how might you share best practice? Can I put that to Melanie, first, please?

**Melanie Hide:** We are very fortunate, I think, within our area, looking at drowning, because we already have a forum, the National Water Safety Forum, where there are like-minded organisations that are here to prevent drowning. There is already a precedent for knowledge sharing and collaborative working. Clearly, it is a case of understanding your shared goals. Quite often, a number of us are charities and we need to be very clear as to which role we would play. Equally, this is a much wider issue, and a lot of the work, as I said earlier, around drowning prevention means that we are doing integrated risk management in communities so that we start to identify who are those stakeholders. It is around understanding the role that each stakeholder can play and agreeing how you are going to work together. In many instances it is still quite early days for us, but in the area of suicide prevention we are in conversation with a number of experts such as Samaritans to understand if we could work with them, whether or not it is on a similar level as Ian. Certainly, training and their knowledge could be of real value to us. It is about putting in resource and time; and prioritising it is the challenge, I imagine, for most organisations.

**Q153 Andrea Jenkyns:** Ian, do you have something to add?

**Ian Stevens:** Yes. Our portfolio has changed, as I said earlier, from six years ago, into thinking how we make a more direct impact in society as a whole. We have been very fortunate to be surrounded by some very good people—Samaritans, operators within the rail industry and the British Transport Police.

We have a lot of knowledge to be able to export and we are very keen to do that, because we understand that not everybody has a huge amount of resources to be able to make their own videos about suicide prevention. We are very keen to share those, and indeed have with the



## HOUSE OF COMMONS

RNLI, the national health service and smaller organisations as well. We are also very fortunate to be part of the National Suicide Prevention Alliance, which I think you will be aware of, as a steering group member and, therefore, will be able to share the things that we know about suicide and take on board the things that that organisation knows as well.

There is always the issue of funding and funding specialist units. We recognise that we will work within the environment that we have, but having the British Transport Police specialist unit, their suicide prevention and mental health unit, the relationship they have with the national health service and their ability to support the programme, is essential for us, as is our relationship with Samaritans and the knowledge that they have.

The issue about all partnerships is that people have different views, different visions and different aims. It is the ability to bring those things together and channel them all in the same direction—I guess that is what you do with multi-agency groups—and the understanding and the facilities that you bring to those groups. We have an awful lot to share. We have a lot of experience and we like sharing it. We are very fortunate that Public Health England turn to us for the support that we can give them.

Picking up the earlier question about being able to generate those sorts of comments in public health documents, where local authorities should be picking that up and then knowing who to turn to, that is a great bonus, because we can start to influence and to manage some of those issues that are critical to Network Rail, the rail operators and perhaps the wider society.

Q154 **Andrew Selous:** I want to ask about the impact on your staff and volunteers of coming into contact with people who very tragically have taken their own lives, and, following on from that, what you have found to be the most effective way of supporting your staff and volunteers who have come into contact with people who have taken their own lives. Melanie, do you want to start on that?

**Melanie Hide:** Yes. This is something that we take very seriously. The nature of rescue and being first responders means that many of our volunteer crew are having to tackle some difficult situations, whether that is life-threatening injury and administering first aid or, in the case of what we are discussing today, a suicide. There is quite clearly trauma as a result of that. We have implemented TRiM, which I know is well recognised within—

Q155 **Chair:** For those following outside this room, can you explain what TRiM is?

**Melanie Hide:** TRiM is essentially a process by which you have a conversation after an incident to understand your own safety and your own wellbeing. I suppose it is like a debrief following quite a traumatic



## HOUSE OF COMMONS

incident. I understand they use it in the armed forces and within emergency services, which is very much where we have taken learnings from a lot of the partners that we come across.

Q156 **Chair:** Could you use the full name?

**Melanie Hide:** I will have to refer to an expert to give me that, if you don't mind.

**Andrew Selous:** Trauma risk management is what we have.

Q157 **Chair:** It is just useful for those outside the room.

**Melanie Hide:** We are using that for crew across all our stations, but we are now looking to bolster that with a view of what we can learn from other organisations that are working with water-related self-harm or suicide so that we can bolster what we are currently doing. The evidence so far is proving, anecdotally, to be positive. Wellbeing is really important, because we are, effectively, an organisation that is run by volunteers and we have to make sure that we are able to continue to deliver the service that we currently provide.

Q158 **Andrew Selous:** How long would you typically have to go on providing that sort of support to your staff and volunteers who have come into contact with an incident like this?

**Melanie Hide:** For clarity, do you mean how long in terms of following an incident or—

Q159 **Andrew Selous:** I mean how long, typically, would the support package of trauma risk management be in place for one of your staff or volunteers who had been badly affected by coming into contact with a suicide?

**Melanie Hide:** In all fairness, I am not an expert in that area. We do have people who can provide that level of detail, if you would like me to come back to you on that.

Q160 **Andrew Selous:** Perhaps you could provide a short written note.

**Melanie Hide:** Yes. It depends on the incident and, again, you can have very traumatic first-aid care that might be different from a suicide-related one. It depends on the individual and the risks that are sitting within that station or within that community. We are finding that by working within a community context there is support within the community, so it is not just a reliance on us as an employer, or it is provided as part of a wider group; and that is what we want to explore. I still think we have more to learn as to what is effective, in addition to TRiM. It is still relatively early days. If you are happy with that, I could come back to you with more evidence as to the length of time we are starting to see with some of the incidents that we are dealing with.

Q161 **Andrew Selous:** That would be helpful; thank you. Ian, what about your side?



**Ian Stevens:** Core to the rail industry, of course, are drivers, because 99% of all fatalities on the network are caused by a train striking an individual, and that will leave a long-term impression on a driver, some of whom may never get back to work. In 2013, the average time for a driver to be off work was 29 days, but, as Mel says, it is individuals and how they react to the trauma that they have faced. There are support programmes across all the train operators. I am not versed to be able to talk about them in detail, but they are there to support drivers and those who are involved in traumatic events. They will run the course until those individuals are able to cope effectively with the trauma that they have experienced.

Q162 **Andrew Selous:** Do you know roughly what proportion of drivers never come back to work?

**Ian Stevens:** I do not, but, again, we could find out that detail. Some people do not react immediately but will react sometime afterwards. We start to try to build from the bottom up. Now, we are trying to build some resilience into our driving community by allowing them to understand that they may be involved in one of these events but that when they are involved in an event, a fatality, there are certain activities that swing into motion. We try to get a British Transport Police officer out to that train as quickly as possible. That officer is trained to be able to help the driver cope with the situation that they are in at the time. It may be that the driver does not want that assistance and wants to cope with it in their own way, and that is absolutely fine, but there are trained people on hand to be able to do that.

Then, using Samaritans support, we have a number of publications that are fairly easy to understand, so that if individuals begin to think they are behaving differently they can try to gain an understanding of why that might be, and then they are encouraged to seek help through the counselling services that exist within their own organisations.

The other side for us is customers, because customers witness an awful lot of activity in terms of suicide at stations. We use Samaritans to support those individuals through a scheme that they run with their volunteers, who come out of their branches to the stations so that they can talk to station staff or to customers. We recognise that we have a responsibility, as an industry, to those customers as well as to our own people.

It is a very comprehensive package of activity that we use to rehabilitate individuals to come back into the working environment, which we encourage as quickly as possible, because we recognise the research that says doing something that is routine gets you back into the work environment and manages that trauma more effectively than being off work. Much of our work is around trying to achieve that.

Q163 **Heidi Alexander:** I have a brief follow-up question to that around the individual members of staff who may seek to intervene in preventing



## HOUSE OF COMMONS

someone from taking their life but are not ultimately successful in doing that. It strikes me that there may be particular needs for that individual when they have tried to stop something happening and have not been able to. Is there specific support in place for your staff around that, but also does that lead to any reluctance among other staff in helping to prevent those incidents in the future?

**Ian Stevens:** It is a very interesting question and one we have wrestled with. We do not believe it has caused any reluctance at all, and the feedback we get from people who have intervened is that it is quite a positive and enhancing experience for them. That is not to say that doing so has not drained them of emotion, because it is a very traumatic environment in which they find themselves.

We have not sensed reluctance. We have seen an upsurge in people who take the training. The training is very much on the basis of, "Only do it if you feel comfortable with it. If you do not feel you can approach the individual, that is not your responsibility; you must be safe and you must be comfortable with your own actions first and foremost. If you then feel empowered and capable of going to have a conversation, then do that."

As to individuals who have tried to intervene and not succeeded, again we use the standard support process that we have in place. We always advertise the programme to our staff so that they know who to turn to. They always have the number of Samaritans to call if they do not want to talk to their own line manager, but the process that we have within the industry is to communicate with the line manager, and the line manager is then empowered to move the individual through a coping process, be that through counselling or some other recommendation. It is a genuine issue for people about, "I have the training, but what happens if I do not feel comfortable with it?" If you do not feel comfortable, please do not use it.

Q164 **Chair:** Thank you. Are there any other points that either of you wish to make before you leave today about what you would like to see in the new version of the suicide prevention strategy?

**Melanie Hide:** Mine is more about the process. For example, how does this inquiry inform the strategy? Will it, or does it follow? Mine is more of a general question: what is the process?

**Chair:** You wanted to ask us a question and it is indeed a very timely point, because we were expecting to see the publication of the strategy so that we could scrutinise that. In fact, it has not yet been published. Our hope is that the voices we hear from in this inquiry will be able to feed into that process. We do not yet have a date for publication. Thank you for asking the question and thank you for coming today.

Examination of witnesses





## HOUSE OF COMMONS

Witnesses: Marie Ash, Shirley Smith, Clare Milford Haven, Hamish Elvidge, Steve Mallen, Dr Marc Bush and Joy Hibbins.

Q165 **Chair:** Thank you for coming this afternoon. It is kind of you to give us your time. It would be helpful if I go round the table to allow us all to introduce everyone here. I am Sarah Wollaston, Chair of the Committee, also a former GP and the MP for Totnes in Devon.

**Steve Mallen:** I am Steve Mallen, chairman of a charity called the MindEd Trust, and I am here following the tragic death of my son last year.

**Andrew Selous:** I am Andrew Selous, MP for South West Bedfordshire. I have just recently joined the Committee.

**Clare Milford Haven:** My name is Clare Milford Haven. I am founder and trustee of the James Wentworth-Stanley Memorial Fund, which was set up eight years ago following the very sad and tragic death of my son James.

**Dr Davies:** I am James Davies, MP for the Vale of Clwyd in north Wales, also a former GP.

**Mr Bradshaw:** I am Ben Bradshaw, the MP for Exeter, and I was a Health Minister in the last Labour Government.

**Hamish Elvidge:** I am Hamish Elvidge, chair of the Matthew Elvidge Trust, which was formed shortly after our third son took his own life in 2009. I am chair of the Support after Suicide Partnership as well as founding co-chair of the National Suicide Prevention Alliance and the National Advisory Board.

**Dr Whitford:** I am Dr Philippa Whitford, the Member of Parliament for Central Ayrshire in south-west Scotland, and I am a surgeon.

**Heidi Alexander:** I am Heidi Alexander, the Member of Parliament for Lewisham East.

**Marie Ash:** I am Marie Ash. I am from Devon and am somebody who has experience in that I have attempted suicide myself. I am part of the Devon Suicide Prevention Alliance.

**Joy Hibbins:** I am Joy Hibbins. I have lived experience of suicidal crisis myself. As a result of not being able to find the kind of help and support I needed, I set up a suicide crisis centre in Gloucestershire in 2013. For the past three years, we have been supporting people both at the crisis centre and out in their homes as well.

**Dr Bush:** I am Marc Bush, the chief policy adviser at YoungMinds.

**Helen Whately:** I am Helen Whately, the Member of Parliament for Faversham and Mid Kent, and I have had a particular interest and



## HOUSE OF COMMONS

involvement in mental healthcare for around 10 years.

**Shirley Smith:** My name is Shirley Smith. I am from the If U Care Share Foundation, the charity that was set up after the death of our eldest son Daniel in 2005. We provide suicide prevention, intervention and support training for families bereaved by suicide.

**Luciana Berger:** My name is Luciana Berger. I am the Member of Parliament for Liverpool Wavertree.

**Andrea Jenkyns:** I am Andrea Jenkyns, MP for Morley and Outwood. I would like to say that it must be heartbreaking coming to something like this when you have all had a loss; so, my heart—and I am sure the Committee's heart—goes out to you.

**Huw Yardley:** Huw Yardley, Clerk of the Committee.

**Laura Daniels:** I am Laura Daniels, the Committee specialist.

**Chair:** Thank you. As has been said, we are immensely grateful to you for coming to share the experiences that you have had and speaking, I know, on behalf of many others whom you are representing here today. Opening the questioning today is Helen.

Q166 **Helen Whately:** Thank you very much. I would also like to emphasise how very helpful I think it is that you are coming to speak to us to share what must be very painful and difficult experiences, but I am sure others will benefit as a result of you doing so; so, thank you.

Joy, I am going to come to you first. Very helpfully, in your introduction, you said you founded a suicide crisis centre and gave us a little context to that. Could you first describe a bit about the services and the support that you are offering?

**Joy Hibbins:** Yes. As well as providing a suicide crisis centre where people can come as often as they like when they are at high risk—they can come in every day—we also found that we needed to go out to people's homes. When someone is at imminent risk they may not be able to make it to our centre; or if they have consumed a large amount of alcohol or drugs, again they may not get to us; or if they have been through something incredibly traumatic and they are just too frightened to leave their home. When people come to us, if they are at imminent risk that day, we support them over a period of hours for as long as we need to; our support is not time limited.

In terms of the longer-term care that we provide, our clients decide how long they stay under our care. We like to try to put our clients very much in control. When I was under mental health services, I felt quite powerless a lot of the time because I was told what care I would receive and for how long. Sometimes you get discharged from the crisis team when you are still in crisis simply because there are not the resources or the people to support you for long enough. Our clients decide how often



they come in to see us, the kind of support they have and when they feel ready to leave us, so they are very much more in control than I felt when I was under services.

**Q167 Helen Whately:** Could you give us your view on the shortcomings of the mainstream services that otherwise the people who would be your clients would be drawing on?

**Joy Hibbins:** Yes, of course. In terms of mental health services, I went through the experience of being supported both by the crisis team in the community and eventually in a psychiatric hospital, because I found the crisis team did not work for me. One issue was that there were so many people involved in the team. At least eight different people would be supporting me, a different person coming out every day. I had been through a very traumatic incident in 2013. It was very difficult for me to build up trust with one person, let alone a team of eight, having to repeat distressing information, finding it difficult to really connect with people because so many were involved.

One thing about our team is that a very small team works with each client; it is generally two, but occasionally it needs to be one because sometimes, particularly, men will come to us and say that it was hard enough to open up to one person and if we had passed them to another member of our team they would not have come back. So, there are times when we need to have just one person supporting the client. A lot of it was based on my own experience of finding it overwhelming to be supported by so many different people.

In terms of psychiatric hospital, I would say that I am a huge advocate of psychiatric hospital. We definitely need more beds. The number of people who die by suicide under the crisis team compared with those in psychiatric hospitals is very marked and we need to pay close attention to that. I find psychiatric hospital more helpful.

**Q168 Helen Whately:** Could I just ask you to go a bit further on the situation for men and how the mainstream services sometimes do not work? There was something particularly you said in your written submission about men's concerns about talking to GPs, which would be interesting to bring up.

**Joy Hibbins:** Absolutely. That was one thing that men have said to us. The reason why they come to us is because they had a concern that if they went to their GP it would be documented on their record and that may impact on both their current and future employment. These were things that were very much being taken into consideration by them when thinking about what kind of help they wanted to access, but they also very much wanted to have that feeling of being known to us, being able to build up a connection and that we would have an opportunity to understand them. We have massive respect for Samaritans, but we do work in a different way in that Samaritans is more anonymous. We are trying to work very closely with individuals and have very individualised



care that is tailored to them, where we get to know and try to understand their situation and their needs as much as we can.

Q169 **Helen Whately:** Finally, do you have a view on whether what you offer could be done by the NHS, the local authority or by some part of the public sector, or is there something particular you do, because you are separate from those formal organisations, that means it is best done by an organisation like yourself—the third sector?

**Joy Hibbins:** I think there is something in the independence, and that goes for independence from GPs and mental health services as well. For some people who have had a negative experience under mental health services—and a percentage do—they are coming to us knowing that we are nothing to do with that service at all.

It is an interesting point about the NHS, because there is certainly interest within other NHS trusts in part of the country. We are having a meeting later on this week with AWP—Avon and Wiltshire Partnership—a very long name. They are thinking of setting up a new crisis centre in Bristol and they are coming to talk to us to see what learning they can gain to inform that service. It may be that in some parts of the country other independent crisis centres following this model could be set up, but the idea of the NHS gaining some learning from some of the things that are working is appealing as well. There are different ways in which this can spread.

**Chair:** Helen, before we move on to your next question, I know Luciana has a supplementary and I have a follow-up.

Q170 **Luciana Berger:** Joy, you know I have had the opportunity and privilege of coming to visit the service that you provide. Perhaps it would be beneficial for the Committee to share a little more about how it looks and feels different from other services, in terms of location. I was particularly struck by the people whom you support and what they said about the building and the rooms where people come together—how that is very distinct from NHS or local authority services. It would be helpful for the Committee to hear that.

**Joy Hibbins:** An interesting thing has happened since you visited. I know you came in January when we were using a town-centre location, which is really convenient; ability to access the centre from all parts of the county by public transport is incredibly important. Now, we have permission to set up a second suicide crisis centre that is in a residential home. That has a really different feel. It is like inviting people into your home. We have a kitchen. Often when people are in that situation they may not have eaten very much and we can encourage them to eat, and it is a very different environment. We have all just started working there and are really enjoying it, but that homely environment is totally different from a medical setting.

Q171 **Heidi Alexander:** Are the people who run your service staff or



volunteers, what are their qualifications and how do you fund this centre?

**Joy Hibbins:** All of us are volunteers. I work on this full time and I am a volunteer; everybody is. As to their qualifications, everyone who is in our team supporting clients at risk of suicide has counselling skills training. All except one are fully qualified counsellors, fully accredited BACP counsellors, but we are not providing counselling; we are providing crisis support. In setting it up, I felt that counselling skills would be very helpful in supporting someone who is in crisis. There is additional training in suicide intervention. For example, there is the ASIST course, which I went on in 2012 and found very helpful.

We have also been very fortunate in that we have always had an advising psychiatrist involved in our charity and another clinical adviser as well. That has been very helpful in the setting-up stages, not in terms of ethos but in increasing the amount of professional training that we all have. The psychiatrists have always been extremely supportive and behind the fact that everything is done from a lived experience perspective. They come in and give other training and learning opportunities, which is very important as well.

You mentioned funding. At the moment we rely predominantly on public donations, but when I was setting it up I saw other charities get funding and have that funding taken away, so I decided that we would set it up on a very low-cost basis right from the start so that even if we did not get a lot of money coming in we would be able to survive. We have not had problems financially. We have been very fortunate in the level of donations that have come in from the public. There is also a feeling in the community of supporting us, so professionals will give their services for free.

As to our town-centre location, they knew somebody whom we had helped and so they were, first, very willing to let us rent the place, but also, after a month, they greatly reduced the rent for us. They obviously wanted to check there were going to be no major issues, which was sensible, but then they decreased the rent. It is the same with the house that we are starting to use as well. I think that good will in the community can also help to sustain an organisation like this if it is not set up as an NHS thing.

Q172 **Chair:** Can I raise a query with you, Joy? One thing that has been raised with us as a Committee is a concern that sometimes other professionals are not informed when somebody has expressed suicidal intent; for example, there was the evidence we heard from Clare Milford Haven. Do you worry sometimes that it is a big responsibility for your volunteers to be making decisions about whether this is beyond their ability or whether they have a duty to inform other health professionals, because this is an individual who might need admitting, for example?

**Joy Hibbins:** Our individual volunteers are not making those kinds of decisions because there are more senior staff around all the time, and all



decisions are referred to a senior member of staff. We very often have to involve mental health services. We understand the situations where we feel we need to inform other people; we are doing it very regularly, whether it is their GP, mental health services or emergency services. We have constant contact with these organisations. When I set it up, I did not expect to have the percentage of people with mental health diagnoses who are also under mental health services care accessing us as well. We get people with very severe and enduring mental health diagnoses whom we are supporting. That is why it is important that we have advising psychiatrists and clinicians so that we can take advice when we need to, and they are very responsive and available at very short notice to us.

**Q173 Chair:** What about involving and encouraging people to share the way they are feeling with family members, which is another issue? How much are you encouraging people to share this with others?

**Joy Hibbins:** We encourage that because it is always a concern of ours when we are the only people they are telling. We only support adults—people of 18 and over. It may be that they just feel they cannot share with family, but they have come to us. The fact is that they have disclosed it to someone, and that is the important thing. We work in a way whereby we care very much about our clients so we build up a very caring relationship that is incredibly supportive. For a percentage of our clients, even after encouragement to share with family, they do not feel they can. The important thing is that they are being very much supported at that time, that they are all over 18 and so are all able to make that decision about who is informed. Our confidentiality policy is set up so that, if there are times when we need to break confidentiality, that would be to an appropriate professional, such as a GP, a mental health clinician or emergency services. We have a very clear policy on when we need to take steps to protect that person.

**Chair:** I wonder whether any of our other witnesses want to make a comment about what they have heard so far, and I know that Dr Philippa Whitford also wants to come in.

**Q174 Dr Whitford:** The Chair raised the issue particularly of a general practitioner, who is obviously central to someone's health story and who is not part of this. You mentioned that the normal team is two but sometimes it is only one. How do you support that one person? How do they manage to be available at all times to support someone? I would be slightly anxious about that. If someone says, "No, I am only speaking to him and I am not speaking to anyone else," how do you support them, when it might be weeks of having to be available to this person?

**Joy Hibbins:** I would say that, in almost every case where it has been one person, it has been me doing it because I have been involved in the initial assessments. It has been me. I work full time and so I have been able to do that. It does not happen that it is every day for weeks and weeks, because, in general, there is an intensive period where they need



support, but then it reduces and that happens very naturally. There has never been a situation where a volunteer has been under huge pressure to work every day. I totally understand that that would be incredibly difficult. It is fortunate that I work very full time, I work very long hours and I am able to provide that individual support if it is needed on a one-to-one basis.

**Q175 Dr Whitford:** Is that not a big pressure on you? Having set it up, I can understand that you are very driven to do that, but, equally, you have to do this for a long time and make it sustainable for you.

**Joy Hibbins:** I have been doing it for over three years. It is very challenging work and it can be very harrowing, but it is not depressing work. People often say to me, "Is this depressing? Isn't what you are doing all the time depressing—working so intensively with people who are highly distressed and suicidal?" But it never is, first, because of the extraordinary qualities that we see in each individual we work with, which is a source of optimism for me because I believe absolutely that every individual we support is able to survive; we do everything we can—we work very tenaciously—to try to help them survive. I have a huge optimism that this person is going to survive; they are going to go out into the world and have a positive impact on the people around them. The kind of optimism that I have about our clients, their survival and them as people, and how they are going to impact on the world in the future, sustains me; so I do not go under through the level of pressure. That may be what helps me personally—and we get great supervision and support.

**Q176 Dr Whitford:** You would not be concerned that the GP is not routinely aware that this is going on—that warning signs in general practice when the client might go there would be completely missed because the GP simply does not know that they are engaged with your organisation.

**Joy Hibbins:** I would say that we have a very good track record on our clients surviving. What we have set up clearly is working. Our clients are surviving in a way that they are not surviving under the mental health service and in a way they are not surviving under GPs. That is no disrespect to or criticism of any of these people at all; it is the way our service is set up that provides a safety net around people. We are frequently communicating with GPs if somebody is at imminent risk.

This happened last week. One of our clients stated an intention to end her life on Saturday. It has been a very distressing week for us because we know this client very well and we felt there was a real possibility that she was going to end her life at the weekend. I informed her GP and mental health services. Ultimately, I had to inform the police because, very unusually, she was no longer engaging with us over the hours that were leading up to it and I felt I had to have a more immediate intervention. I did that; mental health services did not and her GP did not, although they were aware of it as well. We were the ones who were actively and tenaciously ensuring that person survived. I think we have



demonstrated very clearly that, when it is right to inform GPs and the services, we absolutely do that, and we want them to be involved—we absolutely do—and we encourage our clients to inform them and to seek their help.

**Q177 Helen Whately:** Clare Milford Haven, I am going to come to you with some similar sorts of questions. Could you, first, tell us your view on the shortcomings of mainstream services and the ways in which NHS and other services might not be appropriate always for supporting somebody at risk of suicide?

**Clare Milford Haven:** First, I believe that suicide is entirely preventable. I do not think it is an inevitable outcome at all. There is a big difference, though, between feeling suicidal and having a mental health problem. We know that the majority—75%—of people who take their own lives are not in touch with any mental health services. Some of them may be suffering from an undiagnosed mental health problem, but the majority of them are going through a crisis in their life, which can be triggered by debt, divorce, a job issue, a housing issue or a physical issue. It can be triggered by anything. We are in danger of always medicalising these crises. A crisis is a temporary state that changes.

My own personal experience is of my son going to visit a walk-in centre in Newcastle and seeking help for his particular crisis, which had been triggered by an operation he had had 10 days earlier. He went and sought help. He clearly did not want to die because he went looking for help, but his crisis was immediately medicalised and, rather than sitting down and talking to James in more detail, they sent him to A&E. They noted that he felt suicidal, but he was sent off to A&E, and that is not the right environment for someone in a crisis, because your crisis will only escalate in that environment.

I believe, rather like Joy has been saying, that people in crisis need to be dealt with as urgently as somebody who is having a heart attack, has broken their leg, had a car accident, or whatever it might be, but I believe they need to be dealt with in a very different environment, in a calm environment, in one that respects them, that does not judge them and that does not make men feel they might be sectioned, which could affect their job prospects. I believe in parity of esteem totally but in a different environment. I am worried I have not answered your question properly.

**Q178 Helen Whately:** You have. I would like to draw you a little more on what you have implied are some of the shortcomings of A&E as a setting. Perhaps you could expand on that.

**Clare Milford Haven:** Again, one goes from one's own experience. The shortcomings that happened in our case were that the first person James saw was not properly trained; she realised that a young man in his early 20s, albeit nicely dressed and articulate, was in acute crisis because he told her, but she did not act on it in the correct way. To send a young





## HOUSE OF COMMONS

man who was in the highest risk category, in 2006, on his own to A&E I think is horrendous personally.

Other shortcomings were that they wrote down his GP's telephone number and his address, but they never called him and they sent the form, which said that James felt suicidal, to the GP via second-class post to the wrong postcode and it arrived 10 days after James was dead. Our GP rang us up in tears. He could not believe it. They never thought to ask James if he would like them to ring me, and I believe if that had been the case I would not be here today—nice as it is.

**Q179 Helen Whately:** I know we are going to come later to confidentiality involving the family and things like that. I do not want to make this more difficult for you, but did he go to A&E?

**Clare Milford Haven:** He went to A&E but he walked out because it wasn't the right environment. You are just a number; you sit there and you know you have to wait for up to four hours. I think when you are in crisis it is not the right place.

**Q180 Helen Whately:** I am drawing on that because I am about to ask you about the alternative. In our previous hearing we talked about what A&Es can do differently. For all sorts of reasons people will still go to A&E; so, they need to be different, even though it is not the right place necessarily for someone to go to. I think that is a helpful connection between our sessions. What I would love you to tell us a bit more about is what you are doing to offer a better alternative in setting up James's Place.

**Clare Milford Haven:** I will not go on too much because Joy has spoken quite a lot about her crisis centre, but I have always felt strongly that people in crisis need to be dealt with in a different environment, that the environment that we live in, the environment that we go to if we are physically ill or mentally not right, is key to our recovery. I have always felt that a non-clinical, calm, peaceful environment would be very helpful to somebody in crisis.

We are not there yet, but we are intending to set up a service called James's Place in Liverpool. We are choosing Liverpool because Mersey Care, the mental health trust, have a very innovative, forward-thinking attitude. They want to work with us. They are also currently implementing the zero-suicide initiative, and we would very much like to be a part of that as a service to show that, with all the right services in place, you can reduce suicide. That is why we have chosen Liverpool, not that you asked me why.

We will be similar but slightly different. I have been very influenced by what Pieta House, a fantastic organisation in Ireland, is doing. It has opened nine centres in 10 years and is appointment-led. We will be appointment-led—we will not be drop-in—but we will be in touch with all the relevant services: A&E, street triage, GP surgeries and student counselling services. We are building on those relationships now.



**Helen Whately:** Chair, do we have any evidence from Pieta House?

Q181 **Chair:** No. Steve, I know you were keen to come in as well on this point.

**Steve Mallen:** I would like to pick up on the first question, which was to comment on mainstream health services in this area. In the past 18 months or so I have dedicated my work to learning about this sector—which was not something I had previously understood—in memory of my son, and I will tell you now that mental health services in the mainstream are simply not fit for purpose under the current administration.

When you look at the sector, we see that waiting times are deteriorating, access to care thresholds are increasing, and more and more referrals from GP services into secondary care are being refused. We have an NHS budget at the present time that spends less than 10% of its mental health expenditure on young people, and yet 75% of all mental illness has an origin pre-higher education. The current spending at the moment equates to about 0.7% of the NHS budget. You are probably aware of this and you have probably heard these statistics.

Q182 **Chair:** Indeed. It is something that came out of our predecessor Committee's inquiry.

**Steve Mallen:** The comment here is that the way in which mainstream services are presently structured is not just poor but wholly and fundamentally misaligned. It is systematically and systemically wrong, in answer to the question.

As regards access to care, there are issues relating to training standards and issues relating to the prescription of antidepressants, particularly to young people, which has become an increasingly controversial and difficult subject. We note at the current time that less than 3% of the Medical Research Council budget is spent on mental health and yet we are also aware that, according to the World Health Organisation, nearly a quarter of the burden of illness on our society comes from mental health.

These misalignments in the expenditure patterns are fundamentally wrong, and that led me to another conclusion, which brings us round to where we are, because, frankly, I would rather give the NHS less to do in the first place. When we talk about suicide prevention, we are really talking about the end of a process; we are really talking about mental illness, because in 80% to 90% of suicide cases mental illness is a significant factor to a greater or lesser extent. If we could do a better job with people with mental illness, we would obviously bring down the suicide rate.

There is a great deal of discussion about suicide prevention, and we hear very rightly from the railways and the coastguard and so on. But I would like to ask this Committee how we keep people from wanting to go anywhere near the railway line in the first place, because we know—the medical evidence and the scientific community support this—that the vast majority of cases of mental illness, with appropriate prevention and early



## HOUSE OF COMMONS

intervention, are entirely treatable. One way to save the NHS would be to give it a lot less to do by focusing on prevention and early intervention. I should probably stop there.

Q183 **Chair:** Absolutely; that was the conclusion of the predecessor Committee's inquiry into CAMHS. Everyone we heard from was clear that it should be about prevention and early intervention. We are going to go on to touch more on poor experiences of care. I am sorry, Hamish, you wanted to come in.

**Hamish Elvidge:** I want to talk about shortcomings and the assessment and referral process. If Joy was talking about her service, she would talk about the words "compassion, understanding and empathy". Matthew went in to be assessed by mental health services with no history of a mental health problem, but he was in a crisis so he went in as high risk. He went into an assessment, which took one hour, and there was no contact with the family in advance of that assessment. It was just the context of him. He was described as being well-spoken, well-dressed, with good posture and clean-shaven, which I would imagine suggests that he does not have a problem, in their language, and he was discharged, in need of counselling.

I had a very significant conversation with the coroner on my first contact with him. He said, "They appear to have ticked the boxes and not looked into his eyes." That, for me, encapsulates some of the challenges we have within mental health services and describes some of the shortcomings.

**Chair:** Thank you. Looking at those shortcomings, I know that Philippa had a number of questions she wanted to lead off for everyone to respond to. Thank you very much. That was a very important observation.

Q184 **Dr Whitford:** We have heard from some of the members of the group about experiences for people in crisis. I wonder whether some of the other members of the group want to add any particular points to Steve, Clare and Hamish. What is wrong with where people might end up now?

**Marie Ash:** I know from my personal experience of going through A&E, having either self-harmed or attempted suicide, of one occasion being left in the corridor and hearing, "Oh, we all know Mrs Ash; she is always in here." You feel you are worthless anyway; you do not need somebody you have come to ask for help to make you feel even more worthless.

Within Devon, and maybe it is just up in north Devon, we are quite lucky that the people who provide the services—Devon Partnership Trust—are looking at things very differently. I run groups on the psychiatric unit on which I was always a patient and we look at recovery and wellbeing. Again, as people are saying, we need to start at a very young age, to look at their resilience, their wellbeing and how to safely manage issues.



## HOUSE OF COMMONS

That can start from a young age. It is about getting people talking about and sharing those experiences.

On the way up in the taxi, Russ Drayton and I had a conversation with the taxi driver, who told us he had been on antidepressants and that he had thought about taking his own life. It is having that ability and confidence to start those conversations. Some of that is around training. Russ did the ASIST training, which we already know has saved lives. I think the day after he had completed it he did an intervention.

There is a lot wrong within the health service, but also let us look at some of the things that are going right, such as using people with lived experience to help. If you get somebody with lived experience like myself, and I have the counselling skills as well, I can sit with people in a way that maybe a professional cannot. Many times individuals have said, "You understand," and that is very different.

**Q185 Dr Whitford:** There are two things there. One is taking these skills—as I mentioned in the earlier panel, we have kids doing Heartstart. They are actually getting crisis skills, "How to approach someone" skills, but also resilience skills. We get a lot of public information about how to keep ourselves physically healthy. We do not pay all of them that much attention, but we do not get any advice, as members of the public, on how you maintain your mental health—"Let's keep fit for your mental health."

**Marie Ash:** We have somebody up on Moorland View who does tai chi. We are quite lucky that psychiatric units have gardens, and when you see Steve out there with somebody who is highly anxious doing some tai chi and you see the anxiety go down, it is amazing. Why can't we bring that into schools?

**Q186 Dr Whitford:** Like the mindfulness, you mean.

**Marie Ash:** Mindfulness, yes. It can make that difference. Steve was talking about giving the NHS much less to do; let us start it there so that they do not have to face those issues.

**Q187 Dr Whitford:** We also heard different stories from Clare and Hamish of people who are interacting with the NHS perhaps seeking help or perhaps with something that appears to be a different problem. What can we do about training people who are in the frontline, whether they work within mental health or physical health, or those who appear to be bystanders?

**Marie Ash:** Once a month within Devon Partnership Trust they have their trust induction, and I go up and do the recovery section. I talk to new staff about what recovery is, what recovery will mean to that individual and the difference. I hope then, when they go on to their workplace, that they will have the idea that there is a person there and that person has family members who care and love them; they might not know it at the time, but they do. I know this myself. When I took the last massive overdose, I was in the middle of a divorce, my children could not stand to



## HOUSE OF COMMONS

be near me, but that was because of my mental health issues. But you are still a human being.

Everybody was saying about how somebody is dressed and their appearance. What does somebody who is suicidal look like? They are human. You do not look a particular way. You are not your label, your diagnosis or whatever issue it is. You are a human being, and I think we have lost that.

**Q188 Chair:** I know that Marc, Shirley and Steve want to come in on that point, if you are happy, Philippa, and Hamish as well.

**Dr Bush:** I was struck by one parent I was speaking to fairly recently, who described this period of not being able to interact with the health services as a kind of wilderness of mental health. For me, it is about what is happening in this wilderness. We know that the majority of GPs who talk about children's mental health say, "Actually, I feel like I am acting beyond or outside my competence." That is why we see high levels of medication and a long waiting time between initial disclosure or an assessment and getting access to CAMHS. Even when they get a referral, 24% are still waiting or being turned away. CAMHS does not have capacity because the thresholds are too high.

Beyond that, so many children and young people are turning up at A&E already in crisis, perhaps having self-harmed or exhibiting suicidal behaviour. When they get there, they say again they are not met with compassion. I spoke to a young lady who said that, when she was being treated for the physical consequences of suicidal behaviour, she remembers a nurse walking up and down next to the bed kind of tutting, she described it, as a kind of judgment of wasting NHS resources, as if her condition was not as justified as the young person sitting in the bed next door to her.

There is also a bit of concern about what happens if you get the treatment and you are discharged from hospital. This morning I decided to go on the My NHS tool, which is great; it is all about performance transparency in what is happening in the NHS. Most of you will know that a performance measure of the NHS is that within seven days of discharge you will be followed up, because at that period of time you are at greatest risk of self-harm or suicidal behaviour. A quick analysis shows that one in 10 patients are not being followed up within seven days. That means one in 10 people, who perhaps have been in hospital because of that mental health crisis, at the time when they are at greatest risk are receiving no follow-up from mental health.

As to schools, we work in lots of schools with lots of teachers and they say if they are confronted with a mental health crisis, if they are confronted with challenging behaviour, they do not know what to do. Sometimes the behaviour they are looking at, particularly in younger children, might just look like challenging behaviour; it might look like they are acting out. They might be disciplined; they might be sent out of



the class; they might be excluded. That might be early symptoms of emotional distress leading to suicidal or self-harming behaviour.

Finally, there is a really important question about training. I am going to take one very specific bit of this. We know that one in three enduring adult mental health conditions relate to childhood trauma and adversity, and if you face a childhood trauma or adversity you are significantly more likely to self-harm or exhibit suicidal behaviour; yet the majority of services that work with children and young people are not trauma-informed; they do not know how to support disclosure; they do not know how to work in a way that does not re-traumatise children. For us, a really important part of this is looking at what, generally, children's services, education, health, the police and justice are doing to support those children to recover, not re-traumatising them to a point where they may become suicidal. I have other things to say, but I will stop there.

**Q189 Chair:** I am sure we will come back and have other parts of the questioning that will cover it, but thank you very much, Marc.

**Shirley Smith:** With regard to services, access to services and what that means, we are in a situation where we talk about suicide and we forget about the 75% and focus on the 25% that do access services. How do we bring the 75% in if the 25% are already experiencing huge issues to access those services? Unfortunately, people do not have crises between the hours of 9 and 5, when there is access to services. It is all dependent on where you live as to what you can access and when you can access it. The danger is—and somebody said this before—that we love boxes, and can I find that box that I fit into or anybody else within this room will fit into? We look at a one size fits all. Suicide is complex, it is individual, but we totally ignore and do not address the factors associated with it.

One of the most effective services that is continually put on is the listening services—Samaritans. However, Samaritans cannot deal with the practical issues of problem solving, of being able to signpost local knowledge because of the way in which calls go through. As a listening service, if you are dealing with social issues that impact and cause and create hurt, and create pain—a pain that Shneidman called “psychache”—then that is not a mental illness; that is dealing with life and that is dealing with things that have gone on in life that have led you to that path.

To be able to resolve that, we need support and people who are there to support people, which we do not have at the moment. We always talk about mental illness rather than just, “How are you feeling?”—the emotional wellbeing of people. Life will get in the way, but it is what you do about it at that point that is important.

Clare said suicide is preventable. Our son had no previous history of mental illness. He looked no different from any other young man, and 11 years on we are still looking for that reason why, which is the question that most people will have. However, the very fact that he was born male meant that he was three times more likely to end his life. When he went



to school, he was taught to tie his shoelaces but nobody ever spoke to him.

As a parent, I take responsibility also. The mind is as important as the body, and it is okay not to feel okay, but we dress it up. You have to have a mental illness before you do something about it. It starts way before that; it starts at an early age. It is about knowing that it is okay not to feel okay; it is okay to reach out for support. Mental illness does not have a label. We love labels and we love to stick people in boxes. Unfortunately, I do not know many people—and I will stop where I started—who fit in those boxes.

**Q190 Dr Whitford:** Do you think there is a problem that we tend only to use the phrase “mental health” when we mean someone who has mental illness, and, therefore, that is someone who is other? We do not recognise that some days we have great mental health and some days we have bad mental health, depending on what is happening in our own lives.

**Shirley Smith:** I was at a meeting last week where a commissioner started to talk about mental health and how people with mental health need access to service. I thought, “Hang on, mental health.” I have mental health; we all have mental health. These are commissioners. We are seeing mental health as mental illness, and I think that is a real issue.

We provide suicide prevention; we provide that service. People walk in and access our service to be able to look at how they are dealing with life. We know within our area of the north-east, which has the highest rate in the country, that the three factors associated with suicide are bereavement, finance and relationships, but we do not do anything about it. There is a lot of local knowledge there to be able to do more things, and first and foremost we just need to try. People talk about stigma, but the very fact that we talk about stigma creates stigma. Mental health is a stigma. Let us just talk about it being okay not to feel okay, but it is what you do about it that is important.

**Q191 Chair:** Steve, I know you wanted to come in, and Hamish as well.

**Steve Mallen:** As a bridge between these two points, to add a little colour to the NHS experience, in our particular case I want to echo what Hamish said, because my brilliant and wonderful young son, who did not have a history of mental illness, walked into a hospital and his medical notes recalled that he made eye contact, shook their hands and was wearing a clean shirt. I contend that mental illness is a disease like any other. While it can be exacerbated by impaired life paths, deprived situations and so on, it can happen to the most resilient and the best of us, and the sooner that we realise that the better. It is a disease just like any other, and there are contingent factors that can exacerbate and worsen that condition, or even cause it in the first place.



## HOUSE OF COMMONS

In addition to that, I want to echo the point about having to repeat your story multiple times to multiple professionals. It is a particularly difficult thing for somebody suffering psychological trauma to do; it is a particularly difficult thing for a young person to do; and it is an especially difficult thing for a young man to do. My son had to repeat his story five times. Of course, there is no continuity of care so the file does not get passed from one desk to the other. Every time you walk in through a door, you are beginning all over again, and that is incredibly difficult when you have been brave enough to walk into the hospital in the first place.

In addition to that, with regard to the NHS discussion, which perhaps we should move away from a little and start looking about giving the NHS less to do, there has been so much written about this in recent times, so many reports, so many policy announcements and so many budgetary requirements, and so on and so forth. If we want to make a difference to the NHS, we have to zero in and laser focus on the front-line first experience, because that is what dictates the pathways in the vast majority of instances—the point of first contact.

In the case of my son, he was assessed by a mental health nurse who had long experience in mental health, but his experience was restricted to maximum security, highly violent adult offenders, and when a brilliant 18-year-old man walked into the hospital this nurse was on his third day of employment. There is a training and alignment issue that beggars belief, frankly, and that is happening thousands of times every day.

The first-line experience is absolutely critical—the training and appropriate skillsets that are held by those nurses, the social workers and so on. There is a great deal of discussion about psychologists and psychiatrists, and you have had the royal colleges here. The reality is that the vast majority of people never even get to see a psychiatrist, and we can see the value of that when we reference Joy's comment about having access to that level of competence and expertise on site.

My son was referred by a trusted GP on an emergency, acute 24-hour suicide risk. Within a matter of days, he had been downgraded to the status, "You might get an appointment for CBT therapy within six months." To echo Clare's point, they could not even manage to send the correspondence to the right address. The disjuncture between GP and first point of contact is critical. That is the point that the health service should concentrate on.

We hear a great deal about the clinical commissioning groups, the trust structures and so on. The money comes down from Government; it is not ring-fenced; it ends up in balance-sheet remediation or it gets side-lined into physical health; it ends up in adult care and not in adolescence, and so on and so forth. The reality is that front-line services in this country are simply not improving and we are in danger of descending into some sort of Orwellian rhetoric whereby there are ever greater policy





## HOUSE OF COMMONS

pronouncements from the politicians, budget numbers, and so on and so forth, and yet the day-to-day experience of people who walk into hospital is not changing.

If we want to move the NHS part of this debate forward, we have to concentrate, in my opinion, on those first points of contact—the day-to-day experience of the people that you see. Mental health is based in the brain; it is cerebral. It, therefore, is related to empathy and to rapport. Without empathy, rapport and consideration, you are unlikely to generate a positive pathway. That is the system that is missing at the moment. Forty thousand children a year, as Marc has said, are referred by their GPs and then rejected for care, stuck on a waiting list, stuck on antidepressants and so on and so forth. I will stop there, but it is about the first point of contact—the skills, aptitude and appropriateness of the people who see the patients.

**Dr Whitford:** Could I pick that up and then I will come to Hamish? One question is to ask about training. Obviously there is training for the people whom you would expect to see such young people or patients, but in actual fact you have no idea where someone will interact—it could be a school nurse, a teacher, a fireman, the RNLI or whoever. I want to capture your view, Steve, on what kind of training is needed for everyone who is in public service, but particularly within the NHS. As to some of these comments about the people who are in A&E, they may not have “mental health nurse” on their label, but, if they are in A&E tutting at somebody, clearly they need training; some of that is general training and some of it would be suicide prevention training.

**Steve Mallen:** As has been well documented during the lifetime of this and the previous Parliament, the number of mental health nurses in this country has contracted substantially. In other words, the arrow is going in the wrong direction. We have this all the time. There are only 660 psychiatrists in this country who work with young people, for example, and that is significantly less than it used to be as well.

What is happening at the moment is that we have very high workloads against a poorly or inadequately trained but fundamentally incredibly overstretched workforce, and this is the fundamental point. I have received many letters from mental health nurses up and down the country who are well qualified, very dedicated and empathetic. They are not well rewarded and not well recognised. They have very difficult jobs to do, but they simply cannot cope with the volume of demand. The problem that we have with the NHS is that, if we want to introduce things like training standards, the system at the moment is not able to adopt such standards because it is so overstretched, overworked and overladen that it would be difficult to find the capacity to get the people to come away from the hospitals to go on the courses. Clearly, in terms of experience, particularly in the NHS experience, you would hope that there would be some sensitivity as to medical condition; there are differences between depression, bipolar disorder, anorexia and so on, and then there



are difficulties relating to age, gender and ethnicity, and religion can play a part in that as well. In a well-functioning NHS service, in an NHS trust you would want to see an environment that encompasses the ability to treat the broad section of presentations that might come forward.

Q192 **Dr Whitford:** Do you think that this should be part of everyone's training, whether they are a nursing auxiliary, a staff nurse, a mental health nurse or a midwife? In the same way as there are other core skills, no matter what the specialty is that you do, we should be having this kind of training embedded. That is an approach that the Scottish Government took to public service for about 10 years and it cut our rate by almost 20%.

**Steve Mallen:** Intuitively, that must be true. It is obviously the case, as we well know, that many GPs, again very hard working and often very dedicated, have very little training with regard to mental health and mental illness. That is not just in a diagnostic sense; many of them are unaware of the pathways and interfaces that exist in order to access care that is available when somebody presents. Also, it must go right across the system, but this is obviously where I think, Philippa, we are looking at a change in our social narrative because we, as a society, need to train ourselves better with regard to mental health. It should go through all walks of public life; it should go through the teaching profession. In my world, I do not think any teacher would be able to qualify as a teacher without an obligatory paper on adolescent wellbeing, mental health resilience, mental health first aid and so on. That applies to us as a society.

I would go further. One of the greatest difficulties I have in my life is that my son was dying in front of me and I did not have the literacy, the understanding or the education with which to spot the signs, with which to intercede, to know where to turn. Had I known 10% of what I now know, my son, together with many other sons, would be alive, which leads us back to the narrative: prevention, education and early intervention. The solution to the NHS's problem is to raise the next generation to be much more resilient, much more healthy, and much more able to care for itself within the family, the workplace, the community and the school, and not have to go near a hospital. In that way, we can hopefully create a more positive dynamic whereby if we can get some decent performance in the NHS and better access to care, and at the same time we give them less to do, you have a much more positive scenario there.

Q193 **Chair:** Thank you very much, Steve. Hamish, you wanted to make some points.

**Hamish Elvidge:** I want to talk a bit about education. I do not know whether now is the right time.

Q194 **Chair:** We are going to come on to talking more about prevention in young people later with Luciana, so shall we leave that point? Were there



## HOUSE OF COMMONS

any other points about existing NHS services?

**Hamish Elvidge:** One mantra of the National Suicide Prevention Alliance is that suicide prevention is everybody's business. My sense is that everybody should be trained in suicide awareness and prevention. If you take just one example—I am slightly involved in the university world—Wolverhampton University recently has chosen to train all its staff in suicide awareness and prevention. "All its staff" means security, accommodation and catering, as well as tutors and professors. Their view is that, if any of their 20,000 or 30,000 students is in a crisis, it is not the counsellors, the mental health advisers or the student support people who are likely to spot them first; it is any member of staff.

I have a sense that the responsibility around suicide awareness and prevention is slightly aligned to safeguarding children at school or health and safety at work, and it should be raised to the same level of importance. Why should not all people who employ people train them in suicide awareness and prevention? What is surprising is the number of people who feel suicidal during a year. The headline number is 6,000, but the number of people who feel suicidal is probably nearer a million at any point in the year, so why do we not invest and train to prevent those people moving along the health continuum to making plans? We can prevent them from doing that if we have better understanding and knowledge.

Q195 **Chair:** We will approach them for some evidence if you would be happy to share contact details of the person leading that programme.

**Hamish Elvidge:** Yes, I can do that. We can talk about education later, can we?

**Chair:** Yes. We are definitely going to come back to education. Philippa, do you have any other points?

**Dr Whitford:** Not unless there was anyone who did not comment.

Q196 **Chair:** Marc, did you want to add anything?

**Dr Bush:** Education.

Q197 **Chair:** Yes, the education section. Before we come on to that section, there is an area that many have raised in evidence to this Committee, which is the issue about confidentiality and the sense in which sometimes it is being used as an excuse—this is the impression that we have been given—for not sharing with families. I know you will all be aware of the consensus statement around confidentiality, and many of you have commented on that directly in your evidence. But clearly there is a difficulty here because there is a legal definition of the rights of those who have capacity to make a decision about sharing, and we have heard from Joy on the concerns people have about the impact that may have in the future.

Could I ask each of you in turn for your thoughts on the existing



## HOUSE OF COMMONS

statement, on how you would like to see that changed, or whether you think the emphasis should be on health professionals reading it and interpreting it in a different way? I would like to give everyone a chance to comment, but perhaps I will start with you, Shirley, about where you feel the balance lies and what we should do better.

**Shirley Smith:** One thing that we realised about the consensus statement is that it is a statement with regard to the action that comes around the area of confidentiality. One key thing that we find is with postvention support—after-suicide service. One of the main complaints that comes back from people who have been through the SUI process, or a serious case review process, is the transparency and openness around confidentiality. It is seen as a barrier rather than being an opportunity to involve others.

It is the way in which confidentiality is used so that people cannot engage supportive families. I understand why there has to be confidentiality, but for people who have lost loved ones to suicide where people have said, “I want this information, and I want my family to be involved in that process,” if that does not happen, to be sat around in a process where you are hearing that a loved one has died because somebody has not shared that information is extremely difficult; people do see that as an opportunity missed to be involved.

It is the way in which confidentiality is, if I can use the word, “sold.” You could say to somebody, “You have more chance of having recovery from an illness with the right level of support, the right level of engagement and having the right people around,” and that could be family or the opportunity to share that information with people. I think it is seen at that point as just a tick-box exercise: “Would you want anybody else to be involved in your treatment?” That changes. It may be so at that point but we do not ask that question again. It is just taken from the very point of the first referral and it has ticked the box, but people do change their mind. I also understand that in certain circumstances you do not want information shared. However, it is just taken that we ask it once and it is a tick box again.

Q198 **Chair:** If I understand you correctly, you are saying there is an issue both for those who are presenting with suicidal feelings but also afterwards, where families have been bereaved by suicide but it is still being used as a reason not to involve them—so all the way through. Thank you. Marc, do you want to add something?

**Dr Bush:** Yes. It is really tricky, particularly depending on, for us, the age of the young person. We have heard both. We have spoken to children and young people who say at that time it was really important that they did not talk to their family; they kind of needed that space. Some people talked about the relationship with trauma. If your home community or your family is a place of trauma, bringing them into it can escalate that. In some situations, there are good safeguarding and protection reasons why you would not. But we have heard the other side,



## HOUSE OF COMMONS

which is young people saying that they found it hard to reconnect with their family; it was not offered; the health service did not take any kind of proactive steps; and parents were saying that they were at a loss that they did not know something was happening—their child having an in-patient stay, for instance.

Then it gets a bit more complicated when I think people are in in-patient settings, because if they are taking medication sometimes it can be unclear as to whether they are fully giving consent about confidentiality. We know that quite a lot of medical professionals do not really understand Gillick competence. That is worrying for us because children and young people should have an equal say in decisions about their care and treatment. For young people with learning disabilities or those who would fall under the Mental Capacity Act, there is a very poor awareness of that as well. You might have a situation where someone would be up for an assessment in terms of Gillick competence and the Mental Capacity Act, but either it is not done, there is no awareness that it should be done, or there is a judgment made that is incorrect.

We have been talking to a number of parents who have children and young people currently in in-patient services where it seems as if they are fully Gillick competent and they were deemed to have capacity under the Mental Capacity Act, but the assessment has not been done and the severity of their condition and the level of their mental functioning at the moment would suggest that they probably were not that involved in their CPA or their advanced treatment plan. So, for us, there are some worrying issues about the competency of some health staff in making that judgment.

Finally, I have two things. One, it is important, if children and young people are making those decisions, that they have access to advocacy. Advocacy in in-patient services, as I know you know from previous inquiries, is crap, and, if it is bad for adults, it is really bad for children and young people. Lots of parents say they have never been contacted by their child's advocate; lots of children and young people say they did not even know they had an advocate, and yet their advocate might turn up to a CPA meeting and determine what that care pathway is.

Q199 **Chair:** They turn up without having even met the child.

**Dr Bush:** Yes. We had a number of recent cases where neither the parent nor the young person had ever spoken to the person who turned up, yet they were representing their best interests; but there would have been an opportunity to speak to that young person directly.

Finally, it is worth noting that the UN Committee on the Rights of the Child has recently criticised the UK for lacking an adequate legal framework for children to have meaningful participation in decisions about their treatment and care—for under-16s. That, for me, probably highlights the issue, which is that it is really important that parents, loved ones and families are involved, but it is equally important that we



## HOUSE OF COMMONS

increase the protections and safeguards for young people themselves to be involved.

Q200 **Chair:** I have had a query from a member of the Committee on CPA. Can I confirm that means care programme approach?

**Dr Bush:** It is, I am sorry, yes.

Q201 **Chair:** We try to be an acronym-free zone, but it is tricky at times. Did you have any views on the consensus statement itself?

**Dr Bush:** No, mainly because we advocate on what parents and young people think and we have not consulted on it, so I think it is best to leave it at that.

Q202 **Chair:** That is fine; you do not have a view on it. Joy, did you want to come in?

**Joy Hibbins:** One reason why we only work with adults aged 18 and over and not with younger people is because of the concern that I would have about supporting younger people without the knowledge of their parents or other health professionals. It is just something that I felt we could not do. It just feels that there is something fundamentally wrong there. It is something we have discussed in trustee meetings recently and we feel that we cannot do it because of the way our service runs, where for adults the confidentiality side is so important and it is one reason why they will come to us and not access another service. I just do not feel that we can do that for people under the age of 18.

Q203 **Chair:** You have already set out how important confidentiality is to the people using your service. Is there anything else you wanted to add to what you have already said about that?

**Joy Hibbins:** About confidentiality in general, we are clear when other services need to be involved, because we recognise that when somebody is mentally unwell there comes a point where we may not be able to support alone. Indeed, if somebody comes to us and discloses that they have a severe and enduring mental health diagnosis, we always want to co-support with mental health services. The communication between us and mental health services at that point becomes very important in that I think that is one area where there are problems at the moment, even where we have consent from the client to share.

I will give you a couple of examples of issues that we had in the last week. We contacted mental health services about a particular client or asked them to contact that client, and they said they could not unless the client gave their agreement. In one instance where that happened the client felt that the crisis team were deliberately blocking her calls and deliberately refusing to call her, but she really wanted them to get in contact with her. I phoned and explained, "We have had this directive from your senior management that we have to encourage our clients to phone you and that we cannot phone you and ask you to phone the



## HOUSE OF COMMONS

client.” But that blanket policy does not always work because it does not account for individual circumstances. “In this circumstance, she wants contact from you but she believes at the moment that you are deliberately blocking her—that it is something that you have set up on the phone system that is not allowing her to call.”

The crisis team phone was on answerphone and was ringing a very large number of times before it went on to voicemail. When I phoned it, I was surprised and thought there did not seem to be any voicemail answerphone and it was a very long time before it kicked in, but she wasn’t waiting that long. I left a message and said, “I know what your directive says, but please will you phone this person?” The psychiatric nurse very sensibly did, but that was just one of many examples.

This is about individuals. If you are trying to create a policy and being told, “We want to empower our patients to phone us and not to have another organisation,” when someone becomes very unwell they may not be able to do that themselves. They may be extremely traumatised at that point or very distressed.

Q204 **Chair:** So you need to have the support there and take an individual approach.

**Joy Hibbins:** Absolutely.

Q205 **Chair:** Thank you very much, Joy. Marie, do you want to add anything at that point?

**Marie Ash:** Yes. With regard to confidentiality with carers or family members, if what they can feed in is listened to, that aspect is really important. You do not have to disclose anything but take notice of what other people are saying because they know that person; they know what their behaviour is like, if it has changed or if it is suddenly getting worse. I think there also needs to be explanation to the individuals themselves and the family about what the confidentiality is, but also the possibility of advocacy. I know up on the psychiatric unit, when we do the ward round group—a ward round on a psychiatric unit is enough of an anxiety-provoking experience anyway—many people do not know they can have someone in there with them; it can be a family friend or an advocate.

Again, it is about going back to looking at that whole person, with the confidentiality—“What is that person’s life like? What is going on around them?” There could be issues within the family, as was said, that they would not want the family to know, but there could be somebody else outside whom they would want to know. It is about looking at the wider picture. I understand the need for confidentiality to build that therapeutic relationship and to be able to move forward, but a lot of it is about explanation, about holding that person as the unique person that they are and educating them.

Q206 **Chair:** Thank you. Hamish, do you want to come in?



## HOUSE OF COMMONS

**Hamish Elvidge:** Yes, I do. All five members of the national suicide advisory group who have personal experience, three of whom are here today, have direct experience of confidentiality acting as a barrier to three things, and I am mentioning the three things because they are the sections of the consensus statement.

The first thing is risk assessment—involving family, carers or friends in risk assessment. The second part is treatment and sharing information about the individual, which is quite tricky, and we will come on to that. The third thing is the follow-up, which is what happens next, and how you keep that person safe.

In response to the five members of the national suicide advisory group with personal experience, the consensus statement was drafted with the royal colleges. It took about 18 months to do that because it involved all the royal colleges' lawyers, and, to be honest, some people say that the statement itself is a bit of a compromise, but it encourages greater involvement for families, carers and friends in the individual's care and recovery. The statement was published in January 2014, and I have it here.

In September 2016, the advisory group invited the royal colleges to update them on the progress they had made. The truth is that they had not made any progress. I think one royal college had issued it with an email—a newsletter. No change had occurred.

What I want to focus on particularly is that, for me, involving carers' families in risk assessment and follow-up is pretty straightforward, and I do not think there is any risk to the health professionals in that. The trickier one is sharing personal information about the individual. In order to do that, you have to seek permission, but there are ways of seeking permission. In the evidence I provided to you—if you do not mind me referring to it—one way is to say, "Do we have your consent to share information with a family member, friend or colleague?" The chances are that the answer will be, "No." Or you could say, "In our experience, it is always much better to involve a family member, friend or colleague whom you trust in your treatment and recovery, and we know the triangle of care is likely to result in a greater chance of successful recovery. This will result in you recovering much quicker. Would you like us to make contact with someone and would you like us to do this with you now?" I would suggest the chances of getting a positive answer to that are greater and it depends on how you ask the question.

Therefore, it depends on how you train people from the very early stages of qualification right through CPD. Health professionals will vary in age from 18 to 65, and their knowledge, experience and culture will be very different. In my evidence, there were four things I suggested we should do, and Steve and I have talked to Louis Appleby about these things fairly recently and we have had a generally positive response with some action.





## HOUSE OF COMMONS

The first thing is to implement a culture change programme and training in suicidal feelings, prevention and confidentiality for all staff who are in contact with people who are suicidal, particularly professionals who are doing assessment. The second thing is to appoint a senior person, a senior team, to manage that cultural change programme, because cultural change programmes are hard and long in whatever environment you are doing them. The third thing is to carry out research to find out how many people there are where patient confidentiality has acted as a barrier to recovery or maybe has resulted in lives not being saved. The fourth is to involve people with personal experience in that whole process.

The last thing I wrote here for today—and it may be a bit emotional—is that we just cannot allow more lives to be lost because confidentiality is acting as a barrier to appropriate assessment, care and recovery. We cannot. The question is: how do we progress that?

**Q207 Chair:** Your evidence was very powerful on this point. Hamish, have you seen examples of institutions that are putting this into practice? Obviously, it is very disappointing to hear what you have said about the royal colleges, but are there trusts or examples that you could point us to?

**Hamish Elvidge:** No, there are not, but I have a feeling that if we are going to do some research we should look for good practice. It would be a really good addition to the programme.

**Q208 Chair:** Thank you. Clare.

**Clare Milford Haven:** Yes, I have the consensus statement here as well, and there is just one paragraph towards the end that says, “We want to emphasise to practitioners that, in dealing with a suicidal person, if they are satisfied that the person lacks capacity to make a decision whether to share information about their suicide risk, they should use their best professional judgment to determine what is in the person’s best interest.” Goodness, that is a very long sentence, and I think it is very confusing; it is mixed messages.

A person who is suicidal is not in their right mind. When it says “lacks capacity,” it is setting the bar very high. I do not think a person who is suicidal has good judgment at that stage. Does that mean they lack capacity? I do not know. What I do know is that family members—of a loving family, at least—are crucial to the recovery of somebody; their involvement is crucial to the recovery of someone who states that they are suicidal. If a young man went to a doctor and said they were going to kill someone, I think that information would be passed on, but if they say they are going to kill themselves and it is not passed on, it is still one life being lost.

I do not think there is a one size fits all. As has been mentioned so many times, we cannot have a box-ticking exercise. Everyone’s situations are



## HOUSE OF COMMONS

different, and men, in particular, probably are reluctant to disclose to their family members because men have pride and they do not want to look weak. That is the whole cultural thing around men. Perhaps men need much more encouragement to share these feelings, but, if someone mentions they are suicidal, I think the practitioner should err on the side of sharing that information—and not even err on it; I think that information should be shared with family members.

**Q209 Chair:** Do you mean even if they have been asked in a way more consistent with what Hamish has described, because you say the way you ask a question makes an enormous difference to the outcome? But what about where you have an individual, even asked in this much better way, who is clear that they do not want family members to be involved? There is a principle that we are all allowed to make bad decisions. Do you feel strongly that doctors should take a best-interest decision on their behalf if they think that is a bad decision?

**Clare Milford Haven:** I think doctors are about saving lives. So, if a young person—I am not talking about someone under 18, because that is a different set of circumstances—or anyone over the age of 18 says they feel actively suicidal, that they have a plan, or even if they do not have a plan but they mention that word, I feel that the doctor then has a duty to try to save that person's life. I may be making a sweeping statement, but I would believe that in most cases family involvement would help.

**Q210 Chair:** You would take the view that saving the life should take priority in that situation.

**Clare Milford Haven:** Yes, I would. I do not want to ramble on, but there are situations in certain families where a member of the family has created the upset and the unrest in that person that may have led to them feeling suicidal, but at the same time they can avoid perhaps using that person and there must be a close friend. You must feel so isolated when you are feeling suicidal; you must already feel alone, so, to feel less alone, "Let's get your mum involved or somebody you know."

**Q211 Chair:** Thank you. I know Steve is very keen to come in on this point and then maybe we will come back to Marc.

**Steve Mallen:** If we want to comment on how bad the situation is at the present time, because establishing a baseline is important, in my son's case—and I know in a number of other cases that I have had the misfortune to have shared with me—my son made a request, "Please tell my mum," which was not actioned. The default in the system at the moment is box-ticking and the line of least resistance. There is less work involved in not consulting; it is the easy risk. I contend that, because of lack of resources, overwork and everything else, many medical practitioners are hiding behind the right to privacy as a default to getting the work done and moving on to the next case. That is important with regard to the baseline.



## HOUSE OF COMMONS

In addition to that, there are situations within which it is inappropriate to share information and so on and so forth, particularly where there is a risk to the individual, for whatever reason.

The other important dynamic here is that, if there is a default to sharing information, it may be a deterrent for people reaching out for help, and that is already an issue, as we know, with 75% of suicides not being engaged. If there is a default to automatically telling everybody or thinking that information is going to be shared, that is wrong as well.

There is also the complex area of the legal system and the legal framework within which we operate as a society, which preserves the rights of the individual. We have seen a change in the zeitgeist over the past 30 or 40 years towards an emphasis on the rights of the individual and the rights to privacy, but a counter to that, of course, is the right to life.

To me, this is all about evaluation. Involving empathetic family members, friends, communities, or whatever in the improvement and wellbeing of someone in distress, particularly a young person and particularly if they are sitting on a waiting list for months for a first appointment, it is demonstrably proven that, if you engage, you are likely to get a more successful outcome; but that cannot be assumed as a default. Therefore, the evaluation needs to be made, and evaluated and assessed adequately that there is no danger, as it were, to the disclosure—in other words, the risk is nullified with regards to harm. There are obviously complex social family relationships here, which need to be understood. At the same time, we can employ the appropriate semantics and move towards a default, particularly for young people, that says, “Subject to appropriate qualification and subject to appropriate evaluation, we will have a duty of care to share with—”. Obviously, there is a legal framework and a legal protocol there.

Quite simply, in my particular case, the NHS knew for a month that my son was acutely suicidal and they did not bother to tell me. I can tell you now that one phone call might have saved his life, and I have heard that story many times. This is an area that we admit is complicated, but it needs to be improved. The legal protocols need to be improved, but, fundamentally, the difficulty we have is that the current system is not strong and deep enough to take those reforms anyway because it is a box-ticking protocol faced with high workloads and a line of least resistance. Until we lift the bar completely, it is going to be quite difficult to implement those standards. On the last point of the statement, I think it has taken two years to state the bleeding obvious, I am sorry to say.

**Chair:** Too often, as you say, we are hearing cases where people were happy to share and it just was not happening. James wants to make a point and then, Marc, you want to come in and make a point as well, and then we will move on to the next area because we have a lot of issues to cover.



Q212 **Dr Davies:** As to breaking confidentiality, clearly a clinician is obliged to do that and should do that with respect to the authorities—the health services, for instance—when someone is a risk to themselves or to others. You are saying, presumably, that the status of the family in that consideration should be brought more in line with the authorities such that recognition as to how important the family can be in recovery is increased.

**Steve Mallen:** There is very substantial evidence that involving a family increases the chance of a positive outcome. Therefore, if we are about preserving life, about lessening the burden on public health, and so on and so forth, that would be a good protocol, but, yes, that is essentially what I am saying. If the risk is nullified, a GP is usually able to make an appropriate assessment. It does not mean that it is done automatically. The right of the individual—if the individual says no—has recognition and status in law, whether under the UN or any other legislative body, and there is the law of the land that we need to consider in that regard. But if it is indicated, as Hamish says, to a suffering individual that involving others is likely to produce a positive outcome, we should follow that line.

Q213 **Chair:** I am conscious that we have lots to get through. Marc is going to make a point and, Joy, you wanted to make a quick point, but I know we are keen to get on to the issue of education as well.

**Joy Hibbins:** I have been in suicidal crisis myself, so I can talk about it from that perspective. Those closest to me do not know when I am at high risk or imminent risk, because on a previous occasion I did tell the people closest to me and I know the impact. I only found out the impact on them afterwards of the absolute fear and stress, and one of the people closest to me had to take time off work afterwards because of the impact. That means that, in future, the idea that they would know about it would then create additional stress on me at that time. I would feel that I would need to be protecting them, comforting them and looking after them at a time when I am in crisis.

So, there are all kinds of considerations when we are talking about whether it is going to be helpful. I accept that, in general, it is absolutely helpful that the family is involved, but for some of us there are reasons why it becomes harder when the people that we love most know about it, so I have chosen to go to professionals at that time and to take it to them rather than involve the people closest to me.

Q214 **Chair:** Thank you. That is an important point. Marc, did you want to come in?

**Dr Bush:** Yes, very briefly. I know from the young people we have spoken to that it is not just an issue of confidentiality but it is about disclosure. They want supported decision making and an informed consent so that they know, if they are reaching out to the family, that they will be met. That is really important.



The thing to make sure of, I guess, in the whole description about this—I know I have said it before, but I want to bring us back to it—is that some children and young people do not have a connection, do not have a family and a community, and there are other people who could be reached out to, but reaching back to those communities might be damaging. There is also a risk, which is that some young people we have spoken to, for instance LGBT youth, in disclosing suicidal ideation or behaviour would also disclose their sexuality and, depending on the community, that could create additional trauma. For me, it is about how, in those interactions with education or health services, you have a good conversation with children and young people about the decision that they make and then the consequences of that decision, whether to include their family, if they have one, or not.

**Chair:** Thank you. We have many other areas that we need to cover, so I am sorry to move off this one because I know it is a very complex issue.

Q215 **Luciana Berger:** We have already touched on this with some of the contributions that have already been made. As an initial question—and I know other colleagues will ask specifically about schools—the point was made earlier by Steve about how important it is to engage with young people because the majority of adults who are diagnosed with a mental health condition will have developed it as a young person. Does anyone else want to expand on why the focus on young people is so important in suicide prevention?

**Hamish Elvidge:** There is growing evidence that a whole-school approach to wellbeing and mental health is good for academic performance, good for social skills and good for the ability to cope with life's ups and downs. As we know, the problems around anxiety, depression, self-harm and other symptoms are increasing, and, as you referenced, Luciana, 50% of mental health problems in adults start in childhood.

The concern that many of us have is that much of the Government's current focus is on early intervention. For me, on a health continuum of flourishing to feeling suicidal, early intervention is about here. The Government are investing £1.4 billion in that, which is good, and a lot of the reports that come out—such as "Future in mind"—focus mostly on early intervention.

At the end of the day, we all have mental health and all our children have mental health in the 25,000 schools that there are around the country. I think we are at a stage where we need all children, age-relevant, to understand about wellbeing, health and good mental health from a very early age, even to understand about neuroscience; how brain chemistry changes based on different life events; they need to know how to keep well and what the signs of not being well are, both in themselves and their friends; they need to be taught skills to be resilient. We have not got to an intervention yet, have we?



## HOUSE OF COMMONS

They need to have the confidence to ask for help. Asking for help is usually not done because of the stigma associated with seeking help. Stigma is born out of lack of understanding on whatever issue you talk about. Understanding is built, to me, around education and the four steps I have just talked about, and if you have the confidence to ask for help it is then getting the right timely support.

The Government are investing a lot of money in the right timely support, but, as we know, it is not right or timely very often—CAMHS, and so on. Therefore, would it not be better to invest in the education, towards the flourishing end of the health continuum, to prevent people needing to seek help in the first place?

In the latter stages of Matthew's very short period of anxiety and depression, there was a lot of reference to school and what might have been, help he might have sought, and maybe what education he could have had that would have helped him cope with some of his ups and downs in life, which all children have.

It just makes me wonder whether, if we took a cross-departmental approach with the Department for Education, the Department of Health and maybe even the Department for Work and Pensions, and introduced age-relevant education in all schools and offered a whole-school approach, which means it is in the curriculum and is part of the language of education, and we build a group of young people who grow up as parents and employees who get it, we would transform society.

The sad thing to me is that it is quite difficult to transform society in five-year terms where the focus is normally in three years, because you have to create a plan and then you try to win an election; but if we were able to go cross-departmental and develop a 20-year strategy, we could transform society, but it would involve a lot to do with teacher training, continuous professional education, inspection, changes in the curriculum and changes in integrated support services between education and the health sector.

The last thing I would say, which again is a bit of a plea, is that, for me, we should not take the risk of withholding the opportunity to keep our children well and prevent them moving into the vicious circle and along the health continuum towards suicide, which is the subject we are talking about. I think this is a huge opportunity we should tackle.

Q216 **Chair:** That is a very comprehensive response, Hamish. When people are adding comments, if you agree, do not feel you have to repeat them, but just add to or disagree with the points that have been made. Marc and Steve want to come in.

**Dr Bush:** The root of that concern with teachers, I think, is also the same with young people's peers and parents. As a society, we have very low levels of emotional literacy, so it is really hard to talk about these things. When we do interventions in schools, the first thing that happens is that



## HOUSE OF COMMONS

teachers break down. They talk about the difficulty they are facing and the difficulties they are facing in talking to their own children about emotional issues. A lot of the interventions we do are about giving the confidence to the people who are meant to be supporting children and young people with their mental health so that they have enough emotional literacy to provide that support. For me—and I really support what Hamish is saying—it is about how we embed emotional literacy in everything that happens.

I want to talk a bit, which relates to this education part, about the important roles that peers play in two ways, and they are two bits that never get any air time but they are really important. First, you will have seen that the national confidential inquiry recently made a really important link, and it is the first explicit link, between self-harm as an indicator of suicidal behaviour. Historically, there has been a need and an important distinction between the two, but that report shows that, if you have self-harmed you are a hundred times more likely to engage in suicidal behaviour. For us, it is really important, because the literacy around recognising and understanding self-harming behaviour is very low among teachers and parents, but also there is a kind of peer-generated world on giving advice and support around self-harm.

Children and young people are creative, active participants themselves; they go online and there are online spaces that you can either find out about or be encouraged to self-harm, which can escalate into suicidal behaviour. If you put cyberbullying to one side, we know about the dedicated dark web, so these are dedicated self-harming sites like pro-ana sites or cutting sites, which are about how to cut safely and how to restrict your diet, which can be a precursor to escalating suicidal behaviour. Beyond that, on what we call the light dark web, there are things such as Instagram, where if I go on and put a particular hashtag in, which looks as if it just a random set of numbers and letters, it will bring up advice and images of people engaging in self-harming behaviour or encouraging suicidal practice. As much protection as we want to put around young people, they are going to be confronted by this; they are going to come across it. It is only one level down from the things that they post themselves on Facebook, Instagram or Twitter.

We are keen to think about how you build the resilience of young people within schools so that digitally they know they are going to be exposed, they can make sense of what they are seeing and know how to reach out for support. It is great that, if you search for suicide or self-harm right now, a flag will come up and say, "Are you okay?" and, in the best-case scenario, "Here is a number you can ring." For instance, if I went on Instagram now, I could press, "No, thanks," and continue to consume those images. We know that young people create and consume those images, and create and consume that advice. How do we build their literacy to navigate those things so that they do not exacerbate that behaviour but also make sense of it so that it does not create trauma and distress for them?



Q217 **Chair:** You wanted to make a brief point, Steve.

**Steve Mallen:** I want to make an entirely important point, which politicians always understand, about finance and economics. To add into all of this, there is a very strong moral imperative here about prevention and so on and so forth, but there is also an economic imperative. If somebody is experiencing mental difficulty, particularly a young person, not only are they in crisis but so is their family, their community, their friendship groups and so on and so forth. The economic cost of that, both at individual level and to those networks, is astronomical—impaired lives, loss of productivity and reliance on social care—which brings us very much back to the prevention and early intervention point, because if we can prevent people reaching crisis, we will save society a very great deal of money and that will help the Government's finances.

**Chair:** Thank you. Were there any other points you wanted to ask on that one?

**Luciana Berger:** I do not think so. We have probably covered it.

Q218 **Andrew Selous:** We have covered part of what I was going to ask, but earlier Philippa asked a very good question, if I can paraphrase it, about what is "keep fit" for positive mental wellbeing for younger people. We have heard a bit about teacher training and the internet, which is really important, and we have heard about Government. I have not quite heard enough about how we help younger people, although not just younger people—I would push that into the 20s as well—to develop positive mental wellbeing, which will equip them with that resilience hopefully to withstand the crises that we have heard about.

**Hamish Elvidge:** Can I give one example? My wife and I went to a primary school in Oxford that was in special measures. Having been in special measures, they decided to start a programme around emotional wellbeing and health, particularly mental health. We went in to what they called a "circle time". There were about 30 pupils there—boys and girls. The inspirational teacher was talking about how they were feeling. One of the girls, aged 10, said, "I am not feeling great today because when I go home after school I can't talk to mummy because she is always on her mobile phone." What she then said was, "But I have a coping strategy," and they were the words she used; they are not my words. She said, "I have a coping strategy. What I do now when I go home is ask mummy when it would be convenient to talk to her and update her on what happened at school."

That is a very sad story, but it gave me a huge amount of hope around the impact of emotional wellbeing education in our schools. It may have saved that young girl's life, because she might have gone on a vicious circle towards not coping. She now has a coping strategy. It made me think that if all our pupils had that sort of education we would be in a much better place, and, as Marc says, people would be able to cope





## HOUSE OF COMMONS

better with inappropriate images, difficulty in parental upbringing, and so on.

Q219 **Andrew Selous:** Is there a role for parents as well as schools in here? Shirley, did you want to come in?

**Shirley Smith:** Yes. One area that we work on in schools is providing a level of emotional and mental health awareness workshops. I think it is now somewhere in the region of 18,000, if you include the fact that we are working with the premier league and the football league and not just with the individual. All we were able to do previously was to go in for an hour on something that was so important. Young people have a curriculum that they have to follow at the moment, but we are only allowed to have an hour to talk about emotional wellbeing and mental health. The data that came back from that told us that young people needed more. We know that 49% of the young people, if they had a problem, would reach out to a peer, but if a peer is not able to give advice or know what to do at that point, it is a missed opportunity.

We were looking at all levels of how we give young people the tools to be able to support them and to know when to ask for that help; it is not just about the individual themselves but who they turn to. That programme has had immense success. However, regardless of the success that it has had, it has just been scrapped. It is great to be able to sit down and say we need this, this and this, but there are programmes out there that are trying to achieve that but are just being scrapped before they even start because of the lack of finance.

Q220 **Chair:** Joy, do you want to add something about adults on this?

**Joy Hibbins:** It is about the word “resilience”. I have obviously been in suicidal crisis and have attempted suicide. When people talk about “resilience”, it makes me feel that I simply was not resilient enough and that it is somehow a failing in me that caused me to go into crisis. It is just an issue around the use of that word. In my opinion, anyone is at risk of a suicidal crisis given the right set of extraordinary circumstances. There are many things that happen in life that we cannot fully prepare ourselves for—the random, traumatic, totally unimaginable, unexpected thing that happened to me and that can happen to other people. I know I am not alone in having some concerns over the use of the word “resilience”, although with regard to the importance of education in schools I agree with everything that you are saying on that; it is absolutely vital.

Q221 **Chair:** Is there a word that you feel encapsulates better that sense of trying to prepare people—being realistic, you cannot prepare necessarily for every eventuality, but trying to teach people the skills that would help them to—

**Joy Hibbins:** I do not think we even need to replace the word “resilience”. When we talk about education and emotional wellbeing, that is enough, because there is no sense of judgment in those words; you



## HOUSE OF COMMONS

either have or do not have resilience. “Emotional wellbeing” is a neutral term. I know you were all using the word “resilience” a lot, but if the focus was on that, it takes away any issues over the vocabulary of using “resilience”.

Q222 **Chair:** Marc, were you saying you wanted to add one bit to that?

**Dr Bush:** Yes, just a tiny bit, but also I would say the use of the word “resilience” is responding to a Government agenda that uses “character, resilience and grit”. I think we all mean emotional wellbeing and mental health, but, with resilience, I get your point about the language.

It is worth remembering that “Future in mind” and the five year forward view effectively say that the frontline of CAMH services are not health professionals; they are everyone else, essentially. When we are talking about teachers and parents, in the NHS’s mind we are talking about the frontline of CAMH services, which is kind of an odd concept, but that is who we are talking about.

We are trying to think about, practically, what skills we can transmit. We have done some great work with Girlguiding UK, which is looking at some practical skills such as how to self-calm, how to self-soothe, how to remove yourself from a threatening situation and how to create safe spaces. They are rolling that out within the Girlguiding network, which is fantastic. We also do interventions in schools that do a similar programme.

It is really important, because when we talk to children and young people they want to share it with their peers, someone who might understand what is happening. As Shirley was saying before, if you are confronted with that information, if you do not know what to do if someone discloses something that is very distressing or that they want to hurt themselves, they might just ignore it. It is really important that every young person, parent and teacher understands how to self-calm and self-soothe themselves but be offered signposting advice if need be, because they are going to be contacting someone who perhaps is not a health professional.

Q223 **Heidi Alexander:** Marc, I have a brief question to follow up on your comments earlier about the internet and the dark web. Is there more that industry could be doing, particularly some of the new platforms? You referred to Instagram. Are there things that you have identified where you would like to see them doing something that they are not doing currently? My broader question was going back to the comments you made about educating young people to be able to deal with some of the things that they will come across in this space. What does a good education programme look like, and at what age should that education about the internet start around suicide?

**Dr Bush:** As to industry, it is great that there are reporting, flagging and signposting mechanisms, but it is about what children and young people



do with those platforms. Most of it is not happening on a Facebook stream; that is cyberbullying or chat. A lot is happening within people's pockets, so it is WhatsApp or other closed communities. That is where there is a great opportunity to encourage someone into self-harm or suicidal behaviour. For me, there is something about how the industry can collaborate with Government and the charities sector to create—they have it in Australia and Canada—interventions that basically intervene for the young person, either who is part of the conversation or the person who is a victim of that conversation, as it were, to say, "If you need to reach out, here is where to reach out to," because we know those prompts at the right moment can save a life. They are really important.

The reason why they are equally important is this. If I am a young person in year 8 and I am on the way to school, and I have had all these messages about, "You are crap and your life is not worth living. You should kill yourself," through 40 people on a WhatsApp group, and then I turn up to school and I am hearing it at the gates, and I am turning up to my class and hearing it in the classroom and in the playground, it would probably escalate to the point where I think, "The majority of the world thinks I may as well not exist." It is really important that we start intervening where we can, but not in a heavy way, into those closed communities. However, children and young people are the people doing it; they are creating the conditions. So, a lot of it is about education. It is, "Do you realise the consequences of this? Do you understand what you are asking someone to do?"

To get to your last part about education for peers, we wrote a report all about how you build—and I am sorry for the language—digital resilience among children and young people. We have in draft what a curriculumised version of that could look like. We would be happy to share that with the Committee to give you a sense of how you could do it for all ages and subjects.

**Q224 Chair:** That would be very helpful. I know Marie wants to come in and, Shirley, you are saying you would like to make a point.

**Marie Ash:** There are several points in what everybody said. One thing is that we are talking about young people and what their experience of mental health has been. I know for our three sons it was not good; they saw their mother disappear and slowly become a shell, so they are not going to feel like talking about it. They are now between 28 and 34, but I can see in them the fact that, "We do not want to engage with that, because they did not help mum."

Another thing is that our society is so fragmented now that we do not have the support networks that we used to have. There is also an area about personal responsibility—parents teaching children about those positive coping skills. There are places it can be done, and I think we are quite lucky in Devon that we have the Devon Recovery Learning Community. They have courses that are co-produced. You will have someone with local knowledge, someone with lived experience, and you



can go on any courses. We have mindfulness ones, WRAP planning, recovery, and anybody can access them. The beautiful thing is it is free. That is all the way throughout Devon. That is an area where people could gain some of those skills.

If people are in crisis and in a psychiatric unit, use the OT team. That is what we do. We have just started having pamper sessions, and for the first time people walk past that room and have said that the difference was amazing with teaching somebody how to self-soothe when they are highly anxious. We had a couple of people who came in and said, "I can't do that, but I will sit here," who ended up not only having a massage on their feet but giving one. That was in a matter of hours. There is work that can be done in psychiatric units and out in the community, and that link between leaving hospital and going into the community, where there is nothing. What is left out there? So, it is about taking responsibility and learning those skills that I know for myself I did not.

Q225 **Chair:** Thank you, Marie. Shirley, you want to say something.

**Shirley Smith:** Just adding to what Marc said with regard to the internet, if you Google now how to kill yourself, you will find many ways. So, it is certainly having help, because we know that brief interventions or the opportunity to get somebody at that point is really important. Having help rather than how is really important.

Q226 **Chair:** It does change it.

**Clare Milford Haven:** Very briefly, on Thursday I am going to an event that Samaritans and Twitter are having about social media and the effect it has on young people's health. That should be something quite interesting to report back on.

Q227 **Chair:** That would be useful for us to know about. Thank you very much, Clare, for bringing that to our attention. Steve, did you want to add something?

**Steve Mallen:** Yes, very briefly. Obviously, technology is a blessing and a curse, and we need to remember that. The seeds of the problem might be in the seeds of a solution, so to speak, because there are excellent examples now of many applications that young people particularly access, and the great thing about that access is that it is anonymous and remote, which is a very likely pathway for many young people in particular. There are a number of corporations that are developing those. In fact, it is my belief that the next wave of very successful applications for the big tech giants will be in this area. There are also online CBT courses that one can access now so that teenagers can have therapy remotely in their bedroom and anonymously while talking live online to a therapist. There are a number of companies that do that sort of thing now. The technology is a plus and a minus, but let us concentrate on the plus.

**Chair:** Yes. Develop the pluses, thank you.



**Q228 Mr Bradshaw:** I am conscious of the time and we are in danger of losing some of the Committee members. I want to ask about good practice and the multi-agency approach. Marie, you have already touched on how, as a user, you have helped develop that in Devon. Shirley, I think you mentioned the experience in County Durham and Clare the attraction of the model in Liverpool. If you have anything you felt you have not said about those, please say it now. If you feel you have already said what you wanted to say about them, do not feel you have to say it again.

**Marie Ash:** For the Devon Suicide Prevention Alliance it is the fact that we are multi-agency, co-produced and we do work as a collaborative—we were set up through attending the south-west zero suicide collaborative in 2015. There is a wealth that that shared knowledge and different people from different perspectives can bring, but also just working together. That is really important. It is not looking at, “We are the experts,” or, “You are the experts.” It is looking at, “Okay, we have a problem here. How do we solve it?” Everybody can bring something to that.

**Clare Milford Haven:** I agree. In our talks with Mersey Care, it is very much about working together and us providing and funding the service, but we want their knowledge, expertise, skills and the referral pathway running smoothly between all the different organisations. I think maybe that is the way forward, for people to work together—the statutory and voluntary sector to work together. In my opinion, it is the way forward.

**Shirley Smith:** I would just reinforce what has been said. One thing we have in Durham is the early-alert response service. We are the first service to provide an offer of immediate support after a death by suspected suicide linking in with the police. The early alert allows us to give people the option of timely and appropriate support, giving practical guidance, but it has also allowed us to work with the police and provide prevention and postvention training. As first responders, we are equipping our police, because we do not have access to crisis services in Durham unless you are engaged with the mental health service. Our first line of defence in suicide prevention is a police force, which only has the opportunity to section somebody under the Mental Health Act to keep them safe or to take them to A&E. So, we are able to provide first responders with the skills to keep somebody safe but also to prevent further deaths.

We have alerted the public health and multi-agency services around clusters. We have identified five clusters in County Durham, which are, in the truest sense, clusters, but we have also been able to get people from those local communities round the table to provide local services to the people in the areas most affected.

**Chair:** Thank you. That brings us, very importantly, on to the whole aspect of bereavement support. James.

**Dr Davies:** My question is more about Government strategy. Is that



okay?

Q229 **Chair:** While we are on bereavement support, I know, Steve, you had some points to make about the whole issue of bereavement. Thank you very much, as I say, for stressing that early intervention, and Hamish as well. Steve, do you want to say something first and then I will come on to Hamish?

**Steve Mallen:** Yes, absolutely. A part of this narrative that is always lost is the impact of tragedy, because the tragedy itself is often cataclysmic, often in news stories and often well reported—it certainly was in our case—but the aftershock of these things is monumental. One thing we need Government and policy to understand is that, when a tragedy occurs, the effects are very long lasting, the costs are enormous and the people are impaired quite frequently for ever.

A lot is discussed about the cost of suicide to society, and someone has calculated that it costs around £1.5 million. If you amplify that by the number, you get £10 billion. You start to get very big numbers. There is a much larger secondary cost of productivity to our society, speaking in terms of my own family and the thousands of families that have been impacted by that. That is obviously a very significant point.

There are two things. The first, again, is first contact. In our particular case it was a sudden, horrific, horrible accident, police at the front door, no warning, a great big policeman in your living room, and they give you a leaflet that says "Death on the railway." They actually have a leaflet for these things, not surprisingly, and then they leave. That is it. That is the sum total of the interaction that one gets, and you are facing an abyss that is beyond imagination—trust me. That is very difficult. We are aware that people impacted by suicide are themselves at very severe risk. That is often something that is lost.

There are examples of good practice around the country, and I would want to mention an organisation called CHUMS based in Bedfordshire—part charity and part local authority funded. They have a very simple system so that, when the police visit a family, a trained counsellor goes with them, who stays with them, offers them pathways, offers them literature, and immediately makes sure that there is some continuity there, something to cling on to in the darkness. We have to bear in mind—it goes without saying—that when somebody is impacted in the most appalling way, as my family was, your ability to function at any meaningful level is incredibly compromised. Your ability to make decisions is compromised; it is hard to breathe, it is hard to eat and it is hard to walk, never mind deal with organisation, and so on and so forth, in those early days.

Going with that is a much larger point, because, based on the very extensive interaction that I have had with many families, something that causes incredible distress is the whole legal and NHS process that occurs post-suicide, for which there is no guidance and no support. That is a



## HOUSE OF COMMONS

legal minefield, it is tortuous and complex. We need, I think, to look at the incident report process. As you know, there is no statutory obligation on the part of the NHS to undertake an independent review in the case of a death from suicide. That even applies if there is a death in custody. The trust is not obliged to undertake an independent review. To me, that is wrong and the law needs to be changed. Many families are lost in an abyss of grief, torture and torment for months on end as they try to seek the truth, the facts and justice, as it were, for their families and for their individuals without any guidance in a system that is designed to be against them. It is complicated and combative. It is based on concealment and it is based on lawyers, and so on and so forth.

There are also issues associated with the inquest process, which is fragmented. Some coroners are very good, some less so; some jurisdictions are very good, some less so. Again, when people are at their very lowest points, having experienced the most appalling tragedies, they have to face an inquest process and an NHS investigation process, which may have a legal protocol attached to it, and that is incredibly difficult for most people to navigate.

I mention that not simply for empathetic and emotive reasons but out of simple humanity to ease people through their pain and in terms of system improvement. What is happening at the moment is that many independent investigations are not being properly run and many inquests are not being properly concluded. Evidence is being lost and, most importantly, opportunities for reform and continuous learning are being lost. Bereavement support is not just important on a humanitarian level; it is very important on a system learning level, creating better systems and better improvement and so on and so forth.

In my own particular case, one is reasonably well educated and all those sorts of things, so you are able to deal with it. Many people are not, and I have come across horrific stories of what may be loosely termed miscarriages of justice, misappropriation and so on. Many NHS trusts are basically not learning from the experience that they have had. There should be independent SIR reports in the case of every suicide, certainly in custody, by law.

**Chair:** Thank you.

Q230 **Mr Bradshaw:** In this context I had a constituency case recently and I was amazed to discover that the family of somebody who had just taken their own life was not entitled to family liaison officer support of any kind, which is routine in—

**Clare Milford Haven:** If you get your laptop stolen.

Q231 **Mr Bradshaw:** Yes, in the most minor of crimes or a car accident or something you would get this, but if you are a family of someone who has taken their own life you get nothing at all.



## HOUSE OF COMMONS

**Shirley Smith:** We are the only people who have to go through that process who do not have formal support. We have supported over 753 people through a process that have been bereaved by suicide. As Clare has just said, if she had had her computer stolen last week she would have a call back within seven days to say, "Sorry, we have not caught the thief but we have kept you updated." However, going through this legal process—

Q232 **Chair:** So there is nothing at all—no follow-up.

**Shirley Smith:** Nothing at all, with the exception of people like ourselves and Steve, and there are other services around the country, but what support you have is a postcode lottery as to where you are. As members of the SASP, we are campaigning that every person should have the right to timely and appropriate support at a time that matters.

Q233 **Mr Bradshaw:** Shirley, who would that be provided by? Would it be the police?

**Shirley Smith:** At the moment, we provide that support.

Q234 **Mr Bradshaw:** Ideally, if it was to be a statutory right, which organisation or which body would it be?

**Shirley Smith:** You are guaranteed, when there has been a death, that the police will turn up—a doctor to certify and the coroner will be involved. To link that up, it is a bit like your early-alert process; it starts with either the coroner or the police to be able to bring it, but it is multi-agency.

**Clare Milford Haven:** As you were saying earlier, Shirley, a mental health counsellor or somebody should come with the police, like the street triage they have now where a mental health nurse goes with the policeman to a mental health incident. The same should happen when there is a death by suicide for the family, I believe.

Q235 **Chair:** Very often, it might be a junior member of the police, who is not really experienced.

**Clare Milford Haven:** Yes. We have funded recently, with the Oxford Centre for Suicide Research, a video to try to help the police—the first responders—how to deal with the very awkward situation of knocking on the door. It has not been published yet, but it is in process.

Q236 **Chair:** It would be very interesting to see that if you are at a stage where you are ready for it to go to publication.

**Hamish Elvidge:** Can I talk a bit about solutions but provide a little bit of context before I get to solutions? In terms of the number of people who have a need—it is researched a bit—it is between 50,000 and 300,000 perhaps, based on 6,000 suicides a year. It will vary, but it makes sense—between 10 and 50 people. It is already evidenced that if you are bereaved by suicide you are 65% more likely to attempt suicide yourself; that is just a fact. Steve has already talked about the impact on





## HOUSE OF COMMONS

everyday activities. I do not need to go into that. Two thirds of people do not access support. I would imagine that is largely born out of stigma and other things. Maybe they do not even feel they can access support because it is so hard.

We should hold on to the figure that each suicide costs £1.67 million. It is not our figure; it is the Department of Health's figure. Three years ago we set up the Support after Suicide Partnership. The person who runs it is on my left and it has 25 members; one is round the table. We are part of the National Suicide Prevention Alliance. We set it up on the back of support for families being the big new area in the 2012 strategy. It was heralded as the big new thing 10 years on from 2002. So far, the partnership has set up a website, which has been relaunched today, coincidentally. We have just started a survey of people who are bereaved or affected by suicide so that we can understand more. We are certainly hoping to get a survey back from 2,000 people. We are piloting it at the moment.

We have developed a new resource between Public Health England, the National Suicide Prevention Alliance and ourselves around local suicide postvention planning. It has not been released yet by Public Health England, although it is ready to be released, and it is integrally linked to the suicide prevention planning document that has been published. We have on our website access to "Help is at Hand", which was refreshed in September 2015.

Now on to solutions. Shirley has already said that our vision is that everybody bereaved or affected by suicide should be offered and receive timely support. That does involve, or will have to involve, police and coroners to inform an agency, and I will come on to that. There is very good practice in Durham, south-west Merseyside and many other places around the country, but it is a postcode lottery. If an agency is informed about a suspected suicide, the next thing, which Ben refers to, is that local authorities need to be able to provide support, because the worst thing is if you offer support and cannot provide it. It needs to be matched. That would need to be through public, private or third sector—the information resources, counselling support, one-to-ones, group sessions or whatever is appropriate to the individual, which will vary over time, over year 1, 2, 3, 4 or 5.

My view of it, having chaired the partnership for three years and learned rather too much about the subject, is that the best model is where you have a suicide bereavement liaison service within the local area so that every time somebody takes their own life, or if that is suspected, then the family is contacted within a few days. They might not want support at that point—and we can follow up—but they should be offered it. If we did that, it might cost perhaps £12 million a year across the 152 health and wellbeing boards, or something like that. That is the equivalent of saving seven lives in terms of cost benefit. We should not talk about this in cost-benefit terms, but in the current environment we probably would.



## HOUSE OF COMMONS

It just makes so much sense to me that this should be a service that is supported and funded in terms of the liaison role between the family and the support, and the support will come from many different areas and will be very different in its nature. If we do not do that with 6,000 families—and I said this at a conference recently—it is almost like knocking on the door of the 6,000 families and saying, “I am really sorry about your loss, but we cannot offer you any support.”

Now, going back to Victim Support, I have talked to Victim Support about the possibility of this service being added to their service, but that was not successful, although they were very supportive of what we are trying to do. We need that service put in place very rapidly and I do not see why there should be an obstacle.

Q237 **Chair:** Thank you. I am very conscious that we are taking a lot of your time. I know James has a final area of questioning if you could bear with us. Is everyone all right to stay?

**Dr Davies:** My question is to Hamish. What more needs to be done to improve the implementation of the Government’s existing suicide prevention strategy?

**Hamish Elvidge:** How long do you have? I think the context for me is my background—

**Dr Davies:** In summary.

**Hamish Elvidge:** It will be a summary. My background is as a finance director of Sainsbury’s responsible for change, turning strategy into effective implementation. When the strategy came out in 2012, I was asked the question by Norman Lamb, “Do you have any concerns?”, and I said, yes, I had one concern, that we had a strategy here and no programme management, skills or resources to turn the strategy into effective implementation. Then the APPG reported in January 2015, and less than 15% of local authorities had a plan in place. On Tuesday last week you asked the question, “Do we know what the current situation is?”, and the answer was, “We do not know.”

To me, it is extraordinary and very distressing that four years after the strategy was published we do not know how many local authorities have implemented anything. We know some who do, but we do not have the information because there is no mechanism to monitor effective implementation and monitor success.

I have put in my report to you that I think—and I have talked to Gregor Henderson and many other people about this—we ought to appoint a programme management function with appropriate support, light touch, that does all these things. It would monitor local implementation and implementation of national activity. It may be around confidentiality training, zero suicide crisis centres, bereavement support, or whatever it is we want to drive from the top down, although I know, as I have been told so many times, it does not work like that here now in new



## HOUSE OF COMMONS

Government. It would monitor outcomes, report annually and hold people to account. If I said to you, "Who is responsible for implementing the national strategy?"—

Q238 **Chair:** You want to ensure somebody is following up and making sure that best practice is happening.

**Hamish Elvidge:** Yes; we need accountability and reporting.

Q239 **Mr Bradshaw:** It used to be called the No. 10 Delivery Unit, by the way.

**Hamish Elvidge:** I am a bit on straplines today, but my strapline for this is that we cannot allow more lives to be lost because we do not have effective governance and implementation. It is such a waste of time and a waste of money.

Q240 **Chair:** If we have lots of plans but nobody is implementing them, it is meaningless. That is about implementation for you.

**Hamish Elvidge:** If we adopted the Scottish system, although I think it has changed slightly, we would be in a much better position, because the Scottish system has central programme management and local resources to support implementation.

**Dr Whitford:** We also have a Mental Health Minister, which is a first.

**Mr Bradshaw:** We used to.

**Hamish Elvidge:** I hope that was brief enough.

Q241 **Chair:** Does anyone have anything they feel they would like to add to what Hamish has said or anything they want to add to what they have said earlier today about what needs to be in the strategy?

**Joy Hibbins:** I want to follow up on something that Steve said, because I know some of our clients think this is very important. It is the situation about inquests and the lack of support of bereaved family members going through the inquest process where a mental health trust has legal representation and the family members have nothing, often do not understand the process and feel incredibly vulnerable. Is there any way that there could be specialised legal advice and support for bereaved family members through that inquest process to help them to identify the areas of questioning?

**Chair:** Thank you.

**Hamish Elvidge:** One thing discussed at our last Support after Suicide Partnership leadership team was that very question. The challenge to me from one of the people round the table was: why can't the Support after Suicide Partnership set up a service and engage with a lead legal person, together with some people who will provide their services pro bono, and make it available in some way? That is not easy, but it is an idea.

Q242 **Chair:** It is an idea. Marie and Shirley want to come in.



**Marie Ash:** There are services available. In Devon we have Pete's Dragons, which is an absolutely superb service that was set up, very similar to yours, out of the lived experience. If there is a need for that, use these as the ideal. How can we transfer that to the rest of the country? I know with Pete's Dragons that they have done some absolutely amazing work.

**Hamish Elvidge:** They are a member.

Q243 **Chair:** Yes; sometimes we reinvent the wheel when we have good things already.

**Marie Ash:** Yes. Why do that? If you have something that is working and working well, why change it?

Q244 **Chair:** Thank you. Shirley, you wanted to come in.

**Shirley Smith:** I have two final points. The fact is that you have five people who have been bereaved by suicide round this table who have been part of an amazing change that has forced this issue. We have TASC, which is the Alliance of Suicide Prevention Charities, which is doing things that other Departments have responsibility to do and just getting on with things. The time has come where suicide cannot be ignored. I think today has been the opportunity and we are heading there, but in working together, all different agencies, whether it is the voluntary sector or public health—no matter who it is—you can achieve things.

I did not ever expect to be in the situation that I am in today. Our family never expected that and the community I am from never expected that. I appreciate that when we are sat round this table we are probably at the coalface of doing something and being in front of people, but one thing that some people cannot even afford to do, before we get to representation, is bury their loved one. That is something that we need to look at, because not only are you left with the enormity of losing a loved one, feeling the responsibility, the guilt, the blame and the shame—everything that is associated with it—but then the final act of not being able to give a loved one the appropriate send-off adds to it; and we have that situation where people cannot afford to bury their loved ones.

**Clare Milford Haven:** I think that men are an issue we have not focused on in great detail. Men are three times more likely to kill themselves than women. Suicide is the biggest killer of young men in this country. There is focus in the strategy on middle-aged men because the stats tell us that, but we still need to focus on men in a major way and what we can do to create a cultural change so that men feel they can access services without feeling shame, loss of pride and that it is not a masculine thing to do. We must not forget who the main people are who are killing themselves, and it is men.

**Chair:** Thank you. I think that is a really important point to end on today, to bring us back to that key, fundamental point. Can I say, in ending, that what we have heard today has been extraordinarily powerful and I



# HOUSE OF COMMONS

am grateful to all of you for coming and for everything that you have done to contribute to this inquiry? Thank you.