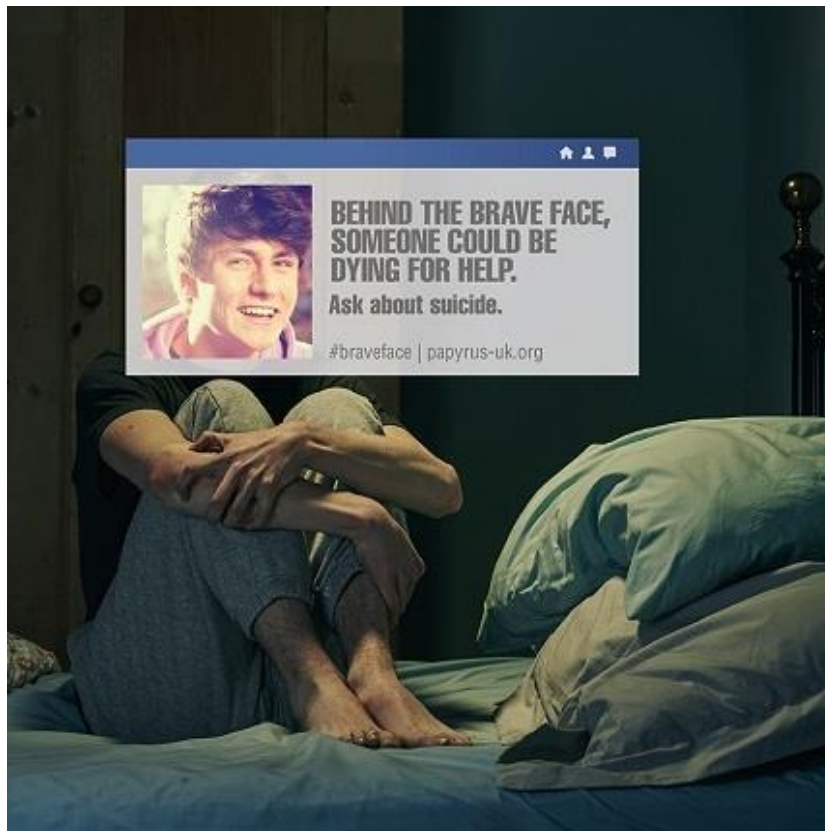


Y Pwyllgor Lechyd, Gofal Cymdeithasol a Chwaraeon
Health, Social Care and Sport Committee

Inquiry into Suicide Prevention

Response from national charity



GED FLYNN

Chief Executive

PAPYRUS Prevention of Young Suicide

Head Office: 28-32 Milner Street, Warrington, Cheshire, WA5 2AD

Registered Charity No. 1070896

INTRODUCTION

- a) PAPYRUS Prevention of Young Suicide is a national UK charity founded in 1997 by parents who had lost children to suicide. Today, it has members and supporters from across the UK who share the common belief that **many young suicide are preventable**.
- b) Our primary focus as a national charity is to prevent suicide in young people aged up to 35 years. **In the UK, suicide remains the leading cause of death in this age group in both genders.** PAPYRUS works towards building a society which speaks openly about suicide and has the resources to help young people who may have suicidal thoughts.
- c) A majority of PAPYRUS trustees have lost a child or young sibling to suicide and most of those who join or actively support the charity have been touched personally by young suicide. PAPYRUS promotes the unique contribution to suicide prevention made by:
 - i) those who are touched personally by the death of a young person to suicide (parents and families who have lost a young person to suicide, colleagues, friends, communities)
 - ii) young people who suffer with emotional distress, self-harm, experience suicide ideation or engage in 'suicide behaviours'
 - iii) those who care for / work with a young person who may be at risk of suicide
- d) PAPYRUS has three office bases in the UK – Warrington, London and Birmingham. The charity runs a national helpline called **HOPELineUK**, taking calls, texts and emails from young people at risk and from caregivers (parents, friends, colleagues and professionals) every day of the year from 10am through 10pm.
- e) PAPYRUS offers training to professionals and communities on suicide awareness, prevention and intervention skills. We work in communities to create suicide safer communities with and for young people.
- f) PAPYRUS is a campaigning organisation, pressing for change, rooted in the experience of our members, supporters and those who access our support or engage in our projects. Through our social media campaigns, we aim to raise awareness of the contribution that each one of us can make to **#saveyounglives**.



1

¹ **#SpotTheSigns** this film can be viewed here: <https://papyrus-uk.org/help-advice/resources/spot-the-signs>

SUBMISSION

1. As a member of the National Advisory Group, PAPYRUS welcomes the opportunity to speak to share evidence with the Health, Social Care and Sport Committee in **Welsh Government**.
2. The charity has been involved in the National Suicide Prevention and Self-Harm Reduction Advisory Group since its inception, represented by Ged Flynn, PAPYRUS Chief Executive.
3. PAPYRUS believes that there should be an acknowledgement in strategy and suicide prevention plans that suicide is **the leading cause of death in young people - males and females under 35**. We are beginning to get the message out there about male suicide but not about young suicide. 200 children (10-180 die each year by suicide. This is information that the public has to dig for; it should be a public health priority.



4. **Suicide Among Children – Building Suicide Safer Schools & Colleges**

PAPYRUS is leading a campaign this year to highlight that **at least 200 children die every year to suicide**. We believe that there is significant under-reporting of child suicides because of stigma and the demand for coroners to reach the highest standard of proof before determining a suicide conclusion. PAPYRUS has developed a very accessible **guide for schools** to help them prevent suicide. It covers identifying the signs that children and young people often share that they are distressed and considering suicide; it contains a how to guide on intervention techniques and skills; it also talks schools through how to respond to a death by suicide in their community. The Guide is available to download for free on the [PAPYRUS website](https://www.papyrus-uk.org/about/our-campaigns/save-the-class-of-2018#preventionguide).² While the current inquiry of the Committee is focusing on over 14 year olds, we must not lose sight of the impact of adverse childhood experiences and the fact that children as young as 9 years of age are contacting PAPYRUS with the desire to die by suicide. Many mental illnesses have their roots in childhood and adolescence. PAPYRUS urges legislators to consider this when making policy in mental health and suicide prevention. We cannot continue to deny that children die at their own hand and often before they are 15!!

² <https://www.papyrus-uk.org/about/our-campaigns/save-the-class-of-2018#preventionguide>

A YouGov poll commissioned by POPYRUS in late 2017 surveyed teachers across the UK. It showed a great desire among school staff to support young people who are experiencing suicidal thoughts but many held a deeply-rooted fear or a significant lack of preparedness to do so. We need to equip all Welsh schools to prioritise suicide prevention: they need to be ready to say “We are doing all we can to help protect children and young people from suicide.” Currently, this is not the case:

Your needs

In 2017 POPYRUS commissioned research amongst teaching professionals. We found:

One in ten (11%) said, on average, a student shares suicidal thoughts with them once a term or more.

Only half (53%) said they would feel confident they could support a student who had shared suicidal thoughts with them.

Classroom teachers less confident compared to Heads/Deputies

48% of classroom teachers said that they would feel confident, compared to 73% of Heads or Deputies.

Classroom teachers also more likely to experience barriers to offering support

45% of Heads/Deputies said that nothing would prevent them from supporting the student themselves, vs 21% of classroom teachers.

Teaching professionals noted a number of barriers which would prevent them from supporting a student with thoughts of suicide:

Almost half (47%) said they weren't trained in suicide prevention.

A third (34%) said they would be worried about making the situation worse.

22% felt that they wouldn't know the right things to say.

15% said they would not know what steps to follow, as their school did not have a suicide prevention policy or procedure.

13% said that they would not have permission to support the student, according to school/college guidelines.

Very few teaching staff felt that it wasn't their role to provide support

12% felt that it was a matter for parents/ Guardians and not the school, and 2% felt it wasn't their role.

Some of the concerns shared:

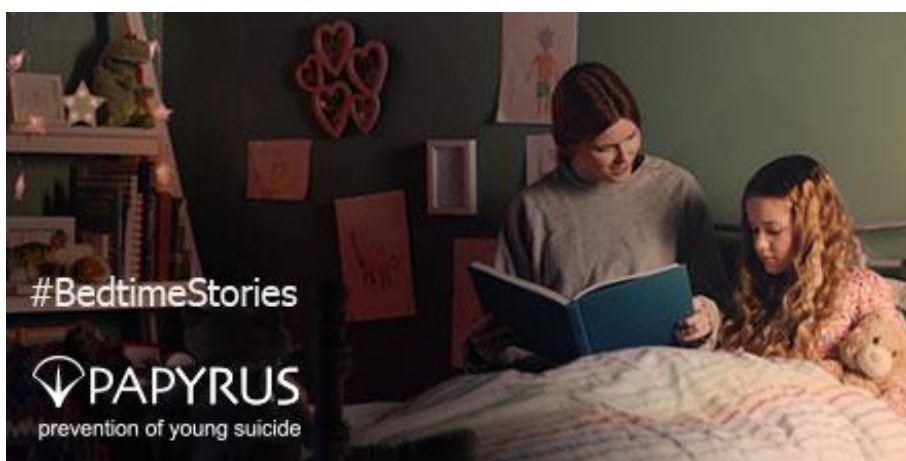
- "I would feel responsible under safeguarding and possibly left to carry the can"
- "I'm not sure if it's attention seeking rather than genuine thoughts"
- "School discourages personal interactions"
- "There are problems getting senior teachers to take notice"
- "We don't have the time to spend with the student"
- "I'd be worried about getting the correct support from the management team and concerned about fulfilling my other roles and responsibilities to other children in my class"
- "I would want to help but don't consider myself qualified for this"

These findings highlight that whilst many teaching staff see it as their role to support students, many have concerns about offering this support – and do not feel equipped to provide it.

Over 200 schoolchildren are lost to suicide every year in the UK. Help us save the #ClassOf2018.

© This is National Suicide Helpline 2018. All rights reserved. 2017 Registration: New, Quainton and Annual School Status for Parents. Welsh 2018 Registration: Suddby, Suddby and Suddby 2018 Registration.

5. **Building a Suicide-Safer Online Environment** is a vital part of saving lives, especially for our young people who often “live online”. POPYRUS has worked tirelessly to highlight the suicide-specific dangers on recipe sites and pro-suicide sites. Some remain despite the efforts of POPYRUS and its partners to reduce access to these: they inform readers on how to kill themselves, lethality ratings and how to obtain means. **In a recent study with Bristol University**, POPYRUS members shared experiences of how their children and young people had been influenced by such online information. Many of their young people had searched how to die before enacting their suicide. We now have the new challenge of social media and ephemeral information apps such as SnapChat which provide platforms for short exposure to long term dangers (sexting, anonymous image transfer, etc.). In its most recent campaign in this area, POPYRUS produced a hard-hitting online film asking parents about their child’s online activity. This has gone viral and, indeed international(!). **#BedTimeStories** is worth a watch and is available here: <https://www.papyrus-uk.org/help-advice/resources/bedtimestories-online-bullying>



“Thank you for your advice and support. I had no idea what to do or say when my child said she felt worthless and would be better off dead.”

Mother of a 9 year old boy who called our HOPELineUK service.

6. **Local and Regional Suicide Prevention plans are ‘getting there’ but need resources and key accountable leads.** PAPYRUS was involved in the preparation of Public Health England Guidance for Local Authorities in Planning Suicide Prevention Activity and Strategy in their communities. Much of this thinking is now shaping the implementation of *Talk To Me 2* across Wales. It is pleasing to see that regional suicide prevention chairs are now in place across Wales, helping to champion and support this agenda through the regional groups.
7. **People affected by suicide have an important contribution to make to prevention.** PAPYRUS exists to recognise and foreground the unique contribution made to suicide prevention by those for whom suicide/suicidality is a **lived experience** (*bereaved parents/caregivers, young people at risk, those who experience and engage with services to support their mental health or reduce suicide risk*).
8. **We need to change the law.** PAPYRUS believes that HM Government should act with urgency to address and reduce stigma created and perpetuated by the State. Suicide is no longer a crime but the State often deals with it as though it still were. Specifically, there is a pressing need to change the law to allow HM Coroners to reach a suicide conclusion at inquests, based on the civil standard of proof (*on the balance of probability*), rather than the criminal standard (*beyond all reasonable doubt*). In its desire to get the law changed, PAPYRUS has the support of many other leading mental health charities, lots of people bereaved by suicide, the Chief Coroner, members of the National Suicide Prevention Alliance, members of the National Suicide Prevention Strategy Advisory Groups (Westminster and Wales respectively) and many others. Despite its best efforts and this widespread support for a change in the law, PAPYRUS has been unable to get the support of the Ministry of Justice to address this important issue. **It would be good to have the support of Welsh Government here too.** Please see [Annex 1](#) for background evidence.
9. **Services are stretched.** PAPYRUS listens regularly to thousands of young people and those who care for them. Many callers to our HOPELineUK services struggle with the support they receive from services which are under-resourced or inconsistent in their care. Often, families report being left in despair as services cannot offer timely or professional support to a young person at risk. Waiting lists are often a problem. Children and young people contact PAPYRUS as a lifeline; many of these are desperate for local face-to-face support but are unable to cope between appointments, remaining at significant suicide risk on a waiting list. This can be unbearable to many young people. Parents, partners and friends often do not know where to turn. We often hear from patients or their parents and caregivers that “*the local mental health crisis team seems to be in crisis*”. Some report that opening times are “office hours only” – mental health crises often happen at night when local services are unavailable. Similarly we hear that young people in the care of CAMHS or Transition (child to adult) services are often left in crisis and, even when they receive a service, find staff who are ill-equipped to manage suicide risk effectively.
10. **Support for People Affected by Suicide** This remains a postcode lottery. A woman told us that she received two long phone calls from Victim Support on having had her laptop stolen. Yet, when her daughter died, nobody spoke to her and offered any help. She asked, does the State value my computer more than my child? Postvention services and support systems are of value in their own right. Suicide is an unimaginable tragedy for family, friends, others affected, indeed whole communities. Moreover, it is an important prevention measure: those who have been touched personally by a suicide are at heightened suicide risk themselves. This is an urgent priority, enshrined in our strategy yet remains poor in terms of services available in Wales.

11. **Suicide training for front line workers in the NHS is limited and not being prioritised.** POPYRUS is aware of so many stories where young people who died by suicide had been let down by a practitioner who did not ask about suicide or, where they did ask, did not follow up appropriately. On HOPELineUK, too, we often hear that a caller has been to the GP but had never asked about suicide. We always do ask. Many GPs seem to minimise the expressed distress, particularly when the patient is an adolescent. Further, there is a catalogue of stories about medics and other professionals completing Personal Health Questionnaires (PHQ9) type assessments and not knowing how to follow up with appropriate support when suicide risk is clearly identified. Many do know that they must refer but the pathway is not always clear to secondary or specialist services. This means that some young people end up at Emergency Departments with little effective support or, even worse, get missed and remain at high risk. Many young people then take their own lives.

There should be a radical reappraisal of the need for GPs and other frontline health professionals to be trained to be suicide-aware and able to intervene effectively where suicide risk is present. Medics and nurses should be required to learn suicide awareness and intervention skills (such as ASIST) before graduating. This should be mandatorily updated frequently just like CPR training for GPs. The likelihood of having a patient suffer unconsciousness or heart failure at a surgery is far lower than the volume of suicide risk being presented daily to GPs yet there is no requirement for suicide prevention training for GPs currently.

Risk assessments often used to assess whether a person is likely to harm or die because of thoughts of suicide are largely ineffective and only help the person completing them rather than the person at risk.

**SILENCE.
THE BIGGEST
KILLER OF
YOUNG PEOPLE
IN THE UK.**

SUICIDE.

We need to talk about it.
#TalkThroughTheTaboo
papyrus-uk.org

 **PAPYRUS**
prevention of young suicide

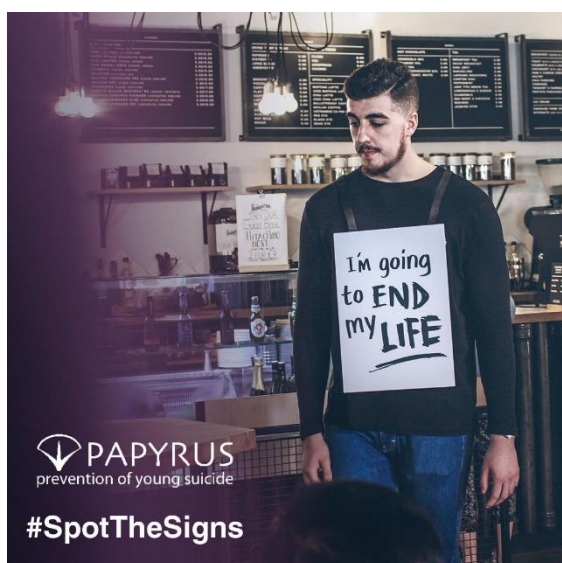
Registered Charity Number: 1070896

12. SHARING INFORMATION TO SAVE LIVES

Confidentiality between patient and doctor is an important principle. However, the safety of the patient is paramount and therefore **sharing of information** may well need to happen in order to save life. The current National Suicide Prevention Strategy for England states that, *'there are clearly times when mental health service practitioners, in dealing with a person at risk of suicide, may need to inform the family about aspects of risk to help keep the patient safe.'* Where the individual is under 18, the issue is even clearer: GMC Guidelines for all doctors dealing with 0-18 year-olds state that they should disclose information if this is necessary to protect the child or young person, or someone else, from risk of death and serious harm. The guidelines make clear that the doctors' ultimate responsibility is safeguarding and protecting the health and wellbeing of children and young people.

Despite this, PAPYRUS is aware of countless cases where parents and close caregivers are not always informed of what is happening when their young person is at risk. Young people at risk and their primary caregivers ought to be included in the **care pathway** wherever possible. Often we hear that parents, in particular, are the last to find out about suicide risk in their young family member, despite professionals knowing that risk. **PAPYRUS believes that, wherever possible, information must be shared to prevent suicide where there is risk to life.** The Consensus Statement³ of the Royal Colleges and the Department of Health must be properly promoted, disseminated and used at local practice level among all health professionals.

PAPYRUS has recently written to all Chief Executives of NHS Trusts across the UK to encourage information sharing. The letter asks NHS bosses to support their staff in making best interest decisions where life is at risk from suicide ideation or suicide behaviours. Where such a decision to share information is challenged, the NHS trust lead is asked to back their colleague in the courts should it come to litigation. We have already had several trusts take up this idea. We believe that it encourages existing best practice, it removes the fear of being sued or challenged, and ultimately saves lives.



*“How can it be OK for me
to be told by my GP
only after my son’s suicide
that he had made
several previous attempts on his life?”*

Father of a 17 year old boy who took his life.

³ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/271792/Consensus_statement_on_information_sharing.pdf

Annex 1

Reaching a Suicide Conclusion by HM Coroner

1. Coroners play a key role in dealing with the aftermath of suicide. We believe that many coroners play a significant damaging role in stigmatising suicide and reinforcing outdated attitudes to those who take their own lives. There is the most compelling evidence to suggest that the increasing reluctance of coroners to return a suicide verdict is linked to the outdated view that suicide is a crime.
2. It is important to note that coroners use a criminal standard (beyond reasonable doubt) when reaching a suicide verdict. This practice is not enshrined in the Coroners and Justice Act, or in the Coroners Rules, but in Case Law which has been brought about, primarily by those who wish to challenge a coroner's conclusion (perhaps because of the stigma associated with suicide, the financial implications of a suicide verdict, or because of the difficulty they have coming to terms with the fact that a person they love has taken their own life).
3. In our brief review of the case law it is evident that prior to the decriminalisation of suicide in the Suicide Act of 1961, there were good reasons to challenge a suicide verdict, certainly to avoid the stigma of committing a criminal act and the financial disadvantages it brought. Case law established that the presumption had to be against returning a suicide verdict and reaffirmed the need for coroners to establish 'intent' on the part of the deceased person. The point is made that suicide is a crime and must be proved by facts and not conjecture. For good reason, a suicide verdict was only to be returned when there was clear evidence of intent (*Southall v Cheshire News Company Limited* (1912) 5 BWCC 251; *R v Huntbach, ex parte Lockley* [1944] 1 KB 606).
4. Following the Suicide Act of 1961 which stated; "the rule of law whereby it is a crime for a person to commit suicide is hereby abrogated", there were a number of legal challenges of a coroner's suicide verdict.
5. These challenges focused around intent and it is clear that the appeal judges had a view of suicide behaviour that was 'of its time'. We can see from two important cases where the deceased young men stepped before an oncoming train, the appeal judges felt evidence from parents, family and friends, that the individuals were in a positive frame of mind prior to their deaths, should not have led to a suicide verdict. It is clear from these accounts that both young men killed themselves. (*R v Dyfed Coroner ex parte Evans* 24 May 1984 (DC); *Jenkins v HM Coroner for Bridgend and Glamorgan Valleys* [2012] EWHC 3175 (Admin)).
6. There is a weight of examples where young people have hidden their suicidal thoughts from those closest to them and were noted to be both outgoing and cheerful prior to killing themselves. Indeed, having resolved themselves to take their own life, they were more settled and calmer than they might previously have been. (The intention to kill themselves is demonstrated by the fact that they bought a suicide kit online and used it to take their own life, as was the case for my own son.)
7. This case law, which shows a poor understanding of suicide behaviour, has led to the practice of applying the most stringent of tests in cases of suicide, such that coroners are increasingly reluctant to deliver a suicide verdict, despite clear evidence that death was indeed self-inflicted. We can cite various high-profile cases where almost everyone would consider the person killed themselves except the coroners who reached a conclusion of 'accidental death'.

8. The clearest reference we can find to the application of such a high standard of proof is in *R v West London Coroner, ex parte Gray* [1986]. Lord Widgery CJ in *R v City of London Coroner, ex p Barber* [1975] 3 All ER 538 at 540, [1975] 1 WLR 1310 at 1313 said:

'If that is a fair statement of the coroner's approach, and I sincerely hope it is because I have no desire to be unfair to him, it seems to me to fail to recognise what is perhaps one of the most important rules that coroners should bear in mind in cases of this class, namely that suicide must never be presumed. If a person dies a violent death, the possibility of suicide may be there for all to see, but it must not be presumed merely because it seems on the face of it to be a likely explanation. Suicide must be proved by evidence, and if it is not proved by evidence, it is the duty of the coroner not to find suicide, but to find an open verdict. I approach this case, applying a stringent test, and asking myself whether on the evidence which was given in this case any reasonable coroner could have reached the conclusion that the proper answer was suicide.'

It will be noted that Lord Widgery CJ alluded to the stringent test, but without reference to what may be called the conventional standards of proof. I cannot believe, however, that he was regarding proof of suicide as other than beyond a reasonable doubt. I so hold that that was and remains the standard. It is unthinkable, in my estimation, that anything less will do. So it is in respect of a criminal offence. I regard as equally unthinkable, if not more so, that a jury should find the commission, although not identifying the offender, of a criminal offence without being satisfied beyond a reasonable doubt.

As for the other verdicts open to a jury, the balance of probabilities test is surely appropriate save in respect, of course, of the open verdict. This standard should be left to the jury without any of the refined qualifications placed on it by some judges who have spoken to some such effect as 'the more serious the allegation the higher the degree of probability required'.

9. The significance of this ruling is to once again give suicide the same status as that of a criminal offence, despite the fact that it was decriminalised 14 years earlier.
10. The result of this and other case law has been to reinforce negative views of suicide, create an increasing reluctance to return a suicide verdict and as a consequence, return the act of suicide to the position it was prior to being decriminalised in the Suicide Act of 1961. For all intents and purposes suicide is still treated as a criminal act. (The continued use of the term 'committed' suicide is a reflection of our continued tendency to criminalise those who take their own lives.)
11. We understand the reluctance of many parents/partners or family members to hear a suicide conclusion returned following the death of a family member, but the consequences of not being open and acknowledging that the person was instrumental in bringing about their own death is to increase the stigma around suicide. This increases the reluctance of those who are considering ending their lives to acknowledge and speak about their suicidal thoughts. It impedes help-seeking. In addition it has the unintended consequence of hiding the true extent of this major public health concern in the UK.

Ends