

S 41

Inquiry into Suicide Prevention

Ymchwiliad i Atal Hunanladdiad

Ymateb gan Y Comisiwn Cydraddoldeb a Hawliau Dynol

Response from the Equality and Human Rights Commission

Equality and Human Rights Commission response to the Health, Social Care and Sport Committee's Inquiry into suicide prevention

About the Equality and Human Rights Commission

The Equality and Human Rights Commission (the Commission) is a statutory body established under the Equality Act 2006. It operates independently to encourage equality and diversity, eliminate unlawful discrimination, and protect and promote human rights. It contributes to making and keeping Britain a fair society in which everyone, regardless of background, has an equal opportunity to fulfil their potential. The Commission enforces equality legislation on age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. It encourages compliance with the Human Rights Act 1998 and is accredited by the UN as an 'A status' National Human Rights Institution. Find out more about the Commission's work at: www.equalityhumanrights.com.

Introduction

The Commission welcomes the Chair's letter of February 9 inviting us to provide written evidence to inform the Committee's Inquiry into suicide prevention in Wales.

Our response focuses on our *Is Britain Fairer? & Is Wales Fairer?* reports and the findings of our Inquiry into non-natural deaths of adults with mental health conditions in prisons, police custody and psychiatric hospitals.

Is Britain Fairer? and Is Wales Fairer?

The Commission has a statutory duty to report on equality and human rights progress in England, Scotland and Wales. Our *Is Wales Fairer? 2015* report brought together evidence to answer the question as to whether Wales was fairer than it was when we published our first review five years before. The report looked at areas of life such as health, education, work, justice and individuals' role in society and the changes that have taken place in each of these. Based on the evidence, the report identified seven key equality and human rights challenges for Wales, and a number of particular priorities for each of these challenges.

One of the seven challenges and its priorities was to:

Improve access to mental health services and support to people experiencing poor mental health.

- Improve access to mental health services.
- Reduce the rate of suicide especially amongst men.

The report states that in Wales the suicide rate for people aged 15 and over substantially increased between 2008 and 2013, up from 10.7 to 15.6 per 100,000 inhabitants.

While the incidence of suicide has increased for all groups of people, the increase is especially marked for men compared with women. The suicide rate has increased for certain age groups: it doubled for people aged 55 to 64 and increased by around 60% for those aged 35 to 54. It is also particularly high for middle-aged men (Office for National Statistics, 2015).

Is Britain Fairer? (2015) states that during the review period (2008 to 2013) suicide rates increased in England and Wales, but decreased in Scotland (although its suicide rate remained the highest in Britain). The gap between men and women widened in the UK as a whole, with middle-aged men having the highest suicide rates:

Between 2008 and 2013, the overall suicide rate increased slightly in England (from 10.0 per 100,000 inhabitants to 10.7) and to a greater extent in Wales (from 10.7 to 15.6 per 100,000 – most visibly among the 35–64 age groups).

The male suicide rate increased in both countries resulting in a widening of the gap between males and females in Wales and England.

In the UK, the suicide rate of males aged 45–49 increased significantly between 2007 and 2013 from 19.4 to 26.8 deaths per 100,000 population, while that of the overall population (counting both men and women) increased from 10.6 to 11.9 per 100,000 over the same period (ONS, 2015).

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH, 2014) highlighted the continued high risk of suicide by patients with mental health issues, within 12 months of mental health service contact. Patients at particularly high risk were those who were recently discharged from hospital (especially in the first one or two weeks) and those who were under crisis resolution and home treatment who were also living alone.

The Commission will be publishing updated Is Britain Fairer? and Is Wales Fairer? reports in 2018. We will share our updated evidence with the Committee.

Preventing deaths in detention of adults with mental health conditions

In 2015, the Commission published a report of our Inquiry into non-natural deaths of adults with mental health conditions in prisons, police custody and psychiatric hospitals in England & Wales in the years 2010 to 2013. Our inquiry focused on non-natural deaths which fall into one of the following categories: self-inflicted/suicide, deaths caused by another person including homicide, deaths; the cause of which is unknown and accidental deaths.

Our Inquiry primarily looked at existing evidence across the three sectors from 2010 to 2013, to examine how organisations complied with their obligations under Article 2 of the European Convention on Human Rights (the Right to Life).

The report's main findings included (please note the report is dated 2015):

For detained patients in hospitals we were not able to access much of the information that follows a non-natural death, such as individual investigation reports. Detained patients are a particularly vulnerable group in the UK who are being held in order to keep them, and others, safe. The care given to them must reflect their specific needs and it is incumbent on society to monitor this care.

In healthcare settings...the Government should take steps to ensure it can be confident that independent investigations are indeed taking place, that staff are supported to speak candidly about events and there are no deaths in psychiatric hospitals that could have been prevented. The Commission considers this to be such an opportunity to reduce the deaths of detained patients that we intend to take this forward with those responsible for providing and regulating psychiatric care in hospitals.

In relation to prisons, the debate about how people are detained needs to go beyond the minimum standards that keep people alive. Those responsible for detention must ensure that people are not punished for behaviours that are viewed as disruptive but in fact are symptomatic of illness. Prisons need to monitor the numbers of prisoners with mental health conditions and their severity so that they can reflect on them and make appropriate arrangements for treatment and support.

It is impossible to talk about the high levels of people with mental health conditions in prisons without questioning whether imprisonment is the appropriate place. As many others have previously stated we remind

the Government that the aim of the penal system should be about rehabilitation as well as punishment. For some people the need for tailored rehabilitation that meets their particular needs might be better served within the community or psychiatric hospitals. This would also mitigate the pressures on prison resources.

In prisons, there was an increase in non-natural deaths between 2012 and 2013, with a further increase in 2014. HM Inspectorate of Prisons (HMIP) have cited their concerns about the increase in people being imprisoned. They and the Prisons Probation Ombudsman (PPO) have also voiced concerns about staff reductions, tougher regimes and less resources and possible links between the deaths and these factors. Any link between these factors and the increase in non-natural deaths since 2013 is complex and needs to be better understood. Therefore those responsible for keeping prisoners safe should work together to understand and address these issues. Any deterioration in conditions of detention and adverse impact on those with mental health conditions should be monitored and remedied.

In the course of our Inquiry we came across cases from PPO investigation reports where deaths have resulted from the failure to identify a prisoner's mental health condition and where concerns were identified but not shared with colleagues. These deaths could have been prevented if prisons got the basics right.

There are very few deaths within police custody, however every year a number of people with mental health conditions die while being detained. The role of the police is not to provide clinical care to people in need of support however they are often the first on the scene so they cannot ignore the need to be able to respond appropriately while minimising the use of restraint. This should always be done in partnership with local health providers (including ambulances).

There is a considerable amount of work being done nationally and locally. These should help ensure quicker assessments and access to clinical care and that people are not being held inappropriately within police cells.

The police should record and publish the use of restraint in order to allay concerns that there is discriminatory use against people with mental health conditions and people from ethnic minorities.

The Report's recommendations were addressed at government, regulators and inspectorates and the leaders and managers of individual institutions. They were:

- Recommendation 1: Structured approaches for learning lessons in all three settings should be established for implementing improvements from previous deaths and near misses, as well as

experiences in other institutions. As part of this, there should be a statutory obligation on institutions to respond to recommendations from inspectorate bodies and to publish these responses.

- Recommendation 2: Individual institutions in the three settings should have a stronger focus on meeting their basic responsibilities to keep detainees safe including implementing recommendations, improving staff training and ensuring more joined up working. Where this is not currently the situation this should explicitly be part of the inspection regimes.
- Recommendation 3: In all three settings there needs to be increased transparency to ensure adequate scrutiny, holding to account and the involvement of families.
- Recommendation 4: The Equality and Human Rights Commission's Human Rights Framework should be adopted and used as a practical tool in all three settings. Adopting it as an overall approach as well as ensuring compliance with each individual element will reduce non-natural deaths and should help to inform and shape policy decisions.

Follow-up report

In March 2016, the Commission published a [follow-up report](#) to our 2015 inquiry into [non-natural deaths of adults with mental health conditions](#) who were detained in prisons, police custody or psychiatric hospitals. The follow-up report examined the steps taken to act on our recommendations over the previous year and was based on information provided to us by inspectorates and regulators we worked with, data, reports and other publications on the subject.

Analysis of evidence showed that changes were being made in some areas where we had concerns in our inquiry, but some key areas still need to be addressed. Data on the number of non-natural deaths in the three settings shows that the overall trends are:

- the number of non-natural deaths is continuing to decrease for detained patients.
- the number of non-natural deaths has continued to increase year on year for prisons.
- the number of non-natural deaths is low, but numbers are fluctuating for police custody.

Following extensive consultation with other regulators and stakeholders over the year, we have revised our recommendations for change. These reflect learning from good practice and where urgent changes are required.

Case study: Dyfed Powys Police street triage service

The Inquiry report included a case study of the Dyfed Powys Police street triage service. Dyfed Powys police launched a street triage service in 2015 for responding to calls where potential mental health issues were identified. The street triage project is an ongoing initiative that sees police and mental health services work together to ensure people get appropriate care when police are called to a person in distress.

The aim was to ensure that the least intrusive options were used whenever possible. Section 136 detentions typically take up a considerable amount of police time. Use of police custody for these detainees has dropped by nearly 50 per cent in the first 12 months, which represents a considerable efficiency saving. Initially, significant effort and persuasion were needed to embed effective partnerships across police, health and social services.

The size and rural nature of the area have influenced the type of triage service developed. A hybrid model was adopted that combined an unmarked police vehicle with telephone support to front line officers. Mental health nurses are now based in the head-quarters and help assess information as it comes through.

A training programme, which started in December 2015, aims to deliver mental health awareness training to every officer in the force, up to chief constable level. Importantly mental health practitioners have been involved in designing and delivering this, including enhanced training for those in the triage team.