HOUSE OF COMMONS

Health Committee

Oral evidence: Suicide prevention, HC 300

Tuesday 29 November 2016

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Watch the meeting

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

Questions 245 - 394

Witnesses

I: Professor Louis Appleby, National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, and Professor Carmine Pariante, Institute of Psychiatry.

II: Rt Hon Jeremy Hunt MP, Secretary of State for Health, Jonathan Marron, Director of Community, Mental Health and 7 Day Services, Department of Health, Professor Kevin Fenton, Director of Health and Wellbeing, Public Health England, and Phoebe Robinson, Head of Mental Health—Secure Care Policy, NHS England.

Written evidence from witnesses:

- Professor Louis Appleby
- Public Health England
- Department of Health

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Examination of witnesses

Witnesses: Professor Louis Appleby and Professor Carmine Pariante.

Q245 **Chair:** Good afternoon and thank you very much for coming to this final session. Could we start, for those who are following the inquiry from outside this room, with you introducing yourselves, starting with you, Professor Pariante?

Professor Pariante: I am Carmine Pariante. I am a professor of biological psychiatry at the Institute of Psychiatry, King's College London, and a consultant psychiatrist at the Maudsley Hospital.

Professor Appleby: I am Louis Appleby. I am a psychiatrist and a suicide researcher. I lead a research group at the University of Manchester where we have a project called the national confidential inquiry that specialises in the safety of mental health care. I also chair the advisory group on the national suicide prevention strategy.

Q246 **Chair:** Thank you very much. Starting with you, Professor Appleby, could you set out for the Committee, drawing on the substantial body of evidence that is now available, what you would think are the most important things for the Government to focus on in the upcoming refresh of the suicide prevention strategy? What are the key points that you feel have a strong evidence base for being included?

Professor Appleby: Suicide by men, particularly in middle-aged men; self-harm, which is a risk factor for suicide and one of the most important, but it is a problem in itself, particularly in young people, and, by extension, the mental health of young people, which drives the self-harm rates; the safety of mental health care, particularly acute mental health care round about the time of acute and relapsing illness; the treatment of depression in primary care; and support for bereaved families.

Q247 **Chair:** Certainly, those are all areas that we will be drawing on, but perhaps one area that is not currently in our brief is talking specifically about men and what we should be doing for them. Where is the evidence that you would like to see drawn out and reflected in the suicide prevention strategy?

Professor Appleby: The first part of the evidence is that men have a high suicide rate by comparison to women. In this country the ratio is 3:1. The highest risk is in middle-aged men—men in their 40s and 50s. The rise in the suicide rate in England since the 2008 recession has mainly been in that same group, in middle-aged men, and they are people who are affected by important risk factors such as economic adversity, alcohol and isolation. They are people who do not seek help readily. Particularly, that middle-aged male group often do not recognise mental health need when it is there in themselves, they do not necessarily look for a health solution to their problems and they do not easily use services as they are currently presented. For example, if you

look nationally, about two thirds of people who die by suicide have had contact with their general practitioner in the year before they die. The remaining third are mainly young and middle-aged men. The need is to provide for them a separate, or at least supplementary, kind of access to services, which they will accept and will seek out.

The evidence is largely based on the figures. It is largely based on what we know about the risks and about their help-seeking, but it adds up to a group at top risk. They are the group whom we should be most concerned about. They are the group at the highest risk and in whom the risk has risen, and they are the most difficult to reach by conventional services.

One reason why we need local suicide prevention plans in every part of the country is that every part of the country has the same phenomena and should be doing its best to reach those vulnerable men. We can do that by addressing some of the risk factors I mentioned. Every local area should have a plan to reduce alcohol misuse, a plan to address some of the economic drivers of suicide rates and a plan to reduce isolation for vulnerable people, and then we should have services that are less conventionally presented, which means services that are not in the health service at all.

There are some very good voluntary sector services. There is one that I think you have visited recently—the State of Mind service—which uses sport as a way to reach men to talk about health and, by extension, mental health. There are quite a few. On the whole, they are smallish, usually local organisations that are addressing men's health. We now have the Time to Change campaign focusing on men to encourage them to talk about their difficulties. We need a version of primary care that is not a building and is available online to men who might not otherwise report their difficulties to their GP.

Q248 **Chair:** We have seen the document from PHE, which is the guidance to local authorities that I think you have been involved in drafting. You set out eight priority areas. Do you feel that there is a single message that you would give? If a local authority was struggling to do all of those, which would be the ones you would most want to see them focusing on, or do you feel they need to do them all, essentially?

Professor Appleby: On the contrary, I restricted myself to eight, and by doing that I eliminated the other 28 that I could have listed.

Chair: That makes the point. They are all important.

Q249 **Andrew Selous:** I want to ask you a bit about social prescribing, which came up earlier. Just now when you were answering Dr Wollaston, one thing you very sensibly mentioned was "a plan to reduce isolation for vulnerable people," and I imagine you had in mind perhaps a community solution. What is your take on the issue of social prescribing where specialist mental health services may not be needed quite yet and may

not be needed in the future?

Professor Appleby: Isolation is a different phenomenon for different people at different ages. It has different solutions. I was thinking of community support—the role of the third sector, for example, and the way the third sector supports conventional services—but I was also thinking of public health in its broadest sense, something as non-health as transport links. If you are isolated and cannot get into the local shopping centre, that is damaging. So I was thinking very broadly about isolation, not just the kind of thing that might easily be prescribed in that terminology.

I am a fan of social prescribing. I cannot say I am an expert on it, but the principle is that for many people their risk is to do with their lifestyle, their social support and their network, and their vulnerability is the lack of those things. That is a critical principle for suicide prevention. Isolation is one of the main risk factors to address, not because it is in itself a huge addition to risk but because it is so common. The statistical risk associated with isolation is not high compared with, say, mental illness or self-harm, but the number of people affected is enormous. The overall benefit from addressing community isolation is huge. Social prescribing is one of the solutions.

Q250 **Andrew Selous:** What more can we do to reach people who are unlikely to access traditional service to help them? How can we do that differently and reach out in different ways? You have given us one or two examples. Are there more you can think of?

Professor Appleby: If you take one group of people for whom isolation becomes part of the suicide pathway, so to speak—that is, young people—almost half of the people under 20 who die by suicide are not in contact with any specialist service. By that, I do not just mean specialist mental health services; I mean social care, youth justice and so on. Yet the range of problems they face would not necessarily be things that would take them under specialist mental health services either. They may face bullying at school and online; they may have an experience of bereavement; they may have family difficulties such as substance misuse or domestic violence. There is a whole range of things that are going on for young people of which isolation then becomes a part. For them, the message is about the range of services that has to be involved. That means schools, the voluntary sector, social services and some of the supports they can provide, but it is the shared support for people whose vulnerability is very broad and very diverse. That is the issue, I think.

Q251 **Andrew Selous:** As a final question from me, do you think there is an issue about a lack of confidence over professionals in the public sector signposting to voluntary and community services because they are just a bit nervous that it does not have that hallmark of approval of being a publicly run service? Is that something you had thought about or think is an issue, and do you think we might be missing out on really very worthwhile support in the community, towards which perhaps GPs and

others are a bit nervous about pointing people because they think there might be some comeback if something goes wrong, for example?

Professor Appleby: I can only speak from personal experience on that; I do not know what the evidence is. My experience of that is that, on the contrary, mental health services, which is my area, are dependent on other services, on the voluntary sector and charities. That does not mean it always translates into close working. There are, I suppose, some barriers, sometimes organisational and cultural, thinking of substance misuse services and how well they work, and thinking of issues of professional confidentiality, which sometimes can hold professionals back. I do not think necessarily that joint working always goes well, but in my experience, I do not think it is because the voluntary sector or those kinds of services are not highly regarded. On the contrary, they are seen as being able to reach people whom we as professionals often cannot reach.

Q252 **Maggie Throup:** Professor Appleby, in your introduction you briefly mentioned depression. Is the detection and treatment of depression in primary care currently adequate, and is it meeting NICE guidelines? If not, what more can be done and what should be done?

Professor Appleby: It is not meeting NICE guidelines. In my research group we looked at the features of services, the clinical configuration of services and the clinical policies—this was mental health services—that were associated with a drop in patient suicide risk, so the introduction of services and the introduction of policies, and we tried to identify the specific changes that mental health services could make that were associated with a reduction in suicide among patients. One of a shortlist of services in that category was implementing NICE guidelines on depression. It is an absolutely key part of improving the safety of services.

Our evidence as to the people who are in primary care or out in the community when they are in the period leading up to suicide is that their contact with primary care comes into one of three categories. First, there are the people whom I mentioned already, who are the people who are not in contact at all, the one third of people who do not have any contact with their GP in the year before they die; for them, they need a different way in. Then there are the people who are in contact but not for any reason that is explicitly mental health, so they are attending but the mental health problem is not identified or for some reason not made explicit; there probably are several reasons why that may be the case. Then there are the people for whom the mental health problem is the reason they are attending, but for some of them at least the service is not providing the protection that they need. Each of those three presents a different problem.

The middle group is in some ways a difficult group because they are people who are already in contact with services, but how does a busy GP recognise depression in somebody who is attending for something else?

What are the warning signs—the markers—when somebody is attending with a different problem? There are some, but expecting a busy GP to pick them up reliably is a difficult problem.

For those who are more obviously depressed or suffering from a different mental disorder, there is the question of adequate treatment. We have a big psychological therapies programme now in England—the IAPT service—that has brought treatment to people who might not otherwise have been treated. There has been a focus on under-treatment of depression, including with antidepressant drugs over the last 10 or 20 years, trying to make treatment more available, but the most recent survey, which is called the NatCen survey, that came out about a month ago—the adult psychiatric morbidity survey, which is a big national survey of mental health morbidity in the community—still found that, for those people who are identified as having depression or anxiety, only about a third are getting treatment. We are quite a long way from an adequate response to need.

Q253 **Helen Whately:** Professor Appleby, in your written evidence to us you pointed out that there are many suicides by patients who are under the care of mental health services, and particularly under crisis resolution home treatment teams. Could you explain to us why we might be seeing significant numbers of suicides among those patients?

Professor Appleby: In England, it is about 200 people a year who die while under the care of crisis teams; that is about three times the number who die under in-patient care. So it has become the main setting for suicide by people who are under specialist mental health services. That is not to say, incidentally, that crisis teams are somehow inherently unsafe, because the rest of the work that we have done on this in my unit has shown that, of that set of service changes that can be introduced, crisis teams are one of those that can make the overall service safer, but you have to do it properly.

You have to do crisis teams properly; they have to be 24-hour services; they have to be services that provide the right level of skill in their front-line staff and the right level of contact. They cannot just be an occasional drop-in to check that someone is taking their medication; they have to be a proper substitute, an alternative, as they were originally designed, to in-patient care. What appears to have happened in some parts of the country is that crisis teams are not now providing an adequate alternative to in-patient care: they do not have the seniority of staff; they are taking on a lot of patients who are at a very high degree of risk who probably need something more protective.

Q254 **Helen Whately:** Do you have a perspective of how extensive that shortfall is—you said "in parts of the country"—and the level to which that is a problem?

Professor Appleby: By definition, there were 200 people last year for whom the protection offered by crisis teams was less than their risk.

There are other people who have audited crisis teams. There is quite a bit of work on what makes a good crisis team. The national audit that other research groups have carried out suggested that most services—I think it was probably just about all—did not quite reach the level of satisfactory standards on most of the criteria. It is a variable problem but a widespread problem as well.

Q255 **Helen Whately:** We have heard from some of our witnesses during this inquiry about a shortage of in-patient beds, and in-patient units feeling a great pressure to discharge or there not being an in-patient bed to which to admit a patient. Is there a connection between that and the number of suicides for patients who are being seen by the crisis resolution home treatment teams and perhaps other patients who should be in-patients instead?

Professor Appleby: Taking our results alongside the reports from people who are in front-line services, I think it is very likely that bed pressures play a part, but bed pressures are about more than the number of beds. How many beds you need depends on what else you have, but in some parts of the country I am sure they do have too few beds; in others, they need stronger community services to prevent people being admitted in the first place and relapsing.

There are three parts to the acute mental health system. There is the in-patient ward, the crisis team and the post-discharge period. Each of those carries its own risk. The period of maximum risk for mental health patients is the first three days after they leave a ward. The people who die in the first two weeks after leaving hospital are people who are more likely to have had short admissions. It is quite clear that turbulence in the system—moving people on too quickly—can put patients at risk.

Q256 **Luciana Berger:** I do not know, Professor Appleby, whether you have had the chance to see the BBC programme "Britain's Mental Health Crisis" that was shown just over a year ago, which covered a home crisis team and the workload that they had. From the research you have done, is their experience an example of what is happening across the country?

Professor Appleby: I am trying to remember which particular crisis we were in at that time.

Q257 **Luciana Berger:** It followed a home crisis team and the workload, juggling quite an extensive—

Professor Appleby: Just to say again, crisis teams, properly done, are a good service and add to the safety of mental health care, but if you put too much pressure on a good service, if you dilute the skills of the staff, ask people to go to crisis teams when they are not ready—a third of people who die under crisis teams have been there less than a week, so it does sound like they are people who might have been in a different setting—then you stretch the service to the point where it starts no longer to look like a good service. If I remember the programme you refer to, that story of people in the frontline having to juggle with their

front-line resources, the beds, the crisis places and the resultant out-of-area admissions—because people being admitted out of area because of lack of local capacity is another part of that whole system—is not an unusual daily experience for staff in the frontline.

Q258 **Helen Whately:** Could I bring us on to talk about A&E? We know that there are some people who seek help in A&E with a mental health problem but they do not always get the care and treatment or access that they might need. Could you give us your perspective on the role of A&E in preventing suicide?

Professor Appleby: The most important role it has is in responding to people who have self-harmed. There are probably about 200,000 people a year who go to A&E as a result of self-harm. They are mainly young people, with the peak ages in the late teens and early 20s. It is the strongest risk factor for suicide that we have. They have a crucial role. Not only that, but we have NICE guidance that says what a good service should consist of. We know that the key element to that service is a proper assessment. It is not all that surprising, in a way, that if you assess people properly a lot of other things follow.

Then, of course, there has to be some kind of support and treatment available, but that initial assessment carried out by somebody who is skilled enough to do it is a crucial step. It is known to be associated with a better outcome, yet it is just over half of the departments in the country that provide that assessment at the moment. It seems to me incredible. These are patients who carry high risk and they are often not treated very well in services; they are often seen as having caused their own problem sometimes because they come backwards and forwards; they sometimes are not the easiest of people to relate to, so they have a bad reputation in the service and they are treated in a rather neglectful way at times, yet about one in 50 of them will have died within a year of leaving the A&E department.

The main reason they die is suicide. They are at the top of the list of high-risk people. The service we provide them at the moment is highly variable and does not really match the values that healthcare should provide. I feel very strongly that every service in the country should provide a high-quality A&E-based assessment for people who self-harm, and it should be the job of commissioners to do that and to demonstrate that.

Q259 **Helen Whately:** Would you want to see that in the form of psychiatric liaison teams, which we have talked about during some of the sessions in this inquiry? Is that what you would like to see in every A&E? Is that what you are suggesting?

Professor Appleby: That could do it. The liaison teams are often multidisciplinary, so it is not always the psychiatrist that has to do the assessment, but it is the skilled assessment, the person who has the skill to carry out a proper assessment of not only the risk, which is one half of

it, but the need, because people self-harm for a reason; their reasons are quite diverse and they are often because of the social problems that they are facing. It has to be a proper assessment.

But it is more than that; it has to be the right setting. A trolley behind a curtain in an A&E department is not necessarily the most humane setting for assessing self-harm. Some places have provided proper private rooms where families can be, where someone's distress can be private and so on. There is more to it than the liaison team, but it is a key component.

Q260 **Helen Whately:** What do you think would be a good aspiration to achieve that? By when should we be trying to achieve that in every hospital? We would love it to be there tomorrow, but that is probably not realistic. Do you have a view on when the aim should be to have that available in every A&E?

Professor Appleby: I suppose I should first say that we have known that this is the situation for something like 30 years, so it is not as if people planning services have not had a warning that this might be a necessary service. It has been a key part of the national suicide prevention strategy since it first appeared in 2002. Yes, I understand it cannot necessarily be created overnight, but I cannot see why it should be later than next year in any service in any part of the country.

Q261 **Chair:** Can I briefly return to that high-risk period post-discharge? How common is it, in your experience, for people not to receive a visit in that high-risk period?

Professor Appleby: It has got a lot better. When we first started collecting data on that, the number of people who died before their first visit was about 40% of those who died after discharge. Now it is more like 10%. Services have responded. I have not spent much time talking about the good things that services do today, but there are some very good things and one of them is in-patient care, which is much safer than it used to be. Another is the way that services have responded to the need to follow people up quickly. There was a seven-day follow-up requirement for a time in services and it is still recorded to what extent people are followed up within seven days. It is much better, but the trouble is that the peak day for suicide is day three, so it has to be before day three if it is to make any sense.

Q262 **Chair:** Where that is not happening, is it predominantly due to poor communication or is it predominantly due to the sheer pressure on services, in your experience? Have you looked at where it does not happen and why it did not happen?

Professor Appleby: It is for different reasons. It goes with care planning. I have mentioned that short admissions are a predictor of early suicide after discharge, but another one is care planning. Care planning is protected, in other words—care planning on the point of discharge. If you are planning care at the point of discharge, early follow-up is a key component of that. Given the pressure on admission to beds, it does not

seem too unreasonable now to say that anybody who is ill enough to need a bed has also been ill enough to be followed up within a few days of vacating that bed. So care planning is the root and the essence of that.

It is worth saying that it is more difficult, because there are some people who are more readily followed up. There are some people who discharge themselves, people who are not in agreement with the service, and so sometimes the early follow-up is missed for people who are slightly falling out of the structure of the service. Bear in mind that those people who fall out of the structure of the service are often the highest-risk people.

Q263 **Luciana Berger:** Can I seek clarification on one of the points you have just reflected on, Professor Appleby, about the proportion of patients that are discharged from hospital and followed up within seven days? I have a copy here of the "Mental Health Five Year Forward View Dashboard," which was recently released from NHS England, and it does show until the last quarter that we have seen the trend improve, but in the last quarter there is quite a decrease, according to the graph that is provided by NHS England itself. Are you aware of that and what do you put that reduction down to in that last quarter?

Professor Appleby: The last figures I looked at were very high, so maybe I have not seen the figure you are referring to. I think the service has done reasonably well on follow-up within seven days, so I would be very surprised if there has been a major drop-off that is real. But my point is that it is not enough. That seven-day follow-up was the right story 10 years ago, but it is no longer the right ambition. It should be a follow-up straightaway. It does not necessarily mean, by the way, that somebody has to follow up the person in their home. We have a lot of ways of following people up now that do not involve a physical visit such as Skype and texting. There are lots of ways in which that contact can be maintained on the day of discharge.

Q264 **Chair:** In other words, in the refresh of the suicide prevention strategy, would you like to see it be three days rather than seven days?

Professor Appleby: In the report that my research unit brought out in October we recommended three days.

Chair: That should be three days. Thank you very much.

Q265 **Dr Whitford:** Professor Appleby, last year there were a number of pilots into zero suicide projects started. What evidence is there for the outcomes, success or progress of any of these?

Professor Appleby: We have to have a healthy degree of scepticism about zero suicide. I am an admirer of zero suicide, but I admire its ambition and the way it has galvanised some parts of the country to put together a suicide prevention strategy that has as its guiding philosophy that no suicide is inevitable. There is sometimes a fatalism that runs through services about people at high risk, which I think we should always try to counter. It may be natural in some senses, but we need to

counter it. The zero suicide initiative has set out to counter that culture of inevitability that you sometimes find, but the evidence that should be built into what services in this country do should come from this country. We probably have better evidence on suicide prevention by services in the UK than any other country. The zero suicide project in Detroit has not been evaluated, whereas services in Britain have been evaluated. I would not copy the substance of zero suicide, but its ambition is a good thing.

Evaluating what is already set up in the south-west, the east of England and Merseyside is happening up to a point; it has not been very systematic, but it is happening. My own research group is partly involved, because it is in Manchester, with what is happening in Mersey and Cheshire.

Q266 **Dr Whitford:** As these obviously seem to be more oriented towards mental health services and, as you said earlier, many of the people who take their own lives are not engaged in mental health services, is that not an inherent limit to the success that you would expect?

Professor Appleby: The majority of people who die by suicide are not current mental health patients, but they are, however, probably the most preventable deaths because they are people who are under specialist services, in close proximity to the highest-skilled professionals, and 50% of mental health patients who die by suicide have seen a professional in the previous seven days. I think they are the right starting point. That is where you have to start and build out from there, but it is absolutely right that suicide prevention is a much broader initiative than that. The local suicide prevention plans that we are so keen to get local areas to develop are about mental health, but they are about much more—primary care, A&E departments and the wider community.

Q267 **Dr Whitford:** Do you think that can be one of the successes of having a zero suicide approach—that it galvanises a whole area to look at that bigger plan—because these plans are not all in place?

Professor Appleby: Yes. That is one of the main strengths—that they are multi-agency. I know quite a bit about the Mersey one, but I have also been to the zero suicide initiative in the south-west. The number of agencies or groups that are coming forward to say they can contribute to safety in their locality is very encouraging. That is the thing to build on. I think the zero suicide sites have strength, but they come out of how we work in this country.

Q268 **Dr Whitford:** In view of your own evidence and the current lack of resources, it looks as if some of these will not be funded going forward. Do you think that funding these types of projects is the best way to spend what little money that exists?

Professor Appleby: Every area should have a plan. Whether we call it zero suicide or whether it is called suicide-safer communities—another development from North America—probably does not matter, but every area should have its suicide prevention plan and it should be as detailed

and comprehensive as the zero suicide sites have developed. How that is resourced is a difficult issue when resources are scarce, but a lot of the early successes of the suicide prevention strategy were not because we had dedicated resources for suicide prevention but because people saw it as sufficiently at the top of their priority list to channel their resources into this area. That is the approach we need. We need local authorities, even though their public health resource may not be as high as they would like it to be, to make suicide prevention their priority; we need the local NHS to make it a priority; we need a contribution from the justice system and from transport. It is partly a question of aligning current resources, but of course more resources would be valuable.

Q269 **Dr Whitford:** It is about joining things up rather than anything else—that multi-agency phrase.

Professor Appleby: That is key to it. The multi-agency element is absolutely key. It has to be local leadership at the right level: people at the top of the local NHS; at the top of the local council and local public health; people who are at the top of the justice system—the head of the police, for example. Those are the people who need to provide the leadership. Giving suicide prevention that kind of pervasive influence on the system and its resources is what is required.

Q270 **Chair:** Hamish Elvidge pointed out to the Committee that we often have these plans with lots of multi-agency involvement, but it is about implementing it and putting it into action. Where do you see the key barriers to implementing all this evidence and these plans? How do we make it happen?

Professor Appleby: That is definitely the biggest problem. The suicide prevention strategy, I would say, is a good strategy; it has been put together by professionals, by people who know about suicide because of their personal experience, by academics who follow the evidence and by charities like Samaritans, who play a key role. Those people have put together the strategy; yet, when it goes out into the system, it becomes optional. How does that happen? That is not a sustainable system for public health. There is a model around at the moment, because of the crisis care concordat in mental health, where there is much greater scrutiny; there is a stronger message to local services about the necessity of an area, and in that case it is about crisis services, but this is the related area of suicide prevention. It is a key message from the top, from the heads of the services, the heads of the Department of Health and so on, that suicide prevention is a non-negotiable priority, a requirement to prepare a plan and then scrutiny of that plan.

One issue is having a plan. I think you will find that the number of local authorities that are reporting that they have a suicide prevention plan is steadily increasing, so that is positive, but the critical thing is what is in it. I have seen good plans, but I have also seen plans that are really just lists of things that were already taking place that have something to do with mental health. “So let’s call that part of our suicide prevention plan.”

That is not really what we have in mind. That is why the eight items are in the local authority guidance, to try to make sure that the content is addressing the absolutely key issues. It is having a plan and the scrutiny of that plan by somebody who is outside that local system. There are the Department of Health, NHS England and various people who might do that, but that external scrutiny is absolutely crucial, and reporting it, of course.

Q271 **Chair:** In areas where it is happening successfully, what is it about that area that makes it happen? Is it all about the local leadership driving this through or are there any other levers that you have seen that make it more likely to be implemented on the ground?

Professor Appleby: I think local leadership is vital because in the end this is a local priority. There are sometimes local characteristics of suicide that have raised its profile—a cluster of deaths, sometimes young deaths, which always carry more public distress with them. Sometimes there is pressure that is felt more in one area than in another. We have to be slightly careful about that, though, because there is a tendency, I suppose, for areas where the suicide rate is higher to be thinking about suicide more, and that is understandable.

The other side of that is that areas where the suicide rate is not high find it easier to pull back. If we are to bring down the suicide rate by the new target of 10%, then every area has to take part, including areas where the rate is fairly average and including areas where it is below average. In the health system, for quite a few years, we have had a kind of outlier culture where the people who take notice are the people who are outliers. Nobody likes being an outlier in the system. That triggers action and I suspect that has triggered action on this, but that is not enough. As a public health initiative, it has to be something that all areas take on even when their rates are not high.

Q272 **Dr Davies:** Professor Pariante, could I move over to the issue of medication? We have seen the use of antidepressant drugs increase rapidly over the last decade or so. First, could you explain to us what you feel the evidence is for their effective use? Is that increase in use justified?

Professor Pariante: It is. If you look at the prescription numbers in England, they have doubled in about the last 10 years, but, as Professor Appleby said, we still have two thirds of all people who are depressed in the community who do not receive treatment. With regard to the increase in prescription, the kind of interpretation that we have is that it is following the fact that more people are aware of depression, more people seek help, more people are prepared to receive help, more doctors are prepared to prescribe, and so we see this as a positive development.

One key thing in the treatment of depression is that only people who need antidepressants need to receive antidepressants, and this is probably what happened in the majority of the clinical situations. The

NICE guidelines and other guidelines are very clear that antidepressants should be prescribed only to individuals who suffer what we define as moderate to severe depression—so a level of severity that has not only a clinical component but a functional component, when life for an individual, the family and the immediate environment really suffer, with work and the environment. These are the people who need the antidepressant treatment and hopefully more and more of these people are taking them.

Q273 **Dr Davies:** Some of the representations made to us relate to the adverse drug reactions that can occur with these and other drugs such as, ironically, increased suicidal ideation. What is the evidence behind that in terms of the severity of risk?

Professor Pariante: Can I just give a one-minute background on the names and terminology that we use, because I think it is quite important to separate suicide as death by suicide—people dying by suicide—as opposed to suicidality, which is a much broader term? This includes thoughts of wanting to die, wishes to be dead or a transient impulse to harm oneself, which remains as an impulse, a thoughts level, or perhaps a manifestation of self-harm that goes into, potentially, cutting oneself or even taking overdoses of medication or excess alcohol intake, which has an element of wanting to harm oneself not only as a consequence but with a potentially lethal intention at the beginning.

I like to make a distinction on this aspect of mental health, although overlapping, as Professor Appleby said, self-harm behaviour in general is a potent risk factor of completed suicide, but they are also distinct. The epidemiology is distinct. Most people who die by suicide—again, as mentioned before—are men, who are middle-aged; most people who commit broader forms of self-harm, such as cutting and small overdoses or experience suicidality as a broader term, are young women. Some medications work more for one and other medications work more for others, and so on. So there are two overlapping but distinct domains. I apologise for being perhaps a little bit pedantic in this distinction, but I think it is quite important because both the mental processes and potentially the biological processes that underpin these two components are again overlapping but separate.

Having said that, I will come to the important point. All the clear evidence of studies and meta-analysis—a kind of review of studies put together statistically over the last 20 years—confirm that antidepressant medication decreased the number of people dying by suicide. It does it within clinical studies. The ecological studies show—and I know these are less easy to interpret—that usually an increase in the prescription of antidepressants is mirrored by a reduction in suicide, and, more worryingly, as it has been shown in the last few years, a decrease in the prescription of antidepressants, especially in children and adolescents following the concerns that you are mentioning, is actually mirrored by an increase in the suicide rate. Both the direct head-to-head clinical

evidence and the historical epidemiological and ecological evidence points to the fact that antidepressants are beneficial in reducing death by suicide rates. There is no doubt about it.

It comes as a consequence of the antidepressant, an effect, if you like, of exactly what they do. The antidepressant drugs, among the other effects that they have, work on the core of hopelessness and helplessness, which ultimately is what drives the dramatic choice for someone to take their own life.

Suicidality is a much broader phenomenon. It is driven probably in most cases by other components—for example, anxiety, inner tension, irritability and physical tension, which in susceptible individuals are in fact increased by some antidepressants. However, the evidence points out that, while the number of people who die by suicide is decreased by antidepressants, there is a small number of individuals for whom, because of their predisposition to increased tension, anxiety and irritability that some antidepressant medication gives, this inner tension, irritability and feeling of jitteriness and so on raises the risk of having this impulse of suicidal thoughts, or, as I said, acts of self-harm that are not lethal. Children and adolescents are particularly vulnerable to this second component. There is a small but real effect of increasing suicidality as a phenomenon, but not an increase in death by suicide.

Having said that there is an increase in suicidality as a broader phenomenon, this increase is small overall compared with the benefit that the antidepressant has in the same population. You need to treat about 100 people to have one person who suffers from an increase in suicidal ideation due to this tension, irritability or anxiety, but you only need to treat 10 people to have one person who improves in his or her depression. So the increase in suicidality is there and it needs to be monitored; the individual with that particular risk has to be identified potentially, when we will know how, sooner rather than later, and monitored, but it should not be something that prevents us from using antidepressants in people who need them, including children and adolescents who need them, from which, obviously, the risk benefit is even more important to establish and perhaps the threshold for prescription should be higher, but there will be individuals with depression who reach a level that will require antidepressants.

Q274 **Dr Davies:** In your view, are there more studies that need to be carried out or further data collection, for instance, to determine which patients are likely to be at greater risk?

Professor Pariante: Certainly, further data collection. There is some evidence, but coming from small studies, that some individuals are genetically more predisposed to develop this broad spectrum of suicidality. Potentially, it is a genetic component that regulates the way the drug is metabolised. Basically, some people in whom the drugs accumulate more suffer more of this side effect, which happens with all medication, and so it is possible that there is a genetic component that

will help us identify those individuals who are at particular risk. Certainly with larger epidemiological studies, we would be able to look at a psychological element or a psychological factor that identifies a particular individual. Also, I guess, it is important to understand more about the difference between the behaviour and how the brain works in a dysfunctional way in the process leading to taking one's death by suicide versus the mental process and the brain process that brings suicidality, because, again, these are separate.

Q275 **Dr Davies:** Of course, there are other classes of drugs that have been linked to increased suicidality, such as antipsychotics, benzodiazepines, Roaccutane and even high-dose steroids? Do you think that the guidelines available to clinicians are adequate for all these drugs?

Professor Pariante: We know which drugs have this effect. The guidelines are clear. The problem is that these events are very rare—even rarer considering there are medications that are not offered for mental health treatment within the general population where perhaps there is simply not the same level of awareness in the environment or vigilance; but they are also very rare, so you potentially have to monitor thousands and thousands of people to prevent an event like this. But the guidance is there and the doctors know it. In a way, it is similar to the monitoring you need to do at the beginning of the antidepressant treatment for every patient.

I represent here the British Association for Psychopharmacology, which is the leading expert organisation in the UK giving advice on the psychopharmacology aspect of the treatment of psychiatric and mental disorders. In our guidelines on antidepressants we recommend a follow-up as early as one week after starting antidepressants, because, again, we know that there is this increased anxiety and increased irritability, and this is where we pick up early signs of people who are at particular risk. This applies even more within the kind of broader spectrum of medication for a certain person taking antidepressants. As Professor Appleby says, a follow-up does not mean another visit—it could be a phone or a Skype contact—but some kind of reassurance that the medication is not having a negative effect from that point of view.

Q276 **Dr Davies:** You would argue that the guidelines are there, but are health professionals aware of them and are they following them?

Professor Pariante: Unfortunately, this is not my area of expertise in terms of measuring this directly. Perhaps Professor Appleby, who is much more epidemiologically based, can comment on this. I can only talk about my personal experience and experience of knowing the colleagues and say what colleagues and people that I know do. In primary care and secondary care everybody is doing the hard work and trying to do it.

Q277 **Dr Davies:** The final follow-up to that would be, from the patient's perspective: do you think there is enough patient information? Should there even be written consent, for instance? Obviously we do not want to

put off those who will benefit from antidepressants from taking them, so there is a difficult balance there, is there not, to strike?

Professor Pariante: It is a difficult balance because, as I said, we are talking about some side effects in a minority of people. They are always outweighed by the benefit even of someone who has moderate to severe depression. For the patient, the most important message is that sometimes having a period of sadness does not mean depression and not everybody who is going through a personal crisis or a difficult moment in their life needs an antidepressant, and the prescriptions should mirror the severity. That should be matched by the clinician and the other mental health professionals offering antidepressants to those who need them. At that point, the trust should be there to reassure the patient that that is the right decision, within the framework of explaining this in terms that this may happen but explaining what it is and reassuring them.

Q278 **Dr Whitford:** Professor Appleby, again, as part of the national confidential inquiry, what do you see are the barriers to collecting good data that is useful to improve the service?

Professor Appleby: We have had a lot of co-operation from clinicians. They have been very supportive. In fact, we could not have done the work that we do without a very high rate of returns—about 98% of clinicians telling us about people who have died under their care. The key to that has been that the information is not going to rebound on them in some way— that this is a confidential data collection and the purpose is improving care; it is not about identifying blame. Learning and blame do not go very well together, so we have been quite clear that that is what the purpose is.

We are very clear that we are interested most in how the system works, rather than what the individual practitioner does, even though the two are related. Our concern is about gaps and failures in the system, or at least, if it is something that an individual does, it is something that applies across the board; it is not unique to a particular practitioner. It is about learning, but it is also about how the system works.

I think people want you to respect their data; they want you to use the information in the way that they have given it, which I think means that, in the end, something comes back that helps them, that they are giving it in order to help. They want to be supported; they want findings that are directly about improvements in their clinical practice. In the confidential inquiry, our recommendations are always about how the service might change and how it might improve, but they are not about how people did things wrong and they are not about, "What we really need is unlimited resources." They are about how the service can be better at doing what it does day to day.

Q279 **Dr Whitford:** We heard in some of the earlier sessions about the length of time that the diagnosis of someone dying by suicide can take; with a coroner's inquest it might be a year before a death is defined in that way.

Do you find that a problem in your data—that suddenly you and the clinician are trying to chase back to data that is not fresh in people's mind and there will be a level of texture you would not capture any more?

Professor Appleby: It is a problem, and it is a problem not just for us in fact. The time between a death and the registration of a death is several months in many cases—a few years in some. It is not unusual for two, three or four years to go by before an inquest is completed. A lot of people lose out because of that, not least the families who are awaiting the inquest, and then it is quite a big and traumatic event for them. One of the biggest changes that could be made in the data system would be a more rapid provisional notification of suicide at the time when a death occurs. That is a system that already operates, for example, in the prison system, where self-inflicted deaths, as they are called because they are not yet subject to official inquest verdicts, are notified, and so immediately the prisons are able to count the number of people. There are certain caveats about how you talk about those deaths that have not yet been confirmed suicides, but, on the other hand, the early notification is the thing that counts. That early notification probably by coroners—coroners are the right people to do it—would be very helpful, but we do not have that system at the moment.

There are one or two pilots where that is being investigated, but it would make a big difference, not just to us in our work where it would mean we were collecting information, as you suggest, in a way that was fresher in people's minds, but it would also mean that our national data are more up to date. When we talk about 2015 suicide rates, which are the most recent data available to us, those figures from ONS—the Official for National Statistics—are date of registration, not date of death. A lot of those deaths occurred in 2014, so we are talking about the 2015 rate as the most recent thing on which we can base our actions and priorities and yet we are referring to deaths that may well have happened two years ago.

Q280 **Dr Whitford:** Would it remain within the 2015 cohort rather than being assigned back into the cohort within which the patient died?

Professor Appleby: It is not at the moment reassigned. In my research group we do reassign it, so when we publish data we go back to the date of death. So our figures are different and they follow a slightly different pattern as a result. But, of course, you then run the slight risk that late inquests will alter the figures once you have published them because they have not yet come through the system. A universal early notification, even a provisional one, not yet subject to legal confirmation, would be very helpful, but it would not just be early; there is a consistency problem as well. Please do not take this as critical of coroners, because I am a huge admirer of their work and the care that they take over suicide deaths, but they are individuals who vary to some extent in their readiness to reach a verdict of suicide.

There is a different system in Scotland, but a consistency across England and Wales, would be a huge help. We already include deaths from undetermined cause, so-called, in our national suicide statistics because suicide itself is underreported at inquest because of the legal threshold for reaching a suicide verdict. So we have to add in the undetermined deaths, but that is a matter of judgment for people. Whether it is an undetermined or an accidental death is a matter of judgment, and sometimes influenced by factors such as family sensitivity or inferences about intent, which are very difficult to draw but can be quite individual between coroners.

You get differences between cities. Manchester has a high suicide rate; Liverpool has a low rate; Newcastle has a high rate; Birmingham has a low rate. Those may be genuine differences, but they may also reflect coronial practice. That is not to take away the independence of coroners, which is an important principle, but consistency across the system would really help us.

Q281 **Dr Whitford:** That was something that we heard earlier and that is quite a big difference between Scotland and England. You quite often seem to have these narrative descriptions from the coroner rather than a diagnosis. Obviously, if you are talking a year or longer, then the ability to recognise clusters or imitations happening in an area just disappears.

Professor Appleby: Yes. The early awareness of clusters would depend on being aware early of the deaths. That can happen to some extent now because people are aware the death has happened, but that is right.

Then the other issue is support for the family. If that was then an accompaniment of early notification, or a sort of right almost of early notification, there are a number of benefits of making at least a provisional decision early to be changed later. I should say that it is slightly easier in the prison system. I referred to that as if that was the model, but in the prison system the majority of suicide deaths are hanging and the uncertainty in coroners' inquests is often about other methods where the circumstances are more ambiguous, so it is not quite straightforward. But early and consistent notification would help.

Q282 **Dr Whitford:** Is there any work going ahead to try to look at having a degree of guidance, definition or structure that would help coroners to reach a more consistent diagnosis?

Professor Appleby: Yes. The role of the chief coroner is important here and he has been very helpful on this, but we are still left with people making judgments, and where judgment is part of the system you will get variation. The chief coroner has helped. We have had pilots. There has been a pilot in County Durham on early notification.

There are steps to try to change the system, but we are still left with that relatively long time period. There are efforts to bring it down in the way that I have said, the chief coroner working with local coroners, but it is

not getting down quickly enough and it is inconsistent. The narrative verdict problem is an additional component of that. Narrative verdicts are not new, but they have been newly used in much greater numbers. When they leave the correct registration of death uncertain, they have had an effect on suicide rates. So we have, certainly for a period of time round about 2009, 2010 and maybe 2011, had an artificially low suicide rate in England probably because of the arrival of the greater use of narrative verdicts. That, of course, did not help us with priorities; it did not help us understand the problem.

Q283 **Dr Whitford:** Sarah asked you about the prevention strategy and how to improve implementation, and we talked about the plans. Work done by the APPG had shown 30% of the areas without suicide plans in 2014 and 40% without multi-agency plans. You said that you thought it had improved, but Samaritans' estimate is that probably it has got worse. Do we have data on things like that, on who has a plan and a plan that functions?

Professor Appleby: I am told Public Health England has figures from a recent survey and that it has improved. One issue is how many people have plans. Sometimes those plans are in development—that is the phrase—and I think we all know what that means. The plans have to be real. Also, my point is that having the plan is the starting point; it is not the outcome. The plans have to be real, be locally relevant and they have to reflect the evidence. I keep pressing this, but we have a lot of evidence on which interventions can be based; they are not always evidence from clinical trials, but we have a lot of good evidence on which local suicide prevention plans can be based. The guidance that went out a few weeks ago with my eight priorities was an attempt to say that having a plan is the start, but then you have to make sure the content is addressing the big-ticket issues. Those are mental illness, self-harm, men and so on.

Q284 **Dr Whitford:** Does your data from the confidential inquiry link into that? Are you looking at that from the point of view of the areas that have a plan that is a real plan, the areas that have a plan that is a piece of paper in a folder and the areas that have no plan at all? Is there any analysis?

Professor Appleby: It is a good idea, but we have not done that yet. We have set out the key components of a safer mental health specialist service, and the local plans are an ideal vehicle for making sure that those evidence-based service features are in place. There is no excuse. If you have evidence based, essentially, on 20 years of collecting data about people who die under mental health care, when you turn that into the key components of a safer service, there is no excuse for a local service not having those components in place. The local plans, although they are multi-agency, are essentially led by public health and mental health services. They are the two key pillars there and are the way in which that can be delivered.

Q285 **Dr Whitford:** Other than getting the plans to be a reality, is there any

particular thing you would want to highlight around the implementation of the national strategy, because we are four years on from it now?

Professor Appleby: That is absolutely the key. Scrutiny of the plans was my other element—

Q286 **Dr Whitford:** So that comes back to data.

Professor Appleby: —so having a plan, the content and then independent scrutiny.

Q287 **Dr Whitford:** Before you move on, when you say scrutiny, which requires data to scrutinise, do you think that would be the data you are collecting or would that require a different form of scrutiny?

Professor Appleby: I chair the advisory group, which essentially is people external to the statutory system. You have heard from some of the people who sometimes are bereaved families who have set up charities, and they are a tremendous asset and could provide the scrutiny. They are people who are already available to the system.

Q288 **Dr Whitford:** So it would be much more a visiting, inspecting and questioning rather than the numbers data that yours is.

Professor Appleby: Yes, but it might not be visiting. There are 150 local authorities, so there would be no reason why the plans should not be subject to scrutiny that involved an independent eye from people who have a strong interest in seeing improvement. In terms of the national strategy, which is your question, that is the absolute key thing. I think you could say that the profile of the strategy across Government could be higher. We are getting good help at the moment from NHS England, the Department of Health and Public Health England. There are so many Government priorities, but this is one that touches so many areas of the system. It should be just as important to the Department for Education, to the Ministry of Justice, to DWP, to business and to help employers looking after vulnerable people. Every Department's interests and concerns should be reflected and its contribution should be recognised in how the national suicide prevention plan plays out. It is a cross-government strategy. It is called a cross-government strategy. That part of it does not always happen.

Q289 **Dr Whitford:** "Health in all policies" comes up regularly here and things do not join up terribly well sometimes. From the point of view of the people on the ground doing it, the key thing is making the plan a reality.

Professor Appleby: On the ground it is the plan, but alongside the plan is the evidence. Just to keep labouring this point—

Q290 **Dr Whitford:** To monitor.

Professor Appleby: —we have the evidence on what services should do. We know what would reduce risk in mental health care, in A&E departments, in primary care, in the wider community, in young people, those teenage suicides that are rising; we know the things that could

make a difference. Every service should be reflecting that knowledge. It is about having a plan and having the right content but making sure that the evidence, which has come from British research—it has not been transplanted from somewhere where the system might be different, so it is highly relevant—should be what we do. There is a compelling case for it.

Q291 **Dr Whitford:** But then we would need to be collecting data to show that we were actually getting somewhere.

Professor Appleby: As well, yes, that is right.

Q292 **Chair:** Could I quickly touch on a couple of points that have already been raised? First, Professor Pariante, you asked if Professor Appleby wanted to comment on how well the guidance was being used by GPs. Do you have any evidence on that or want to comment on that?

Professor Appleby: Do you mean on antidepressants in particular?

Chair: Yes.

Professor Pariante: And especially the early clinical follow-up after one or two weeks of starting antidepressants.

Professor Appleby: I do not have any, but my guess is that is variable, as with most guidance. You have to remember that the history of this is the serious problem of under-treatment. The priority about the treatment of depression with antidepressants is that people do not get a treatment that can be life-saving, and in most other parts of the system that would be unacceptable. Of course, it is right to be cautious about the risks associated with antidepressants—that is absolutely right—and some of the other drugs that people have raised outside, in your question, but let us not forget our biggest problem is that people do not get access to treatment that could be therapeutic.

Q293 **Chair:** That is the key message here rather than to send out a message that they are risky drugs; it is about appropriate application.

Professor Appleby: You have to reflect the risks, but it would be a bad message to get out that you should be even more cautious.

Q294 **Chair:** We should be following the guidelines. We should not be sending out a message that these are dangerous but that they should be used appropriately and appropriately followed up.

Professor Appleby: Yes.

Q295 **Chair:** The key issue is under-treatment.

Professor Pariante: The key issue is under-treatment. There is a small proportion of patients who suffer side effects, which is outweighed by the benefit.

Q296 **Chair:** Thank you. The second point I wanted to touch on quickly,

because I know other colleagues want to come in, is returning to your point about verdicts of suicide. Do you think that the evidential standard could be changed to being the balance of probabilities rather than beyond reasonable doubt?

Professor Appleby: Yes, I do. It is not straightforward, because I think wherever you draw the line, or wherever the system draws the verdict line, there is bound to be a degree of uncertainty and you have to deal with cases where the circumstances are ambiguous. So you have to have a way of doing that regardless of what the system is. First, it is the history of that system. Its equivalence with criminal proof reflects the history of suicide. Of course it was illegal until 1961 in England. There is a principle here, which is that that standard of proof is a reflection of a system that is full of prejudice and stigma, which we ought to dismantle. It causes uncertainty for families, who can be aware that a death was a suicide and are surprised when the verdict is not suicide. Of course, we have to be sensitive to people for whom the verdict is unwelcome.

If you talk to families, there is no single family view of this issue. People have different views about it. The verdict is always going to be unwelcome, but, on the other hand, people know that a suicide has occurred and they sometimes feel the system is being a little bit vague if it comes to a different, undetermined verdict. In the end, families are looking for a proper, full explanation, for their views to be taken into account, for the verdict to be delivered sensitively, for the process to be respectful. Then the verdict comes after all of that. If we get all of that right, the issue exactly of what the verdict is will be less important. It would be better, I think, and more modern for it to change.

Q297 **Chair:** Do you feel there is a risk that we are failing future families if we are not accurately recording and taking action to change the system?

Professor Appleby: Families resent the stigma and uncertainty in the system, and so we owe it to them to be clear about what the evidence shows. In the end, it is not always the most important thing. They also want proper support; they want lessons to be absorbed by the system, for things to change that may have contributed to a death. If we get all of that right, the verdict just becomes one part of how the system responds to a death. The respectful way of responding to a death is that the system changes.

Q298 **Luciana Berger:** Professor Appleby, you mentioned criminal justice a few times over the course of your evidence. Particularly because it has been in the news this week and we have discussed it at previous evidence sessions, I want to look at the issue of suicide in our prisons. I know you have looked at the data on this issue, but perhaps for the record and for this Committee you could share with us your reflections on what has happened to suicide in our prisons over the course of the last five years, and what role, if any, local suicide prevention plans are playing to bring this figure down.

Professor Appleby: The Prison Service has a reasonably good recent track record of suicide prevention. Some of the highest rates of suicide were between 1999 and 2004, and then a much greater effort was put into suicide prevention. A number of changes were made. That was also the time when the new national suicide strategy appeared, so there was a connection between what was happening in prisons and this wider national strategy. The rate began to fall and came down to levels that are about half what they are at the moment. By the time we reached 2008, 2009 and 2010, we had relatively low suicide rates in prison, and since then—so from 2013 onwards—we have had a much bigger rise. The suicide rate now looks like being for 2016 roughly back to the level of that 1999 to 2004 period. Because there are more people in prison now than there were then, the numbers look even higher, but the numbers are not the main issue. The main issue is the rate, because the rate takes into account the prison population, and that is almost back to what it was 10 years ago. Perhaps more importantly, the rate is twice what it was five years ago, so there is a real problem. Preventing it means partly doing the things that were done successfully a few years ago, which was about care planning for people who might be at risk; it was about vigilance for people who first came into prisons, because there is a clustering of deaths in the first few days or few weeks after arrival in prison. It is also about the physical safety of the prison system, the cells themselves, because most deaths are by hanging, so we provide people with the ligature points and the ligatures that they can use to kill themselves by the structure of buildings, many of which are very old.

There is a set of things that can be relearned and reapplied, but there is also a need to make sure that the culture of the prisons is sufficiently supportive to people. These are vulnerable men, wherever they are, whether in prison or out of prison; they are often vulnerable high-risk men. If you put high-risk, vulnerable men, impulsive men with poor coping skills, in an environment that can be harsh and punitive, and make them earn their privileges and provide them with healthcare that is of a lower standard than they would get outside, it is hardly surprising that the suicide rate goes up. We have to reverse all that. It is a matter of prison culture. It is also healthcare. It is a matter of risk recognition. I think it is also a matter of staffing, I must say, but not simply a matter of staffing. It is not simply about staff numbers; it is about how the staff work and how relationships develop between vulnerable people and the staff who look after them. If we get those things right, then I think we can bring the prison suicide rate down.

Bear in mind those people are also at risk when they get out of prison. For the people who leave prison, who are released from prison, their risk is just as high in the year when they leave as when they were in prison, and the maximum risk is in the first month. We have to get the service right for when they get out.

Q299 **Mr Bradshaw:** Professor Pariante, you said that there has been this sort of trade-off, if you like, on overprescription and underprescription and

you gave percentage figures for the risk of people who might have side effects from prescription against the extra suicides that you experience from underprescription. Is it possible to put a quantifiable figure on those extra suicides that we have seen as a result of underprescription of antidepressants?

Professor Pariante: Of untreated—

Q300 **Mr Bradshaw:** Yes, untreated or undertreated. Is it possible to put a figure on that?

Professor Pariante: The statistics that Professor Appleby has mentioned are that about two thirds of people who die by suicide are not in contact with mental health services, so they would be the people who are not receiving antidepressants, if that is what they need.

Q301 **Mr Bradshaw:** But did you not say that there had been an increase in young people taking their own lives as a result of overcautiousness in prescribing?

Professor Pariante: There are two recent papers. I do not have the numbers by heart at the moment.

Q302 **Mr Bradshaw:** Is it possible that you can find those and send them to us?

Professor Pariante: Of course, yes.

Q303 **Mr Bradshaw:** It would not be possible to make a comparison between that figure and the figure Professor Appleby referred to right at the beginning of the session when he talked about the impact of socioeconomic factors on suicide levels in older men. It is not possible to make that comparison now, but if you could let us have those figures it would be helpful.

Professor Appleby: That is between people who are untreated when depressed versus those who are affected by socioeconomic factors.

Mr Bradshaw: Yes.

Professor Appleby: There is obviously an overlap between those two groups in any case. We are talking about a huge number of people; I am not sure what the figure is, but if you look at my groups of thirds of people in primary care, it is a third of the people who are not getting treatment for depression, despite the fact that there is a mental health risk, in all suicides in primary care. As a crude measure, that is well over 1,000 people a year.

Chair: Thank you. We have a final point from Philippa.

Q304 **Dr Whitford:** Professor Appleby, again, in the confidential inquiry you are linking to factors such as deprivation and so on, which we know are associated. When you talked about the suicide rate falling before we see this recent climb, did you see that right across the board, or was it

particularly in the lower social groups? In Scotland when we got the big fall, which was 19% down, it was predominantly among people who were more deprived, whereas, normally, when you increase healthcare, it is nearly always the least deprived who gain rather than the most deprived. But the change in suicide rates in Scotland was in our most deprived groups. When England had been going down, up to the financial crash, was there any analysis of social deprivation?

Professor Appleby: The evidence from the confidential inquiry—and that is about mental health patients—is that there was a rise in how frequently the people who died were facing economic adversity, such as unemployment as an antecedent, unstable housing or what we referred to as serious financial difficulties. That was the question that people had to answer. Those things became more common. There was a suggestion that in mental health patients, where mental illness is part of the picture for them, the socioeconomic factors that were driving the rise in suicide rates were becoming more frequent antecedents in those people as well.

Q305 **Dr Whitford:** That is after the financial crash.

Professor Appleby: Yes.

Q306 **Dr Whitford:** We know it is literally about three times the rate among people suffering deprivation as people in the least deprived groups, but certainly in the kind of 2002 to 2011 drop in Scotland, it was the most deprived groups that went down. You mentioned patients in mental health, so is there not data for people who take their own lives but are not mental health patients? You do not have a database that is everybody.

Professor Appleby: You are asking in particular about their socioeconomic characteristics, which is—

Q307 **Dr Whitford:** Obviously, you need to look at the whole pool to see the pattern.

Professor Appleby: There is inferential evidence, I suppose. We know that the suicide rate after the recession went up in certain parts of the country more than others. It rose more in the north and it rose in the south-west. It did not rise at all in London. London was the only part of the country where the suicide rate did not rise after the recession.

Q308 **Dr Whitford:** But it is not collected as an actual data point inside your confidential inquiry.

Professor Appleby: No. We do not know the economic characteristics of the people who died. To answer your question in a slightly different way, we do know, though, that the changes to the mental health service that improve patient safety have more effect in areas of high deprivation; so in some ways it is the opposite. You are rightly saying that sometimes those interventions work better for people who have perhaps less adversity in their lives, but what we have found is that there was greater effect in areas where adversity was more prevalent.

Q309 **Dr Whitford:** That is what we saw in Scotland with that big drive, but in Scotland, we collect data on all suicides and we collect the social deprivation. In England, the confidential inquiry is only people who were patients within mental health services.

Professor Appleby: It is primarily those people. It is all young people regardless of service content.

Q310 **Chair:** Thank you. Are there any points that you have not been asked that you wanted to make today, Professor Appleby or Professor Pariante?

Professor Pariante: Perhaps I can just stress again the importance of stigma. It is coming out across all the dimensions we have been discussing, and certainly under-treatment of depression is one of the consequences of stigma, so I think the more we can do for that the better.

Chair: Thank you very much for coming.

Examination of witnesses

Witnesses: Rt Hon Jeremy Hunt, Jonathan Marron, Professor Kevin Fenton and Phoebe Robinson.

Q311 **Chair:** Good afternoon. I thank our second panel for coming today. For those following this from outside the room, could you introduce yourselves?

Professor Fenton: Good afternoon, everyone. I am Professor Kevin Fenton. I am the director of health and wellbeing at Public Health England. In that role, I cover PHE's non-communicable disease prevention portfolio, which includes mental health and wellbeing.

Jeremy Hunt: I am Jeremy Hunt, the Health Secretary.

Jonathan Marron: I am Jonathan Marron. I am director for mental health, community services and seven-day services at the Department of Health.

Phoebe Robinson: I am Phoebe Robinson. I am head of mental health at NHS England.

Chair: Thank you very much. Ben is going to open the questions.

Q312 **Mr Bradshaw:** This is a question for the Secretary of State and Professor Fenton, but you are all welcome to try to answer it if you feel like it. We have heard, essentially, from everybody who has spoken to us that the 2012 strategy is great, but there is no national oversight or implementation, no leadership and no accountability. How do you respond to that?

Jeremy Hunt: If we look at the evidence, we have made a lot of progress on the 2012 strategy. If you look at some of the key things, the targeting of high-risk groups, we have seen very significant reductions in

suicide rates by NHS patients. The in-patient suicide rate more than halved over the decade leading up to 2013. Public Health England has put out guidance as to what can be done in places with a high risk of suicides, and we have made significant progress. The reality is that last year we had 4,820 suicides, and we had the tragic death of Connor Sparrowhawk in an NHS in-patient facility, so if we are to have the best mental health provision, we need to do a lot better, which is why I welcome the Committee's looking into the issue and questioning what more can be done.

Professor Fenton: I agree with your observation. Having the national strategic plan for the last few years has driven a focus on suicide prevention and has both stimulated an evidence-based approach across Government agencies and enabled us to provide strong advice to localities on what needs to be done. Despite the progress we have made, we need to go further and faster. Part of that is focusing on implementation. I am really pleased that over the last couple of years, since the last audit of suicide prevention plans, we have seen a significant increase in local authorities who now have a plan, or who are committing to complete their plan by the middle of next year. We estimate that about 90% of local authorities are committed to having a plan in place. We need to ensure that we are quality assuring those plans, supporting local authorities on training and building capacity to implement the plans effectively, and holding them to account and supporting them to ensure that meaningful action is being implemented locally. That is the space that Public Health England is in and that we want to continue to be in, because we are one of the few Government agencies that both works nationally and has the reach to support action locally, so we want to ensure that we are doing more of that moving forward.

Q313 **Mr Bradshaw:** Could you explain exactly how you are doing that? The point made to us by Samaritans and others was that it took the all-party parliamentary group to do its own survey to ascertain how many local authorities actually had a plan and were implementing it. Two years ago, it found that 30% were not, and Samaritans told us that in the last two years, in their experience, the situation has got worse.

Professor Fenton: We completed a survey in October this year and we are still completing the final analysis of that survey. We hope that the results will be published and publicly available by the end of the year. Public Health England's role is to support the development of local plans. We have produced guidance on the content of the plan and the ways in which it should be developed. We also provide data to localities to help them understand their patterns of suicide, as well as the risk factors that are driving local suicides. That can help to strengthen the plan as well. Of course, we provide a range of other support to localities, including bereavement support and training and capacity-building activities. We have just completed a master class in the north-east that brought together all the local authorities in the north-east, all of which have a suicide plan. It was a really important event to get those localities

together to talk about their commonalities, and to talk about how they can go further and faster. We are going to repeat that across the nine regions in the country. In fact, today we have a master class in the north-west bringing together those local authorities as well. PHE has a role to play to support local implementation, but we are also building on the great energy that exists within local authorities to move on this agenda.

Q314 **Mr Bradshaw:** Guidance is all very well, but it is only guidance. A lot of the people who have spoken to us say that the plans should be mandatory. Why aren't they mandatory?

Professor Fenton: The good news is that 90% of localities have developed plans or are in the process of developing them. We fully anticipate that by the end of next year we will have full coverage of the plan. I am not sure that mandating the development of a plan will yield significant additional benefit.

Q315 **Mr Bradshaw:** What about mandating implementation of the plan? It is all very well to have a plan but it is no good if you are doing nothing about it. You could have the best plans in the world, but if you do not implement them, they are useless.

Professor Fenton: Absolutely. For the areas that have developed the plan, we see great energy, and great actions arising from the presence of the plan, and local implementation taking place. If we focus on the development of the plan and support local authorities over the next year or 18 months on implementation, and if we also do work on quality assuring plans to ensure that we are providing feedback to local authorities on how they can be strengthened, and how those plans can go further and faster, I think we will be in a very different place.

Q316 **Mr Bradshaw:** But it is all exhortation, isn't it? We all know what kind of financial pressures local authorities are under, with public health cuts and all the other pressures on social care. You have no power to force them to do any of this.

Professor Fenton: That is correct, but in the environment we are working in now it is about how we provide support, how we look at and share best practice across the system and how we harness the energy and the commitment from local authorities to move forward. There have been many great examples in Cheshire and Merseyside. I have been working with the West Midlands Combined Authority, where they are harnessing the energy of local authorities who are committed to doing additional work on suicide prevention as part of their efforts on prioritising mental health. There is great energy in the system, so it is about harnessing and supporting that.

Q317 **Mr Bradshaw:** Indeed, we visited Cheshire and Merseyside and were very impressed by some of the services available there, but a number of people told us they faced being abolished or cut as a result of the forthcoming NHS and public health cuts in that area. Secretary of State,

you said very categorically at the end of the "World at One" this lunchtime, after their special programme on young people's mental health, that you would hold local authorities to account. How exactly are you going to hold them to account? It is all very well saying that, but how are you going to do it?

Jeremy Hunt: First, it is important to note that a lot of improvements are being made across the system. Indeed, when it comes to money, mental health is one area where investment is increasing quite significantly against a backdrop of a lot of pressures in the health and social care system. The first thing is to have data as to where programmes are working and where they are not. This year, for the first time, we became the first country in the world to publish Ofsted-style ratings that grade the quality of mental health provision across every CCG area, holding to account not just mental health providers for the quality of their care but also commissioners, the people who are responsible for purchasing care. Part of that rating looks at the investment you are putting into mental health.

By the end of this year, we will publish, for suicide prevention specifically, an atlas of variation that will show which local authorities are doing the best job and where there are areas that can be improved. We have found that that is the most effective way. Everyone wants to do a good job, but there is also a lot of innovation going on and we want to create a system where people are encouraged to look at areas that are doing very well. Cheshire and Merseyside is one, and Cambridgeshire is another, where, for example, when you dial 111 the first thing you hear is a computer voice asking whether it is a mental health issue, and if you press 2 on your phone you are immediately put through to a helpline where you can talk to someone then and there about a mental health issue. That makes it incredibly easy for people to talk, and I have seen the call centre where that happens. There is innovation around the country. The truth is that, not just in this country but across the world, we are learning that there are very effective ways to bring down suicide rates, and we want to create a culture where the best ideas are exchanged and copied as quickly as possible.

Q318 **Mr Bradshaw:** But if I am a local government chief facing having to make horrendous choices about the services to keep open and close, why, if I am not being directed or mandated by you, would I prioritise this when I am closing things left, right and centre?

Jeremy Hunt: The reality is that they are prioritising it. We are seeing some very important improvements being made. I do not think we need to have a conversation with people who run local authorities about the costs to the health and social care system—the £1.7 million average cost of a suicide, principally because of the additional mental health support that it is necessary to give bereaved relatives—because I think everyone wants to do this. As Professor Fenton said, there is real energy to do it, but we need to shine a spotlight on the parts of country that are not doing as well as they might be.

Q319 **Luciana Berger:** If we can develop some questions and answers on funding it would be helpful, because many people who have given evidence to this Committee reflected on their personal experience on behalf of themselves and their families of not being able to access services, or of services being restricted—waiting times. We heard in the House from one of our colleagues, the honourable Member for Hull East, who shared the tragic story of his nephew who took his life while on a waiting list for talking therapies. Can I bring you back to the point you made, Health Secretary, on funding? In an answer I received yesterday to a parliamentary question, I was told that mental health spend for this year was £9 billion. On the mental health dashboard that was published by NHS England just a few weeks ago, it says that spend was £9.15 billion. In a response that you made to a public petition, which was used as a piece of evidence to an inquiry, the figure of £11.7 billion was given. For the purposes of accuracy, and for us to understand how much is going to mental health this year, can you tell us which of those figures is accurate?

Jeremy Hunt: I can happily explain to you exactly where the differences in those numbers are. Sometimes, there is a difference between the amount being spent by mental health trusts and the amount being spent in the NHS as a whole because, of course, there is an enormous amount spent on mental health in acute trusts and in primary care provision, but I should write to you and give you the exact breakdown as to why there is a difference in those figures.

Q320 **Luciana Berger:** I would appreciate that, particularly as I have asked a number of parliamentary questions and the answer that I get on countless occasions is that the data are not held centrally. We would not be discussing this in the Select Committee today if it was not for the fact that the annual survey of mental health spend was stopped in 2013, and I hope that your Department will reflect on perhaps re-establishing that so we can all have accurate data going forward. Secretary of State, you have said on a number of occasions in the House, and it is in NHS England's guidance for this year, that every CCG in the country should be increasing the proportion of spend on mental health. I have done a freedom of information request for the last three years to gather that data because it has not been available or collected centrally, and I have shown this year, from the CCGs that have responded and have responded over the last three years, that 57% of clinical commissioning groups across our country are reducing their proportion of spend on mental health; in particular, north Manchester is reducing it by 1.87%, Leeds north is reducing the proportion of spend by 1.64% and south Reading by 1.57%. Please can you explain that to us?

Jeremy Hunt: We do not have the legal ability to mandate a proportion of funding on a specific area of NHS spend, but when we get information like that we take it very seriously. We are publishing ratings that demonstrate outcomes for mental health provision across every CCG in the country. By doing that, we are shining a light on the areas that are

not providing care, and if that is because of the funding, that is something we also need to look into. In order to construct those ratings, which are all done by an independently chaired committee, we look into the areas that are not spending as much as they should and hold them to account for that. That is an important part of my job. Across the NHS as a whole, this year we are on track to spend on an annual basis between £700 million and £1 billion more than we were spending on mental health two years ago. While there may indeed be parts of the country where we are disappointed at decisions that are made locally, the overall picture is of a substantive increase in mental health spend.

Q321 **Luciana Berger:** Forgive me, but 57% of CCGs are not meeting the commitment that you made in the Chamber, which NHS England has told CCGs across the country they should be complying with, and the Prime Minister herself said it at PMQs just the other week. Can you understand why there is a lot of concern across the country that you keep making pledges and commitments that are not being delivered on the ground?

Jeremy Hunt: I have to say that I do not recognise the 57% number, and we will happily look into it carefully. The figures that we are collecting as a Department of Health and as the NHS show a significant increase in mental health spend across the NHS, and we are seeing that. For example, if you look at the number of people who are accessing talking therapies compared with two years ago, and if you look at the number of areas that have set up effective crisis care response teams in accordance with the crisis care concordat—this is not to say that there are not a lot of improvements that still need to be made—we are seeing significant improvements in mental health provision.

Q322 **Luciana Berger:** If you will not accept the figures that I have collected on a standardised freedom of information request from data that is freely available for anyone to look at, your own parity of esteem indicator, your own dashboard, which NHS England published just a few weeks ago, showed—they are different figures and it would be helpful to understand the discrepancies—that at least 22% of the country's clinical commissioning groups have failed to raise the proportion of spend in their mental health budgets. Even by your own standards and your own measurements, you are not meeting that standard. Again, I come back to the question asked by my colleague Ben Bradshaw: what are you going to do to ensure that this money reaches the frontline?

Jeremy Hunt: With the greatest respect, the reason for collecting the information and publishing that dashboard is that we want to implement the recommendations of the mental health taskforce chaired by Paul Farmer, which sees an increase in investment in the NHS of £1 billion[1] in real terms by the end of the Parliament. By 2020, 1 million more people will be treated in mental health, and in order to make sure we deliver that we have realised that the most important thing is to understand

[1] The Department of Health has subsequently informed the Committee that the increase in investment is £1 billion in cash, rather than real, terms.

what is happening in every single one of the 209 CCGs, which is why we are publishing that dashboard; we are not being secret about it. That way, when we identify that 22% of CCGs are not meeting their commitments, we are able to put pressure on them, and I hope when the numbers are published in a year's time you will see those numbers change. That is the purpose of collecting and publishing the data.

Q323 **Luciana Berger:** Can I reflect on the fact that it was four years ago in the Health and Social Care Act that parity of esteem was enshrined in law—equality for mental health? We are four years down the line and, by anyone's standards, I think it is a pretty low bar to say that, at the very least, clinical commissioning groups should be increasing their proportion of spend. Your own figures show that at least a fifth of CCGs are not achieving that now. In the context of this really important inquiry on how we prevent people taking their life—that is what we are discussing—what more can you and should you be doing to ensure that this money ultimately reaches the places for which it is intended?

Jeremy Hunt: I am afraid I do not agree with the thrust of your argument. If you look at what happened in the last Parliament, there has been very significant progress in improving mental health provision. There is a long way to go, but if you look at talking therapies, for example, three quarters of a million more people access talking therapies every year. Our dementia diagnosis rate is now one of the highest in the world. On overall levels of treatment, as we have discussed in the House, about 1,400 more people are accessing mental health services every day. What we decided at the end of the last Parliament was to take that commitment to parity of esteem, which we take very seriously, and to ask an independent group of experts, chaired by Paul Farmer, the chief executive of Mind, what they believed sensible progress towards parity of esteem would be during this Parliament. That is when he came up with his review, and we have accepted and funded his review, which means that during the course of this Parliament we will end up by treating 1 million more people every year, which I think is a very significant piece of progress. That is not to say that there are not very important things within it, but part of that progress is to publish the very data, which, if I may say, you are using to castigate me. The reason for publishing that data is precisely that we want to make sure that every part of the country delivers on its commitments.

Q324 **Chair:** You said you do not have the legal powers to make this happen, but what is the point of the NHS mandate? Where are the levers within this? Who is held to account, ultimately? Is it Phoebe Robinson? Perhaps I should give her the opportunity to come in. Who takes responsibility if this does not happen and the money does not reach the frontline, as we have heard?

Jeremy Hunt: We have the power to set a direction of travel through the NHS mandate, which is a document agreed by the Government and NHS England, but we do not have the power to ring-fence specific sums of money in the CCG allocations.

Q325 **Chair:** What are the consequences? Who takes responsibility if it is not happening? You say you have set the direction. If nobody responds to that, who is held to account for that, Secretary of State?

Jeremy Hunt: Ultimately, I am the person who should be held to account for delivering our manifesto commitments, and indeed any other commitments we make as a Government.

Q326 **Chair:** We legislated for parity of esteem.

Jeremy Hunt: Yes. Parity of esteem is a concept, and we decided to ask independent charities what their view of sensible progress towards parity of esteem would be during the course of a Parliament, because it is a big thing to achieve. That is why we asked Paul Farmer to do his taskforce report, and we have accepted his view as to what proper progress toward parity of esteem should be in this Parliament.

Q327 **Chair:** It is difficult, but there does not seem to be anybody who ultimately will be held to account for its not happening, for money being delivered to the frontline, in order to put those changes in place. I wonder whether, Phoebe Robinson, you want to comment on what you have heard about why it is not happening. We have heard the figures from Luciana Berger about the failure of the shift into mental health services that we had been assured would happen.

Phoebe Robinson: As we set out, there is unprecedented transparency around money. We are setting out what CCGs are spending as a whole on mental health, and on specific programme lines where we are sending out new money. You will note that we have published the amounts of money being spent on early intervention in psychosis, on children and young people's mental health and crisis resolution and home treatment teams. Those are some key programmes of work over the next five years where we expect to see increases in investment. The first thing to say is that the funding for the mental health five year forward view has been published in the implementation plan and it is back-loaded towards the end of the Parliament, so we would not expect to see the majority of that extra £1 billion at the moment. The second thing is that there are some good reasons why we might not want to see ring-fencing; for example, in some areas of the country that have very well-resourced crisis resolution and home treatment teams it might be right for the CCG to choose to prioritise spending their money on something that is not well resourced. It is right that we let local areas decide how they can best meet their population's health needs.

Q328 **Dr Whitford:** Putting the two things together, in that we are four years on from the strategy and, Professor Fenton, you talked about 90% being committed to having a plan by the end of next year—so not even all of them, five years out—and then Phoebe is talking about the money being back-ended, we are actually talking about 10 years for something that was called a priority of change. Is that not a terribly long time, when there will be a lot of people lost, and a lot of those people will be young

people, and families will be affected for the rest of their lives? It seems a snail's pace to do something that was described as a priority—parity of esteem in mental health.

Phoebe Robinson: If I can talk to the mental health agenda, it is not as simple as handing money to people and them immediately being able to deliver services. There is a huge amount of transformation that needs to happen.

Dr Whitford: I realise that.

Phoebe Robinson: There are some good reasons why back-loading finance may make sense, for example, to allow the workforce to be in place to be employed by services. This is a five-year strategy. Paul Farmer's taskforce made it clear that a 10-year strategy would be required to deliver improved mental health services for people.

Q329 **Dr Whitford:** But it almost sounds as if it is going to be 10 years before it really gets going.

Phoebe Robinson: There are very clear commitments by 2020-21.

Q330 **Dr Whitford:** In Scotland's attempts to reduce suicide, it happened very quickly and we got a 19% drop in suicide. It kicked off in 2002 through to 2011 to 2015, so we got change, whereas at the moment it is kind of we will get a plan and then we will get the money through by the end of this Parliament. When will we see a drop in suicides? At the moment, they are going up. I do not mean that it would be to make miracles happen; I know it will take time, but it is almost as if it is not really going to start if we are pushing 10 years before there is actual change.

Phoebe Robinson: There is a very clear five-year set of deliverables that have all been set out.

Q331 **Dr Whitford:** But next year is five years since you published the strategy, is it not—2012?

Phoebe Robinson: I am referring to the mental health five year forward view, which was published this year.

Q332 **Dr Whitford:** Okay, but that is already four years from when the strategy was published. That is what I mean; it is 10 years from the national strategy that was, hopefully, going to really change things, so the back end of this Parliament is going to be 2020 into 2021.

Jeremy Hunt: The suicide rate in England is 10.1 people per 100,000; it is 14.5 people per 100,000 in Scotland. I am afraid I do not think it is fair to the huge amount of work that is happening in mental health services across the NHS in England to suggest that precisely nothing is happening for 10 years since the law was changed in 2012. I think completely the opposite has happened.

Q333 **Dr Whitford:** I am not suggesting it is anything do with staff. Staff need funding and there need to be enough of them, but the rate is going up.

That is the issue.

Jeremy Hunt: But suggesting that nothing is happening is an incorrect criticism of people who are actually transforming mental health provision. The picture of mental health provision in England changed dramatically in the last Parliament. There has been a real focus on it. To have that legislation for parity of esteem in the 2012 Act was a landmark. If you look at the four years since then, you can see the number of people accessing mental health services increasing dramatically. You can see a huge change in transparency. We now know the quality of provision at every single mental health provider in England, something I do not believe happens in Scotland, and that is a very big change, so we can identify where care is good or outstanding and where it needs to improve. We are looking at the overall quality of mental health provision by commissioner—by CCG area—and we are putting in over the course of this Parliament an extra £1 billion to increase it still further. This is a field where there is a huge amount of work to do, but there is a lot of progress, and we can see that in the numbers of people who access mental health services.

Q334 **Luciana Berger:** I have listened closely to what you said, Secretary of State, but I do not think we can talk about what is going to happen going forward without reflecting what has happened over the course of the last five years. The facts speak for themselves. We have lost over 1,500 beds across the country from in-patient mental health services, we have lost over 400 psychiatric consultants across the country and—the recent figures I have from another answer to a parliamentary question—over 6,600 nurses working in mental health. I do not understand how that correlates with your presentation of an altogether rosy picture, because the evidence that we have heard before our Committee over the recent weeks, and everything that I have heard and seen from across the country, is very different from what you are presenting to us today.

Jeremy Hunt: If I believed it was a rosy picture, I would not be talking, in a time of very scarce financial resources, about a very significant increase in resourcing going into mental health during the course of this Parliament, employing potentially an extra 30,000 professionals working in mental health service provision during the course of this Parliament, improvements to the suicide prevention strategy that we are talking about this afternoon, and improvements to CAMHS and a whole range of other areas. I think I have been on the record as saying that CAMHS is the single biggest area where we are currently letting down NHS patients.

I recognise there is a huge amount to do, but I do not recognise the suggestion that there have not been very significant improvements in the last five years. In particular, the number of psychiatrists, according to the figures that I have seen, went up in the last Parliament. We have seen a decline in the number of mental health nurses, and there is a particular issue that we need to address about mental health nurse retention because, while increasing numbers of people are going into mental health nursing, people are dropping out of mental health nursing. Some of them

are going to the private sector, some of them are leaving mental health nursing altogether and some are going to other parts of the NHS to do nursing there. We need to understand what is going on. We have also seen a very big increase in therapists—talking therapies therapists—and a big increase in the number of people accessing mental health services, but it is precisely because I think there is a lot more to do that we need to continue to invest more and train more people to do it.

Q335 **Andrew Selous:** I have a question first for the Secretary of State, and perhaps Professor Fenton might want to come in afterwards. I want to shift the focus a bit towards some of the individual causes that lead people to take their life, such as debt, unemployment, social isolation, drug and alcohol misuse, relationship issues and insecure housing. We know all of those contribute to distress, which can lead to depression and can go on to suicidal ideation, but we also know that for a lot of those people it will not necessarily be appropriate for them to have home treatment or crisis resolution. Secretary of State, when you look at the rest of the public sector landscape—absolutely accepting and understanding that everyone has to live within their budgets, because of the economic circumstances of the country as a whole—to what extent are you concerned about the extra pressures being put on the health service when perhaps there are pressures on local authorities and perhaps citizens advice bureaux locally are not as well funded? As a brief corollary, how do we get the best possible signposting to the help that is out there in the community and voluntary sector? That is an area that I worry about in terms of social prescribing as perhaps not doing as well as we can. I would be interested in your comments on those individual issues, and how the rest of the public sector plays into what health is having to deal with.

Jeremy Hunt: You raise some really important issues. Indeed, I think the whole social prescribing movement is very inspiring in its understanding that often the solution to someone's medical problems may be non-medical. What we learned from the crisis care concordat and the expansion of good crisis care services across much of the country over the last few years is that you need very close working between the NHS and other authorities—local authorities and the police in particular. The same is true for any successful suicide prevention strategy. We are also learning—you heard from Professor Appleby, who knows far more about this than I do—that, when you look at particular at-risk groups, the problems are different. The group for which we have had the most success in reducing suicides are people in the care of the NHS—in-patient suicides— people who are NHS patients. We have seen significant falls in suicide rates. That is one at-risk group. There is another at-risk group, which is men under 50, where suicide is the leading cause of death, and there we understand that there is a big issue around stigma and persuading people to come forward. Men under the age of 50 do not tend to want to walk through a door that says "Mental Health Provision" on it and we have to encourage people to come forward in those situations.

Young girls are another group. Teenage suicide rates are one of the lowest proportions of all age groups, but we have seen a growth in teenage suicides over the last three years as compared with an overall small fall in the suicide rate in the last year. There, the pressure of social media, of exams and the pressure on appearance are things that are probably more pronounced now than they were when we were teenagers. We need to think about those pressures and understand what work needs to happen between the NHS, the schools system and local authorities to try to reduce risk in those groups.

Q336 **Andrew Selous:** Are you satisfied that your colleagues across Government and in local authorities get the significance of their role in working alongside you and the NHS on suicide prevention, or is that an area you have identified where you think more needs to be done? I do not know whether Professor Fenton wants to come in as well on that point.

Professor Fenton: Our experience in working with local authorities, as they have developed and are implementing their suicide prevention plans, confirms that the concept and the commitment to multisectoral working is alive and real in local authorities, because of bringing together around the table the health sector, social services, universities and schools and the correctional services to identify the shared ambition within the locality for addressing suicide, and looking at ways in which all the resources can be harnessed, even in these challenging times, to make real inroads in reducing suicide rates. There are some fantastic examples.

Q337 **Andrew Selous:** I am not sure you mentioned the voluntary and community sector in your list, although I may have missed it.

Professor Fenton: I inadvertently left it off, but absolutely the voluntary sector is part of that multisectoral working as well. It is absolutely critical that they are there at the table because they bring human resources, and at times financial resources, to be part of the solution as well. That interagency working is real, and it is what we are trying to achieve in supporting the development of local plans.

Q338 **Andrew Selous:** My next point is about the link between drug and alcohol services and mental health services. We have heard quite a lot of evidence that, frankly, a number of people are falling between the gaps. I wonder whether, Secretary of State, you might not think it is time to do something radical in terms of merging those two services, because a lot of people seem to get lost between the two. There is a certain amount of finger pointing between the two services, and it seems to me there is often a huge amount of overlap where people who have substance misuse issues have quite severe mental health issues. We have had quite a lot of evidence given to us where there has not been good joint working. My concern, and that of other members of the Committee, is that people are falling between the gaps. What sort of strategic thinking has been done about that issue? I am not personally convinced that there

is good enough join-up in that area.

Jeremy Hunt: You are right to be concerned, and it is a very fair criticism of the way those services are provided at the moment that we do not join them up as much as we should. A couple of weeks ago, I went to St Pancras Hospital and met some remarkable people involved in alcohol rehabilitation services. I talked to them about the fact that the services are disjointed, and they find that particularly challenging. Essentially, they want to provide a holistic solution to their clients, which involves dealing with local authority issues, sometimes homelessness issues, mental health issues and addiction issues all as one package, and to have some confidence that they are going to be delivered consistently as a package over a period of time. I do not think we do that as well as we should at the moment, and one of the things that I hope will be the outcome of the STP process is much more holistic thinking about individuals, across all their needs. That is certainly the intention behind it. I think it is a fair criticism.

Q339 **Andrew Selous:** You see the STP process as a means to drive better co-ordination in that area.

Jeremy Hunt: That is the purpose of the STP process, to join up the care that is offered between local authorities and the NHS. Indeed, we think that is the way to reduce costs, because obviously if you are more effective at getting people better more quickly, in the end they are going to be less cost to the system.

Q340 **Luciana Berger:** Can I come back to the point about the role of local authorities and the services that they should be providing to help in suicide prevention? The reality on the ground for many councils across the country, although there might be the best intentions and will to do it, is that the money simply is not there, so how can they? I reflect on my experience as an MP in Liverpool, where we have had 58% cuts to our local authority budgets since 2010, which throughout the whole life course has impacted on the services that keep people well—everything from our children’s centres to our youth services, our outdoor spaces, our leisure and recreation services and our befriending services for elderly, in terms of contending with loneliness. In Liverpool, we are going to go to a referendum; if we do not raise more money from a referendum, we will have nothing to provide other than statutory services in Liverpool, because we have such a low council tax base. If the money simply is not there, how can the services be provided to meet your aspirations and what is set out in those local suicide plans to provide the voluntary and support services in the community that we know make a difference?

Jeremy Hunt: Professor Fenton might come in, but I would say that the time to answer that question is when we publish the atlas of variation. What we have found when we have done other comparisons of local authorities’ public health provision, in areas like smoking cessation, is that there is not a correlation between the level of funding in the local council and the quality of the provision. In fact, you find councils with

very similar demographics with starkly different levels of provision. I do not deny that these suicide prevention programmes need some funding, but I do not think it is just about funding; it is also about commitment. Some of the awareness-raising efforts that I saw, for example, when I went to Cambridge, are not particularly expensive things to do, but they make a very big difference. We need to look at where the variation is, and identify where it is about funding and where it is not.

Professor Fenton: The only thing to add is that, while recognising the funding challenges that exist, we see new models being developed in regions and across local authorities; local authorities are working together in the jurisdiction to think about efficient or more effective ways of commissioning services and pooling resources to think about focusing on the most effective interventions. That goes back to what Professor Appleby spoke about earlier, which is ensuring that what is commissioned and funded is evidence based. In this very restricted and challenging environment, it is about ensuring that we are spending the money where we are going to get the greatest impact. Local authorities working together, whether in the West Midlands Combined Authority or in Cheshire and Merseyside, where there are nine local authorities working together in new ways and developing new models of care, new models of addressing suicide prevention, is going to be a way forward.

Q341 **Luciana Berger:** Professor Fenton, do you think it is right that your own department spends just 1.4% of its budget on mental health? Does that match with the Government's aspiration for parity of esteem?

Professor Fenton: My department as in Public Health England.

Q342 **Luciana Berger:** The funding, yes. Local authorities across the country spend almost negligible amounts, as a proportion of their entire budget, on mental health.

Professor Fenton: This is an area, as the Secretary of State said, where we will continue to monitor the data, and we have to demonstrate that we are improving over time. Certainly within Public Health England we look at the work we are funding in our specialist mental health teams, but there is a lot of work being done on mental health in other teams focusing on housing, children and young people and families, and other areas where we are integrating mental health and mental health promotion across our portfolio in Public Health England. We are using that approach to strengthen both the nature of the work that we are doing and the impact that we are likely to have. That sort of integration is another strategy that is being employed in local authorities, as they think about managing the resources that they have.

Q343 **Maggie Throup:** This question is for you, Phoebe. We heard earlier from Professor Appleby about the link between depression and suicide. We have also received evidence that indicates that the detection and treatment of depression in primary care is not meeting NICE guidelines, and is inadequate. Is NHS England doing something to address that and,

if so, what is it doing?

Phoebe Robinson: Thank you. I heard that too. There are a number of things that NHS England is doing in that space. The first is around the commitment to see 600,000 additional people in our talking therapy services—IAPT expansion—over the course of the next five years. By the end of this year, we will have already seen 40,000 additional people. That service is evidence based. I am aware that, as part of a recommendation of the mental health taskforce, colleagues in Health Education England are exploring primary care training, which may address some of the case-finding issues that you raised. Our IAPT expansion is targeted in particular at people with long-term conditions who take up a disproportionate amount of GP time. Therefore, the programme is particularly helpful for them. I am also aware that there is an association between physical health and suicide and, therefore, it should support that.

Q344 **Maggie Throup:** You mentioned Health Education England and more training. Is that across the whole spectrum of primary care employees, not just GPs?

Jonathan Marron: They are looking at training for GPs and practice staff in awareness of mental health issues, and whether they can see signs that might lead to people needing particular help. It is about trying to get the whole surgery's staff trained.

On primary care, the other thing that is very clear in the Five Year Forward View is the investment in primary care that we will make over the next few years, getting to £2.4 billion extra by 2021, which is a significant investment in staff, both new GPs and other staff, including therapists, who will be available in primary care. That is a significant investment in the basic infrastructure of primary care that will help tackle some of the challenges that Professor Appleby was raising earlier of whether we are getting proper management of people.

Q345 **Dr Whitford:** Obviously, it is often down to the GP to pick up whether someone is in crisis or in danger, but they often find it very difficult to get someone referred to secondary care. This is particularly to Phoebe and to the Secretary of State. What is going forward as part of the programme to allow swift access? Obviously, if the GP is concerned about someone, it can be incredibly difficult to access that care.

Phoebe Robinson: As part of the Five Year Forward View programme, we have set out the development of a number of evidence-based treatment pathways covering community and mental health, which includes primary care, to look exactly at the gap between secondary mental health services and primary care that we know needs to be better. We are asking an expert reference group what best practice is with reference to the available organised guidance that would be appropriate for that cohort of patients. We will then be able to measure

where localities are against that standard, which gives us the potential to look at the gap.

Q346 **Dr Whitford:** Do you mean the standard of service—what they would require to serve the primary care community?

Phoebe Robinson: It will look at what types of evidence-based care people should get access to within a good community pathway, which includes primary care.

Q347 **Dr Whitford:** The evidence from Peter Aitken of the Royal College of Psychiatrists described that in his area, for a population of 1 million, between 135,000 and 150,000 people would meet the requirement for secondary care services, yet even including IAPT there would only be service for 50,000, leaving a gap of 100,000. How on earth can we meet such a huge gap? What is the vision to do that?

Phoebe Robinson: In reference to liaison in particular, we have set out some very clear commitments around every A&E having a liaison service, and 50% of those services reaching the core 24 standard. In fact, I believe the guidance was published today, and it includes reference to self-harm and other things that the panel may be interested in. In terms of reaching that gap, we said earlier that we expect that this is a 10-year programme, and that within five years we will do some significantly great work to reach 1 million extra people. There will still be a remaining gap, and we talked about workforce limitations as part of the feasibility of trying to do that sooner.

Q348 **Dr Whitford:** Peter Aitken talked on behalf of the college about a 35% to 40% increase in psychiatrists. How would we manage to generate that, from the point of view of finding them, keeping them, training them and paying for that to be done? I do not know whether you want to comment, Secretary of State.

Jeremy Hunt: First, on your earlier point about general practice, you are absolutely right. One striking and worrying statistic about the suicides that we have is that 72% of them had not been in contact with NHS mental health services in the previous year, but a number of them had been in contact with their GP, so GPs are a really important resource. The commitment that we have made for this Parliament is that we will have an extra 3,000 mental health therapists working in general practice by the end of the Parliament—an average of one for every two to three practices—so that we can improve understanding and capacity around mental health in practices. With respect to boosting the number of psychiatrists, we definitely need more psychiatrists, and I would say, along with GPs, those are our two priority areas, and one of the reasons why we announced increasing the number of medical school places by up to a quarter from 2018 is precisely that we recognise the need to increase the pipeline of psychiatrists and GPs.

Q349 **Dr Whitford:** I remember, from being in A&E or on call, when someone came in having self-harmed, or possibly attempted suicide, that if you

could get hold of a psychiatrist, you were told, "No, actually, they are not suicidal and they don't count," and you have someone who is trapped in the hiatus between the services. GPs are concerned about someone and they have absolutely no idea what to do with them.

Jeremy Hunt: You are absolutely right to highlight that. We know that around half of suicides have a history of self-harm, and we know that self-harm is an area that also needs to be tackled in its own right as a growing and very worrying problem. If you wanted to put your finger on the one bit of the current system that is absolutely wrong and sums up why we need to change our approach to mental health, it is the way, with the tiered system that we have at the moment in the NHS in England, people can be told, "I'm sorry, you are not ill enough for me to see you." That is completely wrong and it goes against common sense, and all the principles of early intervention and tackling problems earlier and so on. It is a particularly bad problem in CAMHS, although it is not just in CAMHS. We want to rethink our approach to CAMHS so that we are properly able to say that we are looking at prevention as well as cure. I do not think we do that at the moment.

Q350 **Dr Whitford:** With the cuts to Health Education England, when we are asking them to produce more GPs and maybe a third extra psychiatrists, is a different way of training people envisaged to produce all the extra everything we need because of the increased demand in a department that now has a significantly smaller budget?

Jeremy Hunt: A lot of the cuts to the HEE budget are around things that are controversial, like nurse bursaries. We are expecting HEE to produce significantly higher numbers of doctors, nurses and trained staff for the NHS over the coming decade, but in order to do that we have to make difficult decisions about the extent to which we fund each individual place, and the balance of funding between the individual and the state. That is a difficult decision, but we have made the judgment that the priority is to get more staff in the pipeline because, with the pressures of an ageing population, we are going to need more doctors and nurses.

Q351 **Dr Whitford:** Do we have a timeline for that kind of expansion in psychiatry? I understand, Secretary of State, about the training of more medical students, but they are a very long way from helping us, because they have to get through medical school first. What are we doing with the people who are finishing second year foundation, looking at their specialties and, therefore, ripe to be attracted into a specialty? Are we doing anything particularly to attract them?

Jonathan Marron: We are working now with Health Education England and the other arm's length bodies to develop a workforce strategy for mental health, specifically how we deliver the workforce we need to deliver the commitments set out in the Five Year Forward View over the next five years, and then thinking ahead to some of the longer-term changes that we will need to develop the pipeline. We are looking at new staff—who we need to train and what kind of training supply we can

make. There is some work on new roles and new ways of deploying staff, and indeed how we can reskill existing staff. We are looking at all of those, and work is reasonably well advanced, and we have produced the strategy that was asked for by Paul Farmer in his report.

Q352 **Dr Whitford:** Is there a particular idea? Obviously, you are working on the whole strategy, but is there a particular idea of how to attract people into this specialty, which is a stressful and difficult specialty for people to work in?

Jonathan Marron: There is a series of things. We have looked at increasing exposure to mental health training earlier. That has been helpful. We have had success with GP bursaries, and maybe we need to think about some of those ideas. We are at the stage of looking at numbers and then getting to a practical plan. We put numbers on the supply, but how do we make sure people come through the pipeline? That is the stage we are at.

Q353 **Luciana Berger:** You will be aware that in some parts of the country there are vacancy rates of up to 40% for clinical staff in mental health, so there is an immediate challenge that needs to be contended with. How do you reconcile the introduction of nurse bursaries with the desire to increase the number of, particularly, mental health nurses, who themselves are often more mature students and come with additional experience, in order to contend with the challenging environment that mental health presents? How do you anticipate that you are going to make up for the fact that we have already lost 6,600 nurses in mental health? How are we going to improve that going forward, when we know that already nurses say that the loans will put them off?

Jeremy Hunt: The priority is to train more nurses for the needs of the NHS, including more mental health nurses, and the issue, which we talked about earlier, is particularly around retention of mental health nurses. Our plans for this Parliament are to train 40,000 more nurses than we trained in the last Parliament. Part of being able to afford that is the difficult decision over nurse bursaries. We need to look at the impact of that very carefully. Given that two out of three people who want to go into nursing are turned down at the moment, our judgment is that we will continue to have enough people who wish to go into nursing, but we need to make sure that there is proper provision, for example, for people who want to go into nursing when they are a bit older and when there might be more worry attached to whether they can repay loans that are made. We also want to look at whether there are alternative routes into nursing that do not require full-time study for a degree but where people could go into nursing through an apprenticeship route. We are looking at all these things, but the priority is to get more people into nursing.

Q354 **Helen Whately:** I am going to ask some questions about mental health in A&E particularly to the Secretary of State and Phoebe Robinson. We have heard from many witnesses about the importance of care in A&E for people with mental health needs. Knowing, as we do, that among those

who have taken their own life many have not been under the care of specialist mental health services, and many have not even seen a GP recently, if one of those individuals goes to A&E, that is a critical opportunity to intervene. The best-known model for doing this is psychiatry liaison teams. Could you perhaps give me your views on the importance of those in preventing suicide?

Jeremy Hunt: I think it goes without saying that they are extremely important, but one reason why it is important to look at suicide prevention strategies is because it forces you to look at both elements of mental health provision, namely the provision of care in a crisis but also prevention and what you do on prevention as well. We know that A&Es that offer 24/7 liaison psychiatry services are transformational for people going through a mental health crisis. I have visited an absolutely excellent liaison psychiatry team in Northumbria where I met a nurse who told me that one of her patients threw himself off a bridge the day after she had seen him. I mentioned that in the House last week, but having to cope with that shows the pressure that people working in liaison psychiatry services are under. They are absolutely remarkable. As Phoebe mentioned just now, our commitment is to make sure that all type 1 A&Es have a liaison psychiatry service by the end of this Parliament and that half of them meet the core 24 standards, which is the gold standard of services. We think they are really important and we want to combine our approach to that with a prevention strategy as well that can reach out into the community, and that is why Public Health England's work is so important.

Q355 **Helen Whately:** I personally very much welcome the commitment to increase the level of psychiatric liaison and to make sure that more hospitals have the service. However, in our recent Select Committee trip to Liverpool we heard of a hospital there that was actually cutting its psychiatric liaison service, we believe because the clinical commissioning group had not commissioned it. We were quite shocked by that, going against the direction of travel. I wonder if you have any perspective on that happening and if that is happening in other places as well.

Jeremy Hunt: The NHS is the fifth largest organisation in the world, and, as we discussed earlier with Ms Berger, this is an issue that we have to contend with, but we are investing £247 million during the Parliament into making sure that we roll out liaison psychiatric services across the whole NHS, and that is a commitment that we will honour.

Q356 **Helen Whately:** One thing I have heard is that one of the barriers to rolling out psychiatric liaison and keeping services as well is because of a mismatch in incentives where the mental health trust may bear the cost of providing a liaison service but the acute hospital may see the benefits in terms of being able to provide a better service in A&E, achieve the four-hour target and reduce length of stay. So there is a mismatch in incentives. Is there anything as part of the strategy to increase psychiatric liaison in hospitals that will specifically target that problem, in trying to overcome that?

Phoebe Robinson: The obvious answer here is sustainability and transformation plans that bring together acute trusts with mental health providers, asking them all to look at the best services for their local health economy. On the things we have talked about around transparency, it is really important to us that we are very clear where people are or are not delivering those services, allowing local scrutiny to occur much as you have described here. There are various other bits of work that we do around incentives: for example, we have introduced a CQUIN across 2017 to 2019, published in the planning guidance in September. These are innovation schemes for hospitals in England, one of which is around A&E liaison provision. That is an additional financial incentive where the provider will gain a financial incentive for offering that service in line with best practice.

Q357 **Helen Whately:** I know I have looked at the STP for my area and have noted that they have a good ambition on psychiatric liaison, so I take the point that you flag up there. I welcome the increase in transparency and that psychiatric liaison is one of the points in the dashboard. However, we have heard during this inquiry that there does not seem to be data collected on when patients arrive at A&E and have the initial triage but then may leave while they are waiting to be seen by a mental health specialist. If there is not a liaison team or if that is not managing to meet the demand, that individual may leave without even being seen. That seemed like a critical bit of data that was not being collected. Would it be possible to look into getting that sort of data?

Phoebe Robinson: As part of the next iteration of the mental health services dataset, we are making changes so that we will be able to measure access to liaison mental health services.

Q358 **Helen Whately:** Thank you. This is my final question on this. While it is very good to have the ambition that there should be some level of psychiatric liaison in all A&Es and the core 24, the full model, in at least half by the end of the Parliament, my question is whether we could be more ambitious than that, particularly when we heard from Professor Appleby a moment ago that he had a view that all A&Es should and could be providing a 24/7 service with a specialist assessment within more like a one-year timeline. Could we be more ambitious?

Phoebe Robinson: Our modelling would suggest not, given the workforce constraints that we have talked about. In A&E liaison at the moment, we are only seeing the core 24 standard in 10% of hospitals, and we know that there are significant workforce gaps to get up to the 50%, which we know is realistic for 2020-21. To stretch beyond that, we would be looking at promising something that we could not deliver.

Q359 **Mr Bradshaw:** Very briefly on that, we visited one area where they just lost their service, so there is evidence on the ground that it is going backwards. In Liverpool, two hospitals have just lost their psychiatric liaison service from their A&E departments.

Phoebe Robinson: The funding for liaison is only coming in from 2017-18, so we would hope to see that moving forward.

Q360 **Mr Bradshaw:** So when they get direct funding, they might reinstate it; is that your hope? People have it already and they are being scrapped, as things stand, so you are inventing a new pot of money so they can reinstate them, or what is the plan?

Phoebe Robinson: The plan is as set out over the next five years; we should be able to get to 50% of A&Es with core 24 in all A&Es with some form of mental health liaison.

Q361 **Luciana Berger:** To complete that question, it is the Royal Liverpool Hospital and Aintree that have both stopped funding their psychiatric liaison totally since the end of October, so will they have to wait until 2017-18 before they are able to access funds to consider re-establishing them?

Phoebe Robinson: For the funds that were announced this weekend, local areas are being asked to bid at the moment for access to new funds starting in 2017-18.

Q362 **Andrew Selous:** Briefly, going back to the sustainability and transformation plans, which we have heard some positive reference to in terms of the integration, my question is about the level of clinician involvement in those plans. I have heard it said that they are quite manager-heavy because the clinicians are sometimes too busy doing the front-line work to get to meetings. Is there any reassurance you could give us about the level of clinician input in this and other areas for STPs?

Jeremy Hunt: They should all have heavy clinician involvement and there are some areas where we have given the leadership of the STPs to local authorities, because part of this is also about having local authorities round the table. But I think it is incredibly important and the big lesson of the last decade is that, when you need to make service changes in local areas, make them more efficient, improve safety and care for patients, then it is much better if those changes are led by clinicians rather than managers. That is something that we would encourage in all STPs.

Q363 **Dr Whitford:** Could I come to you, Phoebe? We have heard that, due to the lack of in-patient beds, the crisis management teams often end up trying to manage people at home that we would normally consider as requiring in-patient services. It comes back a little bit to, when you have someone in crisis, what you do with them and where you can send them. What is your response to this, because, obviously, there has been a huge loss of mental health beds over the years?

Phoebe Robinson: There are three important things to look at. The first is that the mental health five year forward view made it clear that we should make crisis services available in the least restrictive setting possible. That is why we have committed to investing in crisis resolution

home treatment teams in every area of England. As we have heard already, we acknowledge those are not currently resourced to the levels that are required to deliver a NICE concordat evidence-based treatment that is shown to be safe for people in crisis.

The second piece of evidence that we should look at is the Royal College of Psychiatrists Crisp commission report, which set out that it is not necessarily a question of beds but flow through the system. We know that around 16% of beds at any one time suffer from bed blocking and delayed transfers of care, and that is why we are doing so much work on clinical pathways to make sure that crisis services can flow. The commitment is that by 2020-21 we will see an elimination of out-of-area treatments, and that is mainly as a result of boosts that are needed in crisis resolution home treatment teams to provide safe alternatives to in-patient care.

Thirdly, we have seen this delivered in certain areas of the country already. For example, in Sheffield there is a very well-resourced crisis resolution home treatment team and a great crisis pathway there. They have no out-of-area treatments and their bed occupancy rates are lower, suggesting that people would always have the opportunity to admit patients when they are in need. So we have seen areas of the country that have been able to do this already, which gives us confidence that the plan we have is the right one.

Q364 **Dr Whitford:** Do we have an even spread of beds in that there will always be people who require in-patient treatment? While Sheffield might have their own beds, there will be other areas where, no matter how good the crisis team is, they are still going to have to send people out of area.

Phoebe Robinson: We would not expect to see the same profile of beds across the country because every area has different pressures. For example, levels of other community provision such as primary care and so on will have a huge bearing on the needs of a local area.

Q365 **Dr Whitford:** What would be considered a reasonable distance? Okay, you are not going to have a mental health hospital in every village, but what are reasonable distances? What we all hear is stories of people being sent 100 miles.

Phoebe Robinson: We have published a definition of an out-of-area treatment for acute care that sets out exactly that, so it is when someone is in the care of their normal hospital. There are good reasons why people might be out of area: for example, if you are on holiday and you have a crisis, it is not appropriate that you would be transferred.

Q366 **Dr Whitford:** It is not really what we are talking about. We are talking about people being sent out of area because the service is not in their area.

Phoebe Robinson: By 2020-21 we hope that all areas will have eliminated out-of-area treatments entirely for this type of crisis and acute care that you talk about.

Q367 **Dr Whitford:** Could I ask you, Professor Fenton, what role you think public health has in tackling suicide prevention, but particularly from the point of view of what came up in our evidence with families around the issue of a consensus on information sharing? We get caught between this whole thing of confidentiality and having sharing and joined-up services, including the family. Exactly where does public health guidance sit within that?

Professor Fenton: Public health has a very critical role to play in this issue. Certainly, local public health leadership is critical in bringing multisectoral partners together to develop the shared ambitions for problems that need to be addressed when it comes to addressing suicide and suicide prevention, and we are seeing great leadership by our directors of public health across the country working with local authorities on this.

Specifically on the data issue, we also know that DPHs have a critical role to play in solving some of the issues with the timeliness and quality of data that is available, especially after a suicide occurs. Again, in a previous panel you heard about some of the challenges with getting data from coroners in a timely way to inform the responses and local action. Again, we are seeing examples where local public health teams are working with first responders, such as police, and with coroners to look at the best ways of getting the data in a much more timely way. This local response, I think, is going to be part of the solution going forward. We definitely need to think about how we support coroners in providing data in a more timely way, but in the meantime, again, local public health leadership is important. Public Health England is there to support DPHs in this work as well.

Q368 **Dr Whitford:** Beyond data from the point of view of looking at it after the fact to learn from it or to spot patterns, what about the issue of actual information sharing at the time of trying to prevent a suicide from the point of view of someone who has attended who is self-harming? There was a lot of discussion, obviously, when the families were here around families not being informed and GPs not being informed. Therefore, you have other bits of the health service that are working completely blind to the fact that the person seeing them with problem X has been struggling and in a self-harm situation very recently.

Jonathan Marron: We think the consensus statement that was worked up by Professor Louis Appleby's advisory group and the royal colleges is a good piece of work. The challenge is probably whether we have done enough for everybody to understand what it says and how it is used. The advisory group and the royal colleges are looking again at what we might do to publicise that a little more. We have a good basis of work.

Q369 **Dr Whitford:** Do you see that just sitting in the colleges?

Jonathan Marron: No. The advisory group is our advisory group and Professor Louis Appleby chairs it for us. We are trying to work with them and with the royal colleges to say what we might do to make this consensus statement a more real, live thing for people on the frontline. That is the first place to look.

Q370 **Dr Whitford:** We are not ready yet. You feel there is more work to be done on it.

Jonathan Marron: We have a great statement and we have to think about how we get it used more.

Q371 **Dr Whitford:** I do not know whether you want to add anything.

Phoebe Robinson: I have nothing to add from NHS England.

Q372 **Chair:** Louis Appleby was clear that he felt the evidence was there and what was needed was clear leadership and implementation.

Jonathan Marron: Yes.

Q373 **Chair:** Is that something you are going to be prioritising?

Jonathan Marron: There are two points to make. There is the point around the delivery of the strategy, and then on the specific point of the consensus statement there was an agreement about how we should share data between professionals and family, where, again, the statement of how we should do it is good; it is back to Louis's point of how we make sure everybody uses it, which is the key challenge.

Q374 **Chair:** Yes—how we put it into practice.

Jonathan Marron: Yes.

Q375 **Luciana Berger:** This is a point coming back to Dr Whitford's question about access to services within the place that you live, or at least close by. The mental health condition in our country that you are most likely to die from is anorexia—eating disorders—and some of those deaths will be attributed to suicide. We heard the story over the weekend of one family who had to do an 800-mile round trip in order for their daughter Fiona to access services in Scotland. Can you specifically come back and add to your answer, Phoebe, and perhaps the Secretary of State as well, about what we are doing specifically for that sector, which we know is chronically underfunded and where people are having to wait until they get to critical BMI before they are accepted into any services, let alone an in-patient bed across the country?

Phoebe Robinson: On specialist commissioned children's beds, currently there is a review going on around making sure that beds are in the right place so that people do not have to make these terrible journeys that you describe. On eating disorders, in particular for children, we have just introduced an eating disorders access and waiting time standard.

Alongside money, I agree, it is an important area, but evidence suggests that people can be treated safely in the community. That is why we have launched the guidance around community eating disorders just this year and we are doing lots of work on both those areas in respect to eating disorders.

Jeremy Hunt: I would add that eating disorders is one of the most frustrating areas where we get this issue where people are told they are not ill enough to get specialist treatment and it is just completely the wrong thing to say. Introducing this new access standard will make a big difference in changing people's experience of care at a local level.

Q376 **Maggie Throup:** I want to change tack a bit now. We have heard from a number of different sources how important support is for those bereaved by suicide, but probably more worrying is how many families do not get any support when they have been bereaved by suicide. In fact, the headquarters of the charity Survivors of Bereavement by Suicide is based in my constituency, so I went along to find out more and they backed up the evidence that we heard. They say two things: one is how important the support is and the fact that many people do not get that support; also, more importantly, many of the survivors of bereavement are at risk of suicide themselves. My question to each of you is, why are people who are bereaved by suicide not getting support as a matter of course?

Jeremy Hunt: This is one of the key areas in the 2012 strategy and I know that PHE has been working with the National Suicide Prevention Alliance to come up with guidance on bereavement services. We have continued to fund the "Help is at Hand" programme on that. I think it is a very important area and I am sure we can do a lot better than we currently do, but maybe Professor Fenton would like to add what is happening.

Professor Fenton: Definitely. This is a priority for us in Public Health England as part of our suicide prevention work. Over the past year we have worked with our partners to develop the "Help is at Hand" resource, again, in partnership with the Department of Health. We have been working on getting those resources out to first responders as well as to members of the public as well, so we have these resources, which are now finished.

We have received excellent feedback from members of the public on the utility of the resources, and now we are trying to ensure that those who need them most will get them. We have both online resources as well as published resources. But we are keen to see what more we can do in this space and, therefore, the partnership with our community partners on this is going to be critical to say, "We have the 'Help is at Hand' resource. What more should we be doing and how do we scale up our access and our impact in this space?"

Q377 **Maggie Throup:** What came over to me in my conversations with the charity—they provide peer support—is that it is the one-on-one support

that makes a difference, not online support. Where people have been bereaved by suicide, they need that arm around them, and when you sit in a room you can see how people react to what is being discussed, and then those individuals who have a lot of personal experience can identify that in other people. Online is not adequate really; we need more than that.

Professor Fenton: I completely agree with you and I use online to provide a sense of the range of tools that we have available, but, again, we are seeing really good models of bereavement support being developed and implemented in local authorities. For example, in Durham there is a referral service of people who are bereaved, especially in the acute phase, where people can be referred to a central point to receive the sort of support that they need for as long as they need. In other jurisdictions, for example, in Cheshire and Merseyside, they are visited by a suicide liaison officer and that bereavement support can be done in a more intensive and, as you rightly mentioned, personal way to support them during this very acute phase.

There are different models that are being developed and implemented locally, but bereavement support is a critical part of an effective suicide prevention response, both locally as well as nationally, ensuring that we have the guidance and resources in place so that we can scale up in providing the support that is needed.

Q378 **Maggie Throup:** What timescale do you put on that?

Professor Fenton: We are committed to strengthening the work that we are doing in bereavement support, so we have plans for producing more resources, in terms of "Help is at Hand", and getting it more to the members of the public as well as first responders. We will continue to work with local authorities as they are developing their suicide prevention action plans to ensure that bereavement support is a critical and strong part of those plans. As we do the quality assurance of those plans in the future and as we do intensive support, we will be asking and supporting local authorities on that.

Chair: I am conscious that, Secretary of State, you have to leave shortly, so James will direct his questions to you.

Q379 **Dr Davies:** In which case I will address my two final questions to you and perhaps the others can answer once you have departed. My first question relates to the media, including social media and the internet, which clearly is very influential in the field of suicide. What more do you feel can be done to ensure that this area follows the guidelines, as in the existing suicide prevention strategy, in relation to the reporting of suicide?

Jeremy Hunt: PHE has published guidelines, so it would be worth asking Professor Fenton's views on whether he thinks there has been an improvement in the behaviour of the media since then.

Professor Fenton: It is really hard to say. We are looking at a recent report of suicides in the south-west, and again there are going to be opportunities for us to work with the media to ensure there is responsible reporting. We have a partnership with colleagues such as Samaritans, which work with media companies and houses to ensure that these issues are handled in an appropriate way, but this is something that we need to be actively engaged in when we have incidents occurring.

Q380 **Dr Davies:** Is there any scope for regulation of the electronic media—social media?

Jeremy Hunt: Obviously, anything to do with regulation of the media is a highly sensitive area, but perhaps I could make a point about social media, which is a distinct issue to the reporting of suicides by mainstream media. I think social media companies need to step up to the plate and show us how they can be the solution to the issue of mental ill health among teenagers and not the cause of the problem. There is a lot of evidence that the technology industry, if they put their mind to it, can do really smart things. For example, I just asked myself the simple question as to why it is that you can't prevent the texting of sexually explicit images by people under the age of 18 if that is a lock that parents choose to put on a mobile phone contract, because there is technology that can identify sexually explicit pictures and prevent them being transmitted. That is something. I ask myself why we can't identify cyberbullying by word pattern recognition when it happens on social media platforms, and then prevent it happening. I think there are a lot of things where social media companies could put options in their software that could reduce the risks associated with social media, and I do think that this is something which they should actively pursue in a way that hasn't happened to date.

Q381 **Dr Davies:** Perhaps we can come back to media briefly afterwards, but could I move on to the final topic, which is children and young people? There is a committed £1.4 billion in the run-up to 2020 for young people's mental health. How do you see this influencing the reduction of suicide among that group?

Jeremy Hunt: We have spent quite a long time this evening talking about the crisis care element of suicide prevention, but what is fascinating when you talk to people in the children and young people's mental health space is how they spend their time talking about prevention. That is why, despite the excellent ambitions in the mental health five year forward view, it is worth re-looking at what we are planning to do on children and young people's provision, not just CAMHS, but also what happens in schools and in GPs' surgeries, to ask whether we can do better than we are currently planning to do. There is a lot of work going on.

It goes right the way back to people who do not have any mental health problems, about what we can do to improve resilience among young people and the understanding of mental health issues. We all face crises

in our lives. Do we do enough to prepare people for those? We are having very good discussions with the Department for Education as to what more can be done on that area, but it is an area that is being very actively considered in policy terms.

Q382 **Dr Davies:** You would agree that a multi-agency approach is going to be critical for young people.

Jeremy Hunt: I agree absolutely; very close working—what happens in schools, in local authorities in terms of that outreach to families, and particularly families where there is a lot of chaos, and what we do in the NHS. There is a lot that we can do to improve things.

Chair: Very quickly before you leave us, I know Luciana has a quick question and I have one final one.

Q383 **Luciana Berger:** Secretary of State, we have heard in the news this week that suicide in our prisons is at its highest level in 25 years, and we heard in the evidence from Professor Appleby that the rate has doubled in the last five years. Can you share with the Select Committee what you yourself are doing with your colleagues and the Ministry of Justice to address this?

Jeremy Hunt: Yes. We have had extensive discussions. I have had three meetings with the Justice Secretary to discuss the issue of mental health in prisons. We recognise that this is a very high-risk group with a very high proportion of people with mental health problems, and we are looking very closely at what we can do to improve mental health provision in prisons. There are some complex issues such as how you can make sure that treatment continues in a seamless way when people leave prison. I had discussions with the previous Justice Secretary on that one as well.

Q384 **Luciana Berger:** Have you visited a mental health service in a prison?

Jeremy Hunt: No.

Luciana Berger: I would advise and suggest that you do to see at first hand how challenging it is.

Q385 **Chair:** On the subject of discussions with the Secretary of State for Justice, have you also discussed the issue about coroners and the underreporting of suicide that has been raised on a number of occasions?

Jeremy Hunt: It is an issue of which we are aware. Ultimately, that is a decision for the Ministry of Justice, but I think, if truth be told, the whole issue of the mental health of the prison population is something where a lot of joining up needs to happen that is not currently happening.

Q386 **Chair:** But this is for the wider service. In fact, they are much better at detecting within the prison service where people take their own lives, but in the wider population we have seen variation around the country in the way that coroners deliver a verdict of suicide, for example, leading to

underreporting. Is that something that you are having discussions around?

Jeremy Hunt: Can I take that away, because I think that is something that I need to look into and write to you with a fuller answer than I am able to give now?

Chair: Thank you very much and for coming today, Secretary of State.

Jeremy Hunt: It is a pleasure.

Chair: If the rest of the panel is prepared to hang on for slightly longer, that would be very helpful, thank you.

Q387 **Dr Davies:** Do the remaining panel members wish to comment further on the media, social media and the internet? You may have nothing to add.

Professor Fenton: We also have to harness the power of good that the internet can provide, especially when it comes to providing online support services, and there are some great interventions that have been developed online, which are targeting young people, that we need to learn from, evaluate and, where appropriate, scale. I agree entirely with what the Secretary of State said about corporate responsibility from internet providers in helping with this. The reality is that the tools are available for us now to be far more intelligent with how we can track risk online and there are opportunities for us to do much better in this space.

Q388 **Dr Davies:** The other area was children and young people, and the opportunities for multi-agency working particularly with new investment going in.

Phoebe Robinson: I can talk about local transformation plans. As part of the £1.4 billion investment, every area in the country has to have a local transformation plan for children's mental health that has to be multi-agency. We know that every part of the country has a local transformation plan and each of them is expected to refresh that plan at the end of this year and to incorporate that into their wider sustainability and transformation plan.

Jonathan Marron: The only thing I would add is to pick out self-harm among young people and teenagers where we do not see a very high rate of suicide. It is tragic when it happens, but we do see much more self-harm. So, as part of the refresh suicide strategy, how we focus on self-harm and try to tackle that which may produce suicide later in life is a key part of the process.

Q389 **Andrew Selous:** I have a very brief follow-up question on the media to Professor Fenton. Over the weekend there was some really unhelpful reporting on suicide not in accordance with the guidelines, and today a major national newspaper has a phrase on the front page that again is not helpful. What will happen in these two instances?

Professor Fenton: A number of things. First, the local area has put in place a response team, and so there are going to be—

Q390 **Andrew Selous:** I am sorry; you are misunderstanding me. What will happen to those two media organisations? What accountability, what follow-up, will there be? Will the editors be rung? Is there any consequence for them? You have a guideline and they are blatant breaches, so what follow-up and what action is there when the press wilfully or, in ignorance, get it wrong?

Professor Fenton: In the past we would work with colleagues, for example, at Samaritans, who would be engaging with the media houses and providing feedback to them about how the issue is being handled in the press. I am not sure that we have had any contact as an agency with media houses on this and this is not something that we would do.

Q391 **Andrew Selous:** You do not see it as part of your role. There is no letter that goes from Public Health England to the editor saying that this is unhelpful and could they think about doing it differently next time.

Professor Fenton: No. This is not a space that we have been in in the past. We really have worked with Samaritans in ensuring that we provide that feedback.

Q392 **Andrew Selous:** Do you know if Samaritans has contacted the two papers in question?

Professor Fenton: I am not sure, but I know that colleagues have raised the way it has been handled as a concern.

Q393 **Andrew Selous:** Might you get back to the Committee as to whether that has happened in this instance?

Professor Fenton: Absolutely.

Andrew Selous: That would be helpful; thank you.

Q394 **Chair:** It is worth pointing out that we have very clear guidance about not publishing explicitly sites where people might choose to end their lives, for example, particularly around teenage suicides, and this was a very clear breach, as we see it, in *The Mail on Sunday*. There need to be some teeth and consequences for that. We know at local level that local partnerships will speak to the local media, but who is doing that at national level? It would be helpful to know who is taking responsibility for that.

Professor Fenton: Absolutely. That will be something that we will do in joining with our Department of Health colleagues.

Jonathan Marron: We will follow up and write with the details of what has happened.

Chair: That would be very helpful. Do any colleagues have any other points that they want to raise? No. Thank you all very much for coming

this afternoon.