



BRIEFING PAPER

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Suicide Prevention: Policy and Strategy

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Summary

Suicide prevention policy in the UK has, in recent decades, developed and expanded considerably as concerns around suicide rates have intensified. In England it has, since September 2012, taken the form of an integrated Government strategy – [Preventing Suicide in England: a cross-government outcomes strategy to save lives](#) – whose aim, principally, is to prevent people from taking their own lives. Since 2017 it has included a commitment to reduce the rate of suicides by 10% in 2020/21 nationally, as compared to 2016/17 levels.

This builds on the previous Government strategy, which was led by the Department of Health and was established by the Labour Government in 2002. More than this earlier initiative, however, the current iteration of the Strategy operates deliberately and explicitly at a cross-Government level which involves a variety of different, albeit overlapping, policy areas. These include health, as well as transport, social security, education, defence, media, and justice policy briefs.

Suicide rates

This briefing paper begins with a statistical overview of suicide rates throughout the UK over time, using the latest data set from the Office of National Statistics, which was published in September 2018. This shows that in United Kingdom in 2017 there were 5,821 recorded suicides. This number of deaths equates to an age-standardised suicide rate of 10.1 deaths per 100,000 population, which is one of the lowest rates observed since the suicide data series began in 1981.

National suicide prevention strategy

Section two provides an overview of suicide prevention policies and strategies in the UK, as well as their various updates; the latest of which from the UK Government is the [Third Progress report](#), published in January 2017. Section three considers national and local oversight of suicide prevention measures, including the two reports produced by the House of Commons Health Select Committee as a result of its [Suicide Prevention Inquiry](#) which took place during 2016-2017.

Suicide prevention in different policy areas

Given the cross-Government nature of the UK Government's Strategy, which is also, to varying degrees, a feature of strategies developed by the devolved administrations, this briefing paper then proceeds to a consideration of each of the policy areas upon which suicide prevention plans touch individually, taking each in turn. These are:

- **Health services** – with details of suicide prevention measures in the [Five Year Forward View for Mental Health](#) (published in 2016), local suicide prevention plans, and NHS support for high risk groups;
- **Education** – setting out suicide prevention measures taken by educational institutions, including schools and the mental health services they provide, as well as further and higher education institutions which have a legal duty under the *Equality Act 2010*

to support their students, including those with mental illness conditions;

- **Employment** – outlining policies designed to keep people who suffer from mental health problems in work, including a proposed 10-year strategy to “break down employment barriers for disabled people and people with health conditions”;
- **Social security** – outlining support for benefit claimants with mental health problems, training and guidance for DWP staff, the risks in ESA and PIP assessments, and concerns expressed recently that people with mental health conditions may face certain difficulties or problems when navigating the new Universal Credit system;
- **Railways** – detailing suicide prevention measures undertaken by the British Transport Police (BTP), as well as the suicide prevention partnership between Samaritans, BTP, Network Rail, and other parts of the rail industry;
- **Prisons** – including current prison service policy and health services for prisoners, Government policy to prevent suicide in prisons, as well as announcements on the funding of, and training for, prison officers to focus on identifying and reducing suicide and self-harm risks, and on improving prison safety;
- **Media** – outlining issues connected to the reporting of suicide, as well as the internet and social media, and measures to mitigate their perceived negative effects on suicide rates, including the Government’s recent Internet Safety Strategy, for which a Green Paper was published on 11 October 2017, the response to which was published in May 2018 and included a draft social media code of practice;
- **Armed forces** – providing information on suicide in the UK regular armed forces, the new Ministry of Defence Mental Health and Wellbeing Strategy (launched in July 2017), concerns around suicide among veterans, as well as the ongoing Defence Committee inquiry into mental health in the armed forces; and
- **Coroners’ conclusions** – explaining that until recently it was considered that the high criminal standard of proof was necessary for a coroner’s conclusion of suicide – namely “beyond all reasonable doubt”. In July 2018, however, the High Court decided that cases decided previously did not state the law correctly, and that the lower civil standard of proof – “on the balance of probabilities” – applies for suicide conclusions. It is understood that permission to appeal this has been granted.

Suicide prevention in the devolved nations

While this paper focuses heavily on policies relating to England – which are under the jurisdiction of the UK Government – it also considers suicide prevention strategies developed and implemented by the governments of Scotland and Wales, as well as the Northern Ireland Executive. Policies from each strategy, as well as those pertaining to separate institutions or systems in the constituent nations of the UK, are considered in the sections covering the policy areas mentioned above when they relate to devolved matters.

The current or latest iterations of each suicide prevention plan from the devolved administrations are:

- **Scottish Government** – [*Suicide Prevention Action Plan: Every Life Matters*](#), August 2018;
- **Welsh Government** – [*Talk to me 2: Suicide and Self Harm Prevention Strategy for Wales 2015-2020*](#), June 2015; and
- **Northern Ireland Executive** – [*Protect Life 2: A Draft Strategy for Suicide Prevention in the North of Ireland*](#), September 2016 (a draft strategy which has been for consultation).

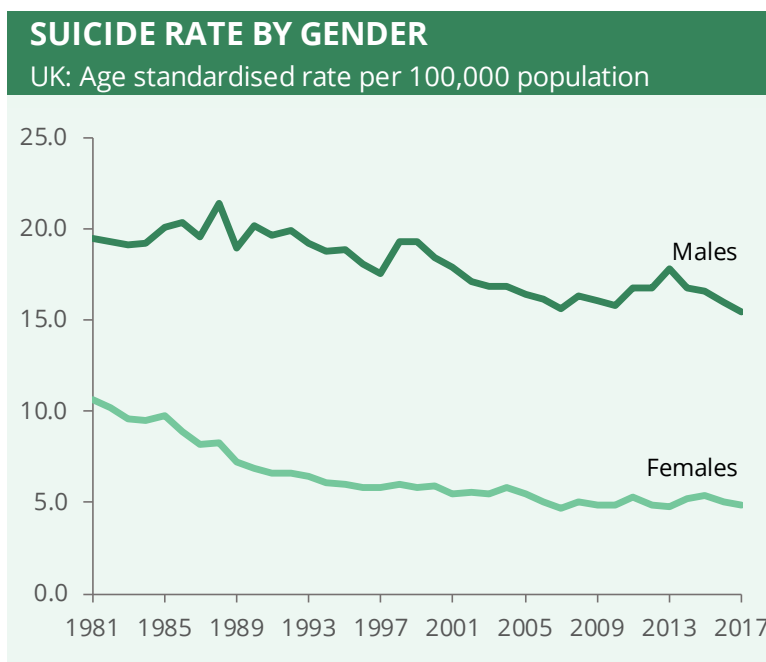
1. Suicide rates in the UK

1.1 Suicide rates by age, gender, and country

In 2017 there were 5,821 deaths in the United Kingdom where the cause was identified as suicide. The number of deaths equates to an age-standardised suicide rate of 10.1 deaths per 100,000 population. This is one of the lowest rates observed since the suicide data series began in 1981, when the rate was 14.7 deaths per 100,000.¹

Men are three times more likely than women to take their own lives, and this gender gap has grown in the past 35 years. The suicide rate among women in the UK has halved since 1981. The rate among men has fallen by around a quarter over the equivalent period.

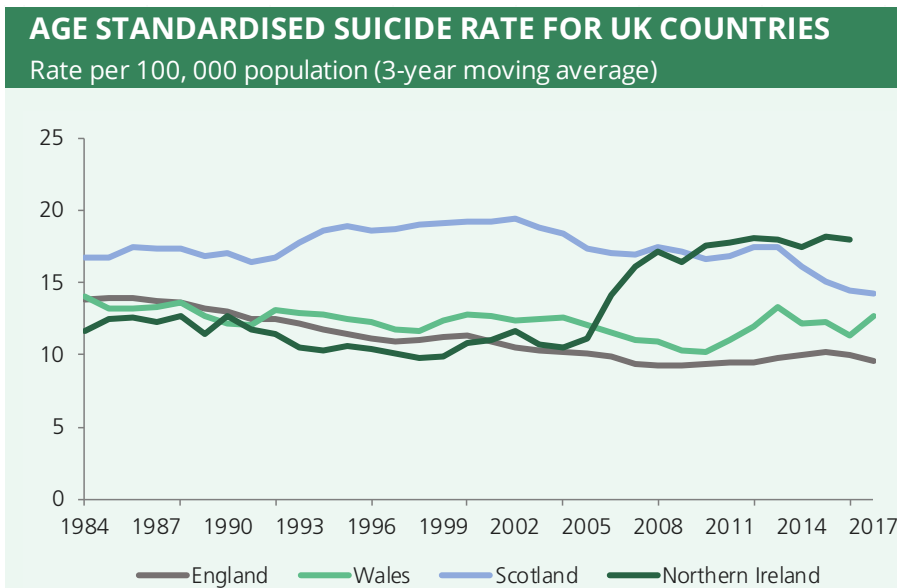
In 2017, the suicide rate fell slightly in both genders. The rate for males in the UK was 15.5 deaths per 100,000 - the lowest rate since 1981. The female suicide rate for the UK in 2017 was 4.9 deaths per 100,000.



Source: ONS [Suicides in the United Kingdom 2017](#)

The suicide rate is higher in Northern Ireland than other UK countries. 2017 data for Northern Ireland has not yet been released. The chart below includes trends up to 2017 for England, Wales and Scotland, and trends up to 2016 for Northern Ireland.

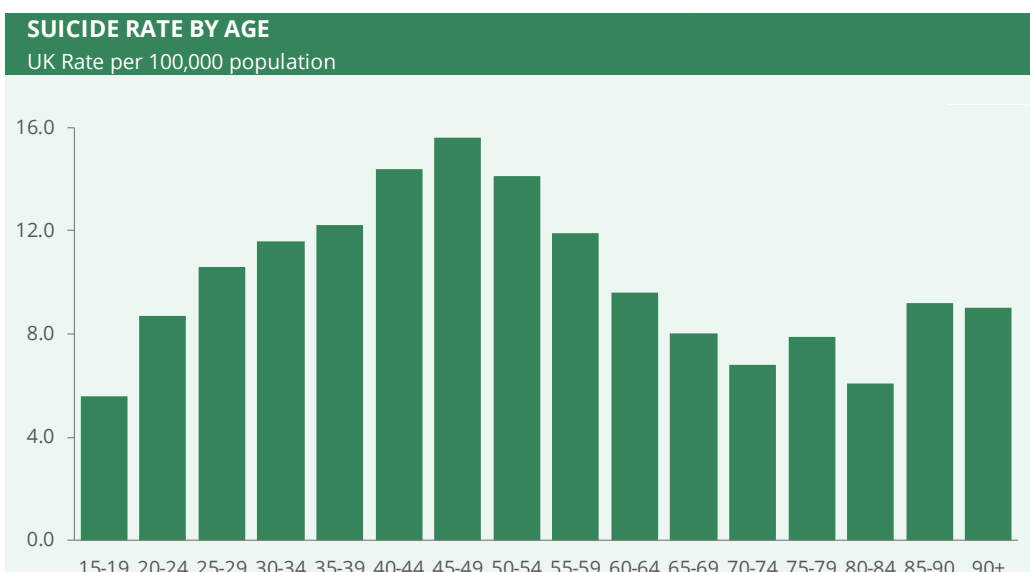
¹ Office for National Statistics [Suicides in the United Kingdom 2017](#)



Note: The sharp increase between 2004 and 2008 in Northern Ireland coincides with a change to the Coroner's Service.

Source: ONS [Suicides in the United Kingdom 2017](#)

The suicide rate is highest for those aged between 40 and 54. The rate among 40-44 year olds is around 50% higher than the overall average.



Source: ONS [Suicides in the United Kingdom 2017](#)

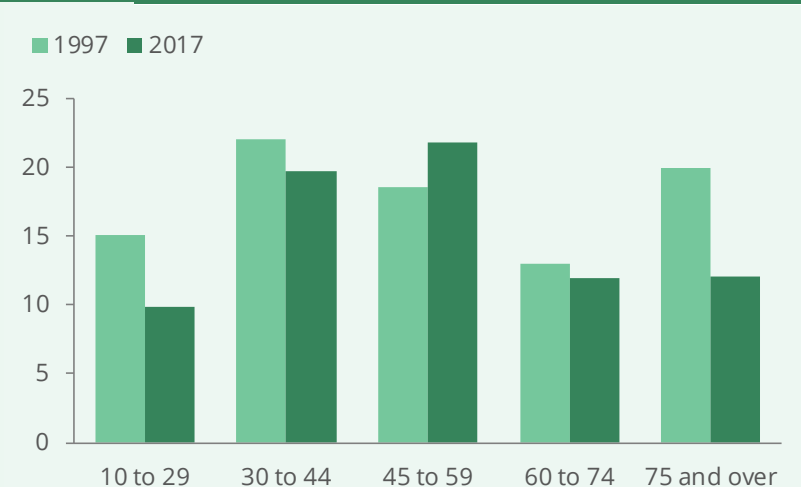
The charts below show how the suicide rate has changed in the last 20 years for men and women of different ages.

In men, the suicide rate has risen among men aged 45-59, while in all other groups rates have fallen. The most marked changes are among the oldest and youngest age groups.

Among women, rates fell among all age groups with the most notable changes being observed in the oldest age groups.

MALE SUICIDE RATE BY BROAD AGE GROUP

UK Rate per 100,000 population 1997 and 2017



Source: ONS [Suicides in the United Kingdom 2017](#)

FEMALE SUICIDE RATE BY BROAD AGE GROUP

UK Rate per 100,000 population 1997 and 2017



Source: ONS [Suicides in the United Kingdom 2017](#)

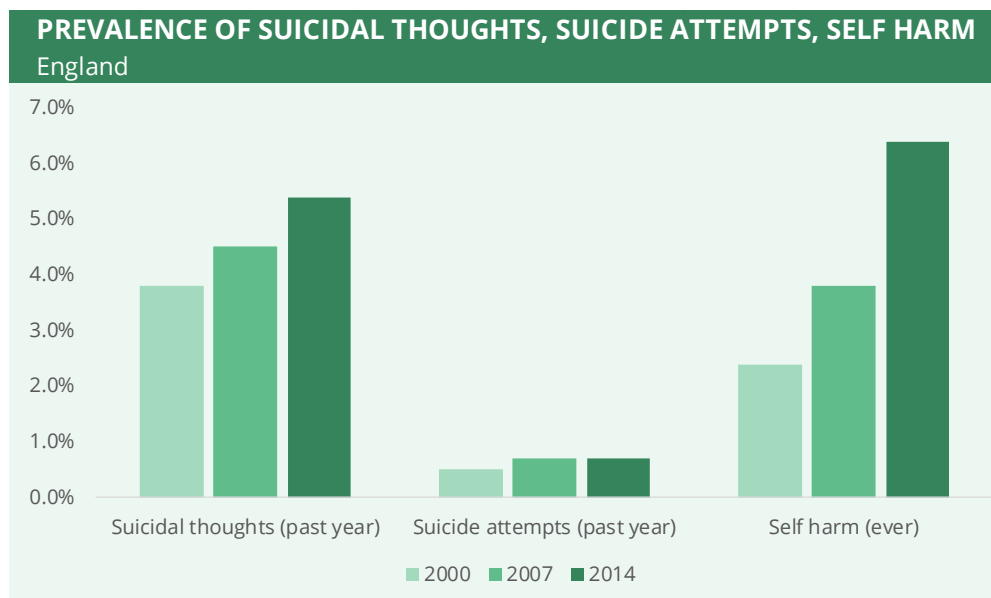
1.2 Suicidal thoughts and self-harm in England

A survey of adult mental health in England has been carried out every seven years. The most recent [Adult Psychiatric Morbidity Survey](#) was carried out in 2014 and the data was released in 2016. The survey included questions on suicidal thoughts, self-harm and suicide attempts. As the report notes, these are “strongly associated with mental health problems”.²

- 5.4% of people surveyed reported having suicidal thoughts in the past year. This is an increase from 3.8% in 2000.

² [NHS Digital, APMS, Suicidal Thoughts](#)

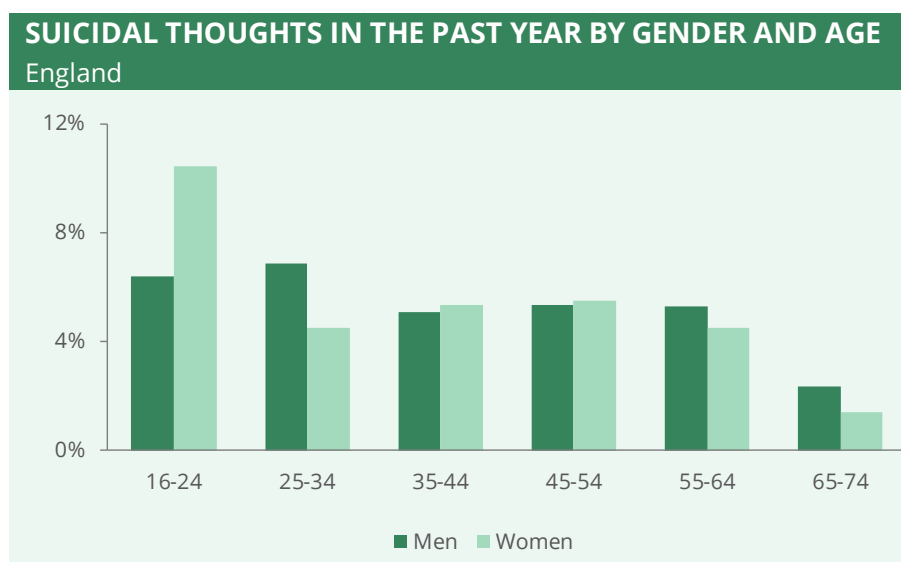
- 6.4% reported having ever self-harmed, up from 2.4% in 2000.
- 0.7% reported having attempted suicide in the past year. This rate has increased slightly since 2000.



Source: NHS Digital [Adult Psychiatric Morbidity Survey 2017](#)

Some groups saw larger increases in suicidal thoughts and suicide attempts over the period – e.g. people aged 55-64.

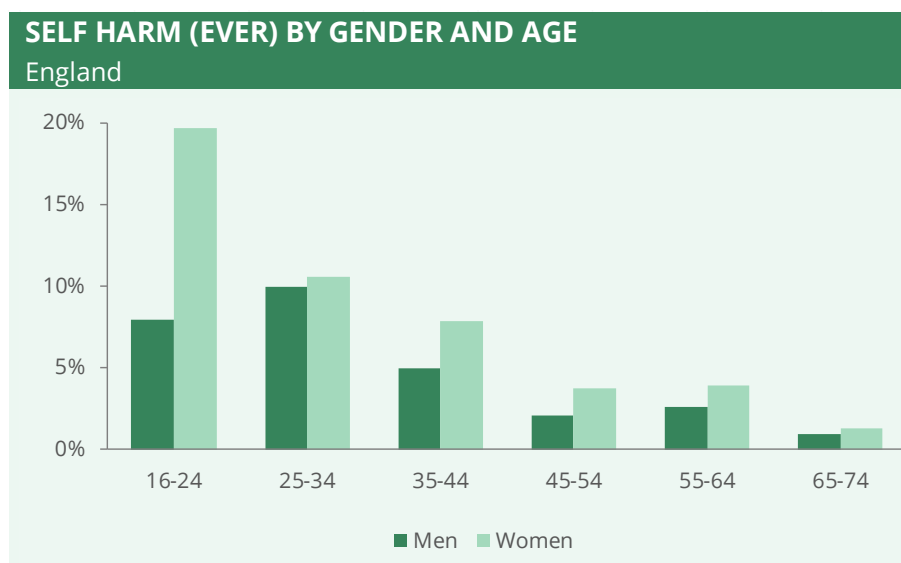
Among women, suicidal thoughts in the past year were most common among those aged 16-24 (10%). Among men, rates were similar in 16-24s and 25-34s (6-7%).



Source: NHS Digital [Adult Psychiatric Morbidity Survey 2017](#)

Women aged 16-24 are more likely to report having ever self-harmed than any other age group, with almost 20% reporting self-harm.

Among men, those aged 25-34 are most likely to report self-harm (10%).



Source: NHS Digital [Adult Psychiatric Morbidity Survey 2017](#)

More data on suicide is available in the briefing paper [Suicide: summary of statistics](#), published in January 2017.

1.3 Concerns around data on suicide

Until recently, concerns were expressed about the consistency of recording deaths as suicide, and the standards required to do so. These were explored in the Health Select Committee's two recent reports on suicide prevention.³

Previously, for a coroner to conclude that a suicide had taken place, a strict standard of proof – “beyond reasonable doubt” – had to be met. In other words, deaths which were probably, but not certainly, due to individual intent would not be recorded as suicide. There were concerns that this could lead to underreporting of suicide. The Health Committee recommended that the standard of proof be lowered to require a “balance of probabilities”, and in the Government's response it said that it is considering this.⁴

The situation developed in July 2018 when the [High Court delivered a judgment](#) which decided that the lower civil standard of proof – “on the balance of probabilities” – applies for suicide conclusions; although it is understood that permission to appeal this judgment has been granted.

³ Health Committee, [Suicide Prevention: Interim Report, Fourth report of Session 2016-17](#), 19 December 2016, HC 1087, paras 27-31; Health Committee, [Suicide Prevention, Sixth report of Session 2016-17](#), 16 March 2017, HC 1087, paras 10-11, paras 142-166

⁴ *Ibid.*, para. 151; Department of Health [DH], [Government Response to the Health Select Committee's Inquiry into Suicide Prevention](#), Cm 9466, July 2017, p24

A more extensive exploration of the issues around data quality, and of coroners' judgments, can be found in Section 12 of this paper.

2. Suicide prevention policy

2.1 UK Government suicide prevention policies before 2012

Before 2012, suicide prevention initiatives in England centred on health policy and were directed through the Department of Health. Following the election of the Labour Government in 1997, the Department of Health published the white papers, [Modernising Mental Health Service](#) in 1998, [Saving Lives: Our Healthier Nation](#) in 1999, and subsequently the [National Service Framework for Mental Health](#) later the same year.⁵ *Saving Lives* set a target to reduce suicides in England by one fifth by 2010.⁶ The *National Service Framework* set standards in five areas of mental health provision, including the prevention of suicide. Specifically, this sought to do so by promoting mental health and well-being, and preventing suicide among those in contact with health and social services, as well as those with “severe mental illness”, monitored by setting certain milestones, mostly for local health and social care communities.⁷

In 2002 the Department of Health published its [National Suicide Prevention Strategy for England](#), which was the first iteration of this Government strategy to reduce suicide rates in England. According to the forward by the then Minister of State for Health, Jacqui Smith, it was designed to be an “evolving strategy which will develop in light of progress made and emerging evidence”.⁸ It specified six “goals”:

1. To reduce risk in key high risk groups.
2. To promote mental well-being in the wider population.
3. To reduce the availability and lethality of suicide methods.
4. To improve reporting of suicidal behaviour in the media.
5. To promote research on suicide and suicide prevention.
6. To improve monitoring of progress towards the Saving Lives: Our Healthier Nation target to reduce suicides.⁹

In addition, it specified that implementation of this strategy would be led by the newly established National Institute of Mental Health in England (NIMH) “as one of its core programmes of work”. The NIMH was an organisation based with the Modernisation Agency at the Department of Health which aimed to improve mental health by supporting changes in local services and “providing a gateway to learning and development for mental health staff and others”.¹⁰

A progress report, entitled [Mental Health Ten Years On](#), produced in 2007 by Professor Louis Appleby, who had helped to develop the

⁵ DH, [Modernising Mental Health Services: Safe, Sound and Supportive](#), January 1998

⁶ DH, [Saving Lives: Our Healthier Nation](#), 5 July 1999

⁷ DH, [National Service Framework for Mental Health](#), 10 September 1999

⁸ DH, [National Suicide Strategy for England](#), September 2002, page 3

⁹ *Ibid.*, pp5-6

¹⁰ *Ibid.*, pp11 & 17

Strategy in 2002, remarked that the suicide rate had by then fallen by 7.4% “to the lowest figure on records – and records began in 1861”, so that the suicide rate in England was “one of the lowest in Europe”. Nevertheless, it reiterated that the original target had been a reduction of 20% by 2010.¹¹

2.2 The National Suicide Prevention Strategy in England (2012)

In September 2012, the Coalition Government published [*Preventing Suicide in England: A cross-government outcomes strategy to save lives*](#). In the foreword, the then Minister for Care Services, Norman Lamb, recognised that in “developing this new national all-age suicide prevention strategy for England, we have built on the successes of the earlier strategy published in 2002”. Although published by the Department of Health, this report established a ‘cross-government’ programme encompassing commitments from departments across the Government, in addition to Health, including “Education, Justice and the Home Office, Transport, Work and Pensions and others”.¹²

It was developed after consultations with experts, including members of the National Suicide Prevention Strategy Advisory Group (NSPSAG), which thereafter monitored the progress of the Strategy. The NSPSAG is a group of experts, bodies, and charities, such as [PAPYRUS](#) – a charity which works to prevent suicide among young people – which collaborates with the Department of Health to examine suicide prevention policies.¹³ Their work was, and is, chaired by the aforementioned [Professor Louis Appleby CBE](#). In his preface, Professor Appleby made reference to the fact that this Strategy, unlike the previous one, had given greater prominence of measures to support families, and made “more explicit reference” to the importance of primary care in preventing suicide.¹⁴

The cross-Government nature of this Strategy was explained in the report:

Suicide is often the end point of a complex history of risk factors and distressing events; the prevention of suicide has to address this complexity. This strategy is intended to provide an approach to suicide prevention that recognises contributions that can be made across all sectors of our society.¹⁵

It also identified the key objectives of this Strategy: “a reduction in the suicide rate in the general population in England; and better support of those bereaved or affected by suicide”.

It specified six “areas for action”:

1. Reduce the risk of suicide in key high-risk groups

¹¹ DH, [Mental Health Ten Years On: Progress on Mental Health Care Reform](#), 29 April 2017

¹² HM Government [HMG], [Preventing suicide in England: A cross-government outcomes strategy to save lives](#), 10 September 2012, page 2

¹³ *Ibid.*, pp53, para. 7.24

¹⁴ *Ibid.*, p4

¹⁵ *Ibid.*, p4

2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection, and monitoring¹⁶

2.3 Strategy updates

First Annual Report (2014)

In January 2014, the Government produced its first annual report, entitled [*Preventing suicide in England: one year on*](#). This provided an update on developments since the implementation of the Strategy, as well as to provide messages “designed to help local areas focus on the most effective things that they can do to reduce suicide”. It provided new figures on the rate of suicides since the publication of the Strategy, as well as new research findings.

It also announced, alongside the publication of this annual report, Government support for the new National Suicide Prevention Alliance with a grant of £120,000 over two years.¹⁷

Second Annual Report (2015)

In February 2015, the Government produced its second annual report, entitled [*Preventing suicide in England: two years on*](#). It highlighted work that was being conducted to prevent suicides and set out priorities for the next year. In his preface, Professor Appleby noted in particular the “alarming rise in self-inflicted deaths of prisoners after the previous fall”, as well as increases in suicides among younger age groups despite an overall fall over the preceding decade.¹⁸

Third Progress Report (2017)

The “Third Progress Report”, entitled [*Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives*](#), was published in January 2017. This came with a foreword from Jeremy Hunt, as Secretary of State for Health, in which he committed to “strengthen the Government’s response to this most tragic of issues”.¹⁹ The report came out after the Health Select Committee’s interim report on suicide prevention was published a month before in December 2016, and Mr Hunt claimed to be addressing many of its recommendations. Specifically, he pledged to “put in place a more robust implementation programme to deliver the aims of the National Strategy”, most particularly at the local level by

¹⁶ *Ibid.*, p6

¹⁷ HMG, [*Preventing suicide in England: One year on – First annual report on the cross-government outcomes strategy to save lives*](#), January 2014, esp para. 57, p17

¹⁸ HMG, [*Preventing suicide in England: Two years on – Second annual report on the cross-government outcomes strategy to save lives*](#), February 2015, esp. p5

¹⁹ HMG, [*Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives*](#), January 2017, pp4-5

ensuring that every local area puts in place a multi-agency suicide prevention plan in 2017.²⁰

This Progress report highlighted, as a priority for renewed focus, patients who are commonly identified as being at higher risk of suicide, such as young and middle aged men, those who self-harm, those in contact with the criminal justice system, and those in the care mental health services, by ensuring safe treatment in community settings and investing in liaison mental health services in acute hospitals. There was also a new focus on support for bereaved families as well as on education and young people's mental health.²¹ It also included a new commitment from the Government to achieve a 10% reduction in suicides by 2020/21.²²

2.4 Devolved administration strategies

Scotland

The Labour-Liberal Democrat coalition Scottish Executive published a suicide prevention strategy in December 2002, entitled: [*Choose Life: A National Strategy and Action Plan to Prevent Suicide in Scotland*](#). It was established as a 10-year plan with the ultimate objective of reducing the suicide rate in Scotland by 20% in 2013.²³

At the end of this period, in late 2012, the SNP Scottish Government established a working group to consider the future strategy and action of the prevention of suicide and self-harm. This resulted in the [*Suicide Prevention Strategy 2013-16*](#) which showed that in the 10-year period following the publication of "Choose Life" there had been a reduction in the suicide rate in Scotland of 18%.²⁴ The new strategy contained 11 Government "commitments" and was developed around five themes, lettered A-E:

- a. "Responding to people in distress" – to engage better with people in distress, noting self-harm as a "clear risk factor for suicide" as well as a "phenomenon that we need to understand and address in its own right".
- b. "Talking about suicide" – involving the development of an "engagement strategy to influence public perception about suicide and the stigma surrounding it", using social media and to encourage "sensitive and appropriate reporting" in the media.
- c. "Improving the NHS response to suicide" – including working with Healthcare Improvement Scotland to support NHS Boards to make mental health services safer for people at risk of suicide.

²⁰ *Ibid.*, p4

²¹ *Ibid.*, para. 13, p9

²² *Ibid.*, p5

²³ Scottish Executive, [*Choose Life: A National Strategy and Action Plan to Prevent Suicide in Scotland*](#), December 2002, p7

²⁴ Scottish Government, [*Suicide Prevention Strategy 2013-2016*](#), December 2013

- d. “Developing the evidence base” – such as by funding the research conducted by SoctSID and the Scottish element of the National Confidential Inquiry into Suicide and Homicide.
- e. “Supporting change and improvement” – including the maintenance of a National Programme for Suicide Prevention, hosted by NHS Health Scotland and the establishment of an Implementation Board to monitor progress of all the commitments of the Strategy.²⁵

On 9 August 2018, the Scottish Government published its new suicide prevention action plan, [Every Life Matters](#). This was designed explicitly to continue the work from the previous strategy as well as “the strong downward trend in suicide rates in Scotland”. In her foreword to this action plan, Clare Haughey, Minister for Mental Health, stated that the suicide rate in Scotland had fallen by 20% “between 2002-2006 and 2013-17”, i.e. the two periods covered by the Scottish Government’s previous strategies.²⁶

This new Action Plan was the result of an [engagement process](#) which took place during March and April 2018, including [five events organised by NHS Health Scotland](#). The resulting publication committed to a new target to reduce further “the suicide rate by 20% by 2022”²⁷ which it planned to achieve through the following actions:

Action 1. The Scottish Government will set up and fund a National Suicide Prevention Leadership Group (NSPLG) by September 2018, reporting to Scottish Ministers – and also to COSLA [the Convention of Scottish Local Authorities] on issues that sit within the competence of local government and integration authorities. This group will make recommendations on supporting the development and delivery of local prevention action plans backed by £3 million funding over the course of the current Parliament.

Action 2. The Scottish Government will fund the creation and implementation of refreshed mental health and suicide prevention training by May 2019. The NSPLG will support delivery across public and private sectors and, as a first step, will require that alongside the physical health training NHS staff receive, they will now receive mental health and suicide prevention training.

Action 3. The Scottish Government will work with the NSPLG and partners to encourage a coordinated approach to public awareness campaigns, which maximises impact.

Action 4. With the NSPLG, the Scottish Government will ensure that timely and effective support for those affected by suicide is available across Scotland by working to develop a Scottish Crisis Care Agreement.

Action 5. The NSPLG will use evidence on the effectiveness of differing models of crisis support to make recommendations to service providers and share best practice.

Action 6. The NSPLG will work with partners to develop and support the delivery of innovations in digital technology that improve suicide prevention.

²⁵ *Ibid.*, pp6-14

²⁶ Scottish Government, [Suicide Prevention Action Plan: Every Life Matters](#), August 2018, p2

²⁷ *Ibid.*, pp2-3

Action 7. The NSPLG will identify and facilitate preventative actions targeted at risk groups.

Action 8. The NSPLG will ensure that all of the actions of the Suicide Prevention Action Plan consider the needs of children and young people.

Action 9. The Scottish Government will work closely with partners to ensure that data, evidence and guidance is used to maximise impact. Improvement methodology will support localities to better understand and minimise unwarranted variation in practice and outcomes.

Action 10. The Scottish Government will work with the NSPLG and partners to develop appropriate reviews into all deaths by suicide, and ensure that the lessons from reviews are shared with NSPLG and partners and acted on.²⁸

Wales

In 2009, the Welsh Assembly Government introduced [*Talk to Me: The National Action Plan to Reduce Suicide and Self Harm in Wales 2009-2014*](#). Its aim principally was to reduce the rate of suicides and self-harm in Wales by targeting those who are at higher risk over a period of five years. This was intended as a cross-Government strategy to deliver action “across all sectors of society” using a combination of direction provided by a national framework and implementation delivered locally. It was explicitly “not a strategic plan for NHS and local government organisations to deliver in isolation”.²⁹ It drew together a broad range of existing Welsh Assembly Government policies and programmes, in particular its strategy on mental health, as well as various new programmes, and it was based upon seven broad “objectives”:

Objective 1: Promote mental health and wellbeing

Objective 2: Deliver early intervention

Objective 3: Response to personal crisis

Objective 4: Manage the consequences of suicide and self harm

Objective 5: Promote learning and research and improve information on suicide and suicide prevention

Objective 6: Work with the media to ensure appropriate reporting on mental health and suicide

Objective 7: Restrict access to the means of suicide.³⁰

In July 2015, the Welsh Government published an extension of this suicide prevention plan, entitled: [*Talk to me 2: Suicide and Self Harm Prevention Strategy for Wales 2015-2020*](#). It followed the rollout of the Government’s [*Together for Mental Health*](#) delivery plan in 2012 which included a number of suicide prevention measures, such as an expansion of the Applied Suicide Intervention Skills Training (ASIST) for those working in all social services and health settings.³¹ It also mentioned the creation of the Suicide Prevention National Advisory Group which was designed to provide a specific layer of national

²⁸ *Ibid.*, p4

²⁹ Welsh Assembly Government, [*Talk to Me: The National Action Plan to Reduce Suicide and Self Harm in Wales 2009-2014*](#), October 2009, pp9 & 19

³⁰ *Ibid.*, p9

³¹ Welsh Government, [*Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales*](#), October 2012

oversight which would produce an annual report. The new suicide prevention strategy aimed further to reduce the suicide and self-harm rates in Wales and to “promote, co-ordinate and support plans and programmes for the prevention of suicidal behaviours and self harm at national, regional and local levels” over another period of five years.³² It prioritised certain high risk groups, in particular middle-aged men, which was a group highlighted as particularly vulnerable by a Samaritans campaign.³³ It outlined six strategic objectives, which were similar to those in the previous plan, albeit with some alterations:

Objective 1: Further improve awareness, knowledge and understanding of suicide and self harm amongst the public, individuals who frequently come in to contact with people at risk of suicide and self harm and professionals in Wales

Objective 2: To deliver appropriate responses to personal crises, early intervention and management of suicide and self harm

Objective 3: Information and support for those bereaved or affected by suicide and self harm

Objective 4: Support the media in responsible reporting and portrayal of suicide and suicidal behaviour

Objective 5: Reduce access to the means of suicide

Objective 6: Continue to promote and support learning, information and monitoring systems and research to improve our understanding of suicide and self harm in Wales and guide action³⁴

Northern Ireland

A suicide prevention strategy in Northern Ireland was developed in October 2006 by the then Department of Health, Social Service and Public Safety (DHSSPS), and was entitled *Protect Life: Northern Ireland Suicide Prevention Strategy and Action Plan, 2006-2011*. This outlined a strategy for the next five years which aimed to reduce the suicide rate in Northern Ireland by 15%. A particular focus was placed on reducing the number of suicides in young males, amongst other high risk groups, as well as addressing the rising rate of self-harm, by pursuing the following objectives:

1. raising awareness of mental health and well-being issues
2. ensuring early recognition of mental ill health and providing appropriate follow-up action by support services
3. developing co-ordinated, effective, accessible and timely response mechanisms for those seeking help
4. providing appropriate training for people dealing with suicide and mental health issues
5. enhancing the support role currently carried out by the voluntary/community sectors, bereaved families and individuals who have made previous suicide attempts

³² Welsh Government, [*Talk to me 2: Suicide and Self Harm Prevention Strategy for Wales 2015-2020*](#), June 2015, para. 36, p15

³³ *Ibid.* paras 57-60, pp19-20

³⁴ *Ibid.*, pp15-17

6. supporting the media in the development and implementation of guidelines for a suitable response to suicide-related matters
7. providing support for research and evaluation of relevant suicide and self-harm issues
8. restricting access, where possible, to the means of completing suicide.³⁵

It was accompanied with an implementation plan containing 62 actions to be delivered locally and nationally.

In 2010, the DHSSPS refreshed the Strategy and its lifespan was lengthened until the end of the 2013/14 financial year. While the reduction of the suicide rate in Northern Ireland continued to be the main goal, it was noted that it was important not to rely solely on a suicide reduction target given the broader social, economic, and environmental factors which have an influence on suicide. It added a new aim “to reduce the differential in the suicide rate between deprived and non-deprived areas” and altered the existing objectives to reflect this.³⁶

Following further reviews, a draft of a new suicide prevention strategy – [*Protect Life 2 – A Strategy for Suicide Prevention in the north of Ireland*](#) – was published in September 2016. Consultation began upon publication and closed on 4 November 2016. An analysis report of the consultation was published in February 2017 which committed to considering “the necessary amendments” to the draft strategy, before submitting the final plan to the Minister for Health for approval.³⁷ Since the collapse of the Northern Ireland Executive in January 2017, and the failure to establish a new one after the Assembly election on 2 March 2017, however, no further progress has yet been made.

The draft strategy seeks “to build on what has been achieved through the previous Strategy whilst taking action to address those areas where gaps have been identified or further improvements deemed necessary”. In particular, it suggests ten objectives focusing on priority areas and risk factors:

- Objective 1 – Fewer people who are in contact with mental health services, die by suicide.
- Objective 2 – Reduce the incidence of repeat self harm presentation to hospital emergency departments.
- Objective 3 – Improve the understanding and identification of suicidal and selfharming behaviour, awareness of self harm and suicide prevention services, and the uptake of these services by people who need them.

³⁵ Northern Ireland Department of Health, Social Service and Public Safety [NIDHSSPS], [*Evaluation of the Implementation of the NI Protect Life Suicide Prevention Strategy and Action Plan 2006-2011*](#), October 2012, p17

³⁶ NIDHSSPS, [*Protect Life – A Shared Vision: The Northern Ireland Suicide Prevention Strategy 2012-March 2014*](#), June 2012, para. 4.2, p35

³⁷ Northern Ireland Department of Health [NIDH], [*Protect Life 2: A Draft Strategy for Suicide Prevention in the North of Ireland – Consultation Analysis Report*](#), February 2017

Objective 4 – Enhance the initial response to, and care and recovery of people who are experiencing suicidal behaviour and to those who self-harm.

Objective 5 – Restrict access to the means of suicide, particularly for people known to be self-harming or vulnerable to suicidal thoughts.

Objective 6 – Ensure the provision of effective and timely information and support for individuals and families bereaved by suicide.

Objective 7 – Provide effective support for “self care” in voluntary, community, and statutory sector staff providing suicide prevention services.

Objective 8 – Enhance responsible media reporting on suicide.

Objective 9 – Identify emerging suicide clusters and act promptly to reduce the risk of further associated suicides in the community.

Objective 10 – Strengthen the local evidence base on suicide patterns, trends and risks, and on effective interventions to prevent suicide and self-harm.³⁸

³⁸ NIDH, [*Protect Life 2: A Draft Strategy for Suicide Prevention in the North of Ireland*](#), September 2016, pp8-11

3. National and local approaches

3.1 National oversight in England

Box 1: Suicide prevention and the restructured NHS in England post-2012

The publication of the Government's Suicide Prevention Strategy came just as the structure of the NHS in England was undergoing major and quite controversial reform through the *Health and Social Care Act 2012*. This Act created NHS England as a national commissioning board, and 212 Clinical Commissioning Groups (CCGs), which were given statutory responsibility for commissioning health services. Since 2013, CCGs have been responsible for commissioning the majority of NHS services, including urgent and emergency care, elective hospital care, and community health services. NHS England is responsible for ensuring that there is an effective and comprehensive system of CCGs, providing commissioning support and guidance, as well as for commissioning some services centrally such as primary care and specialist services.

The 2012 Act rebranded the existing National Institute for Health and Clinical Excellence to the National Institute of Health and Care Excellence (NICE), giving it new responsibilities for social care. NICE provides evidence-based information for the NHS in England and Wales on the effectiveness and cost-effectiveness of healthcare interventions. The 2012 Act also created Public Health England as a directorate within the Department of Health to oversee the local delivery of public health services and to deal with national issues such as influenza pandemics and other population-wide health threats.

The 2012 Suicide Prevention Strategy was designed, therefore, to work with these new bodies. It accorded them varying degrees of oversight, and in section 7 set out how the reforms to health commissioning in England would complement and support the Strategy, much of which is detailed below.

For further information on the NHS in England, see Commons Library briefing CBP 07206, [The Structure of the NHS in England](#).

UK Government oversight

Each of the "areas for action" in the UK Government's 2012 Strategy were accompanied by suggested local and national approaches. While the strategy was clear that "[m]uch of the planning and work to prevent suicides will be carried out locally", it did come with a national implementation framework for [No health without mental health](#), published at a similar time, which covered suicide and supported implementation of the prevention strategy. The Cabinet Sub-Committee on Public Health was charged by the Strategy with overseeing this, and the Cabinet Committee on Social Justice, was given addition oversight in its responsibilities for ensuring cross-government action to address the social causes and consequences of mental health problems, of which suicide prevention was a key component.³⁹

While the initial 2012 Strategy made no mention of the leading role played by the Department of Health at a national level, the First Annual Report (2014) revealed the extent to which this Government department remained at the forefront of driving forward this Strategy:

Development of the cross-government suicide prevention strategy has been led by the Department of Health in our capacity as stewards of the new health and care system and the cross-Whitehall lead on health issues. The Department of Health will

³⁹ HMG, [Preventing suicide in England: A cross-government outcomes strategy to save lives](#), 10 September 2012, pp50-3

continue to have the lead role across government on suicide prevention.⁴⁰

The leading role of the Department of Health was again underlined when the Secretary of State for Health wrote the foreword for the Third Progress Report.

Public Health England

From April 2013, Public Health England (PHE) became the national agency for public health in a role designed to support local authorities, the NHS, and partners across England. It has been assigned a national leadership role to support local areas to help improve outcomes in public health. The Government's strategy gave it a "leadership role" in order to support local authorities with their public health responsibilities, including on mental health and suicide prevention.⁴¹ From this point onwards, suicide was included as an indicator within the [Public Health Outcomes Framework](#) which, according to Professor Louis Appleby, would "help to track progress against our overall objective to reduce the suicide rate".⁴² This Framework includes indicators on suicide, self-harm and excess mortality in adults (under 75) with serious mental illness.

PHE published [guidance for local suicide planning in October 2016](#). It provides guidance around establishing a local multi-agency suicide prevention group, completing a local suicide audit, and developing a local strategy and action plan which is based on the national strategy and local data.⁴³ It also recently published guidance for local commissioners on how and why they can deliver support after suicide.⁴⁴

NHS England

NHS England was, through its role in commissioning primary care, specialised services, prison health, military health, and some public health services, charged with helping in realising the aims of the strategy. It was also given "an important role in providing national leadership for driving up the quality of care across health commissioning".⁴⁵

NICE

[The National Institute for Health and Care Excellence \(NICE\)](#) was also tasked with providing quality standards, including those already in existence which are relevant to suicide prevention, such as alcohol dependence and depression in adults, as well as those in development, such as depression in children and young people, self-harm in adults and vulnerable groups, antenatal and postnatal mental health, and

⁴⁰ HMG, [Preventing suicide in England: One year on – First annual report on the cross-government outcomes strategy to save lives](#), January 2014, para. 5, p17

⁴¹ *Ibid.*, paras 7.5-7.6, p50

⁴² *Ibid.*, p4

⁴³ Public Health England, [Local Suicide Prevention Planning: A Practice Resource](#), October 2016

⁴⁴ Public Health England, [Support after a suicide: a guide to providing local services](#), January 2017

⁴⁵ HMG, [Preventing suicide in England: A cross-government outcomes strategy to save lives](#), 10 September 2012, paras 7.16-7.16, p51

long-term care for people with complex needs.⁴⁶ For more on this, see the next section on health policy.

National Suicide Prevention Strategy Advisory Group

This NSPSAG, which is comprised of academic researchers, representatives of suicide prevention charities, as well as public and Government bodies such as the Department of Health, and which had been involved closely in producing this strategy, was tasked by it to “continue to provide leadership for implementation of this strategy”.⁴⁷ Its chair, Professor Louis Appleby, provided the preface to the report, said that the Strategy was “up to date, wide-ranging and ambitious”.⁴⁸

National Suicide Prevention Alliance

[This is a group](#) of public, private, and community organisations in England, established in 2013. It was founded in response to the ‘Call to Action for Suicide Prevention’, which had been launched by Samaritans with a grant from the Department of Health, and which in turn produced a ‘Declaration’ accompanied publication of the Government’s new Strategy.⁴⁹ Their membership includes the Department of Health and directs their programme of work through a [steering group](#). It provides guidance and support for local areas, and has funded schemes such as the Suicide Bereavement Support Partnership.⁵⁰ In recent years, it provided guidance and toolkits for local authorities to supply bereavement support services, such as [Developing and delivering local bereavement support services](#) and [Evaluating local bereavement support services](#), both published in October 2016.

3.2 Parliamentary oversight of suicide prevention in England

Health Select Committee Inquiry (2016-2017)

The House of Commons Health Select Committee (HSC) conducted an inquiry into suicide prevention in England during late 2016 and early 2017. In anticipation of the publication of the Government’s Third Progress Report, the HSC published an interim report in December 2016 which it hoped the “Government will take into account before drawing its final conclusions”.⁵¹ It highlighted five areas it believed ought to be key to the Government’s considerations:

- (1) **Implementation**—a clear implementation programme underpinned by external scrutiny is required.
- (2) **Services to support people who are vulnerable to suicide**—this includes wider support for public mental health and wellbeing alongside the identification of and targeted support for

⁴⁶ *Ibid.*, paras 7.17, pp51-2

⁴⁷ *Ibid.*, para 7.24, p53

⁴⁸ *Ibid.*, p4

⁴⁹ National Suicide Prevention Alliance, [Annual Review 2012-13](#), p6

⁵⁰ ‘[The Suicide Bereavement Support Partnership](#)’, Samaritans website, 17th June 2014 (accessed 7 December 2017)

⁵¹ Health Committee, [Suicide Prevention: Interim Report, Fourth report of Session 2016-17](#), 19 December 2016, HC 1087, para. 5, p4

at risk groups; early intervention services, access to help in non-clinical settings, and improvements in both primary and secondary care; and services for those bereaved by suicide.

(3) **Consensus statement on sharing information with families**—professionals need better training to ensure that opportunities to involve families or friends in a patient’s recovery are maximised, where appropriate.

(4) **Data**—timely and consistent data is needed to enable swift responses to suspected suicides and to identify possible clusters, in order to prevent further suicides.

(5) **Media**—media guidelines relating to the reporting of suicide are being widely ignored and greater attention must be paid to dealing with breaches by the media, at national and local level. Consideration should also be given to what changes should be made to restrict access to potentially harmful internet sites and content.⁵²

Following the publication of the Third Progress Report, the HSC published its full report on 7 March 2017, in which it provided the following response to the recently updated Strategy:

The Government’s recent focus on suicide prevention and mental health is welcome and necessary. Whilst the Government recognised our work in their progress report, we were disappointed that our concerns were not fully addressed nor were all of our recommendations taken on board... We consider that there are further steps which could be taken to reduce suicide.⁵³

In particular, the HSC said it was “disappointed” that the Government did not adopt its recommendation that all patients who are discharged from inpatient care should receive follow up care within three days. It reiterated its previously stated five key areas for consideration, adding a further two areas:

- **Self-harm** – the HSC welcomed the Third Progress report’s inclusion of self-harm prevention and recommended that “all patients who present with self-harm must receive a psychosocial assessment in accordance with NICE guidelines” and that “[p]atients who present at A&E with self-harm should have a safety plan, co-produced by the patient and clinician, and properly communicated and followed up”.⁵⁴
- **Support for those bereaved by suicide** – the HSC deemed it appropriate for this to be a part of the renewed Strategy and recommended that “ensuring high quality support for all those bereaved by suicide should be included in all local authorities’ suicide prevention plans”, which should abide by certain basic standards.⁵⁵

Above all, the HSC noted that while the Strategy could be improved in several areas, “the key issue is not with the strategy itself, but with

⁵² *Ibid.*, para. 7, pp4-5

⁵³ Health Committee, [Suicide Prevention, Sixth report of Session 2016-17](#), 16 March 2017, HC 1087, paras 10-11, p7

⁵⁴ *Ibid.*, para. 92, p24

⁵⁵ *Ibid.*, para. 114, p29

ensuring effective and consistent implementation across the country”.⁵⁶ It recommended, therefore, the creation of a national implementation board which would oversee the national strategy as well as local authorities’ plans, as well as giving a role to health overview and scrutiny committees to ensure effective implementation of local plans.⁵⁷

The Government responded to the HSC’s reports in July 2017. Amongst its responses to individual recommendations, it said that there “are no plans to establish a National Implementation Board”, although it announced new governance arrangements to oversee and monitor progress of mental health and suicide prevention policies.⁵⁸

These included:

- The creation of an “Inter-Ministerial Group for Mental Health”, comprising ministers from across Whitehall and chaired by the Health Secretary to discuss and prioritise key issues and programmes.
- A cross-Whitehall Director General/Director level group which looks at the full portfolio of the Government’s mental health commitments.⁵⁹
- The establishment of a National Suicide Prevention Strategy Delivery Group, comprising officials from across Government and agencies involved in the delivery of the Strategy and the Five Year View for Mental Health, in order to clarify responsibility for delivering various key aims and improve accountability. For more on this, see the next section on health policy.⁶⁰

3.3 English local government

Box 2: English local government responsibility for health and social care services

Since the *Health and Social Care Act 2012* came into force in 2013, local authorities in England have been responsible for the provision of a range of public health services. Before then, councils had not had a statutory role in the provision of healthcare since 1973.⁶¹ Upper-tier and unitary authorities are responsible for improving the health of their populations, backed by a grant from central Government. They commission or provide public health and social care services, including those for children up to 19 years old, some sexual health services, public mental health services, physical activity, anti-obesity provision, drug and alcohol misuse services, and nutrition programmes. Local delivery of these services is overseen by Public Health England.

In addition to these public health duties, since 2013 local authorities are responsible for statutory Health and Wellbeing Boards which oversee local commissioning and the co-ordination of health and social care services. They are required to produce Joint Strategic Needs Assessments (JSNAs) to identify current and future health and social care needs in their local communities, which contribute to Joint Health and Wellbeing Strategies (JHWSs) to determine joint priorities for local commissioning. For more

⁵⁶ *Ibid.*, para. 12, p7

⁵⁷ *Ibid.*, paras 27-28, p10

⁵⁸ DH, [Government Response to the Health Select Committee’s Inquiry into Suicide Prevention](#), July 2017, Cm 9466, p6

⁵⁹ *Ibid.*, p3

⁶⁰ *Ibid.*, p3

⁶¹ The *National Health Service Reorganisation Act 1973* transferred responsibility for community services (with the exception of environmental health) from local authorities to the NHS. The *Local Government Act 2000* gave local authorities a statutory responsibility to improve the economic, social and environmental circumstances in their area; the *Health Act 2001* also gave councils health scrutiny powers.

information on this, see sections 7 and 8 of Commons Library briefing CBP 07206, [The structure of the NHS in England](#).

The UK Government's 2012 Strategy intended there to be an enhanced role for local government in line with their new public health duties:

37. Much of the planning and work to prevent suicides will be carried out locally. The strategy outlines evidence based local approaches and national actions to support these local approaches.

38. Local responsibility for coordinating and implementing work on suicide prevention will become, from April 2013, an integral part of local authorities' new responsibilities for leading on local public health and health improvement.

39. It will be for local agencies, including working through health and wellbeing boards to decide the best way to achieve the overall aim of reducing the suicide rate. Interventions and good practice examples are included to support local implementation. Many of them are already being implemented locally but local commissioners will be able to select from or adapt these suggestions based on the needs and priorities in their local area.⁶²

It therefore gave English local government responsibility for developing local suicide action plans through their work with Health and Wellbeing Boards (HWBs). It pointed to the implementation framework for *No health without mental health*, published in June 2012, which set out what local organisations could do to implement that strategy.⁶³

The All Party Parliamentary Group on Suicide and Self-Harm Prevention published a report entitled [The Future of Local Suicide Prevention Plans in England](#) in January 2013, four months after the national Strategy had itself been published. It made 23 recommendations to the Government and key actions and stakeholders and concluded that the

future of local suicide prevention plans through this period of transition depend upon several inter-connected factors; leadership and local champions, identification of suicide prevention as a priority, availability of resources and the long-term survival of suicide prevention groups. The future of local suicide prevention plans is fragile; often relying upon the commitment of dedicated individuals.⁶⁴

The report criticised the lack of local suicide prevention plans in England, as it found that whereas 73% of respondents to its inquiry had a local suicide prevention plan, a quarter of respondents had not developed a specific plan.⁶⁵ It noted that there were "no mandatory requirements" for local authorities to set up a multi-agency suicide prevention group or publish a stand-alone local suicide prevention strategy. It recommended in particular, therefore, that the Department of Health require:

⁶² HMG, [Preventing suicide in England: A cross-government outcomes strategy to save lives](#), 10 September 2012, paras 37-39, p8

⁶³ *Ibid.*

⁶⁴ APPG on Suicide and Self-Harm, [The Future of Local Suicide Prevention Plans in England](#), January 2013, p1

⁶⁵ *Ibid.*, paras 44-45, pp19-20

...all local authority areas to develop a suicide prevention plan led by the director of public health or senior member of the public health team and establish a suicide prevention group. Local suicide prevention plans should include provision for self-harm prevention and those bereaved by suicide.⁶⁶

It also recommended that guidance be published for local Health and Wellbeing Boards (HWBs) in order for suicide prevention to be included in local public health strategies, including the Joint Strategic Needs Assessment.⁶⁷

Thereafter, this APPG conducted a further inquiry on local suicide prevention plans in England, which [reported in January 2015](#). It was based on a survey which found that 30% of local areas did not have a suicide prevention plan and that 40% did not have a multi-agency group. It concluded that “there are significant gaps in the local implementation of the local strategy” and recommended that all local areas should have a plan, multi-agency group, and suicide audit. It also recommended that further guidance and encouragement to local authorities and public health teams should be provided by Public Health England and its 15 local centres across England.⁶⁸

The 2017 Third Progress Report aimed explicitly to ensure that “every local area has a multi-agency suicide prevention plan in 2017, with agreed priorities and actions”. It accepted that the APPG’s findings had been “unacceptable”, but claimed that it had worked with local authorities to improve this position pointed to the fact that in November 2016, Public Health England undertook a survey to assess local authority suicide prevention plans and published this information on the [atlas of variation](#). This survey found that 95% of local areas (146 of the 152 local authorities) reported that they now had suicide prevention plans or a plan to develop one.⁶⁹

3.4 Oversight and implementation in the devolved nations

Scotland

The last Scottish suicide prevention strategy, like its predecessor, was led by the Scottish Government and supported by NHS Health Scotland, along with local Choose Life coordinators.

NHS Health Scotland leads implementation of the Strategy through the National Programme for Suicide Prevention in Scotland. In this it organises national and local campaigns, provides guidance on the [Choose Life website](#), and leads workforce development. It also provides leadership and direction for the local *Choose Life* coordinators who are appointed in [each of Scotland’s 32 local authority areas](#) to help

⁶⁶ *Ibid*, p5

⁶⁷ *Ibid*.

⁶⁸ APPG on Suicide and Self-Harm Prevention, [Inquiry into Local Suicide Prevention Plans in England](#), January 2015, pp3-7

⁶⁹ HMG, [Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives](#), January 2017, para. 5, p7

implement local suicide prevention action plans.⁷⁰ These local plans are designed to prevent suicide within communities by promoting awareness, delivering intervention activities, providing practical support for those affected by suicide, and collaborating with local bodies and agencies.⁷¹

The new 2018 Action Plan commits to the establishment of a National Prevention Leadership Group (NSPLG) in September 2018 which will lead on the Scottish Government's suicide prevention "vision" and will report directly to Scottish Ministers. It will develop a delivery plan for ten actions in the Action Plan, which is expected to be published in December 2018. It will also be supported by £3 million in funding over the course of the current Scottish Parliament (2016-2021).⁷²

The Action Plan further commits the NSPLG to working with the Convention of Scottish Local Authorities (COSLA), which is the national association of Scottish councils. It will do this "on issues that sit within the competence of local government and integration authorities".⁷³

Wales

In the original suicide prevention strategy for Wales, national oversight was given to the Welsh Assembly Government as a whole to "follow up with local agencies the progress they are making in implementing the seven strategic objectives in their area" and, where relevant, to engage with UK Government departments to ensure a "collaborative approach" in order to fulfil the objectives.⁷⁴ Local authorities were given responsibility for local implementation in collaboration with local Health Boards, justice agencies, third sector agencies, and community organisations.⁷⁵

The latest Welsh suicide prevention strategy, *Talk to me 2*, specifies that the focus on prevention should be "cross-sectoral with local ownership and implementation supported by national action and leadership."⁷⁶ Like the previous strategy, *Talk to me 2* argued that "no single organisation or government department can take sole responsibility", and advocated what it called a "3C" approach: "cross-governmental, cross-sectoral and collaborative, with shared responsibility at all levels of the community".⁷⁷

National oversight remains with the Welsh Government, while delivery is facilitated at the health board and local authority level. All regions in Wales had previously established multi-agency suicide prevention

⁷⁰ 'National and local implementation', Choose Life website [accessed 18 December 2017]

⁷¹ 'Local action plans', Choose Life website [accessed 7 September 2018]

⁷² Scottish Government, *Suicide Prevention Action Plan: Every Life Matters*, August 2018, p9

⁷³ *Ibid.*

⁷⁴ Welsh Assembly Government, *Talk to Me: The National Action Plan to Reduce Suicide and Self Harm in Wales 2009-2014*, October 2009, p21

⁷⁵ *Ibid.*, pp21-22

⁷⁶ Welsh Government, *Talk to me 2: Suicide and Self Harm Prevention Strategy for Wales 2015-2020*, June 2015, para. 51, p18

⁷⁷ *Ibid.*, para. 6, p6

forums with agreed local reporting structures, and all reporting to the National Advisory Group. Public Health Wales has specific responsibility for the action plan and is chair of the National Advisory Group which would will conduct a “mid-point review” of the implementation of the strategy.⁷⁸

The Health and Social Care and Sport Committee in the National Assembly for Wales is currently conducting an inquiry on suicide prevention which is examining “the extent of the problem of suicide in Wales and what can be done to address it”. It is focussing on suicide prevention for people aged 15 and over in Wales and its stated terms of reference include:

- 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.
- The social and economic impact of suicide.
- 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.
- The contribution of the range of public services to suicide prevention, and mental health services in particular.
- The contribution of local communities and civil society to suicide prevention.
- Other relevant Welsh Government strategies and initiatives - for example *Together for Mental Health*, data collection, policies relating to community resilience and safety.
- Innovative approaches to suicide prevention.⁷⁹

A report resulting from this inquiry is currently being drafted. Transcripts and videos of meetings and evidence-giving sessions, which took place between March and June 2018, can be viewed on the National Assembly for Wales’ [website](#).

Northern Ireland

The first Northern Ireland suicide prevention strategy, *Protect Life*, created a “cross-sectoral” Suicide Strategy Implementation Body (SSIB) to advise on implementation of the Strategy, and a Ministerial Coordination Group on Suicide Prevention was established at the same time to ensure “that suicide prevention is a priority to all relevant Government Departments” and “to enhance cross-Departmental cooperation”.⁸⁰

⁷⁸ *Ibid.*, paras 51-55, pp18-19

⁷⁹ ‘[Suicide Prevention](#)’, National Assembly for Wales website (accessed 7 September 2018)

⁸⁰ NIDHSSPH, [Protect Life – A Share Vision: The Northern Ireland Suicide Prevention Strategy 2012-March 2014](#), June 2012, paras 5.2-5.4, p39

The *Protect Life* strategy committed to £2.2 million investment annually for support to communities in developing local suicide prevention initiatives through local implementation groups. These groups have developed local actions plans and oversee and report on the delivery with properly trained local suicide prevention coordinators.⁸¹

The new draft strategy proposes that the Ministerial Co-ordination group on suicide prevention will continue to provide oversight, but that strategic oversight should continue to be led by the Northern Ireland Department of Health. It also proposes the creation of a new “Protect Life 2 Implementation Steering Group” to work alongside the SSIB other local implementation groups.⁸²

⁸¹ *Ibid.*, para. 1.2, p7

⁸² Northern Ireland Department of Health [NIDH], [*Protect Life 2: A Draft Strategy for Suicide Prevention in the North of Ireland*](#), September 2016, p11

4. Health services

This section sets out the work of health services to prevent suicide. For information on mental health policy in England more generally, see the Commons Library briefing paper [Mental health policy in England](#), published in August 2017.

4.1 Reducing suicide rates

The [Five Year Forward View for Mental Health](#) was published in February 2016 by the independent Mental Health Taskforce. The report made recommendations on suicide prevention and reduction, including an objective to reduce suicides by 10% nationally by 2020/21 (compared to 2016/17 levels).⁸³

NHS England accepted the recommendations of the report and agreed with the Government that to support the transformation of mental health services there will be an additional investment of £1bn per year by 2020/21, including £25 million specifically on suicide prevention.⁸⁴

In January 2018, the former Health Secretary Jeremy Hunt also announced a zero-suicide ambition for mental health inpatients.⁸⁵ This includes a new requirement for NHS mental health organisations in England to draw up detailed plans to achieve zero suicides, starting with those in inpatient settings. The plans include:

- Asking that all suicides by mental health patients are reported and published more quickly;
- Requiring Trusts to “strengthen the package of suicide prevention measures” they have in place;
- Ensuring that there are thorough investigations after all suicide attempts, with a focus on learning from errors; and
- Encouraging a “cultural shift within mental health services” so that suicides are not viewed as inevitable.

The then Health Secretary said this would result in England becoming the first country in the world to roll out zero suicides as a national ambition.⁸⁶

4.2 Local suicide prevention plans

The [Five Year Forward View for Mental Health](#) recommended that all local authorities have multi-agency suicide prevention plans in place by 2017. The plans should target high-risk locations and support high-risk groups, including men and people in contact with mental health services:

⁸³ NHS England, [Five Year Forward View for Mental Health](#), February 2016, page 13

⁸⁴ NHS England, [Implementing the Five Year Forward View For Mental Health](#), July 2016, pp35-36

⁸⁵ Public Health England, Department of Health and Social Care [DHSC], [New Funding for Health and Social Care in England](#), 16 May 2018

⁸⁶ ‘Zero suicide is our simple but powerful NHS mission’, *The Telegraph*, 31 January 2018 (an opinion piece written by Jeremy Hunt MP)

The Department of Health, PHE and NHS England should support all local areas to have multi-agency suicide prevention plans in place by 2017, contributing to a 10 per cent reduction in suicide nationally. These plans should set out targeted actions in line with the National Suicide Prevention Strategy and new evidence around suicide, and include a strong focus on primary care, alcohol and drug misuse. Each plan should demonstrate how areas will implement evidence based preventative interventions that target high-risk locations and support high-risk groups (including young people who self-harm) within their population, drawing on localised real time data. Updates should be provided in the Department of Health's annual report on suicide.⁸⁷

This recommendation was accepted by NHS England in its implementation plan for the *Forward View*, in which it states that by 2017 all CCGs will develop and deliver local multi-agency suicide prevention plans.⁸⁸ A PQ answered in July 2018 noted that "most" local authorities now have a suicide prevention plan, and that it is envisaged that all areas will have one by 2020/21.⁸⁹

In May 2018, the Department of Health and Social Care, Public Health England and NHS England announced the first local areas that will receive funding from a £25 million investment over three years for suicide prevention. The funding has initially been allocated to areas that are worst affected by suicide.⁹⁰ It will include targeted prevention campaigns for men; psychological support for people with financial difficulties; better care after discharge; and improved self-harm services for all ages.⁹¹

However, the Health Committee's [report on Suicide Prevention](#), published in March 2017, raised concerns about the lack of detailed information on local suicide prevention plans:

We welcome the fact that 95 per cent of local authorities have a suicide prevention plan in place or in development. However we are concerned that there is currently no detail about the quality of those plans. It is not enough simply to count the number of local authorities which report that they have a plan in place.⁹²

The Health Committee called on the Government to set out a quality assurance process to assess and report on local plans. The Committee also recommended that Public Health England's suicide prevention planning guidance for local authorities should be developed into quality standards against which local suicide prevention plans should be assessed.⁹³

⁸⁷ NHS England, [Five Year Forward View for Mental Health](#), page 77 (Recommendations for Government)

⁸⁸ NHS England, [Implementing the Five Year Forward View for Mental Health](#), July 2016

⁸⁹ [PO 164869 \[on Suicide\]](#), 24 July 2018 [PO 164869 \[on Suicide\]](#), 24 July 2018

⁹⁰ For the full list of areas, see NHS England, [Suicide prevention and reduction](#), 16 May 2018

⁹¹ Public Health England, DHSC, [New Funding for Health and Social Care in England](#), 16 May 2018

⁹² Health Committee, [Suicide Prevention, Sixth report of Session 2016-17](#), 7 March 2017, HC 1087, para. 21

⁹³ *Ibid.*, paras 22-23

In its response, the Government announced an assurance process to support local authorities to develop suicide prevention plans and ensure their regular review.⁹⁴ This process was due to be tested during the summer of 2017. A PQ response in April 2018, however, said that the Department for Health and Social Care will be assuring the plans “this year”.⁹⁵

4.3 Support for high-risk groups

The [Third Progress Report](#) of the Suicide Prevention Strategy set an objective to target suicide prevention and help-seeking in high risk groups. The national strategy identified these as young and middle-aged men, people in the care of mental health services, people in contact with the criminal justice system, specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers, and people with a history of self-harm.⁹⁶

The Strategy sets out areas of work to reduce suicide among people in contact with mental services, for whom it says suicides are the most preventable. It highlights that around one third of people who die by suicide have been under specialist mental health services in the preceding year, and two thirds have seen their GP. Additionally, just over half of people sought help following an attempted suicide from either their GP or hospital services.⁹⁷

Primary care

For primary care, the updated 2012 Strategy highlights improved training for GPs and their staff in suicide awareness and safety planning. The General Medical Council and the Royal College of GPs provide training for GPs in suicide and self-harm.⁹⁸

The Strategy also notes new models of enhanced primary care, including the [Urgent and Emergency Care Vanguard](#)s, to test new ways for people with mental health problems to access urgent care in the community. The Department of Health has asked NICE to develop a new guideline – [Preventing suicides in community and custodial settings](#) – which is expected to be published in September 2018.⁹⁹

Specialist services and support

For people in the care of specialist mental health services, the Strategy notes a significant reduction in the number of inpatient suicides due to improvements in patient safety, but raises concerns about the rates of suicide for patients in contact with crisis home resolution teams. The Government is focusing on crisis care services in the community,

⁹⁴ DH, [Government response to the Health Select Committee's Inquiry into Suicide Prevention](#), Cm 9466, July 2017, page 5

⁹⁵ [PQ 136535 \[on Suicide\], 24 April 2018](#)

⁹⁶ HMG, [Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives](#), January 2017, p9

⁹⁷ *Ibid.*, para 21

⁹⁸ See DH, [Government response to the Health Select Committee's Inquiry into Suicide Prevention](#), Cm, 9466, July 2017, p15

⁹⁹ HMG, [Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives](#), January 2017, pp12-13

including funding of £400 million to improve 24/7 treatment in communities as a safe and effective alternative to hospital and £247million for mental health liaison services, where psychiatrists and counsellors are available in A&E units to assess, counsel and refer patients onto other mental health services if they show signs of self-harm or other psychological distress, by 2020/21.¹⁰⁰

CCGs are monitored on whether they provide follow-up support within seven days on discharge from inpatient care, which is published in the *Forward View Dashboard*.¹⁰¹ In its inquiry, the Health Committee recommended that patients should receive support within three days. The Government said that NHS England will consider this recommendation in future scoping work.¹⁰²

Information sharing

The [Information Sharing and Suicide Prevention Consensus Statement](#), published in January 2014, is intended to encourage health professionals to share information about someone at risk of suicide with family members and friends. The Health Committee raised concerns that the Statement was not being widely used, and recommended that there should be action to increase awareness and train staff on the tool.¹⁰³ In its response, the Government acknowledged that the Statement has not been promoted well or embedded widely across the NHS, but has been working with relevant Royal Colleges to promote the tool among its members.¹⁰⁴

Perinatal suicide prevention

The Health Committee also noted concerns about the levels of perinatal suicide.¹⁰⁵ The “*Mother and Babies: Reducing Risk Through Audits and Confidential Enquiries across the UK*” report – [Saving Lives, Improving Mothers’ Care](#) – which was published in December 2015, highlighted that almost a quarter of women (23%) who died between six weeks and one year after pregnancy died from mental health related causes, and one in seven women died by suicide.¹⁰⁶ The Government has pledged funding of £365 million between 2015/16 and 2020/21 to provide specialist mental health support to pregnant women and new mothers. NHS England’s [Implementing the Five Year Forward View for Mental Health](#) summarises main activities to improve perinatal mental health services, including the Perinatal Mental Health Community Services Development Fund to fund local projects.¹⁰⁷

¹⁰⁰ *Ibid.*, para 32, p14

¹⁰¹ NHS England, [Five Year Forward View for Mental Health Dashboard](#), January to March 2017

¹⁰² DH, [Government response to the Health Select Committee’s Inquiry into Suicide Prevention](#), Cm 9466, July 2017, p18

¹⁰³ Health Committee, [Suicide Prevention, Sixth report of Session 2016-17](#), 7 March 2017, HC 1087, paras 21 and 95

¹⁰⁴ DH, [Government response to the Health Select Committee’s Inquiry into Suicide Prevention](#), July 2017, pp21-22

¹⁰⁵ Health Committee, [Suicide Prevention, Sixth report of Session 2016-17](#), 7 March 2017, HC 1087, para. 80, p21

¹⁰⁶ MBRACE-UK, [Saving Lives, Improving Mothers’ Care](#), December 2015, pii

¹⁰⁷ NHS England, [Implementing the Five Year Forward View for Mental Health](#), July 2016, pp12-15

4.4 Devolved nations

Scotland

The Scottish Government's new [Suicide Prevention Action Plan: Every life matters](#), published in August 2018, commits the Scottish Government to fund the creation and implementation of refreshed mental health and suicide prevention training by May 2019, and develop a Scottish Crisis Care Agreement.

The Action Plan aims to continue the work from the [2013-16 suicide prevention strategy](#), one key theme of which (Theme C) was "Improving the NHS response to suicide". This highlighted in particular "the increased focus on identifying and treating depression in primary care settings" as well as local patient safety improvements as key to previous prevention measures in Scotland.

To help fulfil these commitments and support implementation of the strategy more generally, NHS Health Scotland hosts the [Choose Life programme](#) which provides leadership and guidance to local suicide prevention coordinators around the Scotland, as well as training courses on suicide prevention action. It coordinates with other agencies closely involved in suicide prevention action in Scotland, including local authorities, NHS Boards, the Police and the voluntary sector.¹⁰⁸

In March 2017 the Scottish Government published a 10-year Mental Health Strategy which is designed to complement current suicide prevention measures.¹⁰⁹

Wales

As previously mentioned, the second objective in the latest Welsh Government's suicide prevention strategy – [Talk to me 2](#) – is "to deliver appropriate responses to personal crises, early intervention and management of suicide and self harm". In particular, this commits the Welsh Government to the mantra that "those who are the first point of contact need to have the necessary knowledge, skills and attitudes to ensure that compassionate and supportive evidence based care is delivered." It recommends that GPs have appropriate suicide prevention education and states that emergency staff "must have the necessary knowledge, skills and attitudes to recognise, assess, signpost, manage and initiate appropriate follow up for those within whom they come into contact and who are in distress".¹¹⁰

Priority action 8 of the [Talk to me 2 Action Plan](#) specifies that Health Boards in Wales should improve the health care response to self-harm, in collaboration with the National Advisory Group (NAG), the College of Emergency Medicine, Public Health Wales, the Wales Alliance for Mental Health in Primary Care, and the Royal College of General Practitioners. This will be a rolling programme over the life of this 2015-

¹⁰⁸ ['National and local implementation'](#), Choose Life website (accessed 28 November 2017)

¹⁰⁹ Scottish Government, [Mental Health Strategy: 2017-2027](#), March 2017, p28

¹¹⁰ Welsh Government, [Talk to me 2: Suicide and Self Harm Prevention Strategy for Wales 2015-2020](#), June 2015, paras 40 & 76-78, pp15-16 and 22-23

20 Strategy subject to annual review by the NAG. It also points to NICE guidance on the short and longer-term management of self-harm and states that Health Boards should ensure that it is being implemented properly.¹¹¹

The Strategy Action Plan commits to reviewing deaths through suicide in those known to mental health services, as well as those not known to mental health services. This involves collaboration between Health Boards, Public Health Wales, the National Advisory Group, and local authorities.¹¹²

All these actions were, at the time of publication, designed to be considered alongside the Welsh Government's suicide prevention measures in its mental health strategy, [Together for Mental Health](#), which was first launched in 2012, and its delivery plan. According to the latest iteration of the mental health strategy's delivery plan, however, which was published in 2016, the goal of preventing and reducing suicide and self-harm in Wales is to be achieved by implementing the *Talk to me 2* Action Plan by March 2019.¹¹³

Northern Ireland

Northern Ireland's Department of Health is currently consulting on a new draft suicide prevention strategy – [Protect Life 2](#). Its key objectives are to reduce the rate of suicide and reduce the differential in suicide rate between the most and least deprived areas.

The strategy proposes various specific actions with regard to health services in order to:

- Reduce the risk of suicides among those in contact with mental health services, and improving patient safety;
- Reduce repeat self-harm by using presentation at hospital emergency departments due to self-harm as an opportunity to act quickly and link those at risk with services;
- Raise awareness of self-harm and suicide prevention services, and engagement with these services by people who need them, particularly mental health services; and
- Improve the initial response to people experiencing suicidal behaviour and who are self-harming by training those who provide their first point of contact. The draft Strategy references explicitly the Scottish *Choose Life* Strategy as something to emulate in its target of training 50% of first responders and health care staff.¹¹⁴

These are designed to work in coordination with recent mental health initiatives, such as the Regional Mental Health Care Pathway, [You in](#)

¹¹¹ Welsh Government, [Talk to me 2: Suicide and Self Harm Prevention Action Plan for Wales 2015-2020](#), June 2015, pp9-10

¹¹² *Ibid.*, p13

¹¹³ Welsh Government, [Together for Mental Health Delivery Plan: 2016-19](#), September 2016, p5

¹¹⁴ *Ibid.*, pp65-73

[*Mind*](#), which sets out the standards expected by all mental health and psychological therapy services in Northern Ireland.¹¹⁵

For more information on mental health policy in Northern Ireland, see the Northern Ireland Assembly Research and Information Service briefing NIAR 412-16, [*Mental Health in Northern Ireland: Overview, Strategies, Policies, Care Pathways, CAMHS and Barriers to Accessing Services*](#) (January 2017).

¹¹⁵ *Ibid.*, p42

5. Education

5.1 Schools

Suicide Prevention in England

The 2012 [Suicide Prevention Strategy for England](#) identifies children and young people as a group for whom “a tailored approach to their mental health is necessary if their suicide risk is to be reduced.”¹¹⁶ The Strategy states that an effective school-based suicide prevention strategy would include:

- a co-ordinated school response to people at risk and staff training;
- awareness among staff to help identify high risk signs or behaviours (depression, drugs, self-harm) and
- protocols on how to respond;
- signposting parents to sources of information on signs of emotional problems and risk;
- a clear referral routes to specialist mental health services.¹¹⁷

The strategy adds that “appropriate training on suicide and self-harm should be available for staff working in schools and colleges”.¹¹⁸

Box 3: Personal, Social, Economic and Health (PSHE) Education

Personal, Social Health and Economic (PSHE) education is highlighted by the strategy as providing an opportunity for schools to teach about issues – such as sex and relationships, substance misuse, and emotional and mental health – that may help children “to recognise, understand, discuss and seek help earlier for any emerging and emotional problems.”¹¹⁹

As noted in the [Third Progress report on the suicide prevention strategy](#), the Government has funded the PSHE Association to produce guidance on providing age-appropriate teaching about mental health problems, including detailed lesson plans for use at Key Stages 1 to 4 (ages 5-16). These resources are available on the website of the PSHE association at: [Guidance on preparing to teach about mental health and emotional wellbeing](#).

Further information on PSHE education is available in the Library Briefing, [Personal, social, health and economic education in schools \(England\)](#).

The Strategy notes that interventions at a community level after a suicide can help prevent copycat and suicide clusters and ensure support is available, and states that this approach may be used in schools, colleges and universities. It then highlights the Samaritans’ Step-by-Step post-suicide intervention service for schools across the UK, whereby Samaritans branches provide guidance and information on the impact of suicide on school communities, and ways to promote recovery and prevent suicide clusters.¹²⁰

¹¹⁶ HMG, [Preventing Suicide in England: A cross-government outcomes strategy to save lives](#), September 2012, p6.

¹¹⁷ *Ibid.*, p22.

¹¹⁸ *Ibid.*, p17.

¹¹⁹ *Ibid.*

¹²⁰ HMG, [Preventing Suicide in England: A cross-government outcomes strategy to save lives](#), September 2012, p41.

Third progress report of the Suicide Prevention Strategy

The [Third Progress report](#) of the Suicide Prevention Strategy for England was published in January 2017. The report emphasised the “key role” that schools and colleges have to play in promoting good mental health for children and young people. It then highlighted Government proposals and actions in this area, including:

- Providing mental health first aid training in schools;
- Expanding [pilots](#) to establish single points of contact for mental health to more schools;¹²¹
- Funding the PSHE Association to produce guidance on teaching about mental health problems; and
- Providing funding to tackle homophobic, biphobic and transphobic bullying in schools.

More information on these is provided in the relevant sections below (and box 3 above).

This report stated additionally that the Department for Education (DfE) had been looking at what good peer support for mental wellbeing looks like in schools, colleges, community groups and online. It added that the Government would also be analysing suicide rates of people at university to explore any lessons to be learned and increase awareness of suicide risk and mental wellbeing (see section 5.2 below).¹²²

Safeguarding in schools

The Government’s Strategy notes that preventing suicide in children and young people is closely linked to safeguarding.

A [parliamentary question](#) in 2015 asked what steps the Government had taken to reduce the incidence of suicide in schools. With regards to what schools should do where they have immediate concerns about a risk of suicide, the response stated:

Where schools have immediate concerns about the risk of suicide, their safeguarding role is set out in our statutory guidance, *Keeping Children Safe in Education*. This emphasises that schools should have a designated senior lead, with responsibility for the handling of safeguarding concerns, in place. Where schools have immediate concerns about the risk of suicide, an immediate referral should be made to children’s social care.¹²³

The safeguarding guidance also applies to sixth form colleges and general further education colleges and relates to their responsibilities towards children under the age of 18.¹²⁴

¹²¹ HMG, [Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives](#), January 2017, p23. See Department for Education [DfE], [Mental health services and schools link pilot: evaluation](#), 9 February 2017 for further information on the initial pilots.

¹²² HMG, [Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives](#), January 2017, p23

¹²³ [PQ 228146 \[on Children: Suicide\]](#), 23 March 2015

¹²⁴ DfE, [Keeping children safe in education: Statutory guidance for schools and colleges](#), September 2016, p3

Further information on the safeguarding responsibilities of schools in England is set out in the Library Briefing, [Safeguarding in English schools](#), published in June 2018.

Identifying mental health issues

As well as outlining what schools should do in response to an immediate suicide concern, the PQ response cited above also noted the key role that schools have in identifying and supporting pupils with mental health conditions more generally. At the same time, however, the Government has acknowledged that teachers are not mental health professionals and, where more serious problems occur, it expects that pupils should receive additional support from CAMHHS services, voluntary organisations and GP practices.¹²⁵

[Guidance](#) published by the Department for Education (and linked to in the [Keeping Children Safe in Education safeguarding guidance](#)) provides advice for school and college staff on how to identify and support students who have unmet mental health needs. This includes information on:

- How and when to refer to CAMHS;
- Practical advice to support children with emotional and behavioural difficulties;
- Strengthening pupil resilience tools to identify pupils who are likely to need extra support; and
- Where and when to access community support.¹²⁶

In addition, the [MindEd website](#), which was set up in 2014 and is funded by the Department of Health and the DfE, provides information to help professionals who work with young people to recognise the early signs of mental health problems.

In March 2015, the DfE published a [blueprint for school counselling services](#), which provides schools with practical advice on setting up and improving counselling services for pupils.¹²⁷ Schools are not required to report centrally on the services they provide, but it has been estimated that 70% of secondary schools and 52% of primary schools in England offer counselling services.¹²⁸

Initiatives to improve mental health in schools

In January 2017, the Prime Minister announced that a new green paper would be published on children and young people's mental health, which would "set out plans to transform services in schools, universities and for families."¹²⁹ The Green Paper was published in December 2017 and outlined several proposals aimed at improving support for mental health in schools, including:

¹²⁵ [PQ 111153 \[on Schools: Counselling\]](#), 7 November 2017.

¹²⁶ DfE, [Mental health and behaviour in schools](#), March 2016, p49

¹²⁷ DfE, [Counselling in schools](#), February 2016

¹²⁸ Care Quality Commission, [Review of children and young people's mental health services: Phase one report](#), October 2017, p23

¹²⁹ ['Prime Minister unveils plans to transform mental health support'](#), Gov.uk, 9 January 2017

- Incentivising schools to identify and train a Designated Senior Lead for Mental Health, with new training to help leads and staff deliver whole school approaches to promoting better mental health;
- Creating new Mental Health Support Teams to work with groups of schools and colleges, and work with Designated Senior Leads in addressing the problems of children with mild to moderate mental health problems, and provide a link to services for children with severe problems; and
- Building on existing mental health awareness training so that a member of staff in every primary and secondary school in England receives mental health training.¹³⁰

Further information on mental health in schools, including the Green Paper proposals, is provided in section six of the Library Briefing, [Children and young people's mental health – policy, CAMHS services, funding and education](#), published in August 2018.

The Government's response to the consultation, which was published in July 2018, committed to taking forward all proposals in the Green Paper. It stated that the first Mental Health Support Teams are expected to be operational from the end of 2019, and that the Government aims to offer training to designated mental health leads to one fifth of schools from September 2019.¹³¹

The response added that the Government was "committed to providing mental health awareness training to every secondary school by 2019 and every primary school by 2022". In the first year, the response said, training had been provided to a member of staff in a third of secondary schools (1,000 schools), and by June 2019 it was aimed to have reached a further 1,000 schools.¹³²

Mental health education on the curriculum

Alongside changes to Relationships and Sex Education, the Government [announced](#) the introduction of statutory health education in July 2018.¹³³ [Draft statutory guidance on RSE and health education](#) was published, with a [consultation](#) on the guidance open until 7 November 2018.

Further information is available in section 4.2 of the Library briefing, [Children and young people's mental health – policy, CAMHS services, funding and education](#).

Concerns over mental health provision in schools

Concerns have been raised that current provision of mental health support in schools is patchy. This was noted by the Care Quality

¹³⁰ [PQ 901024 \[on Mental Health Services: Children\]](#), 10 October 2017

¹³¹ Department of Health and Social Care and Department of Education, [Government Response to the Consultation on Transforming Children and Young People's Mental Health Provision: a Green Paper and Next Steps](#), June 2018, p6.

¹³² *Ibid*, p34.

¹³³ Department for Education, [New relationships and health education in schools](#), 19 July 2018.

Commission (CQC) in a recent review of CAMHS services. The CQC noted that when pupils can access high-quality counselling through their schools, it can be an effective form of early intervention. The CQC also said, however, that it is not always available, and that in some cases there are concerns about the quality of support on offer.¹³⁴

It has been suggested that the funding pressures on schools may have led many to reduce mental health services, such as in-school counsellors. In their [joint report](#) on children and young people's mental health, the Commons Education and Health Committees cited survey evidence that 78% of primary schools reported financial constraints as a barrier to providing mental health services for pupils. This report argued that it was a "false economy to cut services for children and young people" given that over half of mental ill health starts before the age of 15, and recommended that the Government should review the effect of budget reductions on in-school mental health services.¹³⁵

In its [response](#) to this joint report, the Government provided the results of a survey of mental health provision in schools showing, amongst other things, that 56% of primary maintained schools and 84% of maintained secondary schools offered counselling services. The response also stated that the recently announced additional £1.3 billion for core school budgets, along with the introduction of the national funding formula, would "help schools provide more support for those with mental illness."¹³⁶

Bullying and mental health

The 2015 PQ response on suicide prevention in schools noted that children who are persistently bullied are more likely to suffer from poor mental health. The DfE has published [advice](#) for schools, last updated in July 2017, on preventing and tackling bullying. This sets out the Government's approach to bullying, and the legal powers schools have to address bullying. It also outlines principles that underpin the most-effective anti-bullying strategies in schools.¹³⁷

In addition, as highlighted in the Third Progress report on the suicide prevention strategy, in September 2016 the Government Equalities Office announced a £3 million programme to tackle homophobic, biphobic and transphobic bullying in schools. The programme is focused on primary and secondary schools in England which currently have no, or ineffective, measures in place.¹³⁸

¹³⁴ Care Quality Commission, [Review of children and young people's mental health services: Phase one report](#), October 2017, pp23-24

¹³⁵ Education and Health Committees, [Children and young people's mental health — the role of education](#), HC 849, May 2017, p12

¹³⁶ Education and Health Committees, [Children and young people's mental health—the role of education: Government Response to the First Joint Report of the Education and Health Committees of Session 2016–17](#), HC 451, October 2017, pp6-7

¹³⁷ DfE, [Preventing and tackling bullying](#), July 2017

¹³⁸ 'Schools around the country to stamp out LGBT bullying', Government Equalities Office, September 2017; [PQ 6636 \[on Pupils: Bullying\]](#), 9 September 2017

Box 4: Social media and suicide

As noted in Section 10 of this paper, the [second progress report](#) on the Suicide Prevention Strategy for England, published in 2015, noted concerns about the influence of social media but stated that there was “limited systematic evidence, despite stories of individuals who have been bullied or encouraged to self-harm.” The report added that this had to be balanced against the support that vulnerable people may find through social networks.¹³⁹

In their May 2017 joint [report](#) on the role of education in promoting children and young people’s mental health, the Education and Health Committees raised concerns about the impact of social media on mental health. The report recommended that schools should include education on how to assess and manage the risks of social media as part of PSHE education.¹⁴⁰ In its [response](#) to the Report, the Government stated that the expected mental health Green Paper would “address the interface between internet use and mental health issues in children and young people.”¹⁴¹

5.2 Further and Higher Education

Further and higher education institutions (HEIs) have legal duties under the *Equality Act 2010* to support their students, including those with mental health conditions.¹⁴² They also have an established common law duty of care to act reasonably to protect the health, safety and welfare of their students.¹⁴³

The focus of attention in this area has mainly been on HEIs, but the same issues and legal framework apply to further education institutions. As noted above, further education institutions which admit students under the age of 18 have to comply with the same safeguarding regulations as schools.

In [response to a PQ](#) in October 2017, the then Universities Minister, Jo Johnson, stated that: “as autonomous organisations, it is for higher education institutions to determine what welfare and counselling services they need to provide to their students.” He added that “[e]ach institution will be best placed to identify the needs of their particular student body, including taking actions in line with any legal responsibilities under the *Equality Act 2010*.”¹⁴⁴

The most common model of mental health provision within HEIs involves three separate services:

- Wellbeing services to deliver low-intensity support and signpost to non-medical services;
- Counselling services targeted at students with moderate levels of mental distress; and

¹³⁹ HMG, [Preventing suicide in England: Two years on Second annual report on the cross-government outcomes strategy to save lives](#), February 2015, p10

¹⁴⁰ Education and Health Committees, [Children and young people’s mental health — the role of education](#), HC 849, May 2017, pp13-14

¹⁴¹ Education and Health Committees, [Children and young people’s mental health—the role of education: Government Response to the First Joint Report of the Education and Health Committees of Session 2016–17](#), HC 451, October 2017, p8

¹⁴² [PQ 14451 \[on Students: Suicide\]](#), 10 November 2015

¹⁴³ See Universities UK, [Student mental wellbeing in higher education: Good practice guide](#), February 2015, pp43-45, for more information.

¹⁴⁴ [PQ 109171 \[on Universities: Mental Health Services\]](#), 31 October 2017

- Disability services targeted at students in receipt of disabled students' allowances or who experience mental illness which meets a clinical threshold for diagnosis.

Some HEIs also have suicide prevention strategies. The University of Wolverhampton, for example, has framed suicide as a safeguarding issue and has implemented a strategy for effective interventions. Others including the University of Cumbria, have training available for all staff on suicide prevention and awareness, as part of a wider drive to create 'compassionate campuses.'

There are also a number of student-led initiatives that offer mental health support, including:

- [Nightline](#): a service run for students, by students. Trained student volunteers answer calls, emails and messages in person to fellow students;
- [Student Minds](#): a charity which carries out research and campaigns on mental health issues. It trains volunteers and supports student-led societies across campuses; and
- [Students Against Depression](#): a website offering advice, information, guidance and resources to those suffering from depression and suicidal thinking.

Guidance for universities on preventing student suicide

On 5 September 2018, Universities UK, the representative body of university vice chancellors, and PAPYRUS, the aforementioned charity dedicated to preventing suicide among young people, published [guidance](#) for universities in preventing student suicides. The guidance states that suicide prevention, intervention and "postvention" should be connected as a specific strategy as a component of a university's overarching mental health strategy. The strategy, the guidance adds, should be created in partnership with staff, students, and external stakeholders, and should be developed into a multi-agency action plan detailing how, by who and when it will be implemented.¹⁴⁵

The guidance also sets out best practice for universities in preventing student suicides, intervening when students get into difficulties, and responding to student suicides.¹⁴⁶ It ends with a checklist, setting out that universities should, among other things:

- Make suicide safety an institutional priority;
- Develop a suicide-safer strategy and action-plan as a distinct component of their overarching mental health strategy;
- Train suicide intervention and postvention teams, and train all student-facing staff in suicide awareness;
- Create strong links with local and national partners from the health sector, voluntary sector, and local authorities; and

¹⁴⁵ Universities UK and PAPYRUS, [Suicide-safe universities](#), September 2018, p15.

¹⁴⁶ As above, pp17-19.

- Work together with schools, colleges and other universities in the area to ensure smooth transitions between educational settings.¹⁴⁷

Box 5: ONS estimates of suicide among higher education students

In June 2018, the ONS published [experimental statistics](#) estimating suicide among higher education students in England and Wales. These included:

- The suicide rate for students in England and Wales in the 2016-17 academic year was 4.7 deaths per 100,000 students, equating to 95 suicides. This was higher than in most earlier years, although the small numbers per year make it difficult to identify statistically significant differences.
- Between the 2012-13 and 2015-16 academic years the suicide rate of higher education students in England and Wales was significantly lower than for the general population of similar ages (figures for the 2016-17 academic year were provisional).
- Male students had a significantly higher rate of suicide than female students.
- The number of suicides in the analysis was lower than in previous ONS estimates. This is likely because it focused on higher education students only, while previous estimates also covered further education students.¹⁴⁸

Guidance on supporting student mental health

In February 2015, Universities UK published a [good practice guide](#) for UK universities on student mental wellbeing. The guidance highlights a number of areas for consideration in developing institutional policies and procedures, including:

- Duty of care and legal considerations;
- Demand for institutional services versus external statutory services;
- Access to support and guidance services;
- Provision of training, development opportunities and information dissemination; and
- Liaison between internal and external, voluntary and statutory agencies.

It notes that each institution is different, and therefore that the use of the guidance will depend on the nature of the student cohort and the particular challenges the institution may face.¹⁴⁹

The guidance states that to assist in discharging their duties of care, institutions need to ensure that all staff have a clear understanding of their role regarding students with mental health difficulties, which will require appropriate staff training.¹⁵⁰ It adds that staff should feel confident in recognising when students should be advised to seek specialist support and when matters should be referred on to specialist services. Institutions should also have clear and well-publicised referral protocols, policies and procedures.¹⁵¹

¹⁴⁷ As above, p21.

¹⁴⁸ ONS, [Estimating suicide among higher education students, England and Wales: Experimental Statistics](#), 25 June 2018.

¹⁴⁹ Universities UK, [Student mental wellbeing in higher education: good practice guide](#), February 2015, p5

¹⁵⁰ *Ibid.*, p45

¹⁵¹ *Ibid.*

In addition, as part of a [programme of work](#) to address mental health in universities, in September 2017, Universities UK published a [new step change framework](#) to help improve the mental health of university students. The framework was developed to “support higher education senior teams to adopt a whole university approach to mental health.” Among other things, it recommends that higher education institutions work closely with the NHS to consider how mental health care services should be commissioned and delivered to student populations.¹⁵²

In a May 2018 report, [Minding Our Future](#), Universities UK argued that student mental health needs to become a shared priority, with services redesigned to integrate university support with NHS care more effectively. The report stated that in some areas universities, NHS organisations and local authorities are starting to form local partnerships to develop mental health strategies to improve services for students. Universities UK would, the report said, work with health and education bodies to identify how they can be best supported by national policy.¹⁵³

Mental health charter

In June 2018, the Higher Education Minister, Sam Gyimah, hosted a ‘mental health summit’ with universities, students and support groups to discuss better support for students.

At the summit, Mr Gyimah announced that a new University Mental Health Charter would be developed with charities and HEIs outlining criteria that universities need to meet to gain the recognition.¹⁵⁴ In July 2018, the charity Student Minds announced that it would lead the development of the Charter in partnership with the UPP Foundation, the Office for Students (OfS), National Union of Students (NUS) and Universities UK.¹⁵⁵ Further information is available on the Student Minds website: [Get involved – The University Mental Health Charter](#).

At the mental health summit, the Minister additionally announced that:

- A Department for Education-led working group would be set up into the transition students face when going to university; and that
- The Government would explore whether an opt-in requirement for universities could be considered, so they could have permission to share information on student mental health with parents or a trusted person.¹⁵⁶

IPPR report on student mental health in universities

A [report](#) published by the Institute for Public Policy Research (IPPR) in September 2017 stated that levels of mental illness among students in higher education are increasing and are high relative to other sections

¹⁵² ‘[Mental Health in Higher Education](#)’, Universities UK (accessed 3 January 2018)

¹⁵³ Universities UK, [Minding Our Future: Starting a conversation about the support of student mental health](#), May 2018.

¹⁵⁴ [New package of measures announced on student mental health](#), Department for Education, 28 June 2018.

¹⁵⁵ [Student Minds launch University Mental Health Charter](#), Student Minds, 4 July 2018.

¹⁵⁶ [New package of measures announced on student mental health](#), Department for Education, 28 June 2018.

of the population. Noting that poor mental health can lead to increased risk of suicide where support is lacking, the report stated that a record number of students died by suicide in 2015 and that between 2007 and 2015, the number of student suicides increased by 79% (from 75 to 134).¹⁵⁷

The report noted variation in how universities respond to student mental health. While “a range of prevention and promotion activities are widespread across the higher education sector”, for example, the report stated that:

- Less than one third [of universities] have designed an explicit mental health and wellbeing strategy
- Less than half (43 per cent) design course content and delivery so as to help improve student mental health and wellbeing
- Two thirds (67 per cent) do not provide students access to NHS mental health specialists who can deliver interventions onsite.
- 23 per cent do not work closely with NHS secondary mental health services.¹⁵⁸

Amongst other things, the report recommended that the higher education sector should “collectively adopt student mental health and wellbeing as a priority issue, with individual institutions developing their own ‘whole-university’ approaches.”¹⁵⁹

Association of Colleges mental health survey

In February 2017, the Association of Colleges (AoC) published the results of a survey about students with mental health conditions in Further Education in England, which was conducted in November in 2016.

The AoC reported that the survey showed that:

- The number of college students with mental health issues is increasing;
- Almost all (97%) of colleges are providing education on wellbeing as part of work to support students in maintaining mental wellness;
- Reductions in college funding have caused most colleges to make reductions in non-teaching services and less than half of the colleges surveyed were able to support a full-time counsellor or mental health worker on campus;
- 48% of the colleges surveyed said that their relationship with clinical commissioning groups was “non-existent”;
- 74% of those surveyed had referred students experiencing mental health crises to A&E in the last year; and

¹⁵⁷ Institute for Public Policy Research, [*Not by Degrees: Improving Student Mental Health in the UK's Universities*](#), September 2017

¹⁵⁸ *Ibid.*

¹⁵⁹ *Ibid.*

- The AoC called for colleges and local mental health services to “develop better working relationships” and asked colleges to prioritise student wellbeing.¹⁶⁰ The Association made mental health a priority in 2017 and set up a Mental Health Portfolio group to build links and share knowledge about improving practice.¹⁶¹

Mental Health Green Paper

The mental health Green Paper, [Transforming Children and Young People's Mental Health Provision](#), noted the work of Universities UK and the Association of Colleges in improving the quality of mental health support. Arguing that improving adult mental health can only be addressed by working in partnership, the Green Paper stated that the Government would “set up a new national strategic partnership with key stakeholders focused on improving the mental health of 16-25 year olds by encouraging more coordinated action, experimentation and robust evaluation.” It then set out a number of areas that the partnership could look at focused on higher education as a first step.¹⁶²

The Government's response to the consultation, published in July 2018, noted that the mental health of 16-25 year olds is a cross-cutting issue that impacts on the work of multiple Government departments and bodies. It stated that the Cabinet Office had been working with the Department of Health and Social Care, the Department for Education and a range of other organisations to consider next steps in this area. The response also highlighted the measures announced in June 2018 at the aforementioned mental health summit.¹⁶³

5.3 Devolved nations

Scotland

The Scottish Government's suicide prevention action plan, [Every life matters](#), published on 9 August 2018, highlights that “early education for children and young people is critical – focusing not just on suicide prevention awareness, but also on emotional intelligence and resilience.” Staff at schools, colleges and universities, it adds, need to have the confidence to support students who are in distress or have been affected by suicide in other ways.

The Plan commits to ensuring that “by the end of academic year 2019/20, every local authority will be offered training for teachers in mental health first aid, using a ‘train the trainer’ model to enable dissemination to all schools.” It additionally notes that the higher and further sectors “are already engaging with relevant partners, including

¹⁶⁰ ‘Colleges forced to refer students with mental health issues directly to A&E’, Association of Colleges, 7 February 2017

¹⁶¹ Department of Health and Department for Education, [Transforming Children and Young People's Mental Health Provision: a Green Paper](#), December 2017, p34.

¹⁶² *Ibid.*, p34.

¹⁶³ Department of Health and Social Care and Department of Education, [Government Response to the Consultation on Transforming Children and Young People's Mental Health Provision: a Green Paper and Next Steps](#), June 2018, p35.

NUS Scotland, on how to develop further, their responses to the mental health needs of students.”¹⁶⁴

Information on the Scottish Government’s approach to promoting mental health more generally is contained in the [Mental Health Strategy 2017-2027](#). This strategy highlights the role of education in promoting mental health and states that “support from teachers and other school staff can be vital in helping ensure the mental wellbeing of children and young people.” It adds that the Scottish Government will “empower and support local services to provide early access to effective supports and interventions at tiers 1 and 2 and to use specialist CAMHS expertise where it will be most effective.”¹⁶⁵

This Mental Health Strategy sets out 40 initial actions that the Scottish Government will take, including a number focused on education. These include:

- Reviewing Personal and Social Education (PSE), the role of pastoral guidance in local authority schools, and services for counselling for children and young people; and
- Rolling out improved mental health training for those who support young people in educational settings.¹⁶⁶

It also notes the “unique challenges” faced by students of further and higher education and sets out an aim to provide a consistent level of support:

Students of further and higher education face some unique challenges, but we want to ensure a consistent level of support for mental health across the country. These education settings also provide opportunities to help address stigma and discrimination, and support efforts towards self-management.

Working with the NUS, we’ve supported their “Think Positive” project and we will work to explore how this can be developed and built upon in the coming years, particularly for the most vulnerable students.¹⁶⁷

Wales

The Welsh Government’s current suicide prevention strategy – [Suicide and self harm prevention strategy for Wales 2015-2020](#) – highlights schools, further and higher education establishments as among the “priority places” where suicide prevention efforts should be focused.

In a section focussing on educational establishments as priority places, the strategy states:

- School-based suicide prevention programmes are designed to either reduce risk, and/or increase protective factors by: increasing knowledge and understanding of suicide; changing attitudes towards suicide; and increasing awareness of risk factors and encouraging help seeking behaviour;

¹⁶⁴ Scottish Government, [Every Life Matters: Scotland’s Suicide Prevention Action Plan](#), August 2018, pp10 & 16.

¹⁶⁵ Scottish Government, [Mental Health Strategy: 2017-2027](#), March 2017, p8

¹⁶⁶ *Ibid.*, p4

¹⁶⁷ *Ibid.*, p18

- School based prevention programmes are not in routine use in Wales. There is some evidence that they have a short term impact but it is not known if these changes persist in the longer term; and that
- There is evidence that training for individuals who frequently come in to contact with people at risk of suicide, including teachers, increases confidence in recognising those who may be at risk of suicide and referring them appropriately for help. Whether or not such training has an impact on suicidal behaviour has however not yet been established.¹⁶⁸

The strategy then outlines the provision of counselling in Welsh schools and highlights that the school nursing service is also “frequently seen as a source of advice and support for pupils and teachers.” It states that this counselling provision might “contribute to suicide and self-harm prevention efforts, being suitably placed and accessible to children and young people in crisis.” The strategy adds that the importance of emotional support is also acknowledged by colleges of further and higher education.¹⁶⁹

In September 2017, a new pilot initiative was launched in three areas in Wales aimed at strengthening the support from specialist child and adolescent mental health services (CAMHS) to schools. CAMHS practitioners will be recruited to work with pilot schools in three areas across Wales. They will provide teachers with on-site help and advice, with the aim of ensuring that pupils experiencing difficulties receive early help in schools from suitably trained staff.¹⁷⁰

Northern Ireland

The suicide prevention role of schools, as well as further and higher education establishments, was not delivered directly under the suicide prevention strategy that was in place in Northern Ireland between 2006 and 2016, *Protect Life 2006-2016*. However, the role of education institutions in preventing suicide is set out in a table in Annex 3 of the new draft suicide prevention strategy: [Protect Life 2](#).¹⁷¹

In a similar vein to the Welsh strategy, this draft Northern Ireland strategy states that “apart from evidence that training for teachers increases their confidence in recognising those who may be at risk of suicide and referring them appropriately for help, there is no evidence that school-based suicide prevention programmes have a long-term impact on suicidal behaviour and help-seeking in the longer term.” It adds that, “school-based intervention needs to be broadly based (as it currently is) on a whole school approach to the promotion of positive mental health and emotional resilience.”¹⁷²

¹⁶⁸ Welsh Government, [Suicide and self harm prevention strategy for Wales 2015-2020](#), June 2015, pp24-5

¹⁶⁹ *Ibid.*, p25

¹⁷⁰ For further information on this, see: ‘[New initiative to put specialist emotional & mental health support in Wales’ schools](#)’, Welsh Government website, 25 September 2017 (accessed 3 January 2018)

¹⁷¹ NIDH, [Protect Life 2: A Draft Strategy for Suicide Prevention in the North of Ireland](#), September 2016, pp94-105

¹⁷² *Ibid.*, p104

It then highlights the guidance available to schools in this area, including:

- Guidance on [Managing Critical Incidents in Schools](#) which provides a process for schools to follow when a suicide that is in any way linked to the school community, has occurred.
- Broader guidance on suicide prevention that has been developed as part of the “iMatter” programme and was published in March 2016: [Protecting Life in Schools](#).

Additionally, it says that school-based counselling for the post-primary sector potentially contributes to suicide prevention efforts, “being suitably placed to children and young people in crisis.” It adds that further and higher education colleges also “have a range of support services available for students.”¹⁷³

The draft strategy identifies pastoral staff in schools and colleges as among those who come into regular contact with people who are suicidal. It sets out the importance of such staff being trained in suicide awareness and management of those who are suicidal:

Given that service providers in these settings have a vital role as the first point of contact for, and care of, those with suicidal behaviours and those self-harming, it is essential that they are equipped to provide effective support and deal sympathetically with extremely distressed people. They need to have the necessary knowledge, skills and attitudes to recognise, assess, manage, and initiate appropriate follow-up for people who are at high risk of suicide. This requires appropriate training in suicide awareness and management of those who are suicidal, as well as in terms of attitudes towards people who have self-harmed or attempted suicide and their relatives/carers.¹⁷⁴

¹⁷³ *Ibid.*, pp104-5

¹⁷⁴ *Ibid.*, p46

6. Employment

6.1 Suicide rates by occupation

In 2017, the ONS released a [study of suicide rates by occupation](#). Some of their main findings were as follows:

- Men working in the lowest-skilled occupations had a 44% higher risk of suicide than men as a whole;
- Risk of suicide among men who were labourers was 3 times higher than men as a whole;
- For women, the risk of suicide among professionals was 24% higher than for women as a whole – this is mostly explained by high risk of suicide among female nurses;
- Carers, both men and women, had higher risk of suicide than average; and
- Managers, directors and senior officials – the highest paid occupation group – had the lowest risk of suicide.¹⁷⁵

6.2 Employment policy and mental illness

The Government acknowledges that unemployment rates for people with mental health conditions are too high, and that evidence is limited around “what works” to support people with common mental health conditions into work.¹⁷⁶ The Department for Work and Pensions and the Department for Health and Social Care are working together through the joint Work and Health Unit to explore how more people living with mental health problems can be supported to find or stay in work.

Other initiatives include:

- Investing nearly £115 million to deliver a series of trials to examine a range of models on integrated service delivery, in order to develop an evidence base on what works for people with mental health conditions; and
- More than doubling the number of employment advisors based within NHS Talking Therapy services.¹⁷⁷

In response to consultation on its October 2016 Work, Health and Disability Green Paper, [Improving Lives](#), the Government in November 2017 proposed a 10-year strategy to “break down employment barriers for disabled people and people with health conditions”.¹⁷⁸ This includes:

- Improving advice and support for employers by working with them and disabled people, as well as other stakeholders;

¹⁷⁵ Office for National Statistics, [Suicide by occupation, England: 2011 to 2015](#), 17 March 2017

¹⁷⁶ HMG, [Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives](#), January 2017, para 91

¹⁷⁷ [PQ 6691 \[on Unemployed People: Mental Health\]](#), 7 September 2017

¹⁷⁸ Department of Work and Pensions [DWP] and DH, [Improving Life: The Future of Work, Health and Disability](#), Cm 9526, November 2017

- The introduction of an “enhanced training offer” for DWP work coaches – developed in conjunction with a national mental health charity – to help them work with benefit claimants with mental health conditions;
- An additional £39 million to more than double the number of employment advisors in an existing NHS programme treating people with depression and anxiety disorders
- The launch of two employment trials in the West Midlands and Sheffield City Region combined authorities to provide employment support in health settings, beginning in March 2018; and
- Implementing all the recommendations of [the Stevenson/Farmer review of mental health](#), including establishing a voluntary framework approach for large employers to report on mental health and disability within their organisations.

With regard to the latter point specifically, on 9 January 2017 the Prime Minister asked Lord Dennis Stevenson and Paul Farmer to “lead a review on how best to ensure employees with mental health problems are enabled to thrive in the workplace and perform at their best”.¹⁷⁹ The review report - [Thriving at Work: a review of mental health and employers](#) - was published on 26 October 2017. The report noted that:

rates of poor mental health and suicide are higher for employees in certain industries though clearly there are a number of factors which contribute to such trends. For example, suicide rates among men working in construction and decorating are more than 35% more likely to take their own lives, and female nurses are 24% more likely to commit suicide than the national average for women.¹⁸⁰

The report contained a large number of recommendations for employers, the public sector and government centred on the idea of implementing “mental health core standards”, explained as follows:

The mental health core standards should provide a framework for workplace mental health and we have designed them in a way that they can be tailored to suit a variety of workplaces and be implemented by even the smallest employers. We believe all employers can and should:

1. Produce, implement and communicate a mental health at work plan
2. Develop mental health awareness among employees
3. Encourage open conversations about mental health and the support available when employees are struggling
4. Provide your employees with good working conditions

¹⁷⁹ [‘Prime Minister unveils plans to transform mental health support’](#), Gov.uk, 6 January 2017

¹⁸⁰ DWP and DH, [Thriving at Work: a review of mental health and employers](#), October 2017, p23. Note that the term “commit suicide”, while found in several quotations in this paper, has been categorised as a “phrase to avoid” by Samaritans in their [Media Guidelines for Reporting Suicide](#), June 2017, p11. For more on the reporting of suicide, see section 9 of this briefing paper.

5. Promote effective people management
6. Routinely monitor employee mental health and wellbeing.¹⁸¹

¹⁸¹ *Ibid.*, p8

7. Social Security

7.1 Benefit claimants and mental health

At May 2017, of the 2.36 million claimants of Employment and Support Allowance (the main income replacement benefit for people with health conditions and disabilities), 1.17 million – 50% – were recorded as having a mental or behavioural disorder as their main disabling condition. A mental or behavioural disorder was the main disabling condition for just over a third (34%) of those in receipt of Personal Independence Payment (which helps with the extra costs of disability), at July 2017.¹⁸²

Since 2012, the Department for Work and Pensions (DWP) has been undertaking internal reviews in cases where it is alleged the Department's actions are linked to the death of a benefit recipient. DWP states that these "Peer Reviews" are "a tool for staff to look at the handling of a specific case":

The purpose is to scrutinise Department for Work and Pensions handling of particular cases to identify whether processes have been properly followed and if appropriate, identify recommendations for changes to the process. It is a mechanism aimed at ensuring we learn lessons and take appropriate action, rather than about apportioning blame.¹⁸³

Following a ruling of the Information Tribunal¹⁸⁴, in May 2016 DWP published redacted copies of 49 Peer Reviews.¹⁸⁵ The Disability News Service (DNS) submitted an FoI request to DWP in June 2018, asking how many reviews had been carried out since April 2016; how many involved a claimant who had died; and how many involved a claimant of Universal Credit.¹⁸⁶

7.2 Training and guidance for DWP staff

The DWP states that it has systems in place to ensure that Jobcentre staff can identify people at risk of suicide or self-harm and refer them to appropriate local sources of help, but it does not collate records of how many such referrals are made.¹⁸⁷

It further states that it provides "substantial and specific instructions to staff on how to support vulnerable people throughout their benefit journey."¹⁸⁸ All DWP staff undertaking "customer-facing" roles undergo a programme of learning and development to equip them to support vulnerable people to access its services.¹⁸⁹ A "six point plan"

¹⁸² Source: [DWP Stat-Xplore](#)

¹⁸³ HMG, *Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives*, January 2017, para. 94

¹⁸⁴ *John Pring v IC & Department of Work & Pensions (Freedom of Information Act 2000)* [2016] UKFTT 2015_0237 (GRC) (20 April 2016)

¹⁸⁵ See DWP, *Peer reviews of handling of benefit claims*, 12 May 2016

¹⁸⁶ "DWP breaks law over secret reports on universal credit deaths," *Disability News Service*, 23 August 2018

¹⁸⁷ [PQ 67873 \[on Unemployed People: Mental Health\]](#), 20 March 2017; [PQ 71177 \[on Unemployed People: Mental Health\]](#), 25 April 2017

¹⁸⁸ DWP, *Peer reviews of handling of benefit claims*, 12 May 2016

¹⁸⁹ [PQ 53958 \[on Department for Work and Pensions: Staff\]](#), 24 November 2016

sets out a framework for what staff should do when dealing with members of the public who declare an intent to kill or harm themselves. The Department has also established a “Vulnerability Hub” which provides help and advice to staff when dealing with vulnerable people. It signposts them to a range of resources about specific conditions or circumstances which may increase someone’s vulnerability and risk of suicide and/or self-harm.

Information on the DWP’s approach – including its latest [Suicide and Self-Harm Guidance](#), its [Six Point Plan Framework](#), and [Outline Local Six Point Plan for Handling Customers Declarations of Intention to Attempt Suicide or Self Harm](#) – were released in November 2017 in response to a Freedom of Information request.¹⁹⁰ A PQ response in March 2018 said that a further regular review of the guidance was underway, and that any changes identified as a result would be implemented later in the year.¹⁹¹

In addition, the DWP has “safeguarding” procedures to be followed in situations where a claimant deemed to be vulnerable fails to comply with a requirement and, as a result, their benefit payments are at risk. This could include, for example, where a claimant fails to attend a mandatory interview, fails to return a questionnaire or attend an assessment, or fails to undertake a mandatory activity. Home visits are a key element of the safeguards (DWP refers to these as “core visits”) – where staff make attempts to contact the person before a decision is made to impose a sanction or terminate a claim.

In a PQ response 2016, DWP said that it had no intention to publish the internal guidance on safeguards “as it is for Departmental use only.”¹⁹² The Royal Greenwich Welfare Rights Service has produced a detailed [Benefit Safeguards Briefing](#)¹⁹³ drawing on Freedom of Information responses and other sources, which covers DWP safeguarding procedures in relation to Employment and Support Allowance and Universal Credit. The authors caution, however, that the information given may not always reflect the latest position as information released by DWP in response to FoI requests changes regularly.

7.3 ESA and PIP assessments

The DWP uses third-party contractors to provide health and disability assessments to inform decisions about benefits. The Centre for Health and Disability Assessments (CDHA), a wholly-owned subsidiary of Maximus, has since 1 March 2015 held the main medical services contract under which assessments are carried out for various benefits including Employment and Support Allowance (ESA). Personal Independence Payment assessments are carried out under separate contracts. Atos Healthcare (operating as Independent Assessment

¹⁹⁰ [DWP ref: Fol 4521 – available at the *whatdotheyknow.com* website](#)

¹⁹¹ [PQ 130153 \[on Jobcentre Plus: Training\]](#), 7 March 2018

¹⁹² See [POs 42575 \[on Personal Independence Payment: Mental Illness\]](#), [42576 \[on Jobseeker’s Allowance: Mental Illness\]](#), [42577 \[on Employment and Support Allowance: Mental Illness\]](#), and [42578 \[on Universal Credit: Mental Illness\]](#), 21 July 2016

¹⁹³ Available on the *Rightsnet* website, last updated October 2017

Services) holds the contracts for undertaking PIP assessments in Northern England and Scotland, and London and Southern England. Capita Business Services Ltd holds the contracts covering Wales and Central England, and Northern Ireland.

ESA and “substantial risk”

The *Employment and Support Allowance Regulations 2008*¹⁹⁴ include provisions under which people scoring insufficient points in the Work Capability Assessment to be entitled to ESA – who would otherwise be found “fit for work” – can nevertheless be placed in the Work-Related Activity Group (WRAG), in exceptional circumstances. Corresponding provisions also enable people not satisfying the usual requirements to be placed in the ESA Support Group, in exceptional circumstances.

In both cases, the exceptional circumstances are that the person suffers from some specific bodily or mental disablement which means there would be a substantial risk to their health, or the health of another person, if they were found not to have limited capability for work (the usual requirement for the WRAG); or limited capability for work-related activity (the usual requirement for the Support Group).

The rules on “substantial risk” in relation to mental health are set out in Appendix 6 of the CDHA’s [Revised WCA Handbook](#).¹⁹⁵ Revised guidance on substantial risk was issued by DWP in 2015 and implemented in early 2016. The Revised WCA Handbook states:

The main change is that the focus on suicide has been reduced and the question of substantial risk placed in the context of work-related activity (WRA). The Department’s approach is that tailored WRA may be appropriate for most people with mental health conditions, including for people with suicidal thoughts.¹⁹⁶

A Rethinking Incapacity blog of 21 September 2016 by Ben Baumberg Geiger, [The return of the stricter WCA?](#) considers the implications of the changes.

Assessment procedures

In a PQ response on what adjustments are made to ensure that people with a history of suicide, self-harm or other mental health conditions are treated with appropriate care and caution during benefits assessments, the then Minister for Disabled People, Penny Mordaunt, said on 27 June 2017:

If an individual has a mental health condition or there is any indication that a claimant has suicidal thoughts or intentions, assessors are trained to explore the person’s circumstances carefully. Assessors approach this issue with sensitivity and ask questions in a structured way that is appropriate to the individual, based on their knowledge of the claimant’s clinical history and their judgement on the claimant’s current mental state

If the assessor has concerns that a claimant is at substantial and imminent risk with regard to self-harm or suicide, they have a professional responsibility to act quickly in order to safeguard the

¹⁹⁴ SI 2008/794, as amended

¹⁹⁵ MED-ESAR2011/2012HB~001, revised 17 April 2018

¹⁹⁶ *Ibid.*, para. 3.8.2.1

claimant's welfare; this might include speaking to the claimant's GP, and/or calling an ambulance.

Companions are encouraged to accompany the claimant to a face to face consultation and can play an active role. This is helpful for claimants with mental, cognitive or intellectual impairments, who cannot provide an accurate account of their condition due to a lack of understanding, or unrealistic expectations of their ability.¹⁹⁷

Evidence presented to the Work and Pensions Committee, however, suggests that assessments are not working well for some people with mental health conditions.

Work and Pensions Committee inquiry

In September 2017 the Work and Pensions Committee launched an inquiry examining the effectiveness of assessment processes used to determine eligibility for PIP and ESA.¹⁹⁸ On 27 November 2017 *The Guardian* reported that the Committee had been "deluged by people sharing stories about being denied disability benefits or battles to keep their entitlements."¹⁹⁹ It quoted the Committee's Chair, Frank Field MP, as saying that while about 100 letters had been expected, the Committee had received over 3,000 to date, with more than 100 people reporting that they or someone they cared for had felt that their suicidal feelings had worsened or been triggered by the assessment process. Common themes emerging from the complaints from claimants included:

- People being asked "medically inappropriate questions";
- A mismatch between what the claimants had told assessors about their conditions and what the written reports said about them; and
- Assessors overlooking disabilities or illnesses that are not immediately visible.

Other observations, comments and criticisms made in evidence received from organisations concerned with mental health include:

- The current activities and descriptors used in the assessments for ESA, and particularly for PIP, are not fit for purposes, being weighted towards physical health conditions and disabilities and discrimination against those with mental health conditions;
- The structure and content of ESA and PIP assessments (both written and face to face) are not designed in a way that allows claimants affected by mental health problems to accurately express the impact their condition has on them;
- Neither assessment appropriately captures fluctuations in conditions;

¹⁹⁷ [PO 193 \[on Social Security Benefits: Mental Illness\]](#), 27 June 2017

¹⁹⁸ See: '[PIP and ESA Assessments inquiry](#)', Work and Pensions Committee website (accessed 3 January 2018)

¹⁹⁹ '[Inquiry into disability benefits 'deluged' by tales of despair](#)', *The Guardian*, 27 November 2017

- Claimants regularly report that their concerns are not taken seriously by assessors and that their statements are routinely ignored;
- Assessors often do not have the necessary knowledge or expertise to assess the impact of mental health problems;
- The nature of face to face assessments leading claimants to break down due to the distress it causes them, only for the written report to state that the claimant coped well;
- People finding the whole claims, assessment and appeals process confusing and threatening, with detrimental effects in their mental health;
- Instances where the assessment process has led to people being hospitalised, have their medication increased, or attempt to take their own lives;
- Dissatisfaction with the “Mandatory Reconsideration” process for challenging decisions, which many claimants viewed as a tool to dissuade people going to appeal;
- Claimants or those supporting them are not taking their claim to appeal because of the distress the process had caused them up to that point, and/or being overwhelmed at the thought of going through the appeals process;
- Although some people expressed dissatisfaction with the appeals process, the most common view was that the appeals stage was the first time when the full range of information presented as part of the assessment process had been properly considered.
- Appeals Tribunals expressing surprise at the high levels of disabilities among people with mental health conditions who had been initially assessed as not eligible for PIP.²⁰⁰

The Committee also heard evidence from PIP and ESA claimants, and from frontline advisers, at an [evidence session on 22 November 2017](#). A [further session took place on 6 December](#), where the Committee heard evidence from representatives from Atos, Capita and Maximus. Mental health and disability groups [gave evidence to the Committee on 11 December](#).

In December 2017, Rethink Mental Illness published a report, [‘It’s broken her’: Assessments for disability benefits and mental health](#). Drawing on findings from a series of interviews and a focus group-style discussion with people with personal experience of the Work Capability Assessment and of mental illness which took place in January 2017, and an online survey conducted in April 2017 which had over 650 respondents, the report found that assessments can be “traumatising and anxiety-inducing” for the following reasons:²⁰¹

²⁰⁰ [PIP and ESA Assessments inquiry](#), Work and Pensions Committee website. See the written submissions from [Rethink Mental Illness](#) (PEA0405) and the [Royal College of Psychiatrists](#) (PEA0389), November 2017

²⁰¹ Rethink Mental Illness, [‘It’s broken her’: Assessments for disability benefits and mental health](#), December 2017, p7

- “Numerous issues” with the paper forms that claimants must submit, including their complexity, length and the inflexible nature of the questions they ask;
- The requirement for claimants to collect their own medical evidence is “extremely burdensome, often expensive, and time-consuming”;
- Staff who perform face-to-face assessments frequently have a poor understanding of mental illnesses; and
- Delays in Mandatory Reconsideration and appeals mean that claimants may have to wait many months for the correct result.

The Rethink report concluded that the current PIP and ESA assessment procedures “inherently discriminate against people with mental illnesses.” It set out a number of policy recommendations to “dramatically improve the benefits system for people with mental illnesses” including:

- Major reform of the PIP and ESA assessments to reduce the distress caused to people affected by mental illness and better reflect the realities of living with mental health conditions’
- Exempt claimants from face-to-face assessments where clear medical evidence exists that they have severe forms of mental illness, and where assessments are necessary claimants should be encouraged to seek support from carers, friends or family members; and
- All assessors and DWP decision makers should be appropriately trained in mental health.²⁰²

The [Work and Pensions Committee’s report – together with a separate report detailing claimant experiences of PIP and ESA assessments](#) – was published in February 2018.²⁰³ The Committee found that failings in the end to end processes had contributed to a lack of trust in both benefits and undermined confidence among claimants. It made a series of recommendations covering, amongst other things, the recording of assessments, the supply and use of evidence, the clarity of communications, and guidance in relation to home assessments and the role of companions at assessments. The Committee did not make any specific recommendations regarding the assessment of people with mental health conditions, but in light of evidence received from claimants and from organisations it said that the Department for Work and Pensions should demonstrate that it was “alert to the risk to mental health posed by parts of the application processes and seek to offset this.” Accordingly, it recommended that:

...the Department commission and publish independent research on the impact of application and assessment for PIP and ESA on claimant health. This should focus initially on improvements to the

²⁰² *Ibid.*, p18

²⁰³ Work and Pensions Committee, [PIP and ESA assessments](#), HC 829 2017-19, 14 February 2018; *Work and Pensions Committee, PIP and ESA assessments: claimant experiences*, HC 355 2017-19, 9 February 2018

application forms, identifying how they can be made more claimant-friendly and less distressing for claimants to fill in.²⁰⁴

In its [response published on 18 April 2018](#), the Government said that it would commission research from external contractors to cover whether any aspects of ESA and PIP claim forms have the potential to cause distress, to identify what changes should be made, and to test the revised forms with applicants. This work would commence in summer 2018 and a report would be published in 2019.²⁰⁵

Reassessing ESA and PIP claimants

By default, once a person has been awarded ESA or PIP, they will be reassessed at regular intervals to ensure that they continue to meet the conditions for the benefits. Some organisations argue that people with lifelong disabilities or progressive conditions should not have to face regular reassessments. There is particular concern that regular reassessments could cause anxiety and affect the physical or mental health of vulnerable claimants.

In September 2017 the Department for Work and Pensions announced criteria for “switching off” reassessments for ESA claimants in the Support Group with severe, lifelong disabilities illnesses or health conditions who are unlikely ever to be able to work. In order to qualify, the person’s condition must be permanent, there must be no realistic prospect of recovery, and the condition must be unambiguous. Examples given in DWP guidance do not include any mental health conditions, although the guidance states the lists are not exhaustive.²⁰⁶

In June 2018 the Government announced that people awarded the highest level of support under PIP whose “needs are expected to stay the same or increase” would be given “ongoing” PIP awards and would only have to face a “light touch” review every 10 years.²⁰⁷ DWP is working with stakeholders to design the light touch review process, and updated guidance is to be issued “later this summer.”

Further information is given in Commons Library briefing CBP-7820, [ESA and PIP reassessments](#), 13 July 2018.

7.4 Conditionality and sanctions

A benefit sanction – withdrawal of benefit or a reduction in the amount of benefit paid for a certain period – may be imposed if a claimant is deemed not to have complied with a condition for receiving the benefit in question. Further information on the conditionality and sanction regimes for Jobseeker’s Allowance, Employment and Support Allowance and Universal Credit claimants can be found in Commons Library

²⁰⁴ Work and Pensions Committee, [PIP and ESA assessments](#), HC 829 2017-19, 14 February 2018, para 21

²⁰⁵ DWP, [PIP and ESA assessments: Government Response to the Committee’s Seventh Report of 2017-19](#), HC 986 2017-18

²⁰⁶ Centre for Health and Disability Assessments, Revised WCA Handbook, 17 April 2018, Appendix 8

²⁰⁷ [‘Government to end unnecessary PIP reviews for people with most severe health conditions’](#), DWP press release, 18 June 2018

briefing CBP-7813, [Benefit Claimants Sanctions \(Required Assessment\) Bill 2016-17](#), 30 November 2016.

In response to a recent PQ on what assessment the Department for Work and Pensions had made of the effect of benefit sanctions on the mental health of claimants, the Minister of State for Employment Alok Sharma said:

No assessment has been made on the impact of benefit sanctions on the mental health of claimants.

We engage at a personal and individual level with all of our claimants and are committed to tailoring support for specific individual needs, including agreeing realistic and structured steps to encourage claimants into the labour market. These conditionality requirements are regularly reviewed to ensure that they remain appropriate for the claimant.

When considering whether a sanction is appropriate, a Decision Maker will take all the claimant's individual circumstances, including any health conditions or disabilities and any evidence of good reason, into account before deciding whether a sanction is warranted.²⁰⁸

A recent major research programme concluded, however, that welfare conditionality was “largely ineffective in facilitating people’s entry into or progression within the paid labour market over time.” Instead, it found that for a significant number of respondents, conditionality “triggered a sustained range of negative behaviour changes and outcomes” which included, amongst other things, disengagement, increased poverty or destitution, and exacerbated mental health conditions.²⁰⁹

On 12 April the [Work and Pensions Committee launched an inquiry into Benefit sanctions](#). Amongst other things, the inquiry is considering the evidence base for the impact of sanctions, and the robustness of the evidence base for the current use of sanctions as a means of achieving policy objectives.

7.5 Universal Credit

Universal Credit (UC) is replacing means-tested social security benefits and tax credits for people of working age. Around 7 million households are expected to receive Universal Credit when it is fully introduced.

Charities and pressure groups are concerned that vulnerable people with mental health conditions may face particular problems navigating the Universal Credit system.²¹⁰ Concern includes, amongst other things, people’s ability to cope with single monthly payments in arrears, making and managing claims online, and the possibility that people may be subject to inappropriate “conditionality” requirements. While there are arrangements to identify people who might need help to make and

²⁰⁸ PQ 166197 [on Social Security Benefits: Disqualification], 24 July 2014

²⁰⁹ Department of Social Policy and Social Work, University of York, [Final findings report: Welfare Conditionality Project 2013-2018](#), 9 July 2018

²¹⁰ See for example the written submissions to the Work and Pensions Committee’s ongoing inquiry into Universal Credit roll-out from [Mind](#) (UCR0137, October 2017) and the [Scottish Association for Mental Health](#) (UCR0080, October 2017)

manage a claim for UC, or who should be offered additional support, organisations believe that such safeguards as exist are inadequate, leaving open the risk that vulnerable people who struggle to engage with the system will be left without a source of income. They also point out that the removal of “implicit consent” in the UC Full Service makes it harder for advisers and support workers to advocate for their clients.²¹¹

Under the latest plans, the Universal Credit Full Service will be available in every part of the UK by December 2018. Existing benefit and tax credit claimants who have not moved onto UC following a change in their circumstances will transfer to UC by a process known as “managed migration.” This is expected to begin in July 2019 and be completed by March 2023. Over two million households are expected to move onto UC by managed migration, of which around 745,000 will have been claiming Employment and Support Allowance.²¹²

The Government submitted draft regulations on managed migration to UC to the independent Social Security Advisor Committee in June 2018, and SSAC launched a public consultation on the proposals which ran until 20 August.²¹³ SSAC is expected to submit its report in light of the consultation to the Secretary of State in September 2018, after which the DWP will lay before Parliament the final version of the draft regulations.

The mental health charity Mind does not believe that DWP’s proposals for managed migration as submitted to SSAC will work for a significant proportion of people with mental health problems.²¹⁴ It is particularly concerned that the requirements for people to have read and understood communications about managed migration, to contact the DWP within a given timeframe, and to articulate their case for an extension of the deadline to make claim, do not provide necessary safeguards for people at greatest risk. Mind suggests two alternative approaches to managed migration. The first would involve calculating a person’s entitlement to UC automatically, using information already held by DWP on “legacy” benefit systems. The second would retain the requirement for the individual to make a claim for UC, but would remove the power to terminate the person’s existing benefits until they have moved to UC. Mind argues that either approach, or a combination of both, would ensure that benefit payments are not

²¹¹ Where implicit consent is accepted, a third party can deal with the DWP on behalf of a claimant in the absence of valid written authority, or where the claimant is not present at the time to confirm their consent verbally. In the UC Full Service, the claimant must provide explicit consent before information can be disclosed to a representative – although an exception has been made for Members of Parliament, Members of the Scottish Parliament, and Assembly Members in Wales. For further information see the DWP UC Full Service guidance on [Consent and disclosure](#), Version 10.0

²¹² DWP, [Explanatory Memorandum for the draft Universal Credit \(Managed Migration\) Amendment Regulations 2018](#), 1 June 2018, p29

²¹³ SSAC, [Moving claimants to Universal Credit from other working age benefits](#), 22 June 2018

²¹⁴ Mind, [Universal Credit managed migration: Mind’s response to the SSAC consultation](#), August 2018

interrupted throughout the process, which it believes is a “minimum requirement for managed migration if it is to avoid creating hardship.”²¹⁵

Mind also believes that there needs to be “clear, independent, evidence that Universal Credit is safe and accessible for people with mental health problems before any managed migration begins.”²¹⁶ It argues that the regulations should require the Secretary of State to lay before Parliament an independent report on DWP’s readiness for managed migration before July 2019, focusing on how the claims process is working for disabled people and people with health conditions.²¹⁷

7.6 Devolved nations

Northern Ireland

Social security (but not tax credits and Child Benefit) is devolved to Northern Ireland, but the long-established parity principle requires Northern Ireland to keep in step with the rest of the UK in social security matters. The timetable for the introduction of welfare reforms in Northern Ireland has, however, been different to that in Great Britain. In addition, as part of the November 2015 Fresh Start Agreement, a [package of measures](#) was agreed to mitigate the impact of certain welfare changes over the first four years.

Scotland

Until recently, social security was almost entirely a reserved matter in Great Britain, but the *Scotland Act 2016* devolved significant welfare powers to the Scottish Parliament. Amongst other things, the Act transferred responsibility for disability benefits, including Disability Living Allowance and Personal Independence Payment. In addition, the Scottish Parliament now has the power to top-up reserved benefits, create new benefits in areas not otherwise connected with reserved matters, vary the payment arrangements for Universal Credit, and establish its own employment programmes. The Scottish Government is setting up its own social security agency to deliver devolved benefits.

In relation to disability assistance, the Scottish Government is developing its plans, but it has said that:

- It intends to make the assessment processes “fairer, focusing on standards and quality rather than case volumes” and, a first step in achieving this, profit-making companies will not be involved in carrying out assessments;
- It aims to reduce the number of face to face assessments and reassessments by exploring the potential for making better use of existing information held within the health and social care sector and by other public bodies;
- Automatic awards will be available in certain circumstances;

²¹⁵ *Ibid.*, para 5

²¹⁶ *Ibid.*, para 6

²¹⁷ *Ibid.*, para 9

- Longer term or lifetime awards will be available for people whose condition is unlikely to improve; and
- Another person will be able to apply on a claimant's behalf when the claimant requests this to happen.²¹⁸

In addition, participation in the devolved employment programmes Scotland – Work First Scotland and Work Able Scotland – are voluntary, i.e. a person cannot be sanctioned if they refuse to participate.²¹⁹

The Scottish Government's recently published suicide prevention action plan, [*Every life matters*](#), recognises that for many people, their interaction with the social security system may come at a time of great difficulty, such as losing their job or becoming disabled, and that such life events can be triggers for suicidal thoughts. Accordingly, training will be provided for social security staff to enable them "to recognise signs of distress, and to signpost people to appropriate support." It adds:

Within our social security agency we will equip our people to confidently handle and talk about mental health generally, including suicide awareness and prevention. Working with partners, we will develop and utilise a range of learning opportunities that fully equip social security agency staff to have a wider awareness of the challenges and circumstances the person may be facing; to possess a knowledge of the systems and support functions that are available; and importantly, to be skilled in having sensitive conversations including suicide awareness.²²⁰

The Scottish Parliament does not have control over the timetable for the introduction of Universal Credit, but in a [letter to the Work and Pensions Secretary Esther McVey sent on 20 August 2018](#), the Scottish Social Security Secretary Shirley-Anne Somerville called for the roll-out of Universal Credit to be halted, in light of evidence that it was causing "widespread hardship, stress and anxiety." Ms Somerville argued that halting the roll-out would enable problems affecting claimants to be addressed, including payments being received late and difficulties managing the online claims process.²²¹

²¹⁸ Scottish Government, [Disability and employment injury assistance: position paper](#), 27 October 2017

²¹⁹ See Scottish Government, [Scotland's Devolved Employment Services Work First Scotland and Work Able Scotland. 2017/18](#), 23 May 2018

²²⁰ Scottish Government, [Suicide Prevention Action Plan: Every Life Matters](#), August 2018, p4

²²¹ See also the [Scottish Government's response to the SSAC consultation on the draft UC managed migration regulations](#), dated 20 August 2018

8. Railways

8.1 British Transport Police suicide prevention

The British Transport Police (BTP) is the police force for the railways, providing a policing service to Network Rail, rail and freight operators, their staff and their passengers throughout England, Wales and Scotland. It is also responsible for policing the London Underground System, the Docklands Light Railway, the Midland Metro tram system, Croydon Tramlink, Sunderland Metro, Glasgow Subway and Emirates AirLine. BTP's specialist policing approach is based on keeping passengers and staff safe and minimising disruption.

The operational approach of BTP is focused on keeping passengers and staff safe and minimising disruption. The [Strategic Plan 2013-2019](#) sets out the BTP Authority (BTPA) objectives for 2019, to be achieved without increasing costs above inflation.²²²

BTP's approach to vulnerable people receives significant attention. Suicide accounts for the majority of fatalities on the railway: there were 316 public fatalities in 2015/16 of which 278 were suicide or suspected suicide fatalities. Although the relatively small numbers make a clear trend difficult to discern, there appears to be have been an increase in suicides since 2007. This is in line with national trends.²²³

Public Fatalities

There were **316 public fatalities** in 2015-16

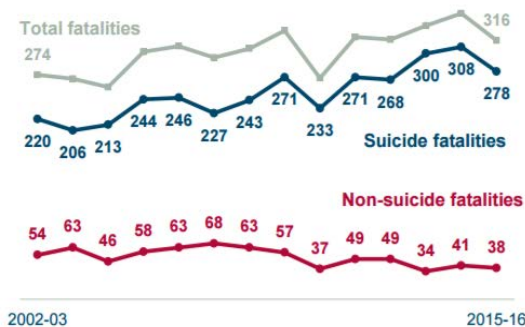
Down by 9.5% compared to 2014-15

of which **38 were non-suicide fatalities**

and

278 were suicide or suspected suicide fatalities

(252 on mainline and 26 on London Underground)



Source: Office of Rail and Road, Rail Safety Statistics, 22 September 2016

Apart from the obvious human cost, the average cost of each fatality on the railway is £198,000.²²⁴ BTP has dedicated teams made up of police officers and NHS nurses who can access medical files and co-ordinate follow-up care. These teams work to put in place Suicide Prevention Plans for at-risk individuals to provide them with continued care and support.²²⁵

²²² British Transport Police Authority, [Strategic Plan 2013-2019](#), September 2013

²²³ Samaritans, [Suicide statistics report 2017](#), p28

²²⁴ Transport Committee, [Rail safety: written evidence submitted by the British Transport Police](#), October 2016, para 8.4

²²⁵ BTP, [Policing your journey: Annual Report 2015/16](#), August 2016, p18

8.2 Rail suicide prevention partnership

Over the last seven years, since 2010, Samaritans has worked closely with the railway industry, and BTP in particular, to improve practice in relation to suicide education and training, prevention and “postvention” (dealing with the aftermath of incidents). There were 1,269 life-saving interventions by officers, rail staff and others in 2015/16 – a rise of 36% compared with the previous year.²²⁶

According to Ruth Sutherland, Chief Executive of Samaritans, in evidence to the Transport committee:

We can now say after seven years of working that perhaps one in seven people in the rail industry—about 200,000 workers—is suicide aware. We have seen more than 1,000 interventions by members of staff who have identified vulnerable people, approached them, talked to them and brought them away from a situation of danger. We feel very positive about the whole partnership.²²⁷

In 2016, the BTP, Network Rail and Samaritans’ [suicide prevention partnership](#) won the Charity Times Corporate Social Responsibility (CSR) Project of the Year award. In 2016, the Duke of Cambridge launched a unique rail industry coalition together with the [Campaign Against Living Miserably \(CALM\)](#) to tackle the issue of male suicide, including Samaritans and frontline services from land, sea and air.

8.3 UK Government support

The UK Government’s 2012 Strategy noted the abovementioned suicide prevention measures, both with regard to the BTP plan and the partnership initiated by Samaritans and Network Rail, which, it noted, “focused on those stations most affected by suicide”.²²⁸

The Government’s Third Progress report noted the Department of Transport’s support for these suicide prevention measures:

101. There has been a long relationship between suicide and the transport network, particularly in respect of the railway network. Network Rail, the British Transport Police and the Samaritans have a long established and successful partnership for reducing the number of suicides on the rail network. The Department for Transport recognises the important and active role which the rail industry and its staff, particularly those at stations, play in reducing as far as possible the instances of suicide and the risk to vulnerable people, on the national rail network.

102. The Department for Transport fully supports both the British Transport Police’s Suicide Prevention Strategy and the railway Suicide Prevention Duty Holders Group’s Nine-Point Plan, and will

²²⁶ *Ibid.*, p2

²²⁷ Transport Committee, [Rail safety 2016-17](#), 6 March 2017, HC 694 Q58 [Ruth Sutherland]

²²⁸ HMG, [Preventing suicide in England: A cross-government outcomes strategy to save lives](#), 10 September 2012, paras 3.19-20. See also the second Strategy update in 2014 which outlined renewed plans by Network Rail and Samaritans for a new five year partnership to “continue efforts to reduce suicides on the railways”: HMG, [Preventing suicide in England: Two years on – Second annual report on the cross-government outcomes strategy to save lives](#), February 2015, para. 50

incorporate the aims of these plans into train operating franchise agreements as the minimum standard which train operators must meet.²²⁹

It further noted the Department of Transport's work on suicide prevention with regard to rail travel, in particular its collaborations with the National Suicide Prevention Alliance (NSPA) and the Department of Health:

105. The Department for Transport continues to look at other ways to work with partners to develop effective mental health crisis care and suicide prevention across the rail network. One example is recognising the essential work done by the NSPA, and its constituent organisations, and the Department for Transport is in discussions with the NSPA's members and the Department of Health on how it may be able to assist partner organisations at both a strategic and delivery level, where this is appropriate.²³⁰

²²⁹ HMG, [*Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives*](#), January 2017, paras 109-5, pp27-8

²³⁰ *Ibid.*, pp27-8

9. Prisons

9.1 Statistics

The Ministry of Justice (MoJ) publishes a quarterly report on [safety in custody statistics](#) for England and Wales.

The most recent [update](#), published in July 2018, details that in the 12 months to June 2018 there were 77 apparent self-inflicted deaths (a rate of 0.9 per 1,000 prisoners) down 22% from 99 in the previous 12 month period.²³¹

The rate of suicides per a thousand prisoners in 2016 was 1.39. This figure is the highest since 1999. The rate more than doubled between 2010 and 2016, when the rate of suicides per a thousand prisoners was 0.67.²³²

Self-harm

In addition, the following self-harm figures were recorded in the 12 months to March 2018:

- Around 47,000 reported incidents of self-harm, an increase of 16% from the previous year, representing a record high level;
- There was a rate of 549 self-harm incidents per 1,000 prisoners;
- Around 12,000 prisoners self-harmed, up 8% from the previous year; and
- Around 3,000 hospital attendances, up 12% from the previous year.
- However, the proportion of self-harm incidents requiring hospital attendance has remained generally consistent in recent years at around 7%.²³³

9.2 Prison service policy

HM Prison & Probation Service issue rules, regulations and guidelines for prisons in England and Wales as Prison Service Instructions (PSIs) and Prison Service Orders (PSOs). The [PSI Safer Custody](#) details how prisons manage prisoners at risk of harm to self, to others and from others. Mandatory actions for Governors and Directors include:

- Having procedures in place to identify, manage and support prisoners and detainees at risk;
- Ensuring reasonable steps are taken to obtain all relevant information regarding prisoner safety, and ensuring this information is shared and acted upon; and

²³¹ Ministry of Justice [MoJ] and National Statistics bulletin, [Safety in Custody Statistics Bulletin England and Wales: Deaths in prison custody to June 2018; Assaults and Self-harm to March 2018](#), 26 July 2018

²³² MoJ and National Statistics, [Deaths in prison custody 1978 to 2016](#), 27 July 2017

²³³ *Ibid.*

- Having in place a learning strategy to improve local delivery of safer custody and prevent/reduce future incidents of self-harm.²³⁴

NICE Guidelines consultation

In 2016 the National Institute for Health and Care Excellence (NICE) launched a consultation on new guidelines on 'Preventing suicide in community and custodial settings'. Draft guidance was published in January 2018 and publication of final guidelines is expected in September 2018.²³⁵

The draft guidelines recommend that prisons and detention centres should set up multi-agency partnerships. These partnerships should include representatives from the institution, third sector organisations, probationary services and those who have been affected by suicide and should develop suicide prevention strategies.²³⁶

9.3 Health services in prison, including mental health and substance misuse services

Since April 2013, NHS England has commissioned health services within prisons and young offender institutions in England. In Wales, Local Health Boards commission healthcare services in public sector prisons.²³⁷ Prisoners receive an initial health screen by clinical staff and at this point can be referred for further treatment.

Between 2012 and 2014, 70% of prisoners taking their own lives were found to have had mental health needs, according to the Prisons and Probation Ombudsman.²³⁸

9.4 Commentary

The National Audit Office (NAO)

In June 2017, the NAO reported on its investigation into [Mental health in prisons](#), and was critical of the Government's response to the problem:

Government does not know how many people in prison have a mental illness, how much it is spending on mental health in prisons or whether it is achieving its objectives. It is therefore hard to see how Government can be achieving value for money in its efforts to improve the mental health and well-being of prisoners. In 2016 there were 40,161 incidents of self-harm in prisons and 120 self-inflicted deaths.²³⁹

²³⁴ MoJ, [Management of prisoners at risk of harm to self, to others and from others \(Safer Custody\)](#), PSI 64/2011, 13 September 2013

²³⁵ 'Preventing suicide in community and custodial settings', NICE website [accessed 7 September 2018]

²³⁶ NICE, [Preventing suicide in community and custodial settings. Guideline version \(Draft\)](#), February 2018

²³⁷ See: 'Healthcare Services for Prisoners' (NHS Wales) and 'Prison Health in Wales' (Public Health Wales)

²³⁸ Prisons and Probation Ombudsman, [Learning from PPO investigations: Prisoner mental health](#), January 2016, p12

²³⁹ National Audit Office, [Mental health in prisons](#), 29 June 2017

The NAO argued that the “Government needs to address the rising rates of suicide and self-harm in prisons as a matter of urgency”.²⁴⁰ It highlighted the lack of data on how many people in prison have mental health problems, and recommended that Her Majesty’s Prisons and Probation Service, NHS England and Public Health England need to collect better data to understand how they are meeting their objectives.

The report also raised the issue of reduced resources in prisons, including staff numbers and funding, which it argued had led to prison governors running restricted regimes as part of which prisoners spent less time accessing mental health services.²⁴¹

The Howard League and the Centre for Mental Health

In November 2016, The Howard League for Penal Reform and the Centre for Mental Health published a report entitled [*Preventing prison suicide: perspectives from the inside*](#). In the accompanying press release, the Howard League designated 2016 the “worst year ever recorded for suicide in prisons”.²⁴² The report highlighted the following key findings:

- Both current and historic risk factors exacerbated vulnerability in prison
- Staff shortages have increased the risk of suicide
- Relationships between staff and prisoners are key. Prisoners need to feel supported, cared for and able to confide in and trust staff
- Prisoners described a culture where, on the whole, distress was not believed or responded to with compassion
- Change needs to happen across the system to recognize the influence of the prison environment on people’s vulnerability
- Arrival, being released and transferred were all cited as times when prisoners felt most vulnerable
- Staff inexperience and lack of training around mental health were seen as a significant factor in increasing risk. Mental health services in prison were mainly seen by prisoners as providers of medication
- Wellbeing groups, the chaplaincy and imams, peer mentor schemes and listening schemes were helpful
- Prisons should be enabling environments, striving to be a psychologically informed environment with an emphasis on the quality of relationships.

The Prisons and Probation Ombudsman

In his 2016/17 annual report the Prisons and Probation Ombudsman described the prison system as “still in crisis”. He said that there had

²⁴⁰ *Ibid.*

²⁴¹ National Audit Office, [*Mental health in prisons*](#), 29 June 2017, Key Finding 12

²⁴² Howard League for Penal Reform, [*2016 becomes worst year ever recorded for suicides in prisons*](#), 28 November 2016

been a “repeat failure” to learn lessons from the past and was critical of current suicide prevention measures in prisons.

I ... remain concerned that current prison suicide prevention measures were designed when prisons had many fewer prisoners and many more staff. Despite some tinkering undertaken in response to concerns that I expressed in previous annual reports, suicide prevention procedures are still badly in need of updating and streamlining, without which I continue to question their fitness for purpose.²⁴³

Joint Committee on Human Rights (JCHR)

The JCHR conducted an inquiry into mental health and deaths in prison, and published [an interim report](#) on 2 May 2017 after the inquiry was interrupted by the 2017 General Election. In the interim report, the JCHR made recommendations for legislation “to address the shocking rise in self-harm and suicide in prisons”.²⁴⁴ These included:

- A statutory duty on the Secretary of State to specify and maintain a minimum ratio of prison officers to prisoners at each establishment
- A prescribed legal maximum to the time a prisoner can be kept in their cell each day
- A legal obligation for the Prison Service to ensure that each young prisoner or adult prisoner with mental health problems has a key worker
- A legal obligation that the relatives of a suicidal prisoner should be informed of and invited to contribute to the Assessment, Care in Custody and Teamwork (ACCT) reviews (unless there is a reason that it should not be the case)
- To deal with the problem that young people, and prisoners with mental health conditions which place them at risk of suicide, have a particular need to be able to contact their families but, from the evidence we received, were often unable to do so, provision should be made in the Prison Rules to enable them to make free phone calls to a designated family member or friend
- Where a prisoner needs to be transferred to a secure hospital, a legal maximum time between the diagnosis and the transfer
- A mechanism to ensure the Secretary of State’s accountability to Parliament for overcrowding
- A mechanism to ensure the Secretary of State’s accountability to Parliament for maintaining the specified staffing levels²⁴⁵

²⁴³ Prisons and Probation Ombudsman, Annual Report 2016-17,

²⁴⁴ Joint Committee on Human Rights, [Government must address crisis of self-inflicted deaths in prisons](#), 2 May 2017

²⁴⁵ Joint Committee on Human Rights, [Mental Health and Deaths in Prison: Interim Report](#), 7th Report of 2016-17, HL 167/HC 893, 2 May 2017

9.5 Prison suicide prevention policy

The white paper: Prison Safety and Reform

On 3 November 2016, the Government published its long-awaited white paper on prison reform.²⁴⁶ The white paper acknowledged the recent increase in self-inflicted deaths and self-harm incidents.²⁴⁷

The white paper pointed to factors including shifts in the nature of the prison population, the increased use of psychoactive substances in prisons and the difficulties of running full and purposeful regimes for the rise in self-inflicted deaths and self-harm incidents.²⁴⁸ It also acknowledged that more frontline staff were needed to address prison safety.

For more detail on the white paper, see the Commons Library briefing [Prison Reform: Recent Developments](#), December 2017.

The white paper was followed by the introduction of the Prisons and Courts Bill published in February 2017. The Bill had second reading in March 2017 but did not complete committee stage, falling at the dissolution of Parliament in May 2017.

Developments since the 2017 General Election

The Conservative party manifesto for the 2017 General Election included measures on prison reform, but no prison reform legislation was announced in the 2017 Queen's Speech on 21 June 2017.

The Government has continued a programme of prison reform.²⁴⁹ In October 2017 then Justice Secretary David Liddington stated that the Government was developing an update to the 2016 white paper and would soon be publishing a prison safety strategy and action plan.²⁵⁰

Mental Health in prisons

The Government has said it has “no plans for a review” of mental health care in prisons but that:

work [is] underway to ensure people are diverted to mental health care services outside prison either before or on their release, and to improve mental health services within prisons.

This work includes:

- Liaison and diversion services at police stations and courts which identify people with mental health needs and directs them to the correct service,

²⁴⁶ MoJ, [Prison Safety and Reform](#), Cm 9350, November 2016

²⁴⁷ *Ibid.*, p40

²⁴⁸ *Ibid.*

²⁴⁹ Ministry of Justice, [Prison reform: open letter from the Justice Secretary](#), 21 June 2017

²⁵⁰ Justice Committee, [2nd Special Report - Government Responses to the Committee's Reports of Session 2016 – 17 on \(a\) Prison reform: governor empowerment and prison performance \(b\) Prison reform: Part 1 of the Prisons and Courts Bill, HC 491](#), 23 October 2017, p2

- Working to increase the use of community sentences for those with mental health needs,
- Directing offenders in prison to the right service to meet their needs,
- New service specifications for secure hospitals,
- Cross working between NHS England and prison and probation service to support those being released from custody.²⁵¹

Training for prison officers

In a PQ response in September 2017 the Government stated that it was

...rolling out new training across the estate to support our staff to identify the risks and triggers of suicide and self-harm and understand what they can do to support prisoners at risk.²⁵²

The training in question is being delivered to new prison officers as part of their entry level training (POELT), and also to existing prison officers and non-HMPPS staff who come into contact with prisoners.²⁵³

Additional funding and increase in prison officers

At the 2016 Conservative Party Conference, the then Justice Secretary, Liz Truss, announced an additional £14 million to recruit 400 prison officers.²⁵⁴ In the Autumn Statement on 23 November 2016 the Chancellor, Philip Hammond, announced that he had “exceptionally agreed to provide additional funding to the Ministry of Justice to tackle urgent prison safety issues increasing the number of prison officers by 2,500”.²⁵⁵ A Treasury policy paper stated:

The government will provide up to £500 million of additional funding across the period to the Ministry of Justice. As announced by the Lord Chancellor and Secretary of State for Justice, as part of the Prison Safety and Reform white paper, this will enable the recruitment of 2,500 extra prison officers to improve prison safety. It will also fund wider reforms to the justice system.²⁵⁶

In a speech on prison reform in July 2018 the current Justice Secretary David Gauke stated that the target of raising prison officer numbers by 2,500 had been met.²⁵⁷

9.6 Devolved nations

Scotland

In 2017, there were 28 deaths in custody in Scottish prisons.²⁵⁸

²⁵¹ [PO HL9270 \[on Mental Health Services: Prisons\]](#), 05 July 2018

²⁵² [PO 9658 \[on Prisoners: Suicide\]](#), 13 September 2017

²⁵³ [PO 8540 \[on Prisoners: Mental Illness\]](#), 11 September 2017

²⁵⁴ Conservative Party, [Truss: Prisons: Places of Safety and Reform](#), 4 October 2016

²⁵⁵ [Autumn Statement 2016: Philip Hammond's speech](#)

²⁵⁶ HM Treasury, [Policy paper: Autumn Statement 2016](#), 23 November 2016, section 6.3

²⁵⁷ Ministry of Justice, [Justice Secretary launches fresh crackdown on crime in prison – speech](#), 10 July 2018

²⁵⁸ [‘Prisoner Deaths: Deaths in Prison Custody 2017’](#), Scottish Prison Service [accessed 3 September 2018]

In 2011, responsibility for the provision of health care services to prisoners in Scotland moved from the Scottish Prison Service (SPS) to NHS Scotland. Following this change, there was a national review of the SPS Suicide Risk Strategy, entitled “Act 2 Care”.²⁵⁹ The new strategy, [*Talk to Me*](#), was published in November 2015 and came into effect on 5 December 2015.²⁶⁰ The key aim of *Talk to Me* is for multi-agency partnerships assuming shared responsibility to care for those at risk of suicide in custody.

Northern Ireland

On 21 November 2016, the then Justice Minister for Northern Ireland Claire Sugden announced a review into the monitoring of vulnerable prisoners in Northern Ireland prisons following five deaths in custody in close proximity.²⁶¹

A review by the Criminal Justice Inspection Northern Ireland (CJI) at Maghaberry Prison in August 2017 found continued shortcomings in the care and support for the most vulnerable prisoners.²⁶² This followed a report in May 2015 which labelled Maghaberry as one of the most dangerous prisons in western Europe. Chief Inspector of Criminal Justice in Northern Ireland, Brendan McGuigan, said that “further work was needed by the wider criminal justice and healthcare systems to provide alternatives to custody for highly vulnerable prisoners”.²⁶³

²⁵⁹ Scottish Prison Service, [Talk to Me: Prevention of suicide in prison strategy 2016-2021](#), November 2015

²⁶⁰ [‘Talk to me’ Strategy](#), Scottish Prison Service (accessed 7 September 2018)

²⁶¹ [‘Sugden: almost half of NI’s prisoners have addictions’](#), BBC News, 21 November 2016

²⁶² Criminal Justice Inspection Northern Ireland, [An unannounced visit to review the progress against the 2015 recommendations](#), 22 August 2017

²⁶³ *Ibid.*

10. Media

Suicidal behaviour can be prompted by the way suicide is reported in the media.²⁶⁴ The risk of such behaviour can increase when a media story describes the suicide method, uses a graphic or dramatic headline or image, and repeatedly or extensively sensationalises a death.²⁶⁵

The UK Government's [Suicide Prevention Strategy for England](#) noted that there were "two key aspects to supporting the media in delivering sensitive approaches to suicide and suicidal behaviour":

- promoting the responsible reporting and portrayal of suicide and suicidal behaviour in the media; and
- continuing to support the internet industry to remove content that encourages suicide and provide ready access to suicide prevention services.²⁶⁶

10.1 Press

Many newspapers and magazines have signed up to the [Independent Press Standards Organisation](#) (IPSO). The IPSO [Editors' Code of Practice](#) includes a clause on the reporting of suicide:

5. *Reporting Suicide

When reporting suicide, to prevent simulative acts care should be taken to avoid excessive detail of the method used, while taking into account the media's right to report legal proceedings.²⁶⁷

The clause is marked * to indicate that there may be exceptions to the clause (and others) where they can be demonstrated to be in the public interest.

According to an April 2017 IPSO [blog](#), since September 2014, IPSO has upheld only one complaint and resolved three between publication and complainant on the reporting of suicide.²⁶⁸

The National Union of Journalists has published [guidance](#) (March 2015) on the responsible reporting of mental health, mental illness and death by suicide.

10.2 Broadcasting

Ofcom's [Broadcasting Code](#) (April 2017) sets out the rules for programmes broadcast on television and radio in the UK.

²⁶⁴ See, for example, M Sisask & A Värnik, '[Media roles in suicide prevention: a systematic review](#)', *International Journal of Environmental Research and Public Health*, Vol. 9, 2012

²⁶⁵ , [Recommendations for reporting on suicide](#). Reporting on Suicide website [accessed 16 August 2018]

²⁶⁶ HMG, [Preventing suicide in England: a cross-government outcomes strategy to save lives](#), September 2012, p43

²⁶⁷ IPSO, [Editors' Code of Practice](#), January 2018

²⁶⁸ Niall Duffy, "[How the UK press takes reporting of suicide seriously](#)", IPSO Blog, 27 April 2017

[Section 2](#) of the Code covers “Harm and Offence” and needs to be read in conjunction with [Section 1](#) on “Protecting the Under-Eighteens”.

Section 2 includes this on suicide:

Violence, dangerous behaviour and suicide

2.4 Programmes must not include material (whether in individual programmes or in programmes taken together) which, taking into account the context, condones or glamorises violent, dangerous or seriously antisocial behaviour and is likely to encourage others to copy such behaviour. (See Rules 1.11 to 1.13 in Section one: Protecting the under-eighteens.)

2.5 Methods of suicide and self-harm must not be included in programmes except where they are editorially justified and are also justified by the context. (See Rule 1.13 in Section one: Protecting the under-eighteens.)

Rules 1.11 to 1.13 of Section 1, referred to above, state:

Violence and dangerous behaviour

1.11 Violence, its after-effects and descriptions of violence, whether verbal or physical, must be appropriately limited in programmes broadcast before the watershed (in the case of television), when children are particularly likely to be listening (in the case of radio) or when content is likely to be accessed by children (in the case of BBC ODPS) and must also be justified by the context.

1.12 Violence, whether verbal or physical, that is easily imitable by children in a manner that is harmful or dangerous:

- must not be featured in programmes made primarily for children unless there is strong editorial justification;
- must not be broadcast before the watershed (in the case of television), when children are particularly likely to be listening (in the case of radio), or when content is likely to be accessed by children (in the case of BBC ODPS), unless there is editorial justification.

1.13 Dangerous behaviour, or the portrayal of dangerous behaviour, that is likely to be easily imitable by children in a manner that is harmful:

- must not be featured in programmes made primarily for children unless there is strong editorial justification;
- must not be broadcast before the watershed (in the case of television), when children are particularly likely to be listening (in the case of radio), or when content is likely to be accessed by children (in the case of BBC ODPS), unless there is editorial justification.

(Regarding Rules 1.11 to 1.13 see Rules 2.4 and 2.5 in Section Two: Harm and Offence.)

Ofcom publishes guidance notes on its Code. These include:

- [Guidance notes: Section two - Harm and offence](#)
- [Guidance notes: Section one - Protecting the under-eighteens](#)

General [guidance](#) on the Code states that compliance is the responsibility of individual broadcasters.

10.3 Internet

In her 2008 report, [Safer children in a digital world](#), Tanya Byron recommended that the application of the law to the encouragement of suicide should be clarified.²⁶⁹ The *Coroners and Justice Act 2009* subsequently amended the *Suicide Act 1961* to consolidate and simplify previous legislation and to make clear that the law applies to online actions in the same way as it does offline.²⁷⁰ Under section 2(1) of the 1961 Act (as amended), it is an offence to conduct an act capable of encouraging or assisting the suicide or attempted suicide of another person with the intention to so encourage or assist. The offence does not require the person to know the other person or identify them. Crown Prosecution Guidance states that:

In the context of websites which promote suicide, the suspect may commit the offence of encouraging or assisting suicide if he or she intends that one or more of his or her readers will commit or attempt to commit suicide.²⁷¹

The impact of the internet and social media

The second [progress report](#), on the Government's Suicide Prevention Strategy, published in February 2015, noted the "limited systematic evidence" on the influence of social media on self-harm and suicidal behaviour:

12. There is concern over the influence of social media but limited systematic evidence, despite stories of individuals who have been bullied or encouraged to self-harm. This has to be balanced against the support that vulnerable people may find through social networks. A recent systematic review of the research literature has confirmed that young people who self-harm or are suicidal often make use of the internet. It is most commonly used for constructive reasons such as seeking support and coping strategies, but may exert a negative influence, normalising self-harm and potentially discouraging disclosure or professional help-seeking.²⁷²

The report set out the following "emerging findings" on the role of social media in the aftermath of youth suicides:

- Suicidal tweeters show a high degree of reciprocal connectivity (i.e. they follow each other), when compared with other studies of the connectivity of Twitter users, suggesting a community of interest.
- A retweet graph shows that users who post suicidal statements are connected to users who are not, suggesting a potential for information cascade and possibly contagion of suicidal statements.
- The reaction on Twitter to the Hayley Cropper Coronation Street suicide storyline was mostly information/support and

²⁶⁹ [Safer children in a digital world: the Report of the Byron Review](#), March 2008, para 15

²⁷⁰ Ministry of Justice, [Encouraging or assisting suicide: implementation of section 59 of the Coroners and Justice Act 2009](#), Circular 2010/03, 28 January 2010

²⁷¹ Crown Prosecution Service, [Policy for prosecutors in respect of cases of encouraging or assisting suicide](#), February 2010 (updated October 2014), para 20

²⁷² HM Government, [Preventing suicide in England: Two years on Second annual report on the cross-government outcomes strategy to save lives](#), February 2015, p10

debate about the morality of assisted dying, rather than statements of suicidal feelings.

- Tweets about actual youth suicide cases are far more numerous than newspaper reports and far more numerous than tweets about young people dying in road traffic accidents, which suggests that suicide is especially newsworthy in social media. In newspapers there is no significant difference between the two types of death, in terms of number of reports per case.

14. A lot of work has already been done by industry and government to equip parents and schools in keeping children and young people safe online. Given the global and changing nature of the internet, continuing that joint approach to better awareness through education is much more likely to be effective than an approach based solely on technical solutions.²⁷³

An October 2017 [literature review](#) by the [UK Council for Child Internet Safety](#) (UKCCIS) found:

(...) According to a survey conducted by Livingstone et al. (2011) for EU Kids Online, 7% of the children surveyed have seen sites relating to self-harm while 5% have seen sites relating to suicides. According to Mascheroni and Ólafsson (2014), seeing potentially negative user-generated content (related to hate, pro-anorexia, self-harm, drug-taking or suicide) is the third most common risk reported by children aged 11-16. In the UK, as noted earlier, 11- to 16-year-olds' exposure to such content has risen slightly between these two studies. Some of the primary causes of suicidal ideation are:

- cyberbullying
- grooming and online abuse
- emotional and behavioural difficulties.

In a study conducted by Biddle et al. (2012), 13 of the 22 individuals interviewed who had survived 'near fatal' suicide attempts reported using the internet as a source of information. There is also increased evidence that the individuals using novel suicide methods have researched them on the internet (Chen et al., 2013; Gunnell et al., 2014).

Although technical controls exist for blocking such content through home network-level filters, support systems are required to help a child recover. A summary of the practice findings of the UKCCIS Evidence Group seminar (Livingstone & Palmer, 2012) noted that health/nursing staff failed to recognise the importance when their suicidal patients disclosed their online activities.

Although helpline-related support services have already made a positive impact in this area (see Dinh et al., 2016), an enabling environment from parents and carers would prove to be especially beneficial for vulnerable children. However, although online communities dedicated to suicide, self-harm and eating disorders such as bulimia/anorexia can be seen to perpetuate harmful behaviour, they also act as support systems for excluded and marginalised children by providing them with peer support and positive identity formation (Bond, 2012; Polak, 2007). In a systematic review conducted by Daine et al. (2013) on the influence of the internet on self-harm and suicide in young

²⁷³ *Ibid.*

people, it was found that methodologies used by studies in this area affect the inferences drawn. In their review Daine et al. found purely quantitative studies are more likely to find a negative influence compared to a qualitative or mixed methods study.

Thus, it is important to understand children's motivations behind the use of and access to self-harm information online and their membership of communities centred round such practices...²⁷⁴

Internet Safety Strategy

In October 2017, the Government published an Internet Safety Strategy [green paper](#) containing proposals to tackle unacceptable behaviour and content. The paper included plans for a social media code of practice, as required by [section 103](#) of the *Digital Economy Act 2017*. A consultation on the green paper ran from 11 October to 7 December 2017.

The Government's [response](#) was published in May 2018. Annex B sets out a draft code of practice for providers of online social media platforms. The draft code applies to a range of abuse as well as to conduct that "negatively impacts mental health and wellbeing".²⁷⁵ The code requires, among other things:

- Links for users to access appropriate off-platform support for a range of issues: crime, bullying, mental and physical health and wellbeing, suicide and self-harm²⁷⁶
- Appropriate mental health and wellbeing training and support in place for all moderators²⁷⁷
- Users being made aware of the prevention, identification and consequences of behaviour which is contrary to the policies of the platform. This should include strategies for users who persistently engage in abusive behaviour or behaviour which may promote risky and dangerous behaviour, intentional self-harm or damage other users' mental health and wellbeing.²⁷⁸

10.4 Health Committee report on suicide prevention (March 2017)

In its March 2017 [report](#) on suicide prevention, the Health Select Committee said that it was concerned about the level of non-adherence to the guidelines on media reporting of suicide. The Committee recognised the "excellent work" of Samaritans in this area but said that it was "concerned that there appears to be no accountability or responsibility for monitoring adherence to the guidelines".²⁷⁹

²⁷⁴ Sonia Livingstone et al, [Children's online activities, risks and safety: a literature review by the UKCCIS Evidence Group](#), UKCCIS, October 2017, section 11.4

²⁷⁵ HM Government, [Government response to the Internet Safety Strategy Green Paper](#), May 2018, p66

²⁷⁶ *Ibid.*, p64

²⁷⁷ *Ibid.*, p64

²⁷⁸ *Ibid.*, pp65-6

²⁷⁹ Health Committee, [Suicide prevention](#), 16 March 2017, HC 1087 2016-17, para 120

The Committee recommended that there needed to be a nominated person within Government or Public Health England who was “ultimately responsible for ensuring that the Government has a firm grasp of the current media situation and for supporting Samaritans and other organisations and individuals”.²⁸⁰

The Committee recommended altering the IPSO Editors’ Code of Practice so that the term “excessive detail” became “unnecessary detail”. It also recommended a strengthening of Ofcom’s Broadcasting Code.²⁸¹

In response, the Government said that it was “committed to a free and open press” and would not interfere with what the press chose to publish:

The Cross-Government Suicide Prevention Strategy sets out the importance of responsible media reporting of suicide. We have supported the Samaritans over many years, which has built strong relationships with the broadcast, print and online media and has developed guidelines for the responsible reporting of suicide. The National Lead at Public Health England works closely with the Samaritans to share information and to highlight needs for proactive engagement, for example emerging clusters and high profile inquests. Whilst there has been great progress in how the media reports suicide, sadly we still see examples of poor reporting. Our stakeholders continue to look at ways in which they can work proactively with the media to improve this.²⁸²

On the Committee’s recommendations on IPSO’s Editors’ Code and Ofcom’s Broadcasting Code, the Government said that these were matters for each body and not the Government.²⁸³

10.5 Devolved nations

Scotland

The Scottish Government’s [suicide prevention strategy](#) refers to the need to encourage “sensitive and appropriate reporting” in the media:

We will work closely with NHS Health Scotland...and other agencies to develop and implement an engagement strategy to influence public perception about suicide and the stigma surrounding it and will use social media, in addition to other communication channels, to communicate key messages about suicide and its prevention.

We know that media reporting of suicide can increase the number of suicides in a locality. The quality and nature of that reporting can be a factor and we have worked with the National Union of Journalists (NUJ) to develop guidelines and deliver training on sensitive and appropriate reporting. We will continue to work with the NUJ and others to encourage the implementation of media guidelines and challenge inappropriate reporting when it occurs...²⁸⁴

²⁸⁰ *Ibid.*, para 124

²⁸¹ *Ibid.*, paras 128-133

²⁸² Department of Health, [Government response to the Health Select Committee’s inquiry into suicide prevention](#), Cm 9466, July 2017, p27

²⁸³ *Ibid.*, p30

²⁸⁴ Scottish Government, [Suicide Prevention Strategy 2013-2016](#), 2013, p9

The Scottish Government's recently published suicide prevention action plan, [Every Life Matters](#), notes in Action 6 that the newly established NSPLG (see section 3.4 of this paper) will work "to develop and support the delivery of innovations in digital technology that improve suicide prevention":

If used positively, the internet and other technologies can be used to influence suicide prevention both locally and nationally. This could include providing online support to people who may be at risk of suicide, raising awareness of sources of support, facilitating individuals' ability to manage themselves and develop resilience, and encouraging safe use of the internet.

We need to maximise the positive influence of social media and its potential for key messaging, working with NHS24, NHS Health Scotland and other interested partners to develop a strong online suicide prevention presence across Scotland that caters for all ages.²⁸⁵

Wales

The Welsh Government's [suicide prevention plan](#) for 2015-20 includes an objective to "Support the media in responsible reporting and portrayal of suicide and suicidal behaviour".²⁸⁶

Northern Ireland

The Northern Ireland Government's [draft strategy](#) for suicide prevention includes an objective to "Enhance responsible media reporting on suicide".²⁸⁷

²⁸⁵ Scottish Government, [Suicide Prevention Action Plan: Every Life Matters](#), August 2018, p14

²⁸⁶ Welsh Government, [Talk to me 2: suicide and self harm prevention strategy for Wales 2015-2020](#), June 2015, p16

²⁸⁷ NIDH, [Protect Life 2: a draft strategy for suicide prevention in the north of Ireland: consultation analysis report](#), February 2017, p26

11. Armed forces

Box 5: Facts about suicide in the UK regular armed forces

The suicide rate among males aged 15-59 years in the UK general population in 2017 was 18 per 100,000 compared to a UK Armed Forces rate of 8 per 100,000 in 2017. The MOD publishes [annual statistics](#) on suicide and open verdict deaths in the UK regular armed forces. Analysis of the twenty-year period between 1998 and 2017 shows:

- The male suicide rate for the UK regular armed forces was statistically significantly lower than the UK general population;
- The overall UK regular armed forces male suicide rate was 8 per 100,000 personnel at risk, with the Army had the highest rate (9 per 100,000) and the RAF the lowest (5 per 100,000);
- There were 309 suicides and open verdicts among UK regular armed forces personnel: 292 among males and 17 among females.

Historically, the only age group with a statistically significant increased risk of suicide compared to the UK general population were Army males aged under 20 years of age. However, the number of suicides in this age group has fallen and for the latest twenty-year period, the rate of suicide in young Army males was the same as the rate in males of the same age in the UK general population.²⁸⁸

There has been a declining trend in male suicide rates in the armed forces since the 1990s and are below those of the population as a whole.

The Ministry of Defence has in recent years paid greater focus to the mental health of regular and reserve personnel and it is now a priority for the Department.²⁸⁹ Suicide and self-harm is one of the four core areas of the Mental Health Steering Group.²⁹⁰

The Defence Committee is examining mental health and the armed forces. In the first of two reports, the Committee recommended improving data collection to identify the level and locations of veteran suicides.

11.1 A new strategy

The MOD launched a new [Mental Health and Wellbeing Strategy](#) in July 2017. While the Strategy does not specify explicit suicide prevention tactics, it does identify measures designed to prevent the onset of mental health illnesses. In an armed forces context, these include pre-deployment training to develop resilience to whatever situations they may face; pre- and post-deployment briefings and post-operational decompression; resilience training throughout Service life with specific training for those in command; peer to peer support; and welfare and chaplaincy support. Externally, the MOD financially supports charities and specific initiatives that address mental health, such as a 24 hour veterans mental health helpline.²⁹¹

²⁸⁸ Ministry of Defence, [Suicide and open verdict deaths in the UK armed forces: annual summary and trends over time 1 January 1984 to 31 December 2017](#), 27 March 2018

²⁸⁹ Ministry of Defence, [Defence people mental health and wellbeing strategy 2017 to 2022](#), 20 July 2017, p3 (foreword by the Secretary of State for Defence)

²⁹⁰ The other three are: stigma reduction; occupational stress; culture and behaviours.

²⁹¹ Further information on mental health support given to Veterans can be found in Library briefing paper CBP07693, [Support for UK Veterans](#), June 2018, section 4

Further information mental health in the armed forces can be found in a briefing note by the Parliamentary Office of Science and Technology, [Psychological health of military personnel](#), 3 February 2016.

11.2 The numbers

The Strategy states that the armed forces have seen a declining trend in male suicide rates since the 1990s and that the male suicide rate has been statistically lower than the UK general population since 1997. The MOD publishes annually statistics on suicide among the UK regular armed forces (available on the Gov.uk [website](#)).

The statistical analysis provides some clues as to why suicide among the male regular personnel is lower than the general population: higher than usual levels of fitness and lower levels of ill-health; strong group loyalty; and bonding and mutual dependence encouraged at all levels in the Services.²⁹²

11.3 Suicide among Veterans

However, the MOD does not collect information on suicide rates among Veterans and The Samaritans have bemoaned the lack of routinely collected data on suicide deaths among Veterans (the Samaritans received a £3.5 million grant from the Government in 2016 specifically to support Service personnel, veterans and their families).²⁹³ The head of research at the Samaritans wrote a blog on "[suicide in the UK armed forces](#)" on the back of the grant award. The MOD says it is compiling a Veterans register and has established a Veterans' Board to address the specific needs of veterans.²⁹⁴ The Health Minister, Jackie Doyle-Price MP, told the Defence Committee the Government could do better on tracking suicide rates among veterans.²⁹⁵ The [Veterans Gateway](#) provides resources and support on a range of issues including mental health and those feeling suicidal.

Post-operational suicide rates

In terms of post-operational rates of suicide, Defence Minister Tobias Ellwood said the MOD's own studies into deaths occurring among veterans of the 1990/91 Gulf war the 1982 Falklands campaign showed "that there was no excess in the rates of suicide in these groups of veterans and is lower than comparative rates in the civilian population."²⁹⁶

When asked specifically about the rate of suicide among personnel who have seen active service in Afghanistan and Iraq, the Ministry of Defence

²⁹² ['Suicide and open verdict deaths in the UK armed forces: annual summary and trends over time 1 January 1984 to 31 December 2016'](#), Ministry of Defence, 30 March 2016, para 15-17

²⁹³ ['Samaritans to offer armed forces and their families specialist support and training'](#), The Samaritans, 16 March 2016; ['Suicide in UK Armed Forces - What We Need to Know to Provide the Best Support Possible'](#), *Huffington Post*, 6 May 2016

²⁹⁴ [HC Deb 10 July 2017 c6](#)

²⁹⁵ Defence Committee, [Mental Health and the Armed Forces, Part One: The scale of mental health issues](#), HC 813 2017-19, 25 July 2018, qq182

²⁹⁶ [PQ347 \[on Veterans: Suicide\]](#), 30 June 2017

said the suicide rate among those deployed was lower than those who had not deployed:

For the period 1 August 2002 to 31 December 2015, the rate of coroner confirmed suicides and open verdict deaths amongst those who had previously deployed to either Iraq or Afghanistan and were still in Service at the time of their death was 0.9 per 1,000. This compared to a rate of 1.6 per 1,000 for those UK service personnel who have not been identified as having deployed to either Iraq or Afghanistan prior to their death.²⁹⁷

11.4 Defence Committee inquiry

The Defence Committee is examining mental health in the armed forces during the 2017-2019 session. The inquiry is split into two parts: part one assesses the scale of mental health issues and part two the provision of mental health care. The Committee published Part One in July 2018 and [Part Two](#) is underway.

The Committee was concerned by the lack of national data on veteran suicides and recommended the MOD improve data collection:

We recommend that the Ministry of Defence works with the justice departments across the four nations to record and collate, as part of existing suicide records, whether someone had been a veteran to monitor the level and locations of veteran suicides. This will enable it to identify whether there are particular groups of veterans or particular locations where more effort is required to prevent such tragic events from occurring.²⁹⁸

²⁹⁷ [HL3467 \[on Armed Forces: Suicide\]](#), 30 November 2016

²⁹⁸ Defence Committee, [Mental Health and the Armed Forces, Part One: The scale of mental health issues](#), HC 813 2017-19, 25 July 2018, para 45

12. Coroners' conclusions

Summary

Until very recently, based on a body of case law built up over many years, it was considered that the high criminal standard of proof was necessary for a coroner's conclusion of suicide in England and Wales – namely “beyond all reasonable doubt”. This meant that, in order to return a conclusion of suicide, the coroner (or jury) had to be sure that the deceased intentionally took their own life.

A number of calls were made for the standard of proof to be lowered, not least because of the potential impact this was having on the quality of data on suicides.

The High Court has now decided that previously decided cases did not correctly state the law, and that the lower civil standard of proof applies for suicide conclusions - “on the balance of probabilities”. It is understood that permission to appeal has been granted in the case in question.

12.1 Statutory requirements

[Part 1 of the Coroners and Justice Act 2009](#) (the 2009 Act) deals with coroners and inquests in England and Wales.

A coroner must investigate a death where (s)he is made aware that the body is within that coroner's area and (s)he has reason to suspect that:

- The deceased died a violent or unnatural death;
- The cause of the death is unknown; or
- The deceased died while in custody or state detention.²⁹⁹

Section 5 of the 2009 Act sets out the matters the coroner must ascertain:

- Who the deceased was;
- How, when and where the deceased came by his or her death;
- The particulars (if any) to be registered concerning the death.

The scope of the investigation must be widened to include an investigation of the broad circumstances of the death, including events leading up to the death in question, where this wider investigation is necessary to ensure compliance with the European Convention on Human Rights (ECHR), in particular Article 2 (relating to the State's responsibility to ensure that its actions do not cause the death of its citizens).

At the end of the inquest, the coroner – or the jury if there is one - must make a ‘determination’ of the matters set out in section 5 and a ‘finding’ about the details required for registration of the death.³⁰⁰ A determination may not be worded in such a way as to appear to determine any question of criminal liability of any named person or to determine any question of civil liability.

²⁹⁹ *Coroners and Justice Act 2009*, section 1

³⁰⁰ *Coroners and Justice Act 2009*, section 10

Another Commons Library briefing paper, [Coroners' investigations and inquests](#), published in June 2017, provides information about coroners and their work.

12.2 Conclusions

The 2009 Act and associated secondary legislation no longer use the word 'verdict' for the finding at the end of an inquest, using instead the word 'conclusion'.

Conclusions can be short-form or narrative. It is for the coroner to decide which is more appropriate to the case in question. The coroner can also, in addition to a short-form conclusion, make a brief narrative conclusion to explain the reasons for the determination.

The outcome of an inquest is recorded in the Record of Inquest (Form 2). The document previously used was an Inquisition. Form 2 is set out in the Schedule to the [Coroners \(Inquests\) Rules 2013](#).³⁰¹ The notes to Form 2 list the short form conclusions, one of which is suicide.

12.3 Chief Coroner guidance

The first Chief Coroner published guidance, [Conclusions: short-form and narrative](#).³⁰² This advises that, wherever possible, coroners should conclude with a short-form conclusion:

This has the advantage of being simple, accessible for bereaved families and public alike, and also clear for statistical purposes.³⁰³

Paragraphs 60 to 63 deal specifically with the suicide conclusion. The guidance makes three points:

- Encouraging coroners not to avoid a conclusion of suicide where appropriate;³⁰⁴
- Requiring coroners to make express reference in each case of possible suicide to the two elements which need to be proved: that the deceased took his/her own life; and that the deceased intended to do so (or, put together, 'he/she intentionally took his/her own life'); and
- Suggesting wording to alleviate the impact of the conclusion of suicide where proved.

12.4 Suicide conclusions: statistics

The Ministry of Justice publishes annual coroner statistics. [The most recent annual bulletin](#), published in May 2018, presents statistics of deaths reported to coroners in England and Wales in 2017. This notes that the proportion of conclusions recorded as suicide has remained

³⁰¹ SI 2013/1616

³⁰² Guidance No 17, 30 January 2015, revised 14 January 2016

³⁰³ *Ibid.*, para. 26

³⁰⁴ Footnote to text: "The job of the judges is to apply the law, not to indulge their personal preferences": Lord Bingham in *The Rule of Law* (2010)"

broadly constant over the past five years, increasing from 9% of all conclusions in 2016 to 11% in 2017, with some regional variations:

This proportion varies from 3% in Portsmouth and South East Hampshire area to 28% in North West Wales^[305], mirroring the latest ONS data release on suicides in the UK^[306] which suggests Wales has the highest suicide rate of regions in England and Wales.³⁰⁷

ONS coding

The Office for National Statistics (ONS) codes all deaths. This is mostly automatic, but the coding software cannot easily handle the free text format of a coroners' narrative conclusion. In 2017, 55.2% of narrative conclusions were coded as resulting from an external cause of death (as opposed to a disease).³⁰⁸

Some narrative conclusions clearly indicate the intent and mechanism of death; ones which do not are defined by the ONS as "hard-to-code". If the coroner does not unambiguously indicate whether the fatal injury was intentional or otherwise, the ONS codes such a death as accidental.³⁰⁹

Professor Colin Pritchard of Bournemouth University, after analysing coroners' conclusions, is reported to have suggested that there was an underestimation of suicides in the UK by around 30% and as much as 50% among young people.³¹⁰

12.5 The standard of proof for a conclusion of suicide

Form 2

Note (iii) to Form 2 deals with the standard of proof at inquests generally. It distinguishes conclusions of suicide and unlawful killing from all other conclusions:

The standard of proof required for the short form conclusions of "unlawful killing" and "suicide" is the criminal standard of proof. For all other short-form conclusions and a narrative statement the standard of proof is the civil standard of proof.

³⁰⁵ Footnote to text: "Note that City of London has been excluded from this analysis due to a disproportionately low number of inquest conclusions (19) distorting the trend."

³⁰⁶ Footnote to text: "Please refer to [Suicides in the United Kingdom 2017](#) for data on UK suicide rates released by the ONS. Footnote to text: "Please refer to [www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2016registrations](#) for data on UK suicide rates released by the ONS; note that 2017 data is not yet available at the time of publication of this bulletin."

³⁰⁷ Ministry of Justice, [Coroners Statistics Annual 2017 England and Wales](#), p11

³⁰⁸ Office for National Statistics [Suicides in the United Kingdom 2017, Table 14](#)

³⁰⁹ *Ibid.*

³¹⁰ 'Thousands of suicides hidden to comfort grief-stricken families', *The Times*, 6 January 2017 [subscription required – accessed 12 October 2017]

The criminal standard of proof is “beyond all reasonable doubt” which is a much higher threshold than the civil burden of proof which is “on the balance of probabilities”

A footnote to the Chief Coroner’s guidance on conclusions observed that “there is an ongoing discussion as to whether suicide should be proved to the criminal or civil standard. The Ministry of Justice are considering the alternatives”.³¹¹

Previous case law

A body of case law, built up over many years, considered the standard of proof required for a coroner’s conclusion of suicide. For example, in a 2013 case, Mrs Justice Lang DBE provided this reasoning for the “beyond reasonable doubt” requirement:

35. ...a high standard is deliberately set in order to ensure that such serious findings are only made on the basis of absolutely clear and compelling evidence. See: *R v West London Coroner, Ex Parte Gray* [1988] 1 QB 467 at 477 (Watkins LJ). In that case, the Court explained the need for the high standard of proof as being because suicide is regarded as “a drastic action which often leaves in its wake serious social, economic and other consequences.”

(...)

37. In summary, the approach of the Courts to suicide verdicts reflects (a) the fact that a finding of suicide is a serious matter which can cause serious distress and stigma, and other adverse consequences; and (b) the complexities of human psychology which can cause people to harm themselves seriously or to put themselves in very dangerous positions without the clear intention to end their lives.³¹²

The leading textbook on coroners (*Jervis on Coroners*) sets out this information about the requirement for the criminal standard of proof and the impact on statistics:

At least since 1984 it has been consistently held in England that the standard of proof in suicide cases should be the same as in criminal prosecutions, i.e. beyond reasonable doubt, although there is no crime involved and an inquest is not a criminal trial (or any sort of trial). The comparative difficulty in obtaining a conclusion of suicide may well mean that official statistics significantly underestimate the occurrence of suicide.

All other definite conclusions (except unlawful killing) operate on the civil standard i.e. the balance of probabilities. This logically means that if the coroner (or jury) is satisfied *on the balance of*

³¹¹ Chief Coroner, [Guidance No.17: Conclusions: Short-form and narrative](#), 30 January 2015, revised 14 January 2016, p11, footnote 44. The decision in [R \(Maughan\) v HM Senior Coroner Oxfordshire and others](#) includes the following: “Counsel for the coroner in this case contacted the Chief’s Coroner’s office to find out whether there is any such ongoing discussion or consideration and was told that, so far as the Chief’s Coroner’s office is aware, there is no active review of this issue currently being undertaken by the Ministry of Justice”. [2018] EWHC 1955 (Admin), paragraph 16

³¹² [R \(Lagos\) v HM Coroner for City of London](#) [2013] EWHC 423 (Admin)

*probabilities that it was suicide, but is not satisfied beyond reasonable doubt, the conclusion must be an open one...*³¹³

New High Court decision

On 26 July 2018, the High Court delivered its judgment in a judicial review, [R \(Maughan\) v HM Senior Coroner Oxfordshire and others](#).³¹⁴

The question considered by the court was:

whether a coroner or a coroner's jury, after hearing the evidence at an inquest into a death, may lawfully record a conclusion to the effect that the deceased committed suicide reached on the balance of probabilities; or whether such a conclusion is only permissible if it has been proved to the criminal standard of proof (i.e. so that the coroner or jury is sure that the deceased did an act which was intended to and did cause his or her own death).³¹⁵

Inquest conclusion

The Senior Coroner had accepted that there was insufficient evidence upon which the jury could be sure that the deceased intended to kill himself and that therefore the jury could not be permitted to consider a 'short-form' conclusion of suicide. He had invited the jury to record a narrative conclusion on the basis of questions provided to them. The questions were accompanied by written instructions, one of which was:

"The standard of proof you should apply when considering these questions is the balance of probabilities. In reaching your conclusions, you therefore have to be satisfied it is probable (more likely than not) that something did or did not happen."

The jury's narrative statement included a finding that, "on the balance of probabilities, it is more likely than not that [the deceased] intended to fatally hang himself that night".

Judicial review

The deceased's brother claimed judicial review on the basis that the jury's conclusion was unlawful, as it amounted to a conclusion of suicide reached on the balance of probabilities when the law was clear on the necessary standard of proof. He argued that the coroner had erred in law in directing the jury in a way that allowed them to apply the civil standard of proof to the question of whether the deceased intended to kill himself.

The Court disagreed that the criminal standard of proof had to be applied:

Given the nature and function of a modern inquest, it seems to us that there is today no relationship or analogy between coroner's proceedings and criminal proceedings which can in principle justify applying in coroner's proceedings the criminal standard of proof.³¹⁶

³¹³ Paul Matthews, *Jervis on Coroners*, 13th edition, 2014, paragraphs 13.70-71 (footnotes omitted)

³¹⁴ [2018] EWHC 1955 (Admin)

³¹⁵ Paragraph 1

³¹⁶ Paragraph 38

The Court considered that the correct standard of proof for the conclusion of suicide, whether in short or narrative form, should be the civil standard, and dismissed the claim:

75. In summary, we are unable to accept the claimant's contention that a conclusion of suicide at an inquest requires proof to the criminal standard. We are satisfied that the authorities relied on to support that contention either on analysis do not support it or do not correctly state the law. We consider the true position to be that the standard of proof required for a conclusion of suicide, whether recorded in short-form or as a narrative statement, is the balance of probabilities, bearing in mind that such a conclusion should only be reached if there is sufficient evidence to justify it.

76. It follows that there was nothing wrong with the coroner's directions to the jury in this case and that the jury's conclusion was lawful. The claim must therefore be dismissed.

It is understood that permission to appeal has been granted.³¹⁷

12.6 Previous calls for change

Health Committee inquiry into suicide prevention

[The Health Select Committee's inquiry into suicide prevention](#) in England included a focus on the quality of data on suicide. Witnesses raised concerns that coroners used narrative conclusions to "alleviate the impact of the conclusion of suicide", but that this was leading to data inaccuracy and an underestimation of the number of suicides.³¹⁸

In its [interim report](#) published in December 2016, the Committee recommended that the standard of proof for conclusions of death by suicide should be changed to the civil standard of proof, rather than the criminal standard of proof.³¹⁹

In its [full report](#), published in March 2017, the Committee repeated its recommendation about the change in the standard of proof.³²⁰ It also noted that, given the Chief Coroner's guidance that discourages the use of open conclusions, coroners had two options when facing a suspected suicide which does not meet the standard of proof:

The coroner can record the death as accidental (which would not appear in the suicide registrations and would therefore skew the data) or can choose to use a narrative conclusion.³²¹

The Committee recommended that improvements were needed in the way narrative conclusions are recorded by coroners to improve data accuracy for suicides.³²²

³¹⁷ Bridget Dolan QC & Debra Powell QC, "[This was probably suicide: the criminal standard of proof is no longer required](#)", *UK Inquest Law Blog*, 26 July 2018 [accessed 6 September 2018]

³¹⁸ Health Committee, [Suicide prevention: interim report, Fourth Report of Session 2016-17](#), 13 December 2016, HC 1087, para. 28

³¹⁹ *Ibid.*, para. 31

³²⁰ Health Committee, [Suicide prevention, Sixth Report of Session 2016-17](#), 7 March 2017, HC 1087, para 151

³²¹ *Ibid.*, para. 155

³²² *Ibid.*, paras 161-164

In its response to the Committee's report, the Government said that it was considering whether the standard of proof should be lowered.³²³

PAPYRUS campaign

PAPYRUS, the charity for the prevention of young suicide, has called for a change in the way coroners' reach conclusions in cases of suicide.³²⁴

Early Day Motion in February 2017

Norman Lamb tabled this EDM on 8 February 2017 which gained twelve signatures:

SUICIDE AND THE CRIMINAL STANDARD OF PROOF

That this House notes that, despite the decriminalisation of suicide in 1961, the criminal standard of proof of beyond all reasonable doubt continues to be applied in reaching a conclusion of suicide in coroners' courts; recognises that this contributes to the stigma around suicide, which prevents many young people from seeking help and support; further recognises that the criminal standard of proof obscures the true scale of suicide in England and Wales and prevents the collection of accurate national statistics; expresses support for the campaign led by the national charity PAPYRUS Prevention of Young suicide, founded and governed by parents and families who have been touched personally by suicide in young people, to change the burden of proof required by law to that of the Civil Standard, on the balance of probabilities, for reaching a conclusion of suicide; further notes the support this campaign has received from the first Chief Coroner, the National Suicide Prevention Alliance, and many of the suicide prevention and mental health charities across the UK; and calls on the Ministry of Justice to bring forward proposals for a change in the law so that the Civil Standard rather than the criminal standard of proof is applied in determining a suicide cause of death.³²⁵

³²³ Department of Health, [Government response to the Health Select Committee's inquiry into suicide prevention](#), Cm 9466, July 2017

³²⁴ 'Campaign to change the law', PAPYRUS [accessed 6 September 2018]

³²⁵ [Early day motion 930 of 2016-17](#)

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