

Inquiry into Suicide Prevention
Ymchwiliad i Atal Hunanladdiad
Ymateb gan Unigolyn
Response from An Individual

Summary of key points

- 1) The best information about the causes of suicide, comes from talking to people who have attempted suicide and survived. This needs to happen more often to help us to understand:-

If people ask for help, do they get it?

If they didn't get help, were they told why not?

What are the characteristics of people who do not get help?

Is the help offered useful? If so what was helpful? What was unhelpful?

If they saw their GP before the attempt, did they discuss suicide and if not, why not?

Did anything happen when they asked for help which made things worse, and/or discouraged them to ever ask for help again?

Does the clinical record and the person's intention agree. Is a suicide attempt recorded as a suicide attempt or is it recorded as self-harm?

What were the reasons for the attempt? Were they caused by voices? Were they related to a diagnosed mental health problem? Were they related to an un-diagnosed mental health problem? Did the person belong to the group who have mental health problems too severe for Primary care mental health support services and not severe enough for secondary mental health services?

What are the protected characteristics of people who attempt suicide, those who do not get help, and those who do?

- 2) The best information on what helps to prevent suicide when people feel suicidal, comes from those who have felt suicidal and not gone on to make an attempt. We need to be talking to people in this group more to find out what works

3) When evaluating interventions to see if they are having an impact on suicide rates, the data that best indicates change due to higher numbers with a clear correlation with suicide rates, is:

Self-harm seen by GPs

Self-harm which requires hospital treatment

Suicide attempts

Escalating self harm and suicide attempts

It would be extremely helpful to make suicide ideation and self-harm notifiable conditions to ensure a) we know what resources are currently being spent on this group, and b) we have excellent quality data through which to monitor and evaluate suicide prevention measures.

4) We need to investigate all suicides because we need to know:
what contact people have with health or social care services immediately before the event? (including GP, 999 and A&E).

Are they ex users of secondary care services, and hence were they ready for discharge?

Had they re-referred themselves under the measure and not had an assessment? Or had an assessment and not been taken back on for a service?

Were they referred to and not taken on by secondary services?

Were they under the care of the mental health crisis service, and hence was everything done that could have been done?

Had a family member or other member of the public raised concern with services? If so did this lead to an offer of help or not?

If they saw a GP in the week before death, did they raise the issue of feeling suicidal? If so was help offered or denied?

If they were not considered to have a mental health problem, what help would have been available to them in their area? How easy is it for people to find out about this help?

What are the protected characteristics of people who die by suicide?

- 5) We need to look more closely at coroners decisions on the deaths of women with a diagnosis of Personality Disorder, as there is evidence that these deaths are more likely to be recorded as accidental, when they are actually suicides, because staff feel that these people are wanting attention and hence the death is not intended. There is a risk that female suicides are therefore being under-reported.
- 6) We need better self-harm and suicide risk assessment processes, based on the research into causes of suicide, rather than research based on demographic groups. Focusing on demographic groups causes inequity of service, and values some lives more than others, some suffering more than other suffering. This is not compliant with the Public Equality Duty.
- 7) We need a wider range of innovative interventions and trainings, preferably co-productively designed with self-harmers and people who have survived suicide attempts, to create differences in different areas, in order to build practice based evidence on what makes a difference.
- 8) We need standards for the delivery of training, and the teaching/training qualifications and supervision of trainers, so that it meets the evidence base for training effectiveness in improving knowledge in action.
- 9) We need an assessment of current staff attitudes to self-harm and suicide, and to their knowledge and practice, to underpin a plan to improve attitudes, knowledge in action and high quality supervision of staff.
- 10) We need to consider mandatory training for frontline staff in suicide and self-harm prevention options, on the same basis as first aid (including in the work-place), and CPR. (GPs have said that they would use suicide and self-harm prevention far more than CPR in their day to day practice).

- 11) We need to look at the impact of interventions not directly aimed at reducing suicide and self-harm, which none the less have an effect on the incidence of it. Eg school health curriculum, communication skills, picking up vulnerabilities such as ASD/ADHD early, including in high academically achieving children, and in adults in touch with mental health services.
- 12) We need to do more about the causes of suicide, such as domestic abuse, bullying in any context, harassment of any kind in any context, sudden change in financial circumstances, debt, poverty, homelessness, unsuitable housing, rates of violent crime, accident prevention, not coping with serious health changes, access to work, access to services, quality of life, work based stress, not coping with grief, - both in terms of prevention and in terms of support.
- 13) We need to be increasing conversations about suicide and self-harm, which challenge assumptions, increase compassion and understanding, increase tolerance, and reduce anger.
- 14) No progress can be made without financial investment. There is not enough slack in the system to release the money and time required on the frontline at present. There are significant gaps in the knowledge of a large proportion of health, social care and mental health workers and professionals, and significant problems with attitudes, which require investment in training, supervision and staffing levels sufficient to ensure staff can be released to do the training; much data and research needs to be done to help us assess the costs of doing nothing compared to the costs of intervention and to underpin the development of effective training and interventions; and new services need to be developed for currently unserved groups. None of this can be done without additional investment. However, it is likely that any up front investment will lead to savings elsewhere when services become more effective. At the end of the day this is about the value of life and the cost of loss of life, even if money were not saved a willingness to invest shows that the Government cares. Not investing suggests they don't.

The Committee is calling for evidence about:

- The extent of the problem of suicide in Wales and evidence for its causes - including numbers of people dying by suicide, trends and patterns in the incidence of suicide; vulnerability of particular groups; risk factors influencing suicidal behaviour.

I am responding to this as a person who has attempted suicide on several occasions and faced negative attitudes and extremely distressing reactions both from people in the community including members of my own family and from health service staff, especially those working within mental health services. The latter particularly increased my vulnerability and ultimately had the greatest impact on my actions.

I belong to the occupation with the highest risk of suicide, consistently, with rates 4-5X that of the general population. [REDACTED]. I know a number of people in that profession who have committed suicide, and have been concerned about this issue for many years, before I was affected myself.

The suicide rate for women in the profession is 5 times the average, which brings it roughly level with the suicide rate for the most at risk age group for men.

However, even though 1 in 4 deaths by suicide are women, they are not taken seriously. Instead they are often labelled with Personality Disorder and face attitudes which make the situation for them far worse.

As the [REDACTED] I have seen existing information on this issue, which shows that women who commit suicide generally are dealing with more of the issues found to be affecting people who die by suicide than men, suggesting that they work harder to survive and suffer more before they take the decision. The focus on men fails to acknowledge women's heroic bravery and struggle, denies an adequate response to this suffering and minimises and neglects it in an unjust way. As a representative of service users I have discussed shocking situations with independent advocates. The story which sticks in my memory is the woman who attempted suicide 5 times, requiring intensive physical hospital care on each occasion, whilst 'under the care' of the crisis team, who discharged her after 6 weeks, because that is the maximum time of their intervention, without her having made any progress, without referring her to other services, and without any admission to protect her. This story whilst extreme, reflects many stories I have heard, and my own, which is that mental health

services, and sometimes emergency services, do not take suicidal ideation in women seriously, and rarely admit women at risk. I remember one story of a woman who had cut her wrists and was bleeding in the park by the bandstand, who phoned 999 and was told that no-one would be responding. She was just left there at night in the cold, alone. Fortunately she survived to tell the tale. The ultimate message women go away with, is that female lives are not as valuable as male lives, and that their suffering and well-being do not matter to mental health staff or policy makers.

The issue that perplexes me the most is the lack of investigation of attempted suicides, as this seems to be the best possible resource for understanding and responding to the questions you are asking. After people are dead you will at best be guessing, when the survivors can be absolutely accurate about the complex issues involved.

The other lost opportunity is in not keeping figures on presentations linked to suicidal feelings, because we don't get any understanding of what helps people to survive, and eventually be free from this struggle. Too often staff assume that those who come forward for help can't really be suicidal, or they wouldn't be looking for help, rather than seeing the survival of suicidal people as a success for intervention.

There is an assumption that people from disadvantaged urban communities are the worst affected. However, the other professions consistently in the top 5 affected occupations include farmers, and the other 4 are professionals with relatively high incomes – vets, Dr's, Dentists, and pharmacists. All these groups have access to the means in the form of anaesthetics/guns.

The suicide figures given for Wales are all based on local authority areas, and are expressed as absolute numbers rather than as rates. If you look at the suicide rates, as in deaths per 100,000, the suicide rate in Carmarthenshire is by far the biggest, with the annual absolute figures being in 2nd -4th place with them in fourth place on rolling 3 year deaths, with all other authorities with higher figures having much bigger populations. The increase in suicides in Carmarthenshire coincided and increased in proportion to the reduction in absolute numbers of acute psychiatric hospital beds per head of population. At the time suicide rates started to climb, rural Carmarthenshire had the highest rates of psychosis in the 3 counties of Hywel Dda. And yet the proportion of beds per head in Carmarthenshire has persistently fallen faster than those in Ceredigion with the highest number of beds per head, and

Pembrokeshire also with significantly more beds per head, and both with very much lower suicide rates. Carmarthenshire has a 1/3 of its population living in poverty, with the majority of these being the rural poor. A significant proportion of suicides here are in the rural population. Hywel Dda also has a lower number of Consultant psychiatrists per population than any other area in Wales. (Though I have yet to be convinced that consultant psychiatrists do anything to prevent suicide, and in my own experience some have contributed to the cause of my own attempts. The low rates of consultants here probably reflect a general problem with staffing rates in mental health in this area.). Even in the new proposals for transforming the health service the plan is to again give Carmarthenshire much fewer of the new recovery beds, than Ceredigion or Pembrokeshire. With 2 and a half times the population of Ceredigion, Carmarthenshire will have the same number of beds as they do.

One of the critical issues is the demographic based approach, as a result of the leadership role of Public health based on figures relating to the groups most at risk. By focusing on population groups rather than on individual circumstances, risk assessment measures keep failing to identify those most at risk and inequalities in services inevitably arise. What we do know from studies in Manchester working with survivors is that 3 factors are consistently present in all suicide attempts and hence likely to be present in all suicides. 1) unbearable suffering, or situation, 2) which is seen by the individual to be inescapable, and 3) where the individual believes there is no help available. This absolutely converges with my own situation, when I attempted suicide. But these factors are not reflected in any of the risk assessment processes.

Although the majority of suicides are in the general population and are not known to mental health services, it does not mean that they did not have a mental health problem, or that they did not seek help. Figures show that the vast majority have visited a GP in the final week of their lives. We need to know more about what happens in this last visit to see if the clues were there, or whether having got there the individual bottles out of talking about the situation. I know from personal experience just how hard it is to talk to professionals about these feelings, and have myself usually left it until it was too late to make much of a difference, and often described those feeling in euphemistic terms which may mean I was not understood. For me this has largely been a result of the extremely negative views of society and particularly of those I would have to ask for help.

We also know that one of the highest risk groups are those who self harm, and that the incidence of self harm is a far better indicator of the size of the problem than the actual number of deaths, as it is a bigger number showing trends more quickly and more obviously than actual deaths. We need to keep on top of data on both self harm and suicide attempts - which are too often recorded as self-harm when the motivation is completely different.

But our services and staff do not notice or understand self-harm or take it seriously. In women it is usually dismissed as Personality Disorder which is considered to be treatment resistant (although it is not), and for which it is claimed that hospital treatment is unhelpful – when the most effective model has been in residential units. The evidence actually suggests, not that hospital is the wrong place for people with personality disorder, but that it is not doing the right things for them. In addition many services are denied to people with Personality Disorder, including community mental health services and crisis team services. There was at one point a Government health circular, specifically telling crisis teams not to deal with patients with a Personality Disorder. The real risk here is that Personality Disorder is massively over-diagnosed, especially in women, and hence those who need hospital care are frequently denied it as a result. The quality of diagnosis is persistently extremely poor, with very few having a sufficient clinical history taken, very few involving evidence from family, friends, neighbours or colleagues, and very very few involving the evidence based psychological instruments, which have been shown in peer reviewed research to be far more accurate than intuitive face to face diagnosis. Sometimes, despite an evidence based tool ruling the diagnosis out, consultant psychiatrists have persisted in their view that the patient has this condition. A psychologist joked to me that the diagnosis was a result of ‘[redacted] a psychiatrist’ – unfortunately there is fairly good evidence that this may, in a significant proportion of cases, be true. As is the observation that it is more often given to highly intelligent, feisty women who ask questions and want explanations – behaviour which appears to make mental health staff extremely uncomfortable. I remember a consultation event where a psychiatrist warming to the value of her input, told about an OT seeing a patient, who had a difficult and conflictual relationship with this OT, and the psychiatrist prided herself in intervening, by recognising –without even meeting the client concerned – that they had a ‘Personality Disorder’, and therefore should not have a service. Not everyone gets on with everyone else. A conflictual relationship with one person, does not mean that you have a Personality Disorder, but this is the way service users, especially women

who self harm or feel suicidal, are routinely treated. In addition with the greater availability of adult autism assessments and hence understanding of autism in mental health services, it has become apparent that women, particularly, do not have their autism picked up as children, until they present to mental health services later in life. We now know that many women with autism have been mistakenly diagnosed with personality disorder, and that the standard treatments for personality disorder cause damage and harm to people with autism. We also know that people with autism have a lower threshold to psychosis, and that psychotic symptoms are not always taken seriously in this group, or conversely that many autistic individuals have been diagnosed with psychosis, when they are actually autistic. The point is that misdiagnosis leads to inappropriate treatment and inappropriate treatment increases the risk of both iatrogenic harm and suicide.

My personal experience is that no one has ever asked me what led to my suicide attempts, and the contribution made by voice hearing was therefore not identified. Whenever I tried to talk about my voices I was told I was lying. This contributed to the inescapability of this unbearable situation, and the feeling that I would not get help. The experience of an incomprehensible diagnosis of Personality Disorder just added to my distress and confusion, and seriously undermined any limited self-esteem I had left when in a crisis. Experience kept reinforcing that I was right to believe that I would not get help. I could not understand why other people who heard voices were taken seriously and helped with compassion, and I was not only not helped, but often treated with contempt. I was diagnosed with Aspergers last year, after 5 years asking for and being refused an assessment and 14 months on a waiting list, but the diagnosis of Personality Disorder has only just been dropped as a result of better history taking by a new psychiatrist in my care and involvement of my family, and I have only just been diagnosed with psychosis by this consultant, 16 years after seeing my GP about my first voice hearing experience.

It is very clear that where a woman has a poor relationship with a member of mental health staff she stands a very high risk of being diagnosed with Personality Disorder on the basis of this alone. This includes women who make any kind of complaint about mental health services, and underpins the importance of complaints being treated with extreme confidentiality so that complaints do not affect either diagnosis or care. However the current NHS complaints process is not fit for purpose because it does not provide this protection. As a result it contributes to suicide risk.

There is also a tendency to attribute suicide in women with Personality Disorder to accidental death, as self-harm and suicidal behaviour is seen as 'attention-seeking', or as a 'coping mechanism', and therefore any death would be un-intended. This is very likely to be leading to significant under-recording of female suicides. Incremental self harm is persistently regarded as bad behaviour, rather than recognising the real intentions of failed suicide attempts and risk of eventual suicide.

We know that mental health problems also create a suicide risk, as this group has by large orders of magnitude the highest suicide rates. But mental health staff seem (not without notable exceptions) to have the worst understanding and attitudes of any group within society about suicide and self-harm, frequently seeing it as bad behaviour, selfish, 'the coward's way out', as manipulative or attention seeking. I remember hearing a very senior member of staff recounting his feelings about a telephone call from a suicidal person, as feeling 'held over a barrel'. This staff group has the greatest potential impact on suicide rates, and also has the greatest need for retraining. The same staff member triggered two of my suicide attempts first with a very harsh letter which contradicted another Dr's diagnosis regarding an issue I had never discussed with him, and the next year with a particularly vicious and judgemental letter refusing me any further treatment as a result of a confidential letter I had written to a different manager on a subject which had absolutely no relevance at all to the writer of the vicious letter. On both occasions the letters arrived on the Friday of a bank-holiday weekend, when there was no support available.

It is critical that training of staff supports understanding, compassion and staff self-efficacy through feelings of competence and good treatment protocols to follow. The negative perceptions of staff about people who report feeling suicidal or wanting to self harm, says far more about the support they need to cope with the demands of their job and of working with high risk individuals, than it does about the intentions of service users. I believe you cannot change these attitudes without being very clear about what they are, which requires some research, and without having survivors who can bust the many myths about suicide, actually in the training room to challenge assumptions and prejudices.

- The social and economic impact of suicide

There are estimates of how much suicide costs. It is a very large amount of money.

We also pay very heavily for the negative attitudes to suicide, which cause immense and unnecessary distress to all concerned, and which are magnified by the taboos and reluctance to talk about it openly. You can only think suicide is easy, if you have not attempted it. You can only be angry if you have not experienced the depth of distress which drives it. You can only see it as irresponsible if you have not lived with the experience of being a burden on and source of distress to others, or have lost face and status – which is known to be particularly high risk for people in the public eye, when they are publicly shamed in the media. You can only see asking for help with suicidal feelings as ‘attention seeking’ rather than taking responsibility, if you have never struggled with it and forced yourself to try to put others first by asking for help when it is extremely difficult to do so. When the messages you hear from others are all so judgemental, if you become suicidal it can be immensely difficult to admit it and hence to ask for help, and sometimes you cannot even admit it to yourself. Feelings of shame and guilt can be so intense, promoting secrecy and avoidance, that you may not even feel that you deserve help. These attitudes make preventing suicide extremely difficult. If you lose someone close to you, you are more likely to commit suicide yourself. Each suicide touches and affects many people around them, including the professionals involved before and after it, who have to deal with the situation and the bereaved.

- The effectiveness of the Welsh Government’s approach to suicide prevention - including the suicide prevention strategy *Talk to me 2* and its impact at the local, regional and national levels; the effectiveness of multi-agency approaches to suicide prevention; public awareness campaigns; reducing access to the means of suicide.

Talk to me 2 is not working. The responsibility arrangements, committee structures and accountability/reporting structures are not convergent, are unnecessarily complex, and impede partnership working, due to lack of clarity of where responsibilities lie, and hence promote the opportunity to abdicate responsibility and to do nothing. The leadership with Public health puts it outside of frontline services, and has prevented front line action. Responsibility needs to be firmly placed at the door of frontline services, and with individual practitioners, with all services having a responsibility to report directly to government on key areas of activity, including how they are collaborating with other

local partners. The role of those effected by suicide is undermined by the arrangements for leadership and accountability, as those organisations supposedly leading (RPBs) do not have the right mechanisms for service user involvement. There is then a requirement for reporting through the LMHPBs, which is undeliverable unless they also lead on the delivery. The LMHPBs do have better service user and carer involvement, potentially including people affected by suicide, but even this varies greatly in quality from health board to health board.

Although there is a real concern, this is not driving change. The regional structure is unclear and clunky. It is not clear which group covers Powys. It seems much more logical to divide regions along health board lines, which are co-terminus with Regional Partnership Boards. We also need to ensure people affected by suicide are in all the regional groups and at the National level, and that they are central to the next up-date of Talk to Me. (Talk to Me 3??) It is critical that Health Boards, and WAST, and not just mental health, have clear lines of responsibility on this due to the role of GPs and emergency services. We need to have someone with Personal responsibility for this at executive level in each health board, to work with a local partnership including the LMHPBs, to deliver government strategy, and we need a specific budget allocation ring fenced for this work. It is very, very clear that apart from the minority known to mental health services there is no specific service to help people who self-harm and are suicidal who do not tick the current boxes for either primary or secondary care eligibility. We know that around 70% of people presenting with mental health problems fall between Local Primary Mental Health Support Services, and Community Mental Health services, and hence get no service.

We also know that GP's are very poorly prepared and resourced to deal with mental health. You do not have to have a mental health problem for your physical health to be dismissed as being caused by one. This is a very dangerous situation. GPs have very limited training in mental health in their core under-graduate training and often do no other training on the subject. This inadequately prepares them for being the first line for support for people who are self-harming or are suicidal. They also have no in house expertise, alongside practice nurses and health visitors, who could improve services and increase capacity and understanding at this level. It is extremely easy to find examples of GPs and A&E staff who have an extremely unhelpful attitude to mental health, which can verge on contemptuous and dismissive, clearly demonstrating a lack of status for mental health and a feeling that it is not their business. The recent suicide of an asylum seeker in Swansea,

after trying everything to get help, without success, demonstrates just how inadequate our services are for this situation. We also know that mental health training of paramedics and A&E staff, as well as staff providing care for terminal and life limiting or chronically disabling conditions is also seriously inadequate. 10% of suicides are in people with such chronic physical health problems

We have a reducing number of GPs, who spend a lot of their time on mental health. It could solve a lot of problems to include the employment of mental health and suicide and self-harm prevention practitioners in every practice, using underused consultation rooms and taking part of the workload off GPs, as requirements within the Primary Care contracts. It is clear that GPs would have far more opportunity to use training in suicide and self-harm prevention, than they have for CPR, and would save more lives by doing so. Suicide and self-harm prevention training needs to be mandatory on the same basis as first aid and CPR.

We need health boards to all have a clear suicide and self-harm prevention strategy within their IMPTs which specifically references where they are working with LMHPB's, RPBs LA's, and with other agencies on this through an overall partnership group on the LHB footprint.

If you want evidence of what's working look in the areas where suicide rates are falling. I believe the only area in the UK doing that is Scotland, where they have a specific government budget and 22 Choose Life coordinators. Taking into account the calculated costs of suicide, the programme more than pays for itself.

The TTM2 strategy recommends evidence based training, but a recent document relating to this showed that there is very little training with such an evidence base. The only training which has demonstrated a fall in suicide rates is the Good Behaviour Game used in schools, which isn't specifically a suicide intervention. It is clear that any training needs to be regularly repeated just as CPR training and first aid training need to be repeated. The benefit of the Good Behaviour Game is that unlike other trainings it meets the best evidence base for learning and development, by including real time practice of new skills in context, and rewards for improvement. Any training with the best content in the world is only as good as the ability of its design and its trainer to change understanding and behaviour. None of the existing trainings have a robust quality assurance structure, with adequate evidence based

training qualifications for trainers about how to train and evidence based teaching supervision structures.

The idea of a 'once for wales' training programme for suicide and self-harm, given the lack of evidence base would be unhelpful. We need diversity in the system in order to identify best practice and to support continual improvement. It is important that Universities are more involved in the evaluation of trainings than in their design and delivery. A dual role of doing both creates a conflict of interest, and hence potential evaluation biases, and whilst Universities have a very good record on research quality, their teaching quality is considerably more controversial, with many of their teaching staff not having any teaching qualifications or evidence based teaching supervision structures and processes. It is critical that all trainings are centred around the experience of those affected by suicide and self-harm who can personally describe and answer questions about their state of mind at these times and what did or did not help them.

Getting partners together locally to deliver TTM2 has been a real struggle. There seems to be a tendency for little groups to start and fizzle out through various committees, working without any coordination, with both duplication and gaps. When they find out there is a group somewhere else, the interested parties seem to melt into the background, presumably because it then becomes somebody else's business.

There is as yet no campaign which has successfully addressed the taboo of talking about suicide and self-harm. This is because we can only overcome the stigma and shame of feeling this way, by accepting that it is a reasonable response to an unreasonable situation. Ironically unless we accept suicide and self-harm, we will never prevent them, because if you cannot talk about it without being judged, you cannot ask for help. This seems to be more the case for men, who seem to be more affected by what people think about them, than women are (partly because women's cultural and historical expectations of not being respected are engrained and hence they are more accustomed to it). By far the greatest number of suicides is in the group who don't get help. I had a long talk with a local woman recently who was really struggling with her anger at the suicide of a young man who had left 2 children. Because of my experience I was able to talk to her about what it feels like, about the statistics, and about the fear of being judged if you ask for help, and about the need to accept suicide before we can prevent it. The fact is that suicide is not so easy, and not so cowardly as people

generally realise. It takes a great deal of courage and extreme distress to overcome the instinct of self-preservation. The conversation really helped her, as apart from anything else her anger and confusion were really painful for her. We really need to have these conversations for the good of our society, with those who demonstrate such anger and confusion.

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

The first and most important task is to stop public services and the mental health service in particular, from *causing* suicide and self harm. This is only possible with investigations following suicide and self-harm, and particularly following suicide attempts, working with the individual to evaluate service contributions.

We then need a specific service for suicide and self-harm prevention which has no eligibility criteria, apart from the presenting individual feeling so distressed that self-harm and suicide become an option for the individual seeking help. This needs to be available through non-stigmatising environments, not labelled as mental health services, such as GP practices, or well-being projects, and it needs to include an option for space and time away from the situation, to give people the space and protection they need to first face, and then work through their difficulties, based on an essential basis of providing hope of change. There is absolutely no point in taking someone out of an unbearable situation and providing hope only to return them to it with the situation unchanged. (eg returning to an abusive relationship, to homelessness, to unemployment, to isolation, to financial distress, etc).

The Samaritans provides a service beyond compare, and yet is not publicly funded.

It is far better and more appropriate than CALL helpline, which is frankly dangerous when used in a crisis. The CALL helpline is a risk in suicide and must be removed from automatic inclusion in care plans as part of a crisis plan. In my experience their time limit on calls can mean putting the phone down on very high risk individuals which can be enough to precipitate an attempt. Their call handlers can be harsh and judgemental in a crisis. They are very good at giving information, but may be eclipsed by local information lines developed under the Social Care and Well-being Act even in this role.

The Health Boards all need to have a suicide and self-harm prevention strategy with full health board sign off as part of the IMTPs, based on a primary care response, an A&E response, and a response for services dealing with people with life-changing long term health disability, life limiting and terminal illnesses, in addition to a mental health service response. This needs to be developed in co-production with survivors of suicide and those bereaved by it, as well as self-harmers, and to be the direct responsibility of one of the Health Board's executive team. The strategy needs to include making intentions to, or actual self harm, and attempted suicide notifiable, so that we have better records to inform all policy and monitor progress, and a requirement for investigation of all suicide attempts and self harm incidents presented for medical treatment to identify the social causes, any mental health issues, and any impact, positive or negative, from anybody, be they members of the public, employers of the person, people with authority over the person, or public service staff. This is required to build up an evidence base and better understanding of the causes and contributors to these actions, to identify good and bad practice to underpin training programmes. It also needs to include the introduction of mandatory suicide and self-harm prevention training to all front line staff in primary care, emergency care, care for disabling, life limiting and terminal conditions, and for all mental health staff, with equal status to CPR training. All training must be subject to continuous improvement processes and evaluation through service outcomes, in order to establish an evidence base of training that makes the most difference. Strategies need to ensure no one falls through the net, that all are treated with compassion, dignity and respect within a non-judgemental framework, and that all staff have sufficient support and supervision to deal with any negative feelings they have, such as feeling helpless about people's mental distress, or feeling angry about the situation.

It is also critical that NHS complaints processes are made safer for people complaining to assure complete confidentiality so that a complaint against one member of staff will not affect care provided by others, that it will not affect diagnosis, and that services cannot be withdrawn on the basis of relationship breakdown following a complaint, without absolute proof that the complaint was motivated only by fraud or criminal and unprovoked intention to harm the person complained about. It is essential that no one loses a service as a result of a complaint, without being provided with an accessible and appropriate alternative. Complaints that relate to service or staff impact on suicide and self-harm are particularly sensitive and require extensive support for all those involved. It will be very hard for staff to be told that their actions, or

inactions have precipitated self-harm or suicide attempts, or indeed led to suicides, but it is essential to recognise failures in order to learn from them. Staff teams should be supported and helped to change their practice and not be in any way punished unless they 1) refuse to accept responsibility and apologise to the client and/or their family, 2) refuse to change their attitude, practice or approach in the light of findings, or 3) can be shown without doubt to have acted with the *intention* of causing harm to the patient, including intention to precipitate a suicide.

The strategy needs to include a mental health element which addresses the quality of Personality Disorder and Autism screening and diagnosis, the involvement of families and social networks in mental health diagnosis, legal rights of access to a second opinion for any diagnosis of exclusion, like Personality Disorder, the differentiation of suicide attempts motivated by voices and those motivated by psychology, and mandatory training for all mental health staff in suicide and self-harm prevention, with compassion, dignity and respect in a non-judgemental approach.

There needs to be additional support for the social circle of people suffering intentions to self-harm or feeling suicidal. The social circle will be dealing with the same feelings of anger, helplessness and frustration as health staff, and need equivalent support, as well as support to better understand the drivers for these actions in their loved ones, and in how they can help. It may be cost effective and helpful for support and training to be delivered to relevant staff and social circles together, when someone with these difficulties presents to services, as this will be the point when training and support will have the greatest impact. It is critical to promote honest and open, respectful, compassionate and accepting conversations between people struggling with self-harm and suicidal compulsions, and staff, as well as close social contacts in order to address the taboo of not talking at the most critical time, and to break down the judgemental attitudes to these behaviours.

Local Authorities and social services have influence over many of the social determinants of suicide, self harm and mental health. Particular emphasis needs to be given to critical issues such as social inclusion, overcoming isolation, supporting access to services, safe-guarding, employment support, suitable housing, access to leisure services, access to life long education, promoting dignity and respect, a human rights based approach to services, and promoting social acceptance of people who self-harm or struggle with suicidal compulsions.

Local authorities in partnership with the police need to do more about domestic abuse, bullying in schools, colleges, Universities and work-places, and bullying between users of social housing.

The police and Victim Support need to put more focus on the prevention of violent crime, sexual exploitation, modern slavery and harassment, and provide more support not just to the direct victims of crime, but also to the indirect victims, such as those facing allegations, but proven innocent before being charged, and anybody taken in by criminals pretence of being good people, such as friends and family who may feel extremely distressed and betrayed by criminals. These people do not currently get any support, but may be devastated by the situation.

The fire brigade need to be including suicide risk in their assessments of fire safety in people's homes, as fire is a method used for suicide that also puts others at risk including fire service staff. They need to also be able to present a strategy and actions to support their staff to prevent staff suicides, and in this show how they are collaborating with LHB footprint suicide prevention partnerships. Where a fire is used for suicide, they need to have an effective support policy for their staff to help them to deal with this. Our local fire brigade has abdicated responsibility for involvement in the Talk to me 2 strategy because they feel the actions are not their responsibility despite recognising their staff are priority people in the strategy.

The partners within the crisis concordat need to be represented on Health Board footprint partnerships to prevent self-harm and suicide. They have a very critical role to play and need to be up to speed with what all the partners are doing, and to ensure all the partners know what they are doing. As with health board emergency front line staff, all frontline officers and support staff need to have training in self-harm and suicide prevention based on compassion, respect, dignity, acceptance and hope for change within a non-judgemental framework, and have access to support to deal with the emotional repercussions of this kind of work. This work also needs to cover the risks to people 'in contact with' the criminal justice system.

It is critical to change the attitude to 'frequent users' of 999 and emergency services. They are demonstrating an inadequacy of services, rather than being inadequate themselves. There needs to be a more compassionate term used for them, such as 'indicator patients' or 'unmet need patients', or 'currently unserved patients'. Until there is a service for everyone in a self-harm or suicidal crisis most of these

people have nowhere else to go. It is also critical that emergency services, including 999, pre-hospital care and A&E, all accept and embrace the fact that these people are part of their core business and are not a distraction from 'people who really need help for physical injury and life-threatening physical conditions'. Self-harm and suicide attempts are equally life-threatening, or potentially disabling, and deserve the same status and attention as other presentations.

Education establishments need to focus on managing student/pupil workloads, exam stress, and policies to minimise and address bullying, or harassment in their communities. Staff need training to recognise the danger signs for self-harm and suicide, and to have first aid level training in how to help people and where to refer them for longer term support.

Local authorities need to also put more into addressing poverty and supporting people at risk of suicide and self-harm as a result of it. It is clear that council tax for instance is a much higher proportion of the value of the home in the lowest band than it is in the highest band. This inequity which disproportionately disadvantages the poorest, needs to be addressed. In addition charges for social care are disproportionately affecting people on below poverty incomes, where their benefits are only just above the threshold, and for people in marriages or civil partnerships who are not in control of the household budget, and whose budget control is below poverty level. We need better funding for and access to benefits advice, support with benefits appeals and debt management advice.

- The contribution of local communities and civil society to suicide prevention.

Enhancing community and individual responses to people who self-harm and are suicidal is particularly challenging. It requires more identification with afflicted people and more understanding of their distress, whilst discouraging anger and judgemental attitudes. Various art forms, which tell representative stories may help to develop this identification with others in extreme distress. It could be dangerous however, to have survivors tell their own stories as they would be at high risk of both traumatisation over what happened and/or of public anger, especially through anonymous channels such as social media. It is also shown that there is a risk to showing the means,

It also requires education which improves understanding of mental distress and the causes and drivers of suicide and self-harm. Most of all it requires the right support at the right time by the right people within communities affected by these problems, to help them to understand and reduce their anger, and to instead show how a more accepting attitude can help people, and how talking about it in a measured way, can make it easier for people affected to come forward for help. Providing this support will gradually increase the capacity of individuals and communities to be more effective in supporting and helping people who struggle with self-harm and suicidal compulsions. Whilst people like me can make an impact it is essential that survivors of suicide are not expected to fulfil this role, as they would need high levels of support and adequate and fair rewards.

Politicians, high profile individuals, and leaders could do more to keep this issue in the spot light and to chase resources to improve responses to it, as well as providing role model positive responses which do not demonise people who self-harm or attempt or commit suicide. They need to keep making this a priority. In addition we need much better adherence by the press to standards of reporting on these things, given the risks of copy cat actions.

- Other relevant Welsh Government strategies and initiatives - for example *Together for Mental Health*, data collection, policies relating to community resilience and safety.

As already stated, self-harm and suicide attempts, and reports of suicidal feelings/compulsions should be made notifiable to maximise the reliability of data. Key staff such as emergency and primary care staff need training in the relevant codings for suicidal feelings/compulsions, suicide attempts and self harm, to improve data collection. We need detailed investigations of every suicide attempt, to include drivers, social issues, health issues, mental health issues, precipitating events, impact of public sector staff, impact of other people's behaviour on the individual, impact of diagnosis, impact of responses to complaints about the mental health service, impact of quality of Care and Treatment planning, including quality of crisis plans, impact of local availability of acute psychiatric beds, or other services such as psychological therapies and occupational therapies, impact or waiting times for access to services and assessments, and of staff shortages, impact of interventions, or lack of interventions, impact of stigma and discrimination, impact of accessibility problems of services to people with protected characteristics, impact of co-morbid problems, impact of

mis-diagnosis, impact of access to, or no access to social care, and crisis teams. It would be extremely helpful to at the very least differentiate between attempts precipitated by psychology and those precipitated by voice hearing/hallucinations.

We need accountability for providing psycho-social assessments for everybody presenting with self-harm and suicidal feelings/compulsions as recommended by the NICE guidance, which may mean creating roles with appropriate training specifically and only for doing this, due to the shortages of professional staff to do it.

It is essential that government policy looks at diagnoses of exclusion, and 'dustbin diagnoses' (ie given casually when the service finds the person 'difficult'), such as Personality Disorder, and the quality of the diagnostic process. It is essential that people have access to a second opinion where they find this diagnosis does not help them to explain their problems, and where they find the treatments offered do not help. It is essential that Personality disorder is only ever used as a diagnosis where evidence based psychological assessments have been carried out with evidence from the individual's family and social circle regarding their history and presentation when not in the company of mental health staff. It is critical that there are facts in the records, in the form of observations which are not value laden, to underpin any diagnosis, and to ensure that they are not applied only when someone complains. For instance for the same behaviour, the observation 'she was silent' is not value laden, the observation 'she refused to talk' is. It is essential that everyone considered for a diagnosis of psychosis or Personality Disorder is first screened for Autism Spectrum, as the conditions are sometimes difficult to distinguish and require completely different treatment, and autism can change the presentation of psychosis, which can be under-diagnosed in autistic individuals who actually have a lower threshold to psychosis than the neuro-typical population.

The policies need to make individual organisations report on their involvement with suicide and self-harm prevention planning and implementation directly to government, in terms of their own contributions to actions and their contributions to partnership working. There needs to be no place to hide from failure to make this a priority and failure to act in collaboration with all other partners.

It is absolutely critical that survivors of self-harm, and suicide attempts have meaningful opportunity to reflect on the quality of their care, and to provide comments anonymously, and for these comments to be used to

improve services. It is similarly necessary for the people around them to do so, including where the individual dies.

There is currently no service to help people deal with the trauma of a near death suicidal experience, which can contribute to future suicide attempts. Having attempted suicide leads to a lower threshold at which suicide becomes an option, and makes future attempts easier, as it seems to reduce the inhibitions to taking your own life. Few appreciate the trauma of failing to commit suicide, of not even being able to get that right, of being alive when you want to be dead. Surviving suicides have been the most distressing experiences of my life, alongside not being believed about my voices and not being able to get help to control them. Living for years, wishing that I had not survived, even if not currently suicidal has also been a terrible experience. The hardest of all has been the feeling that all my suicidal crises and attempts were entirely preventable had I been accurately diagnosed and appropriately treated. And that I have been left with far more serious mental health problems as a result of persistent failure to recognise autism and psychosis, with repeated failure to provide appropriate treatment as a result of being mis-diagnosed with Personality Disorder. I was persistently refused any second opinion, or any answers to my questions or explanations of what behaviour was disordered, and staff utterly and repeatedly refused to meet with and listen to my family's evidence of what I was like growing up, my mental health and personal history, and by behaviour outside of the mental health service. They simply blocked all discussion about diagnosis and rebuked any questions as a lack of willingness to 'listen to professionals' and characterised my distress about diagnosis as a 'long term conflict'. The only observation in my notes given to justify this diagnosis referenced a complaint about the service, which was, but should not have been, placed on my medical records. My experience has been that coming for help has led to disdain, contempt and punitive responses too often. I survived therefore I wasn't really suicidal. I asked for help, therefore I wasn't really suicidal. 'Considering suicide' was seen as irresponsible and cowardly, rather than there being any recognition of me heroically struggling to overcome the compulsion to die, asking for help was manipulative and attention seeking instead of responsible. Far too few people recognised just how hard I worked to find a reason to live, and to battle with the voices on my own, or just how difficult it was to ask for help when previous responses to my requests for help had been so judgemental and punitive. I really felt that some staff wanted me to die, and even more often that my life simply wasn't worth enough to be saved. The anger from my own family added to all this. This trauma, is something I and my family continue to live

with, even though I finally have a diagnosis which makes sense and helps and a crisis plan that is meaningful, and treatment and support that is making a difference. It remains hard to be confident that were I in the same position again, the response would be any better.

The failure to provide any funding or resources to support the prevention of suicide is shameful. It sends out the very strong message that Welsh Government doesn't care, and feels that people's lives are not worth saving.

It is critical that the new curriculum on health and social care in schools, has a fixed curriculum, which is influenced by people who have survived mental health problems, rather than being left to individual teachers, as there are clear resilience issues and skills, as well as clear needs to address stigma and discrimination and to create more open minded and compassionate attitudes to mental health, and to give pupils more confidence that their mental health should never be a matter of shame or seen as a weakness of character.

- Innovative approaches to suicide prevention.

We need funding for more research into suicide and self-harm, specifically with a survivor perspective. Survivors ask different and more relevant research questions, and create more effective evaluative processes for training and interventions. We need to evaluate staff attitudes to suicide and self-harm to underpin the design of training and to identify those who most need it.

Training must be designed with survivors and people affected by suicide, and they must have a say in how it is delivered. It may be appropriate to involve them in delivering training, but care needs to be taken to ensure that they are not re-traumatised in the process.

Anyone dealing with self-harm and suicide risk needs a lot of support, and enough techniques to help to give them confidence as helpless feelings of staff compound and contribute to negative attitudes.

The way suicide risk is measured needs to be transformed. It needs to be led by the personal experiences of survivors, and be personal rather than demographic. It doesn't matter what the drivers or risk factors are, if the person sees the situation as unbearable, inescapable, and help as unattainable they are at high risk.

There are many, many things people can do to help others bear their pain, to bring hope of change, and to provide help or facilitate access to it. People ask for help not because they don't want to die, but because they don't want to 'want to die'. People need to be rewarded for the responsibility shown by asking for help. They need compassion and hope that makes it possible to ask for help again if they need to. People need to be asked what is unbearable and inescapable and what help they don't think they will get. Sometimes these situations are remarkably easy to resolve once they are revealed. Sometimes they are more long term and harder and support is needed for much longer. However I have yet to meet a situation where nothing could be done.

It is unacceptable to claim that the cost of effective prevention is too great, and also unrealistic, as the costs of suicide to society far outweigh what it would cost to prevent it.