



Health Committee

Oral evidence: Suicide prevention, HC 300

Tuesday 31 January 2017

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[Watch the meeting](#)

Members present: Dr Sarah Wollaston (Chair); Luciana Berger; Rosie Cooper; Andrea Jenkyns; Andrew Selous; Maggie Throup; Helen Whately.

Questions 395 - 447

Witnesses

I: Ruth Sutherland, Chief Executive, Samaritans, Dr Peter Aitken, Chair of the Faculty of Liaison Psychiatry, Royal College of Psychiatrists, Hamish Elvidge, the Matthew Elvidge Trust, and Councillor Richard Kemp, Deputy Chair, Community Wellbeing Board, Local Government Association.

Written evidence from witnesses:

- [Samaritans](#)
- [Royal College of Psychiatrists](#)
- [The Matthew Elvidge Trust](#)



Examination of witnesses

Witnesses: Ruth Sutherland, Dr Aitken, Hamish Elvidge and Councillor Kemp.

Q395 **Chair:** Good afternoon. Thank you very much for coming this afternoon for our follow-up session on the Government's now published updated plans on suicide prevention. I apologise for our being a slightly depleted Committee this afternoon. A couple of members are not well and some are committed to speaking in a debate in the House. For those who are new to us, could you introduce yourselves to those following from outside this room, starting with Mr Kemp?

Councillor Kemp: I am Councillor Richard Kemp. I am a constituent of Ms Berger, although not a voter for her, it must be admitted. I lead the Liberal Democrats in Liverpool, but I am here because I am the deputy chairman of the LGA's community wellbeing board, where I lead on public health.

Ruth Sutherland: I am Ruth Sutherland, chief executive of the Samaritans and co-chair of NSPA.

Dr Aitken: I am Dr Peter Aitken, a consultant psychiatrist and chair of the faculty of liaison psychiatry at the Royal College of Psychiatrists. I am representing the Royal College of Psychiatrists.

Hamish Elvidge: I am Hamish Elvidge, chair of the Matthew Elvidge Trust and also chair of the Support after Suicide partnership.

Q396 **Chair:** My opening question is to both Ruth and Peter. Has the updated strategy met your expectations?

Ruth Sutherland: No. I think it is the same as when we opened last time on implementation, resource, accountability and leadership at national and local levels. While the refreshed strategy contains a lot of good things, it is still light on the how. It is not telling us how the 10% target is to be achieved, how the implementation is to be resourced, where the leadership lies and how we will know whether we are getting there and what the progress is.

Dr Aitken: That is a difficult act to follow. I think a no is a safe place to start. If we look at the ambition in terms of investment and progress for mental health services, there are some causes for happiness. It is good to see some of the investment that is coming in the five year forward view, and the general tenor that closer integration of physical and mental health and closer integration of health and social care is a good thing. It is just difficult to see from where we sit the division of responsibilities between primary prevention and health and wellbeing boards and secondary intervention by mental health services, perhaps governed by sustainability and transformation plans.

Q397 **Chair:** Last time round, the funding due to come into the programme was described to us as being too little and too late, because it is not



coming immediately. Is that true?

Dr Aitken: Yes. The general sense is that the level of uplift required in mental health spend to meet the ambition and the strategy is not available. To give specific examples, while it is welcome that liaison psychiatry services are being rolled out across the five year forward view and there is investment in improving access to psychological therapies for children, and in maternal health and so on, if you look at the detail of the 10 recommendations of the national confidential inquiry as to what ought to happen, it is hard to see where the help is to get crisis and home treatment teams 24 hours a day; it is difficult to see how we protect and build on community treatment for people who do not want to come for care. There are some real concerns around the core elements of mental health delivery that are not met in the five year forward view piece.

Q398 **Chair:** Is there anything you would like to add about the funding issue, Ruth?

Ruth Sutherland: Yes. It is too little too late, but it is also in the wrong place. It is unclear. We think it is in NHS England, but it is unclear how it is to be distributed. If it is to be through the health route and go to CCGs, it is only £33,000 per CCG; it is a tiny amount of money within their much larger budget, with all the other pressures and things they have. If it went to the local authority and it were ring-fenced, it would be likely to have more impact. It is still too small but, if you have a small amount of money, put it in the right place and use it to the greatest effect.

Q399 **Chair:** If there is only a small amount of money, what is your message about where it should be and where it isn't at the moment, if that makes sense?

Ruth Sutherland: If it went to the local authority and was ring-fenced for the purpose, it could be tied. There are good examples of local authorities joining together and pooling their resources and making the most of them. It could be incentivised in that way, so that you get more money if you can work collaboratively with others. There is a very complicated picture locally in terms of STP plans and health and wellbeing boards. We want some clarity about where the responsibility lies and who is going to oversee it. Health and wellbeing boards—Richard may want to say more—would be a place for it. The directors of public health are there; they have the lead in suicide prevention, and if the money were ring-fenced within those budgets perhaps it would make more impact.

Q400 **Chair:** Hamish, last time you came before us you very powerfully told the Committee that it was all about implementation. Could you share your thoughts with us about the implementation plan, and any points you have about funding in addition to those that have already been made?

Hamish Elvidge: I want to make one general point at the beginning. I welcome your recommendations. In a sense, I welcome the Government's response, particularly the profile they have given to suicide prevention over recent months. The fact that the Prime Minister is talking



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about suicide prevention is very positive and sets a good background. They set out a lot of good aspirations. I will come on to talk about governance and programme management. I wondered whether it would be helpful in your final report to ask the Government to ensure that their responses include very clear implementation plans, accountabilities and timescales for each and every aspiration they have. There is a lot of good intent in the Government's work, but not a lot of clarity around how it is to be delivered. It would be good if we specifically asked the Government to respond in that way against each of the things they are keen on and aspire to do. I think that would hold them to account a little more clearly.

On implementation more generally, I am very pleased with your direction. I suppose we should be pleased that 95% of local authorities either have a plan or have a plan in development. The facts are that 75% have a plan and 20% are in development, but our concern is that we have no understanding of the quality of the plans, although there is an aspiration to provide some insight into that. We also have no understanding at local level what funding and what resource is being put behind the plan to give us confidence that it would ensure effective delivery.

If we added together all the 150 plans for a particular strand—one might talk about high-risk locations, for example, and access to means—we need to be confident across all the plans that it will make a difference at national level. We need to have that perspective. The Government talk very effectively about the need for programme management and the role of the advisory board and the National Suicide Prevention Alliance, but it is very difficult to work out from their aspirations what is going to happen and when. Will adequate resource be put behind it at national and local levels?

I would like to make four recommendations, one of which is slightly pinched from Ruth—but that's fine. The first is the appointment of a national implementation board. My sense is that it should be convened as soon as possible. It should meet biannually or maybe more frequently in the first 12 months of its appointment. It should be cross-department—the Department of Health, Public Health England, NHS England and all the other people involved in suicide prevention—and they should be asked to review and update their plans at regular intervals and gain commitment to deliverable dates. It should also include external scrutiny to assure us of the quality of the plans. I wonder whether it should be chaired by the Minister for public health and innovation whom the advisory board met last week.

Secondly, supporting the national implementation board there should be the appointment of a programme manager, with good experience of complex implementation programmes. They should be responsible for pulling together an integrated implementation programme at both local and national levels, which would have, as we have talked about endlessly, clear actions, accountabilities and timescales for delivery.



Thirdly, that programme manager should be asked to pull together a single view of suicide prevention implementation activities across England at national and local levels, which would include effective implementation of local plans. It might include bereavement support, but also some of the national areas we are looking at around confidentiality, burden of proof, the media and more.

The fourth thing, which I think would be helpful to the national implementation board, is the implementation of centres of good practice around the country, perhaps matched to Public Health England regions, because from my experience, if you have centres of good practice you get more effective implementation around them. If we had those things in place, we would have a much higher chance of success, certainly hitting the 10% target, although some of us would like a more aggressive target than that. As I have said before, we cannot allow many more lives to be lost because we do not have that in place. The Government have high responsibility for putting it in place.

Q401 Chair: Do the rest of the panel have anything they want to add, or do they disagree with any of that?

Ruth Sutherland: I agree. I have a couple of extra points. I understand there is to be a cross-Government committee on mental health. If there were an implementation group chaired by a Minister, that Minister could report to the cross-Government committee to make sure that all the other actions could be improved across Government and Departments.

The guidance from Public Health England for local area plans, which is very good, needs to be turned into some kind of quality standard or outcomes framework, so that the guidance becomes the measure of how well they are doing. That is what the implementation group could look at, and a small piece of work needs to be done to make that possible.

Councillor Kemp: I would not support the creation of a national implementation board. I well accept that there are times when you need to get together nationally to prod Government and Ministers to look at changes in legislation, privacy laws or things like that, but if we accept the workings of the last health Act, which are to localise things and make health and wellbeing boards more important, we have to challenge the strategies of each of those boards and look in their eyes to see whether they are doing something about it. It all comes back to implementation, and the partnerships and delivery mechanisms you can create. Suicide does not take place here—perhaps it does—but in communities, neighbourhoods and streets, and it is the quality of our local plans and strategies that will count.

Q402 Chair: Indeed, and Maggie will ask specifically about local implementation, but do you feel that having national oversight would at least be able to pick up whether there are areas that are not doing it properly?



Councillor Kemp: If I were to have national oversight, I would be looking at the health and wellbeing boards as a whole and how they are tackling this. I do not see the value of aggregating information at that level unless it is against the very specific types of points I mentioned before. I have been involved with some of these things for a very long time. They create a life and purpose of their own, which often saps the energy of what people are trying to do in local communities. You perhaps could have a de minimis structure in which you look at some key things, but once you say "implementation board" it will grow like Topsy, and will end up as a national body to do things, and I do not think that is the way to deal with these issues.

Q403 **Chair:** The message I am getting from Hamish is more about picking up where it is not happening, but perhaps you would like to clarify what you see, Hamish.

Hamish Elvidge: The appointment of a national implementation board with effective programme management does not at all take away accountability for implementation at local level. All it would do is ensure that it is effective implementation, and you would have an overall view as to whether the strategies at local and national levels were effective in moving towards our target reduction. It absolutely would not remove accountability; in fact, it would strengthen it.

Q404 **Maggie Throup:** Councillor Kemp, do local authorities feel equipped to produce and implement suicide prevention plans?

Councillor Kemp: The fact is that, as has already been said, 95% of local authorities have a strategy, and they are doing that willingly. There is no insistence that they have one now, and they do it very much as part of their day-to-day work. The last thing I would ever want is for a council to have a suicide prevention strategy that does not link up with the work we are doing with specific needs groups, through our drug and alcohol teams and a whole range of places where we target people who are high risk for a lot of reasons.

I believe there is a will, but there is not always the ability to put things in place. The local partnerships being developed by health and wellbeing boards, for example, are in different places in different areas, based largely on history. In my own area of Liverpool, although I am not a controlling councillor, I think the health and wellbeing board is working very well on picking up these and other issues, because it is an iteration of what we have been doing since the mid-1990s. The concept of partnership and working together is well embedded, but you would not expect me to answer that question without saying that we have severe capacity issues. We will have a further 9% cut in our public health grant, and it is public health that deals with this issue. That is on top of a £200 million in-year cut in 2015. We are struggling to do our best in very difficult circumstances, but the general impression I get when I look at a lot of the health and wellbeing board plans, which is part of my role in overseeing the board, is that they take suicide seriously. They are



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seriously trying to do something about it but cannot always do what they want to do.

Q405 **Maggie Throup:** In a previous session, one of our public health witnesses, Dr Ann John, told us that action on suicide prevention needed to be made mandatory for local authorities. What are your thoughts on that?

Councillor Kemp: I would never be in favour of that, because we have too many statutory duties on us at the moment. I have sat in meetings like this with central and local partnerships when new duties have been imposed on us and never the resources to deal with them. When 95% of local authorities are doing their best with the strategy on a voluntary basis, going to a mandatory system would, first, create resentment, and then it would mean us coming back to you to say, "Do not do this unless you give us the money. We're doing the best we can." Make it mandatory if you are going to guarantee us a good supply of money to deal with it; otherwise, it is better to have 95 volunteers than 100 pressed men.

Q406 **Maggie Throup:** Do you think that the Government's updated strategy will help local authorities to get suicide prevention on the agenda?

Councillor Kemp: Yes, and we are doing something about it as well. Everyone here is beginning to say that we now need to move to the implementation stage. I have a mock-up here, but we will send you the final version. We are doing our own strategy for local government, which is not to replace the national strategy; it is talking about best practice. How do you join up? What do you do on the ground? We now move to the implementation stage. Local government is backing what central Government are doing and trying to produce that rigour and best practice throughout local government. We will circulate this to you as soon as it is finished in the next couple of weeks.

Q407 **Maggie Throup:** That would be very welcome, because a lot can be learned from what is already going on.

Councillor Kemp: Absolutely. I suspect there is nothing new at all here. We are just trying to point out what is best so that that good practice is shared equally across all areas.

Q408 **Maggie Throup:** Hamish, you have already talked about your thoughts on a national implementation board, and we have heard a counter-argument from Councillor Kemp. Who do you think should be responsible for quality-assuring local authorities' suicide prevention plans?

Hamish Elvidge: The national implementation board. That is one of the roles it would play. I do not think it is realistic for the board to bring in 150 suicide prevention plans and audit them, but it would be perfectly appropriate on a selected basis that we ensure that those plans are fit for purpose and, most importantly, that there is resource and funding put behind them so that they turn into effective delivery rather than just



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remaining plans. It would be a light-touch approach by the implementation board.

Q409 **Maggie Throup:** Do you want to expand on what measures could be used for quality-assuring the plans?

Hamish Elvidge: The suicide prevention planning guidance issued by Public Health England in October sets out the areas and the approach that should be taken. We should be doing a light-touch assessment against that approach and providing support to local authorities to enable them to do as good a job as they possibly can. I would use the measure of the Public Health England suicide prevention planning framework to do an assessment.

Ruth Sutherland: A quality panel of experts could be drawn from around the country. I do not think the implementation group should be responsible for the quality; it needs to be separate and independent, but they could nominate the panel or set it up, and it could report. It would be quite simple to make the guidance into quality standards, which then could be assessed.

We have been involved in master classes around the country to deliver the guidance. There are 75 people from each of the nine regions. Six of them have happened, so we are in the middle of them. There is some evidence that what comes from those master classes is that there is not a lot of implementation support available. People are saying they want to do it and they have the guidance, but they are not quite sure what to do. We still come back to the question about what a good plan looks like. There is also a question about competing priorities. If it is left to health and wellbeing boards to work out, and suicide prevention does not come up as a priority, however good the local action is, it will not get air time, so we will be perpetuating the variation in experience that we have around the country. Bereavement support is not available everywhere, nor is training for GPs. For quality, we will be looking for some kind of common standard or expectation, so that everybody can expect that to happen in their local authority.

Q410 **Maggie Throup:** What sort of timescale would you like to put on that?

Ruth Sutherland: Producing the quality thing?

Maggie Throup: Yes.

Ruth Sutherland: It is absolutely the next step. Now we have the guidance, it is quite easy to turn it into quality standards and set up an implementation group and a panel. There is no reason why that cannot start, particularly as we have good momentum with enthusiasm at the moment. It needs to be met with, "This is how you do it." That is how we know how we are doing.

Q411 **Maggie Throup:** Councillor Kemp, you have already talked about good and best practice, which we know is happening in many locations, but



why do you think there is such wide variation in what is going on at local level?

Councillor Kemp: The problem with localism, which is also its strength, is that local people decide local priorities based on local indicators. They get pulled different ways for different reasons. That is why I am all in favour of looking at what the community wellbeing board is doing rather than trying to pick out a particular view. Do they have a clear view of the overall health issues in their area? Are they correctly prioritising them? Are they making sure that partnerships are developed? Whether it is suicide, drugs or physical health problems, it is all the same issue to me. I am doing a session on loneliness. We could have loneliness strategies, but they all come together at the end of the day. That is why I am particularly interested in looking at the quality of the local leadership and asking key local questions like that, against which we will then decide whether suicide is the key priority. At the moment we can see very clearly that it is a priority, but only as part of the overreaching services that affect all the vulnerable people in our communities.

Q412 **Maggie Throup:** What do you think are the key barriers to local authorities implementing effective suicide prevention plans?

Councillor Kemp: We still have two problems, which are related. The first is that money is often channelled through the NHS and spent before we are aware of it because it does not necessarily come to our health and wellbeing board. The £1 billion by 2020 to address mental health went straight through to the CCGs and we found out about it later, so we did not have the opportunity to enter into the local discussion. We understand that a considerable amount of it has not been spent on mental health anyway, which we find worrying.

The second thing—this is where the good health and wellbeing boards are doing better than the poor ones—is that we are trying to bring together very different cultures. I do training in the health service, as well as in local government, on these issues. To me, it is marked that the health service people are very much command and control. No matter what we have with STPs or health and wellbeing boards, they still wait for the Secretary of State to issue an edict and pass it down, whereas we are much more bottom-up and organic in the work we do as councillors. There are still cultural issues between the two, but we are getting there. There is much greater understanding between the two sectors than there was three years ago.

Q413 **Maggie Throup:** It is a matter of getting the money in the right place.

Councillor Kemp: It is getting the money in the right place and properly discussed by all the partners before it gets swiped by some of them.

Q414 **Maggie Throup:** Ruth, do you want to add to that?

Ruth Sutherland: No, I agree.



Q415 **Maggie Throup:** My final question is to each of you. If we were sitting here discussing it in 12 months' time, where would you like progress with implementation to be? Where would you like us to be then?

Ruth Sutherland: I would like us to have an implementation board reporting on the quality of the plans happening at local level, saying that so many per cent are in the green zone and so many are in amber. It is good that 95% say they have them, but we do not know what is in them.

Councillor Kemp: For me, it would be that, 12 months in, each of the health and wellbeing boards had done a review of what it was doing in terms of theory, practice and partnership and was revising what it wanted to do locally on the basis of local experience.

Hamish Elvidge: For me, it would be that we were hugely encouraged by the effectiveness of the implementation of the local plans and they were beginning to make a difference towards our 10% reduction target.

Dr Aitken: I would like to see sustainability and transformation plans explaining transparently how they are going to deliver the mental healthcare necessary in the suicide prevention strategy and being very clear about how that is going to be managed and monitored.

Q416 **Luciana Berger:** Councillor Kemp, you talked very specifically about resources, funding and the 9% cut in public health coming down the line. In your own words, local areas are struggling to do their bit. Can you elaborate on that further, particularly on what is going to happen after the next financial year when the ring fence for public health is removed, and what you anticipate will be the impact on areas where suicide is a particular challenge, and where they will be stretched in terms of resources?

Councillor Kemp: The areas that will be most stretched are probably those in greatest need, because that is the stretch in local government finance throughout the country. We know that suicide and loneliness, not exclusively, have great links with economic and social deprivation. That is in the sorts of areas you and I represent, the Manchesters and Newcastles, where we are least able to cope by putting up council tax. For example, as you know, we have been debating in Liverpool whether we should put up the social care precept. The fact is that, because we have a very low tax base, we do not get much by doing it, compared with, say, Surrey, which gets four times as much. We have poor people who need help but we have a very low tax base. The pinch points will come in the poorer urban areas, which is not to say there are not problems of suicide, perhaps for different reasons, in rural areas, but the most deprived areas will take the biggest hits.

Q417 **Helen Whately:** I would first like to ask a follow-up question on implementation. You talked very helpfully about implementation plans and how to make them happen, and the question of finance, but do any of you have a view on the workforce challenge? It is all very well talking



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about the money and the plans, but I have heard that the greatest challenge in so many of our aspirations in mental health is the workforce to provide them. Would any of you like to say something about that before we move to questions about the strategy in more detail?

Dr Aitken: I will take that in the first instance. There are a number of obvious problems with workforce that we can all see. There are insufficient psychiatrists in post currently; many posts are vacant. There are inadequate numbers of psychiatrists in training to fill the available posts. We have similar concerns about general practice. It is a very hard-pressed specialism; GPs work long hours and take on a tremendous amount of responsibility. We can look further than that at the nursing workforce. In mental health, there is a national shortage of band 5 nurses. It is difficult to staff wards; it is difficult to staff crisis teams. It is a very difficult picture. Unfortunately, the response in delivering anything like the rising numbers of workforce in the domains that we need is three to five years away.

That is not to say that there are no green shoots of recovery. It is certainly very welcome that there will be additional medical school places. It is extremely welcome that those medical school places are likely to be in favour of schools that will turn out general practitioners and psychiatrists and people with an orientation to mental health, but it seems to me that within the timeframe of the strategy we will have to think very differently about how we mobilise whole communities— notions of shared society—to provide a different response to vulnerable and lonely people and people who are hopeless, to try to guard against them having to encounter a mental health service or general practice service that is ill equipped to meet their needs at the moment.

Councillor Kemp: I support that from a local government viewpoint. I am not in any way decrying the need for the specialism Peter just mentioned, but it is about who sees whom on a day-to-day basis. One of the things I would like guaranteed through the implementation plans is that people in the DAATs and those who make day-to-day contact with the most vulnerable are particularly trained, in so far as they can be—you cannot always be—for what suicide risk looks like. Looking people in the eye might perhaps be the only way to do it. When you have done that, and you see that Richard Kemp is a bit vulnerable, how do you process that through a proper local system? Sometimes the most important people are those on the ground at the lowest level who see people day in, day out. How do we then layer it up to Peter's level? It will only start if we do the early identification at the ground floor.

Ruth Sutherland: Can I add something about releasing the capacity of the general public? It is still quite light on the information and education awareness elements of what could be done by the general public.

Q418 **Helen Whately:** You mean the strategy is quite light in that area.



Ruth Sutherland: Yes. There are no recommendations about mobilising the public. One of the things the dementia care pathway did very successfully was to join up all the different people—Dementia Friends and so on. I would also put in a plea for the voluntary sector. All the Samaritans services are provided by volunteers. They are lay people, not specialists, but they play a vital role. On obesity, smoking and things like that, we have lots of big public health campaigns targeting the general public and what they can do. We have not had one in this way. We have time to change. The strategy is successful in reducing stigma, but it is not mobilising what we as individuals can do to help and support people around us, be it in the workplace or wherever in the community.

Q419 **Helen Whately:** That is very helpful.

Hamish Elvidge: I want to pick up the point about training. The Government say that the training of GPs and GP surgery staff in awareness of suicidality and safety planning is a crucial role. I am sure that also applies to nursing and A&E staff, but, sadly, that is as far as it goes. That is one of our concerns about many aspects of the strategy and the response; there are no recommendations for action with clear accountability. If I were a GP, a member of GP staff or a nurse, I would welcome the opportunity to have training in suicide awareness and mental health and how to keep people safe. We need to create a vision and an implementation plan that delivers it to support the staff who are there. That would be hugely helpful, but we cannot actually do it unless the vision and the plan are articulated, and resource and support are put behind it. It is no good having intent without actions to support it.

Q420 **Helen Whately:** That is very helpful, and there is an overlap with a question I was planning to ask. I have some questions that deal generally with support for people who are vulnerable to suicide and how the strategy addresses that. The first area is your views on the proposals to support the third of people who end their life by suicide and have not had any contact with health services in the period leading up to their death, and whether more could or should be done in that area. What is missing from the strategy for that group of people?

Councillor Kemp: It is a very difficult area. I speak from personal experience; a relative of mine tried to commit suicide at the beginning of this month. Fortunately, she did not succeed, but she would appear in none of our indicators of likely candidates. She is a health professional, which is why she very nearly succeeded.

The big question for me—I would be happy to put it to you and share it with everyone—is how we talk to the general public about something that is a very rare event. There will be 1 million of us with dementia, but there might be—I do not know—6,000 suicides; 60,000 might try it one way or another, but it is still a relatively small number. How do you get general messages out about what to look for and recognise without scaring the whole community unnecessarily? We as local government are certainly



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struggling with how to deal with that 30%. The 70% is easy, but I am not sure we have answers for the 30%.

Ruth Sutherland: I reinforce the point about information, education awareness and public understanding of suicidal behaviour. It is quite common—it is not necessarily normal—for people to have suicidal thoughts. It is believed that it applies to one in six of the population. For most people, those thoughts dissipate because of the people around them, but for those who get deeper into the journey, their thinking gets more and more concrete and they programme themselves not to tell anyone and give any outward signs because they do not want anyone to stop them. You do not want anyone to stop you because you have worked out that this is your escape route from the terrible pain you are in, so the deeper you get into the journey, the harder it is to spot because people are working very hard to make sure nobody knows anything is wrong.

If upstream we are all more aware that life is difficult and sometimes you need someone to interrupt your dark thoughts, and if people are better able and equipped to do that, we are likely to have more success. The information and education stuff is important, but we need research with high-risk groups. Research generally on suicidal behaviour is small compared with the impact of what happens. There is a popular belief that men do not want to talk, that they are a high-risk group and we just have to tell them to talk more, but at Samaritans 50% of our 5.4 million contacts each year are with men. Given the right circumstances—complete confidentiality and a non-judgmental, listening approach—men do and can talk. Let's have some more research about high-risk groups before we decide how we are going to do that work.

Dr Aitken: For me, the tough bit is the distribution of a thankfully rare event across society. Some of that distribution is slightly more aggregated in groups of people where we attribute hope that we would be able to intervene, like self-harm, and make a difference. The reality is that we have some way to go before we are 100% effective in delivering the mental health services that we know can modify some of the risk.

We seem to be struggling horribly in the prison system at the moment. We have a captive population—literally—of people we ought to know well and be able to keep safe. We do not seem to be able to keep people safe. We have networks. The college has a network of excellence as to what prison health and mental health standards ought to look like. Many prisons have signed up to that, but such is the social component of suicide that the pressures in jails, almost a metaphor for the pressures in society, can very swiftly overcome all the collective effort of the health and social care services for which we are accountable statutorily.

Then you move out into the community space and think about how we could respond in localities where we know there are risk hotspots. How do we make the railways safer? How do we make sure that lonely,



vulnerable, isolated people have some degree of contact and a sense of social connectedness? How do we deal with loneliness in the crowd where a person who is apparently around other people can inwardly feel incredibly lonely? Those hidden characteristics bedevil our effort.

For all the effort we make and for all the work we put into risk assessment and all the boxes we tick and check, we are continually undone by the shock and horror of the experience we have heard in this room when somebody, with apparently none of those risk factors, takes their own life. It is such a destructive experience for everybody—the 10 immediate family members who are scarred for two or three generations to come and all the health and social care workers, voluntary workers and community effort that has gone into trying to protect someone. It comes like a bolt from the blue and puts everybody back on the defensive. It is a really difficult thing. Research will always be welcome; we can learn a lot from high lethality survivors and people who have made attempts, and from family experiences. We must do a lot more to understand as best we can the context in which these unexpected events arise, but my sense is that we must avoid the trap of focusing all our energy on specific high-risk populations, because even there suicide is a rare event. As a society, we must resist that trap and think about how we can have such a good system of scrutiny for loneliness, isolation and vulnerability that people cannot leak through in the way they currently do. It requires a robust implementation plan, and I am very sympathetic to the advice offered to you by Hamish.

Hamish Elvidge: I want to come at this from a slightly different angle. In the Government's five year forward view they talk about children and the importance of building resilience, promoting good mental health and wellbeing and looking at how we can do more upstream to prevent mental health problems before they arise. I know there is another Select Committee considering that, but in the context of suicide prevention it is an important angle to take. To look at long-term investment in policy changes to position wellbeing and mental health at the centre of the culture and ethos of our education would make huge changes in society. I realise it would take 20 years to do that, but if all Governments could make a commitment to long-term investment in policy changes in education around wellbeing and mental health, we would find that fewer people were unable to cope with the life situations they face. I think that will be the subject of the next inquiry and I look forward to hearing more about it. That is a serious part of suicide prevention.

Q421 **Helen Whately:** I am conscious that the clock is ticking. I will set out the broad topics on which I am keen to get your views. One is about making sure that suicide prevention in primary care is given sufficient priority. Another area is specifically on follow-up support for patients discharged from in-patient care, which we have talked about. Another area is liaison psychiatry in A&E. Do you have any views on the pace of the roll-out and extension of liaison psychiatry services to every hospital and whether it might be speeded up? I realise that you might not all want



to talk about every one of those subjects, but I am keen to get the views of those who do want to talk about them.

Dr Aitken: Shall I start in reverse order with a subject dear to my heart? The notion that there should be a mental health service in a general hospital and in general health systems seems obvious to many of us. The national confidential inquiry into perioperative deaths published a report last week setting out nine rather grim case studies showing the consequences of not having effective mental health services in our hospitals. There are many helpful recommendations about having an effective mental health service, to paraphrase it. Services that see folk who attend accident and emergency departments revolutionise the opportunity to detect stress, distress and suicidal risk. NICE guidance is very clear. An effective biopsychosocial assessment will go a long way to helping to identify what is needed in a person's recovery plan.

I am afraid that the rate limiter in delivering those services is simply workforce. We had a very careful look at the realities of the workforce when we sat down with NHS England. We made a plan that we felt was deliverable, so that by 2020 there ought to be an effective 24-hour, seven-day-a-week liaison mental health service to general hospitals in England that have an accident and emergency department. We reckon we can do that. It will be a struggle, but we will get there, remembering that it will mean drawing on staff from other hard-pressed services like crisis response and home treatment, and it will draw in consultants working elsewhere. There are consequences to deciding to prioritise in and around A&E.

When it comes to primary care, it is clear to me in practice and in published research that a substantial number of GPs—more than a third—are very skilled in mental health practice and very good at it. They carry a lot of morbidity and risk in their work. Probably the same number again are interested and keen, and with support can do fantastic things. For the small percentage of GPs who find mental health work difficult, usually within a primary care team there will be others who can help to fill that skills gap.

The Government have invested wisely in expanding improved access to psychological therapies—the IAPT programme—but it might be helpful for this Committee to understand that IAPT workers are in a model of care that is ill suited to suicide risk assessment. It is important the Committee understands that the IAPT investment, while it can help to manage and treat depression and anxiety, does not in itself help the general practitioner re-equip with suicide risk assessment skills or management. If an IAPT service finds somebody to be suicidal in the context of their work treating them for depression and anxiety, they will in most instances refer them back to the GP or make an onward referral to specialist mental health services. We think that problem needs urgent address in the context of the five year forward view and integration.

Q422 **Luciana Berger:** Can I seek a point of clarification for the purpose of our



records? Could you expand the last point about IAPT workers? I know that the Royal College of Psychiatrists has raised concerns about the level of training of IAPT workers. Perhaps you can explain the distinction where an IAPT worker may or may not have the same level of training that you have as a psychiatrist.

Dr Aitken: The thing about improved access to psychological therapies is that they are an extremely robust evidence-based approach to delivering a person the right care for their established depression or anxiety. The IAPT worker will be appropriately skilled to the task, so whatever particular therapy has been decided upon for the treatment of that anxiety and depression will be delivered by a very well-trained worker at the level that worker is meant to be trained to. It is a very specific set of skills, usually in a stepped care model, from basic advice, help and treatment through to complex psychotherapy. The whole range is there within IAPT. However, the IAPT service does not have the front-end multidisciplinary biopsychosocial risk assessment machinery that community mental health teams or even general practice primary care teams do. They are very much a delivery mechanism for highly effective care interventions for somebody who has already been assessed as having depression or anxiety.

Unfortunately, for people with depression, referring back to Ruth's point, the reality is that very many have intrusive thoughts of suicide; they have suicidal ideation. Sometimes that suicidal ideation will become intent, but at the point it becomes intent the IAPT service is not equipped to manage the risk, so the intentful person, or the person who is speaking about ideation, may very often find themselves being pushed back to the general practitioner or the community mental health service.

Q423 **Chair:** Are the workers trained to be able to pick up suicidal risk?

Dr Aitken: No.

Q424 **Chair:** Does that worry you?

Dr Aitken: They detect it in the sense that once people start speaking to them about suicidal things their response is, "I'm sorry. You carry too much risk for this model of care. You must move back to another part of the healthcare pathway."

Q425 **Chair:** If somebody is expressing suicidal ideation, they are not trained to explore whether they have moved on to having suicidal plans and intent.

Dr Aitken: They may very well have those conversations with them, but, as soon as the issue of suicide risk arises, the majority of the work will move over to general practice or back to the primary care liaison mental health team, or whatever the interface for special services is. Liaison psychiatry and IAPT are two very important and welcome investments in the five year forward review. I am just positioning them in relation to the suicide piece.



Q426 **Helen Whately:** The final thing is to do with follow-up to support patients discharged from in-patient care.

Dr Aitken: This is a difficult one, isn't it? When in a week of risk do you look in to try to prevent a bad thing happening? The evidence is pretty clear that somewhere within the first 24, 48 or 72 hours the relief of coming out of hospital translates perhaps into the sudden realisation that you are back in the mess you had left in the first place. It seems to be very important that, no matter what kind of institution you have come out of, whether a mental or general hospital, some form of face-to-face contact within three days would be recommended by the evidence base. We have debated long and hard whether that is instead of or in addition to some other follow-up in the first week. The general consensus in most meetings is that, if it were my parents, me or my kid, I would want a couple of visits face to face in the first week. Many hard-pressed crisis response teams at the moment are barely able to make a telephone call check in that first week, so you can see the implication for resource immediately. If we are already dealing with a limited resource pool, it proves quite challenging to think a bit about how that commitment can be kept.

Q427 **Helen Whately:** That is a workforce point, and it may bring us back to the earlier point about needing a different response. Does anyone else on the panel want to come in on those topics?

Ruth Sutherland: I would agree with all of that. The only thing I want to add is that we should not put too much expectation on primary care fixing all of this, because there is just too much for primary care to do. This is quite a rare event in a caseload in a GP practice. If we put all our expectations into that, or train all GPs to do it, they will not be able to do it. It is about the reality of what happens there. The second point is to remember the role of the voluntary sector in primary care, and how that can become part of the system to try to help and support, particularly in bereavement services and that kind of thing.

Councillor Kemp: I do not know whether we are going to come to this in a separate question, but, picking up that point, it is very important that we look at what communities can do. There is no way we can professionalise away all the difficulties we face. Almost everything I do with public health could be better done if more people looked at the culture of what happens in their own families and communities: obesity, drugs, alcoholism and things like that.

I am not saying that we can train everyone in the community to be aware of the dangers of suicide, but we could start to recreate our communities and recognise, for example, people who are lonely. Just encouraging people to say hello on the way to the shops sometimes has a tremendous impact on people's lives. Are you aware that, if the weather is bad, someone cannot get out? Even if they have everything in, when you knock on the door they feel incredibly better because someone has made the effort to check that they have a loaf of bread and a pint of milk. Is



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that a suicide prevention strategy? Of course it isn't, but it is a neighbourhood engagement strategy that is likely to dampen down progression into areas that need more professional help. There is a lot we can do. Politicians like ourselves have often broken down those community links for a whole variety of good reasons, and perhaps we have to take more responsibility for putting them together again.

Q428 **Chair:** Are you very disappointed that some aspects of the updated strategy relating to primary or secondary care should have been included but are not?

Ruth Sutherland: If those things happened it would be good, but it is about whether they could.

Q429 **Chair:** It is more about implementation.

Councillor Kemp: It is the doing.

Q430 **Andrew Selous:** Following Councillor Kemp's point, Ms Berger, myself and possibly others have just been to the Jo Cox Loneliness Commission in Speaker's House, which is dealing with exactly that issue, which you are completely right to raise. Thank you for putting it on the record, Councillor Kemp. Can I start with those bereaved by suicide? Do we have data to know the prevalence of support for people who have been bereaved by suicide and go on to take their own life at a later date? I do not know whether Dr Aitken, Ruth Sutherland or any of you may be aware of the prevalence of that.

Hamish Elvidge: The information I have is that people who are bereaved by suicide are 65% more likely to go on to take their own life, but I would like to go away with the question and come back with the available evidence, which I do not have to hand.

Q431 **Andrew Selous:** It would be helpful to get that data, because it is an important issue. We have looked at it, and it would be helpful to get some figures. Starting with you, Mr Elvidge, I would like to ask for your views on what the strategy says about supporting those bereaved by suicide.

Hamish Elvidge: First, I am encouraged that you are suggesting that local suicide prevention plans should include suicide bereavement support as a mandatory part of the plan. It is important to understand up front what effective support means. The guidelines issued in January are based on the principle that everyone bereaved or affected by suicide should be offered appropriate support. It is better if that appropriate support is offered in the first week, even the first 24 hours, and that would include information, resources, counselling and how to handle an inquest and an NHS serious incident review. The other side of that is that it cannot mean having just a few services available at local authority level and hoping people might find them. It needs to be a proactive service supported by the police and the coroners who need to be involved and others.



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In the interim report, you mentioned many of the important things around the cost of suicide, the impact on the number of people affected and increased risk at a personal level. The Government talked about three areas. They talk about "Help is at Hand," the NSPA workstream and the new postvention resources that have been made available to local authorities, but they do not set out a clear plan of action, and we have talked about that as a general issue.

"Help is at Hand" was renewed and reissued in September 2015, but we are a very long way away from having it disseminated to everyone affected by suicide—a very long way. The Support after Suicide partnership is developing a dissemination plan, which it is reviewing next week, and our hope is that we will be able to get to a point where all police, GPs, nurses and A&E staff are aware of the resource and make it available to families bereaved by suicide, but we are still a long way away from that.

The Government then talk about the funding of the NSPA that has enabled it to set up a support after suicide workstream. The workstream is run by the Support after Suicide partnership and is 80% funded by other charities and trusts. Through that, we have been able to develop a website that acts as a hub for support in the UK. We have launched a survey to find out more about the impact of suicide on people's lives, and we are doing dissemination. The Government also talk about postvention resource. It is good that we now have that resource available.

At the moment, even though 95% of local authorities have suicide prevention plans, we have no idea how many have an effective support service available. I want to talk about four things that could happen to improve the situation we are in. One is that people bereaved by suicide should be considered as a high-risk group in the strategy. The second is that we ought to have a named individual, perhaps from within the Department of Health or Public Health England, who is made responsible, with support from the NSPA and the Support after Suicide partnership, to ensure that support after suicide is proactively offered to everyone affected by it.

All local authorities should be asked whether or not they have a bereavement service in place and, if not, when they plan to do it, because we have no visibility, facts and data. I wonder whether local authorities could be incentivised to implement an effective Support after Suicide partnership service. Maybe that could fund the role of a suicide bereavement liaison officer who would be the person co-ordinating the development and implementation of the service and act as the central point for contact with affected families. At the moment it is just by chance. There are some great services in Durham, Cornwall and Merseyside, but everyone bereaved by suicide is not offered support across England, which is a stark variation from people who are victims of crime, as we mentioned last time.



Q432 **Andrew Selous:** That is very helpful. You have partly touched on my next question on which I would like to hear from all the panel. What are your views on the quality assurance process for local plans? Will it be successful in ensuring support for people bereaved by suicide?

Councillor Kemp: It comes back to the quality of the partnership and the relationships. Following the previous answer, across the Liverpool city region and Cheshire, for example, we have very strong liaison between the coroner services and a named director of public health on families that have suffered bereavement by suicide, partly because they have particular bereavement counselling needs; it becomes very internal. I can tell you this from the experience I had. It was not that they had died because they were 92. What did I do wrong? Why did I not spot this? There are particular bereavement problems, but also a propensity to say, "I might as well go too because my son, daughter or whoever has done it." That liaison happened because locally the leaders of the system recognised a particular need and created a partnership to deal with it. Similar work is going on elsewhere. I am always given props from the back, so I shall wave this DOH document at you. It describes what is happening in five counties.

We have to be very clear that there are best practices all over the place, and the way we can achieve the maximum is to make sure that everyone knows about them and achieves them. Incidentally, that does not cost money. In the system I was describing we are probably saving money because we are dealing with things quickly, and that is probably what public health is all about.

Q433 **Andrew Selous:** That is a very helpful answer. I would like to move on to the consensus statement on sharing information with families. I have some questions to you, Mr Elvidge, specifically about the progress, or lack of it, on the part of royal colleges that we need to see with regard to the consensus statement. I confess to being slightly shocked by the lack of progress that has been unearthed so far. How do we take this matter forward with the royal colleges in an effective manner?

Hamish Elvidge: I was very encouraged by what the Select Committee said about professionals needing better training on how to involve families in care and assessment. You recognised the fact that, if that is done, it is likely to result in support and better recovery, but it is disappointing that so little has been done about it. The sum total of the Government's response was simply that we should do more to promote the consensus statement. That consensus statement has now had its third anniversary. No details were provided on how it is going to be achieved and when the statement might be embedded in best practice for GPs, nursing, A&E, psychiatry or whatever. As we well know, awareness does not drive practice change.

We talked last time about the statement having three distinct sections around assessment and providing information, which seems uncontroversial. We also talked about how to ask the question about



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confidentiality. I will not go through it again, but it was interesting that when the Chair and I were on the “Today” programme on Radio 4 just before Christmas, I was contacted by many people who asked for a transcript of the question I asked. One of those was a fairly substantial NHS trust. They asked me to speak on suicide prevention at their conference, which is coming up, because they were so determined to embed that type of practice into all their health professionals.

I hesitate to say it, but last week a friend, who may even be in the room, said to me that it was very odd that change should be driven by a bereaved parent talking on the radio. Good as it is, maybe there should be other ways of achieving change. If I could, I would like to go through a few areas and recommendations that I think could drive effective change. This is borne out by the fact that some progress has been made since we last met. Steve Mallen—he is in the room—and I have met Sir Simon Wessely of the Royal College of Psychiatrists, and we also had a long discussion on the subject at the National Advisory Board last week. Both of those were very encouraging, because they seemed to generate a sense that something now needs to be done to embed the consensus statement into the culture and behaviours of people coming across those with suicidal feelings. We are very pleased to be involved in those discussions.

Born partly of those encouraging discussions are five things that I want to mention. One is that we ought to bring together again all the royal colleges. We did it four and a half years ago to produce the consensus statement. It would be good to bring together all the signatories to the consensus statement to agree a vision and a long-term implementation plan. To me, the long term is likely to be five years in terms of a cultural change in behaviour. All staff who are likely to be in contact with people who are experiencing suicidal feelings should be trained in mental health suicide awareness and on the consensus statement, and that should be embedded in the core curriculum of each of the royal colleges. It should be embedded into initial training and continuous professional development. When we went to the Royal College of Psychiatrists last week, they agreed that that was exactly the sort of thing that should happen; each profession should embed a cultural change programme. It might be facilitated if we appointed somebody to have responsibility for enabling that to happen. It is more likely that all the royal colleges would get together and direct change if there was leadership from the top.

It would be helpful if the Department of Health did some research into the number of cases where confidentiality has acted as a barrier to successful assessment, treatment and recovery. We already know hundreds of anecdotal pieces of evidence around that, but the research itself would bring it to light, particularly in relation to people who have given permission for their suicidal feelings to be shared with their family and, for whatever reason—maybe workforce issues—that has not been followed up. Finally, people with lived experience should be heavily



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involved in all that activity, which is happening substantially. That is proving to be valuable, and we greatly appreciate it.

Q434 **Andrew Selous:** You have answered some of the questions I was going to come to. The concerns you expressed about the slow progress made by the royal colleges have been very firmly noted by the Committee. Thank you for putting that on the record again. In taking forward the issue, do the Government need to give more teeth or more authority to the National Suicide Prevention Strategy Advisory Group in terms of their work with the royal colleges? Would that body, perhaps with some beefed-up authority, be the right one to drive change with the royal colleges? I do not know whether Dr Aitken might want to come in on that as well.

Hamish Elvidge: It could be. The meeting we had with Sir Simon Wessely was facilitated by Louis Appleby, chair of the advisory group. He is setting up meetings with the Royal College of Nursing and GPs shortly, which we look forward to. A lot of the onus of responsibility is on the royal colleges and through the NHS trusts to embed a new world of training around the consensus statement. I read the consensus statement again last night. It does all it needs to in providing permission for people to contact families where it is in the patient's best interests and safety. We do not need to change that, but we need deep-rooted cultural change, which I think will take time. Peter might like to say more.

Dr Aitken: Simon Wessely set the scene very well in his blog. We at college council have had a good conversation about what we might need to do to set the direction of the College of Psychiatrists to make sure that happens. I wonder, however, when I meet colleagues in my practice how nervous they are of legal consequences that possibly are not there. Doctors are occasionally rather in awe of their legal colleagues. Some of us worry that something bad will happen if we are not very careful about confidentiality.

Others take the view that, if you know a suicide will have a terrible impact on 10 family members for generations to come, you can see that a clear harm is involved as a consequence of letting something happen that you could prevent by sharing information. Many of us in psychiatry now are in it only because of a change of culture in favour of co-production with people who use services, and the fact that we work with patients and carers to redesign services that are destigmatised, accessible, transparent and good for people to use. Those are the services that have made it worth my while to be in my profession. There is a tidal wave of transformation that will help this to be much easier, certainly in psychiatry.

My sense is that it would be very helpful if trust legal departments, legal authorities and defence unions were involved in the conversations so that when doctors ask for advice from their trust's legal departments or from their defence union they are offered support that is sympathetic to the consensus statement, because if as a doctor you have to make a decision



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on your own late at night and you phone the defence union which comes straight back with, "Be very careful about that," you tend to be very careful about it.

Q435 **Chair:** Is that something the royal college itself has undertaken to discuss with defence unions?

Dr Aitken: I am not aware we have taken any decision to discuss it directly with the defence unions ourselves, but it is certainly the obvious thing to do.

Q436 **Chair:** Can I move to the concerns that the Committee expressed in its report about the under-reporting of suicide and the variation around the country in the way suicide is reported? One of the recommendations we made was for a change in the law to allow conclusions of suicide to be on the balance of probabilities. Could I ask members of the panel whether you agree with what the Committee said, and whether you have any comments on the issue of data in the Government's updated strategy?

Ruth Sutherland: We agreed with the recommendations and were pleased that they were there, but we thought that the work around coroners could have been stronger. Obviously, knowing who dies by suicide and when is fundamental to prevention. There is such variation in coroners' experience about whether or not they release information to public health departments that there needs to be a lot more about trying to get a more consistent approach. The whole issue about narrative verdicts and the skew that is creating means that it is not possible to attribute some deaths to anything and they fall out of the statistics, and there is such growth in narrative verdicts that that will increase. A simple thing would be for the coroner to do a short-form report as well as a narrative report, so there is no ambiguity for the person who enters the data about where they should categorise it. That would need to be enforced everywhere; otherwise, it will cause big holes.

A practical thing that could be done is to recommend a review of the death registration process. There is such a gap in the time you have to register a death that that can also skew the figures. In Scotland, it has to be done within eight days. If we did a review in England and brought that in, we would have much more accurate data. That is something we thought was missing. If the Chief Coroner were to issue guidance to enable free access by public health teams to all the necessary records, it would make an immediate difference. I do not know how much influence the Chief Coroner has when guidance is issued. I do not know how easy it is to enforce it at local level; I do not know how that works.

Q437 **Chair:** I will be meeting the Chief Coroner on behalf of the Committee shortly. If you write to me on the points that you want raised with him, I will be happy to do that on behalf of the Committee.

Councillor Kemp: Coroners are a local government service in some ways—it is one of those difficult areas between central and local government—and one of the things I pick up from this is that perhaps we



at the LGA ought to be doing more with coroners to look at issues like this, and take our general practice into the coroners' practice. I have discussed the issue with a number of coroners, not only in our own areas, and I think we should be aware that, although everyone would like to support your recommendation—certainly in principle the LGA does—nevertheless we face very human situations where mental health in many cases is a shameful thing to talk about anyway, but suicide is a doubly shameful thing. Coroners are sometimes in a very difficult position, given the medical evidence and trying to deal with grieving families—not to give the wrong decision or recommendation, but to cope with a situation where many families are put into further stress because it is officially ruled that their loved one has committed suicide.

Q438 Chair: The case was made to us very powerfully that you do not deal with stigma by colluding with it; in dealing with it, you also have a responsibility to future families who could be bereaved. I agree it is very difficult.

Councillor Kemp: I accept that, and that is why we need to talk to coroners about these issues in a wider sense.

Hamish Elvidge: To make some general points, one is that we have invested a huge amount of time and money in accurate data. The ONS is working very hard with Public Health England to ensure that suicide data are accurate and available at local level. If we accept the principle that accurate data drive accurate decision making, in my view all the areas Ruth spoke about very articulately should be brought together as a programme of change to ensure that we get more timely, better and accurate data.

Another slight concern has been expressed at the advisory board. There is a sense that there is a risk associated with the 10% target reduction being diametrically opposed to the need for accurate data. We would be very concerned if that risk came to fruition, and that because the Government had set a target they were reluctant to drive real change in the need for accurate and timely data.

Dr Aitken: The college has been quite thoughtful about this. There are some principles worth sharing. The first one is that we would be guided by the sensibilities of the bereaved, to refer to Richard's point. I think that at this point in the evolution of social attitude to mental illness stigma and suicide and stigma we ought to be guided by the pace of the bereaved. We as a profession are used to ambiguity. We like qualitative and quantitative data. We are quite happy, given the relatively low numbers of suicides, to help make sense of the stories as much as the hard numbers. In that context, we would ask for consistency. If we are in the middle of a strategy and measuring progress, does it make sense to change currency at this point? We feel that the timing of any change in currency ought to coincide with a change in strategy and the measurement of its delivery, so if it is timely we will support it. If it is timely to wait, we are equally happy to support that.



Q439 **Chair:** I agree that you want to be able to compare past with present practice, as well as geographically. Do you envisage that you could ask coroners whether, if there was a change in the law, they should also record whether or not under previous standards it would not have counted? Do you think it is possible for that kind of thing to happen?

Dr Aitken: I think that is possible. We had a period in Devon, when in an effort to get to grips with the very low number of people taking their own life and trying to make some sense of it by postcode, we attributed likely suicide to people who looked to us as if they had taken their own life. The coroners' verdicts were much fewer than that by the time of the inquests and so on, so it is entirely possible to run the two systems. A more open system that people can see and where the stigma of having that label is managed, with a slightly more confidential look at likely suicides, might be one way of compromising.

Q440 **Chair:** It could be another way of doing it, if you did not change the evidential standard but there was a way to clearly record it.

Dr Aitken: You could have a period when you apply both standards and take a view as to what is acceptable to the bereaved.

Ruth Sutherland: "Undetermined intent" is still included in the suicide statistics. If it is not determined as a suicide but as an undetermined intent, you can still respect the wishes of people and not mess up the statistics, because they are already included.

Q441 **Luciana Berger:** The last section is about the media. My questions are predominantly to Ruth, but if anyone else wants to pitch in at any point we are keen to hear from you. In our previous session, we heard from Professor Kevin Fenton from Public Health England. He was asked specifically about what action was being taken to counter irresponsible reporting. He said that he did not believe that Public Health England was responsible, nor could he identify whose responsibility it was. We know that the strategy itself refers almost exclusively to the work that Samaritans does. Do you think that the Government and Public Health England are doing enough to ensure that irresponsible media reporting is not causing more people to take their life by suicide? If not, what specific action would you like to see?

Ruth Sutherland: Unfortunately, I do not think the Committee has been well served on this item, with all respect to Kevin Fenton. The issue has become conflated. There is good practice guidance and then there is regulation. Those two points have been lost in the reporting and it has become a discussion about accountability and responsibility. I do not think the idea of Duncan Selbie, or even the Minister or the Prime Minister, writing to *The Sun* to say, "Stop it," will work. We are pleased that the work of the Samaritans has been recognised as making a contribution. We did it completely on our own initiative and have been praised for that.



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There is guidance on good practice. It says in the document I have here that the guidance must have teeth. It is not guidance that needs teeth; regulation needs teeth. Regulation of the print media is by IPSO, and Ofcom regulates the broadcast media. Both have codes that mean they should not be reporting particularly on the method, because we know that is the most risky thing, but the regulation is not strong enough. We would like it to be stronger. It says things like “excessive” or “when editorially justified.” Those are the exceptions, whereas it should be much stronger. The regulatory codes need to prevent mention of detailed descriptions of method, not just say “excessive.” The regulation could be tightened up much more.

We have found the most traction on good practice. It is carrot and stick. The carrot bit helps more. We monitored over 6,000 articles last year. When we see practice that is dubious or breaches the code, we report that to them. Generally, that results in some training for the journalists. We offer a kind of media advisory service, so that if you are planning an article or something you can consult us and get guidance. If we see you doing something that is not very good, we will tell you why it is not very good and work to help you improve. The training bit works well.

We would like the regulation to be much stronger, but there are limitations to it, which we have to find a way through. For example, online newspapers are not covered by the regulation. You could print something in your newspaper online and it would not be covered by the code. As to the whole business of whether the internet can be regulated, we are in a very difficult situation. We have found that by persuasion Facebook and Google and many of the big search engines respond quickly when we highlight things that should not be there; they take them down, but very often their own codes are not strong enough. For example, if we point out something to a search engine that we do not work with much, they might say that it does not breach their code or guidance. Perhaps there could be a push for their own guidance to be stronger.

When the Secretary of State made his deep dive on suicide, one of the things we highlighted was bad practice on Wikipedia. He said he would meet them and talk to them about it. I do not know whether or not he has. Even if he did, what would he actually be able to do? It has to be more about pushing good practice and naming and shaming. Facebook, Twitter and Google are worried about what people think about them. They want to comply. Recently, we had some very bad examples on the internet where there was live streaming of suicides in progress. As soon as we saw them, we worked with those people and all of them were taken down. All the people we know took them down, but it is difficult to remove all traces of them ever having been there. When you went to online newspaper articles—for example, the *Daily Mail* reported it online—even though they said they had taken it down it was still possible to trace the source online. That was difficult. In terms of what Government could do, there is an international perspective. Many of the sites we cannot get to comply with us are not covered by UK legislation. They are hosted



elsewhere and do not want to comply with anything here, so if Government could do anything to try to get greater adherence to codes of practice internationally it would be very welcome.

All the work Samaritans does in this area is funded by donation. Every year we have to make a decision about how much of it we can do. We think we have knowledge, experience and understanding of the topic. We would welcome working with anybody who wants to enhance and develop that work, particularly in the online space where we need greater resource to do more monitoring and get to the stories as soon as they happen, but, more importantly, to do it proactively and get it on their codes of practice at the beginning. The other area that needs more resource is local newspapers. We rely on our network of Samaritan branches to monitor some of that, but it is not as rigorous as it could be, because it is a resource problem. We would also like to do more training at local level. We do all of that reactively and we would like to do it more proactively. There is a lot of room for development.

Q442 Luciana Berger: I had lots of different questions, and you have covered almost all of them by your very comprehensive answer. I was particularly struck that the refreshed strategy we have seen did not address social media or the internet; it referred only to traditional media. Thank you for addressing that particular point where we would like to see a bit more progress. One of the themes that has presented itself during the course of this inquiry is language. We talked about it in our interim report, even during the course of our discussions. National newspapers, two in particular, have used a term that the Select Committee has been advised should not be used when referring to suicide. Are there things particularly around language that you feel should be tightened up in the available guidelines?

Ruth Sutherland: It is mostly to do with training, awareness and maybe some of the cultural change. If you do not keep on it all the time, they just go back to a default position, but when it becomes custom and practice it is language that is not used. We still have much to do in public education and general education for everybody.

We are particularly worried that new and emerging methods should not be reported. There is a lot of interest in those in the media; people cannot believe that you could use that as a method and things like that. We need to be careful about new and emerging methods and about celebrities or opinion leaders who might die in particular circumstances. We have all sorts of contingency plans if, say, a high-profile celebrity were to die by suicide. We have all sorts of plans about how we would work with the media about the method used and how they reported it. For example, we were very proactive on how the death of Robin Williams was reported.

By and large, we have been at this work since 2005 and I think we have had a lot of success. We report internationally. When we go to conferences on research into this work and what it has done we are



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always applauded for leading, but it does seem a bit much that it is down to a small charity to do that important work. We would like it to be more mainstream.

The final thing is about public trust and confidence. Much of the work we do is necessarily behind the scenes because we do not want to make it a story, hence the idea about Government having accountability. It would be a story if one commented on the press and tried to regulate the internet in some way. We would like to find ways to report on what we do, so that people can have trust and confidence that something is being done. We have not yet found a way to do it. Whether through the advisory group or whatever, we would be happy to report regularly on what we have done, if that would promote confidence that something was being done.

Councillor Kemp: I do not think we should look at just the dark side of the media. I am sure Luciana is as proud as I am that one of our local radio stations in Liverpool, on which both of us have appeared, is doing half an hour every Monday on mental health issues, destigmatising and bringing things out into the open. In addition to dealing with the problems that you and Ruth have outlined, we also ought to be saying to the press, "If Radio City can do it, why can't a lot more?" because that brings in the use of language. For example, I apologised for accusing a Labour member of being a nutter. It was totally inappropriate language. I could have bitten off my tongue after I said it and I will not do it again, but that is a word in common usage. If I use it, that permits other people to use it. I explained that on Radio Merseyside and they got lots of comments about what is appropriate language to use. The media can be a very powerful tool if we engage with them and enable them. If we treat them as the enemy, we will not take full advantage of them.

Q443 **Luciana Berger:** It is worth putting on record that at a previous session we welcomed the Mind Media Awards, for example, that also operate there. There is a contribution by all forms of media that do great work in that regard, including Radio City, as has been mentioned.

Ruth Sutherland: If I may add one last comment, there is legislation in place that you cannot incite suicide online. It has never been used, partly because it was ill-informed legislation in the first place. It is very difficult to prove that you have incited a suicide. All I urge is that, if there were to be legislation in this area in any shape or form, we do the work to make sure that it is useful.

Hamish Elvidge: It is helpful if reporting includes the impact of suicide on families, particularly the support that is available. If every single article talked about that and talked less about the means, it would be helpful.

Dr Aitken: The teenage community that live in my house do not read papers; they live in a world of memes, curiously dark humour, unfortunate stigmatising video clips and various other things that they



pass from pillar to post among themselves. The only good thing is that all of them—they are all in different schools—seem to be having quite decent conversations now about social media. It has moved beyond the pitfalls of sending awkward pictures of yourselves to one another; it is now about how you avoid attracting unwelcome attention and imagery to your inbox. I think more could be done in schools.

Q444 Rosie Cooper: I know there are no experts on deaths in prisons sitting before us, but I would like to ask a general question about suicide in prison and the prisons ombudsman. I would like to put in evidence a letter I received from the prisons ombudsman. Do you believe that prisons ombudsman reports ought to be mandatorily considered by NHS trusts providing care to prisoners? Even when there has been a suicide in prison and it has gone to the coroner, there appears to be no mechanism by which the board is required to examine its involvement or failings. The prisons ombudsman reports, which comment and/or reflect on the impacts on prisoners' health, particularly mental health, vulnerabilities, the number of staff who are there to help and the processes being applied, do not go back to the board, and it is not under any obligation.

In the case of the Liverpool Community trust there is evidence that the prisons ombudsman was told that everything was getting better when it was getting substantially worse, yet the prisons ombudsman says they do not have the resources. How do you think we can tackle a situation like that? I know that is a tough one from the left field, but it is important in the sense that those people are very vulnerable and one part of Government is flagging up a problem and the people who are delivering the service are not obligated to deal with it.

Hamish Elvidge: Can I respond to that in a general way, not specifically in relation to prisons, because what happens in prisons is probably relevant to coroners' section 28 recommendations? It would be helpful if there were a mechanism whereby all the recommendations were not just relevant to the individual location—prison or local authority—but could be brought together with a requirement to implement change across the system in relation to any section 28 recommendation, or any prison recommendation, so that we get systemic improvement in practice through the investigative review. That is what I would recommend.

Councillor Kemp: Two years ago when my wife followed Rosie to become Lord Mayor of Liverpool, I went to dinner in Walton prison because she had been doing something there. A fair number of people from the catering trade were incarcerated there, and we had a lovely dinner produced by a first-class chef, who had done a wrong thing. It was an excellent meal. Some of us then went to the prison and said, "We have a variety of skills." They included someone who said, "I'll do a sort of Fifteen for you," which is the sort of thing they have in Wormwood Scrubs. I cannot remember now what it is called. It was a whole series of things to work with prisoners to improve their mental health, and would eventually decrease, hopefully, the suicide and self-harm rates there. But my impression from Walton was that the staff were so busily engaged in



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containing a difficult situation that they could not even begin to cope with offers of help from outside because they had such difficult guidelines and circumstances.

I would answer the question not on the detail you have given, Rosie, but in the more general context that communities and prisons should be much more porous, and more things should happen together. There is help available to prisons and lots of people would give it, but the Prison Service does not seem to be structured to take advantage of it.

Q445 **Rosie Cooper:** I totally agree, Richard, but I was wondering more about the NHS side of it. You do not have enough nurses; you are not dispensing medicines in a timely fashion and not identifying vulnerable prisoners. Vulnerable prisoners are not given resources. That is identified by the prisons ombudsman but it falls into an abyss. Nobody is required to act on it. We might reflect on that. I wonder whether you agree that there ought to be a mandatory part, if that is the case.

Dr Aitken: The difficulty of mandating it is where the resource would come from and the staff who could reasonably be expected to turn up and make it work better. They would have to overcome the barriers that we have just been hearing about. We have a quality network for prison mental health services, running from the royal college. It can set standards; it can help prison mental health services, see where they are at and where they would need to get in order to be of the quality they might want to be. There are now 42 prisons in the network and they contribute to as much of the work of the prison as they can reasonably be allowed to. Interestingly, in the first years of the network there was a diminution in suicide, but, unfortunately, as the wider system pressures have come into play in the prison system, the good progress that was being made by the network seems to be faltering. I do not think it is for lack of knowing what is to be done; it is simply an inability to do it.

Q446 **Rosie Cooper:** While I appreciate those comments, do you think at the very least it ought to be a paper that the board ought to consider?

Dr Aitken: Which board?

Rosie Cooper: The NHS board looking at those resources.

Dr Aitken: Would that be the local mental health trust or the local CCG?

Rosie Cooper: In this case, Liverpool Community trust.

Dr Aitken: We provide for prisons in Devon. We as a trust board would receive information and would be required to act on it, and that is right and proper.

Rosie Cooper: That is the question.

Dr Aitken: If we as a trust are accountable for a service, we ought to be receiving useful information in relation to its operation.

Q447 **Rosie Cooper:** The prisons ombudsman says he does not have the staff,



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nor can he follow it up. If he receives an assurance that is fine, but those boards are not required to consider it, and that is an incredible bit to be missing.

Dr Aitken: Our board would welcome all learning. It is a learning organisation, so if there is a good report from the prisons ombudsman we will want to receive it.

Chair: Is there anything about the updated strategy that you wish to comment on that you have not been asked about today? No? In that case, thank you all very much. We thank you for coming. We appreciate your time.