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BRIEFING PAPER

Number CBP 08221, 5 February 2018

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.

This briefing paper begins with a statistical overview of suicide rates throughout the UK over time, using the latest data from the Office of National Statistics, which were published in September 2017. These show that in Great Britain in 2016 there were 5,668 recorded suicides which represented a slight fall since 2015 and the lowest overall number since 2010. The 2016 suicide data for Northern Ireland has not yet been published.

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.

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 and social security** – outlining support for keeping people in work who suffer from mental health problems,

benefit claimants with mental health problems, training and guidance for DWP staff, and risks in ESA and PIP assessments;

- **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, as well as Government policy to prevent suicide in prisons;
- **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 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), as well as concerns around suicide among veterans; and
- **Coroners' conclusions** – which examines problems identified with the accuracy of suicide data, namely in the way coroners return a conclusion of suicide – the standard for which is the criminal standard of proof, i.e. "beyond reasonable doubt". Some have claimed that this has resulted in the number of suicides to be underestimated in official ONS data.

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 Strategy 2013-2016*, December 2013 (a new strategy is due to be published in 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).

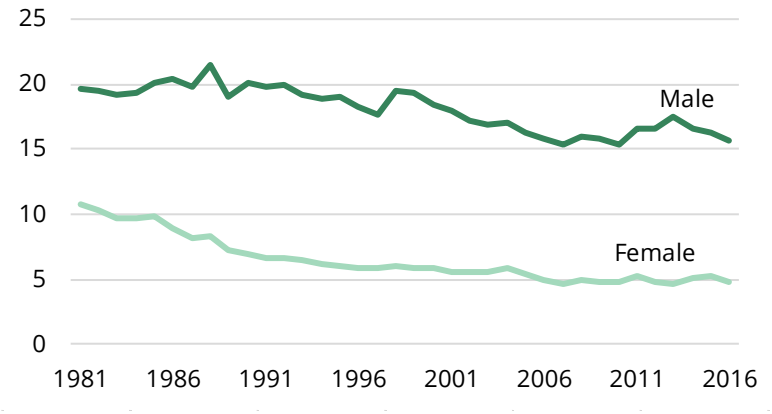
1. Suicide rates in the UK

1.1 Suicide rates by age, gender, and country

In Great Britain in 2016, there were 5,668 deaths where the cause was identified as suicide. 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 Great Britain has halved since 1981. The rate among men has fallen by around a quarter over the equivalent period.

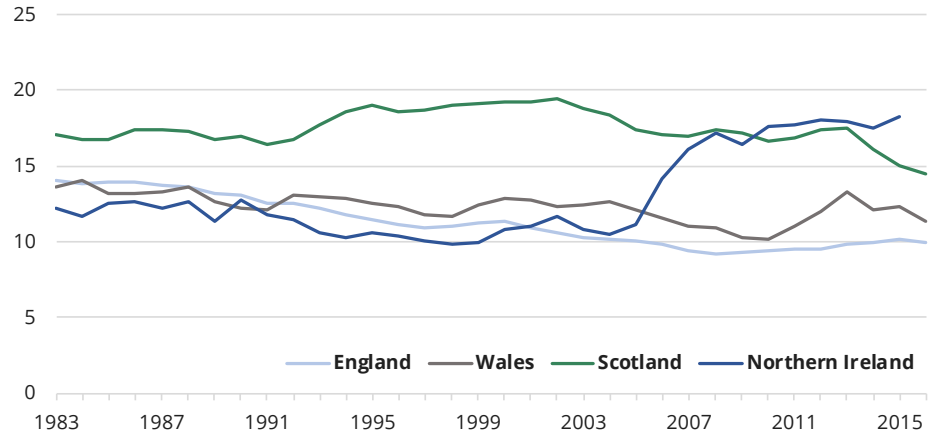
In 2016, the suicide rate fell slightly in both genders. The number of suicides was the lowest it has been since 2010.

Suicide rate by gender, 1981-2016, Great Britain
Age-standardised rate per 100,000 population



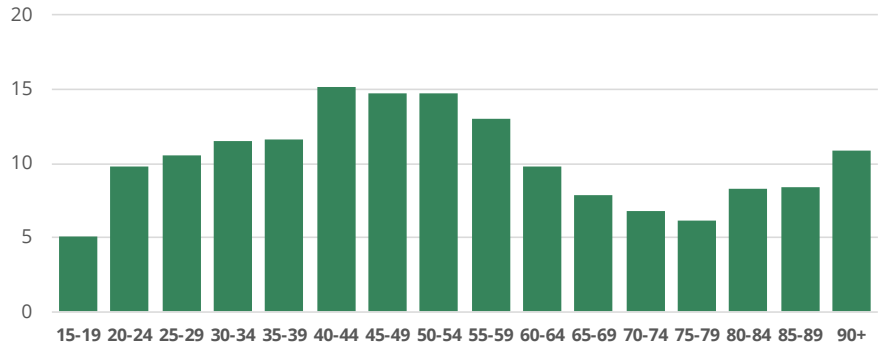
The suicide rate is higher in Northern Ireland than other UK countries. 2016 data for Northern Ireland has not yet been released. The chart below includes trends up to 2016 for England, Wales and Scotland, and trends up to 2015 for Northern Ireland.

Age-standardised suicide rate, UK countries, 1981-2016
(Rate per 100,000 population, 3-year moving average)



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.

Suicide rate by age group, Great Britain, 2016, rate per 100,000 population

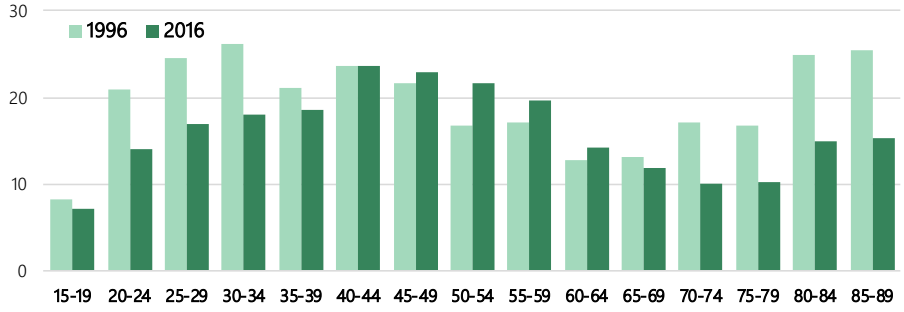


The charts below show how the suicide rate has changed in the last 20 years for men and women of different ages.

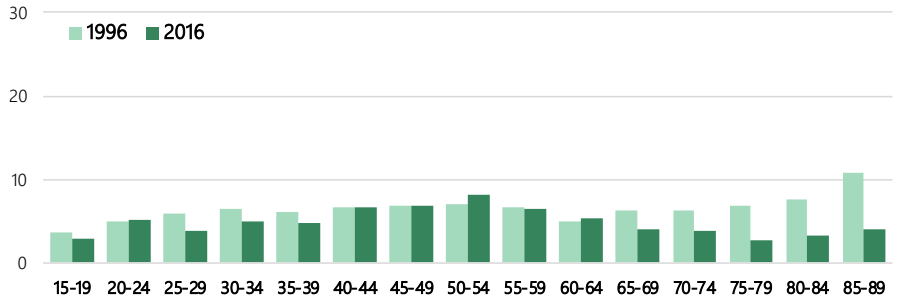
In men, the suicide rate has fallen among younger and older men. Among men aged 40-69 there has been either little change or a rise.

Among women, the most notable trend is a fall in the suicide rate among older women and those aged 25-34.

Male suicide rates by age group, 1996 and 2016 - rate per 100,000 population



Female suicide rates by age group, 1996 and 2016 - rate per 100,000 population



1.2 Suicide rates by occupation

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

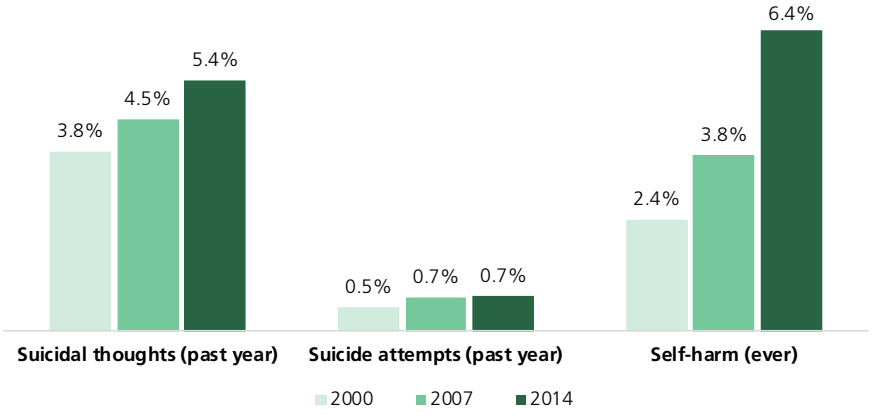
- Men working in the lowest-skilled occupations had a 44% higher risk of suicide than men as a whole;
- Risk of suicide among men who were labourers was 3 times higher than men as a whole;
- For women, the risk of suicide among professionals was 24% higher than for women as a whole – this is mostly explained 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.[1]

1.3 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.
- 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.

Prevalence of suicidal thoughts, suicide attempts and self-harm
England, 2000-2014



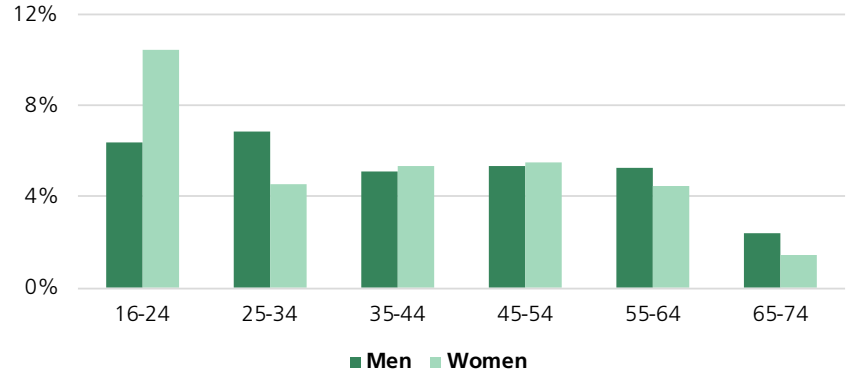
1 Office for National Statistics, *Suicide by occupation, England: 2011 to 2015*, 17 March 2017

2 NHS Digital, APMS, Suicidal Thoughts

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

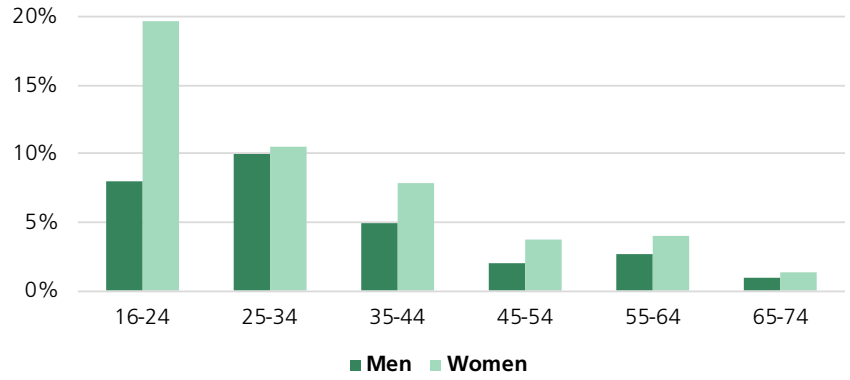
Among women, suicidal thoughts in the past year were most common among those aged 16-24 (10%). Among men, rates were similar in 16-24s and 25-34s (6-7%).

Suicidal thoughts in the last year, by gender and age
England, 2014



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%).

Self-harm ever, by gender and age
England, 2014



More data on suicide is available in the briefing paper Suicide: summary of statistics.

1.4 Concerns around data on suicide

Concerns have been expressed about the consistency of recording deaths as suicide, and the standards required to do so. These are explored in the Health Select Committee's two recent reports on suicide prevention.[3]

A death being recorded as suicide depends on the judgement of an individual independent coroner. Witnesses to the Health Committee

[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

expressed concern over whether such judgements were being made consistently, and that the residual stigma around suicide leads to pressure not to record deaths as suicide.

For a coroner to conclude that a suicide has taken place, a strict standard of proof – "beyond reasonable doubt" – must be met. In other words, deaths which were probably, but not certainly, due to individual intent would not be recorded as suicide. There are concerns that this could lead to under-reporting 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]

If the above standard is not met, one of the options available to the coroner is to record a narrative conclusion regarding the death. In these cases, there will not always be enough information about the death to allow it to be coded as suicide. There is concern that this could also lead to the under-reporting of suicide.

A more extensive exploration of the issues around data quality, and of coroners' judgments, can be found in Section 11 of this paper.

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

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

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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 monitoring[16]

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. It set out an action plan with seven objectives for local and national implementation:

- raising awareness of the risk factors associated with suicidal behaviour;
- ensuring earlier and more effective care and support;
- improving and increasing the provision of services;
- removing the stigma that people can feel about seeking help for emotional and mental health problems so that people get help when they need it most;
- providing effective and sympathetic support to family members, friends and loved ones affected by suicidal behaviour and completed suicide;
- supporting the media to ensure that the depiction and reporting of suicide and suicidal behaviour is done in a sensitive and appropriate way; and
- improving the quality, collection, availability and dissemination of relevant information to ensure better design and implementation of services.[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

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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

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.

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 29 November 2017, the Scottish Minister for Mental Health, Maureen Watt, revealed that the Scottish Government will conduct a public engagement exercise on a new draft suicide prevention strategy and action plan "with a view to publishing a final version in Spring 2018".[26]

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".[27] 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

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25 *Ibid*., pp6-14
26 SW WA 29 November 2017, S50-01542
27 Welsh Assembly Government, *Talk to Me: The National Action Plan to Reduce Suicide and Self Harm in Wales 2009-2014*, October 2009, pp9 & 19

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.[28]

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.[29] It also mentioned the creation of the Suicide Prevention National Advisory Group which was designed to provide a specific layer of national 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.[30] It prioritised certain high risk groups, in particular middle-aged men, which was a group highlighted as particularly vulnerable by a Samaritans campaign.[31] 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 action[32]

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

28 *Ibid*., p9
29 Welsh Government, *Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales*, October 2012
30 Welsh Government, *Talk to me 2: Suicide and Self Harm Prevention Strategy for Wales 2015-2020*, June 2015, para. 36, p15
31 *Ibid*. paras 57-60, pp19-20
32 *Ibid*., pp15-17

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
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.[33]

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.[34]

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.[35] Since the collapse of the Northern Ireland Executive in January 2017, and the

33 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

34 NIDHSSPS, *Protect Life – A Share Vision: The Northern Ireland Suicide Prevention Strategy 2012-March 2014*, June 2012, para. 4.2, p35

35 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

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.
>
> 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.[36]

[36] 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 of the post-2012 Strategy

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.[37]

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-

[37] HMG, *Preventing suicide in England: A cross-government outcomes strategy to save lives*, 10 September 2012, pp50-3

> Whitehall lead on health issues. The Department of Health will continue to have the lead role across government on suicide prevention.[38]

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.[39] 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".[40] 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.[41] It also recently published guidance for local commissioners on how and why they can deliver support after suicide.[42]

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".[43]

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

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38 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
39 *Ibid*., paras 7.5-7.6, p50
40 *Ibid*., p4
41 Public Health England, *Local Suicide Prevention Planning: A Practice Resource*, October 2016
42 Public Health England, *Support after a suicide: a guide to providing local services*, January 2017
43 HMG, *Preventing suicide in England: A cross-government outcomes strategy to save lives*, 10 September 2012, paras 7.16-7.16, p51

and vulnerable groups, antenatal and postnatal mental health, and long-term care for people with complex needs.[44] 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".[45] Its chair, Professor Louis Appleby, provided the preface to the report, said that the Strategy was "up to date, wide-ranging and ambitious".[46]

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.[47] 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.[48] 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".[49] 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

44 *Ibid*., paras 7.17, pp51-2
45 *Ibid*., para 7.24, p53
46 *Ibid*., p4
47 National Suicide Prevention Alliance, *Annual Review 2012-13*, p6
48 'The Suicide Bereavement Support Partnership', Samaritans website, 17th June 2014 (accessed 7 December 2017)
49 Health Committee, *Suicide Prevention: Interim Report, Fourth report of Session 2016-17*, 19 December 2016, HC 1087, para. 5, p4

> wellbeing alongside the identification of and targeted support for 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.[50]

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.[51]

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".[52]
- **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.[53]

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

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50 *Ibid*., para. 7, pp4-5
51 Health Committee, *Suicide Prevention, Sixth report of Session 2016-17*, 16 March 2017, HC 1087, paras 10-11, p7
52 *Ibid*., para. 92, p24
53 *Ibid*., para. 114, p29

ensuring effective and consistent implementation across the country".[54] 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.[55]

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.[56]

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.[57]
- 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.[58]

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.[59] 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

54 *Ibid*,. para. 12, p7
55 *Ibid*., paras 27-28, p10
56 DH, *Government Response to the Health Select Committee's Inquiry into Suicide Prevention*, July 2017, Cm 9466, p6
57 *Ibid*., p3
58 *Ibid*., p3
59 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.[60]

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.[61]

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.[62]

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.[63] 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:

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60 HMG, *Preventing suicide in England: A cross-government outcomes strategy to save lives*, 10 September 2012, paras 37-39, p8
61 *Ibid*.
62 APPG on Suicide and Self-Harm, *The Future of Local Suicide Prevention Plans in England*, January 2013, p1
63 *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.[64]

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.[65]

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.[66]

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.[67]

3.4 Oversight and implementation in the devolved nations

Scotland

The latest Scottish suicide prevention strategy, like its predecessor, is led by the Scottish Government and supported by NHS Health Scotland, along with local Choose Life coordinators. NHS Health Scotland hosts the National Programme for Suicide Prevention, which supports the delivery of the Strategy as it related to population health. 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 implement local suicide prevention action plans.[68] These local plans are

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64 *Ibid*, p5
65 *Ibid*.
66 APPG on Suicide and Self-Harm Prevention, *Inquiry into Local Suicide Prevention Plans in England*, January 2015, pp3-7
67 HMG, *Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives*, January 2017, para. 5, p7
68 'National and local implementation', Choose Life website (accessed 18 December 2017)

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.[69]

The latest iteration of the Scottish Government's strategy announced the creation of the Implementation and Monitoring Group designed to keep track of progress of the implementation of the all the commitments in the strategy.[70]

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.[71] Local authorities were given responsibility for local implementation in collaboration with local Health Boards, justice agencies, third sector agencies, and community organisations.[72]

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."[73] 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".[74]

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 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.[75]

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:

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69 'Local action plans', Choose Life website [accessed 18 December 2017]
70 Scottish Government, Suicide Prevention Strategy 2013-2016, December 2013, p14
71 Welsh Assembly Government, *Talk to Me: The National Action Plan to Reduce Suicide and Self Harm in Wales 2009-2014*, October 2009, p21
72 *Ibid*., pp21-22
73 Welsh Government, *Talk to me 2: Suicide and Self Harm Prevention Strategy for Wales 2015-2020*, June 2015, para. 51, p18
74 *Ibid*., para. 6, p6
75 *Ibid*., paras 51-55, pp18-19

- 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.[76]

This inquiry is currently receiving evidence.

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".[77]

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.[78]

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.[79]

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76 'Suicide Prevention', National Assembly for Wales website (accessed 19 January 2018)

77 NIDHSSPH, *Protect Life – A Share Vision: The Northern Ireland Suicide Prevention Strategy 2012-March 2014*, June 2012, paras 5.2-5.4, p39

78 *Ibid*., para. 1.2, p7

79 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

As mentioned above, suicide prevention policies in the UK historically have centred on health policy, particularly pertaining to mental health, and in England have been led or driven forward by the Department of Health. This section briefly sets out the work of health services in England, as well as elsewhere in the UK, to prevent suicide.

For more information on mental health policy in England in particular, see the Commons Library briefing paper CBP-0747, *Mental health policy in England*, last updated on 23 August 2017.

4.1 Five Year Forward View for Mental Health

The *Five Year Forward View for Mental Health*, published in February 2016 by the independent Mental Health Taskforce, set a number of primary objectives for the whole health system in England on suicide prevention. This included a key objective that by 2020/21, the number of people taking their own lives will be reduced by 10% nationally compared to 2016/17 levels. This would be helped by improved the seven day crisis response service across the NHS.[80]

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.[81]

As mentioned above, the Government formally accepted the commitment to achieve a 10% reduction in suicides by 2020/21 in its Third Progress Report of the National Suicide Prevention Strategy, refreshed in January 2017.[82]

4.2 Local suicide prevention plans

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

> 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

80 NHS England, *Five Year Forward View for Mental Health*, February 2016, p13
81 NHS England, *Implementing the Five Year Forward View For Mental Health*, July 2016, pp35-36
82 HMG, *Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives*, January 2017, p5

> 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.[83]

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.[84] Public Health England has also published planning guidance for local authorities to form their plans,[85] and NHS England's progress report on the *Forward View* notes that a quality assessment of local plans was to take place in 2017, commissioned by the Department of Health.[86]

The Government's Third Progress Report of the 2012 Strategy committed to working further with local authorities to support them in complying with PHE guidance and to ensure that the status of local plans are updated regularly to drive improvement and guarantee that they incorporate the latest information and best practice. In particular, it was concerned to focus on bereavement. Public Health England refreshed its Help is at Hand guidance for those bereaved by suicide in 2015 by people who have experience of suicide bereavement.

In its aforementioned report on Suicide Prevention, the Health Committee 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.[87]

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 authorities' suicide prevention plans should be assessed.[88]

The Government, in its response to the Committee, announced an "assurance process" – under development between the Department of Health, the Department for Communities and Local government, PHE, and the NSPSAG – the purpose of which would be to support local

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83 NHS England, *Five Year Forward View for Mental Health*, p77 (Recommendations for Government)
84 NHS England, *Implementing the Five Year Forward View for Mental Health*, July 2016
85 Public Health England, *Suicide prevention: resources and guidance*, January 2017
86 NHS England, *Five Year Forward View for Mental Health: One year on*, February 2017, p23
87 Health Committee, *Suicide Prevention, Sixth report of Session 2016-17*, 7 March 2017, HC 1087, para. 21
88 *Ibid*., paras 22-23

authorities in developing multi-agency suicide prevention plans. This process was due to be tested during the summer of 2017.[89]

4.3 Support for high-risk groups

The Third Progress Report set an objective to target suicide prevention and help-seeking in high risk groups better, including those who might be identified in a health service context, such as young and middle-aged men, people in the care of mental health services, including inpatients, and people with a history of self-harm.[90]

In particular, 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. At present, 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. NHS England's mental ealth programme is geared towards the importance of intervention.[91]

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.[92]

The Strategy also notes new models of enhanced primary care, including the Urgent and Emergency Care Vanguards, 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, to be published in 2018.[93]

Specialist services and support

For people in the care of specialist mental health services, the Strategy notes that a significant reduction in the number of inpatient suicides due to improvements in patient safety, but notes 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, 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

89 DH, *Government response to the Health Select Committee's Inquiry into Suicide Prevention*, Cm 9466, July 2017, p5
90 HMG, *Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives*, January 2017, p9
91 *Ibid*., p12
92 See DH, *Government response to the Health Select Committee's Inquiry into Suicide Prevention*, Cm, 9466, July 2017, p15
93 HMG, *Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives*, January 2017, pp12-13

patients onto other mental health services if they show signs of self-harm or other psychological distress, by 2020/21.[94]

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.[95] In its aforementioned 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.[96]

On 31 January 2018, the Health and Social Care Secretary, Jeremy Hunt, announced 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". In particular, his plan involved:

- asking that all suicides by mental health patients be 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.

This would, Mr Hunt argued, result in England becoming "the first country in the world to roll out zero suicides as a national ambition".[97]

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.[98] 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.[99]

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94 *Ibid*., para 32, p14
95 NHS England, *Five Year Forward View for Mental Health Dashboard*, January to March 2017
96 DH, *Government response to the Health Select Committee's Inquiry into Suicide Prevention*, Cm 9466, July 2017, p18
97 'Zero suicide is our simple but powerful NHS mission', *The Telegraph*, 31 January 2018 (an opinion piece written by Jeremy Hunt MP)
98 Health Committee, *Suicide Prevention, Sixth report of Session 2016-17*, 7 March 2017, HC 1087, paras 21 and 95
99 DH, *Government response to the Health Select Committee's Inquiry into Suicide Prevention*, July 2017, pp21-22

Perinatal suicide prevention

The Health Committee also noted concerns about the levels of perinatal suicide.[100] The "Mother and Babies: Reducing Risk Through Audits and Confidential Enquiries across the UK" (MBRRACE-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.[101] 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.[102]

4.4 Devolved nations

Scotland

One of the five key themes of Scottish Government's latest suicide prevention strategy is "Improving the NHS response to suicide". The latest Strategy highlights 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. In order to improve on these, the Strategy made three commitments on behalf of the Scottish Government:

> Commitment 6: We will work with Healthcare Improvement Scotland to support improvements for NHS Boards that focus on areas of practice which will make mental health services safer for people at risk of suicide, for example, transitions of care, risk management, observation implementation and medicines management.
>
> […]
>
> Commitment 7: We will work with the Royal College of General Practitioners and other relevant stakeholders to develop approaches to ensure more regular review of those on long-term drug treatment for mental illness, to ensure that patients receive the safest and most appropriate treatment.
>
> Commitment 8: We will build on work already done in relation to…the Mental Health Strategy to test ways of improving the detection and treatment of depression and anxiety in people with other long-term conditions.[103]

To help fulfil these commitments and support implementation of the strategy more generally, NHS Health Scotland hosts the *Choose Life* programme which – amongst other things – provides leadership and

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[100] Health Committee, *Suicide Prevention, Sixth report of Session 2016-17*, 7 March 2017, HC 1087, para. 80, p21
[101] MBRACE-UK, *Saving Lives, Improving Mothers' Care*, December 2015, pii
[102] NHS England, *Implementing the Five Year Forward View for Mental Health*, July 2016, pp12-15
[103] Scottish Government, *Suicide Prevention Strategy 2013-2016*, December 2013, pp9-13

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.[104]

The suicide prevention strategy is designed to work in coordination with other Government initiatives designed to tackle mental health issues, such as the Scottish Recovery Network, See Me Scotland, Breathing Space, and the Scottish Centre of Healthy Working Lives. In March 2017 the Scottish Government published a 10-year Mental Health Strategy which will work alongside the current suicide prevention Strategy and announced that a new strategy and action plan will be forthcoming in 2018.[105]

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".[106]

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 2015-20 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.[107]

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.[108]

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104 'National and local implementation', Choose Life website (accessed 28 November 2017)
105 Scottish Government, *Mental Health Strategy: 2017-2027*, March 2017, p28
106 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
107 Welsh Government, *Talk to me 2: Suicide and Self Harm Prevention Action Plan for Wales 2015-2020*, June 2015, pp9-10
108 *Ibid*., p13

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.[109]

Northern Ireland

The first suicide prevention Strategy, *Protect Life*, announced 62 actions, some of which related to health service provision specifically, including:

- Providing GP depression awareness training;
- Creating a deliberate self-harm registry;
- Enhancing crisis intervention services; and
- Encouraging the development of local suicide cluster emergency response plans.[110]

According to the proposed suicide prevention strategy for Northern Ireland, as drafted in 2016, £7 million per annum was then being invested by the Northern Ireland Department of Health for suicide prevention services, and during the period 2006/7 to 2015/6 £50 million had been invested by the same Department in order to implement the first Strategy, *Protect Life*.[111]

The draft 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.[112]

These are designed to work in coordination with recent mental health initiatives, such as the Regional Mental Health Care Pathway, *You in*

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[109] Welsh Government, *Together for Mental Health Delivery Plan: 2016-19*, September 2016, p5
[110] NIDHSSPS, *Protect Life: A Shared Vision*, June 2012, para. 1.3, p7
[111] NIDH, *Protect Life 2: A Draft Strategy for Suicide Prevention in the North of Ireland*, September 2016, pp40 and 76
[112] *Ibid*., pp65-73

Mind, which sets out the standards expected by all mental health and psychological therapy services in Northern Ireland.[113]

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).

[113] *Ibid*., p42

5. Education

This section briefly sets out the role of educational institutions in helping to prevent suicide in England. It also notes concerns that funding pressures could be leading some institutions to reduce the mental health services they offer.

The final part of the section outlines the role of education establishments in preventing suicide, as set out in the suicide prevention strategies in Scotland, Wales and Northern Ireland.

5.1 Schools

The Suicide Prevention Strategy for 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."[114] 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.[115]

The strategy adds that "appropriate training on suicide and self-harm should be available for staff working in schools and colleges".[116]

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."[117]

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).

Noting that interventions at a community level after a suicide can help prevent copycat and suicide clusters and ensure support is available, the

[114] HMG, *Preventing Suicide in England: A cross-government outcomes strategy to save lives*, September 2012, p6.
[115] *Ibid*., p22.
[116] *Ibid*., p17.
[117] *Ibid*.

strategy 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.[118]

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.[119]
- Funding the PSHE Association to produce guidance on teaching about mental health problems
- Providing funding to tackle homophobic, biphobic and transphobic bullying in schools.

More information on these is provided in the relevant sections below (and box 4 above).

The progress report additionally stated 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.[120]

Safeguarding in schools

The suicide prevention strategy notes that preventing suicide in children and young people is closely linked to safeguarding and the work of Local Safeguarding Children Boards.

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

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118 HMG, *Preventing Suicide in England: A cross-government outcomes strategy to save lives*, September 2012, p41.

119 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.

120 HMG, *Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives*, January 2017, p23

> 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.[121]

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.[122]

Further information on the safeguarding responsibilities of schools in England is set out in the Library Briefing, Safeguarding in English schools.

Identifying mental health issues

As well as outlining what schools should do in response to an immediate suicide concern, the parliamentary question 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.[123]

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.[124]

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.[125] Schools are not required to report centrally on the services they provide, but it has been estimated

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121 PQ 228146 [on Children: Suicide], 23 March 2015
122 DfE, *Keeping children safe in education: Statutory guidance for schools and colleges*, September 2016, p3
123 PQ 111153 [on Schools: Counselling], 7 November 2017.
124 DfE, *Mental health and behaviour in schools*, March 2016, p49
125 DfE, *Counselling in schools*, February 2016

that 70% of secondary schools and 52% of primary schools in England offer counselling services.[126]

Initiatives to improve mental health in schools

In a speech 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."[127] The Green Paper was published in December 2017.[128] It includes several proposals aimed at improving support for mental health in schools, including:

- Incentivising schools to identify and train a Designated Senior Lead for 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
- 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.

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.

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 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. However, the CQC said it is not always available, and in some cases there are concerns about the quality of support on offer.[129]

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. The 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

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126 Care Quality Commission, *Review of children and young people's mental health services; Phase one report*, October 2017, p23

127 'Prime Minister unveils plans to transform mental health support', Gov.uk, 9 January 2017

128 PQ 901024 [on Mental Health Services: Children], 10 October 2017

129 Care Quality Commission, *Review of children and young people's mental health services; Phase one report*, October 2017, pp23-24

15, and recommended that the Government should review the effect of budget reductions on in-school mental health services.[130]

In its response to the Report, the Government provided the results of a survey of mental health provision in schools showing, among other things, that 56% of primary maintained schools and 84% of maintained secondary schools offered counselling services. The response said 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."[131]

Bullying and mental health

The 2015 parliamentary question 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.[132]

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.[133]

Box 4: Social media and suicide

As noted in Section 8, 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.[134]

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.[135] 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."[136]

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130 Education and Health Committees, *Children and young people's mental health — the role of education*, HC 849, May 2017, p12

131 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

132 DfE, *Preventing and tackling bullying*, July 2017

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

134 HMG, *Preventing suicide in England: Two years on Second annual report on the cross-government outcomes strategy to save lives*, February 2015, p10

135 Education and Health Committees, *Children and young people's mental health — the role of education*, HC 849, May 2017, pp13-14

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, p8

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.[137] They also have an established common law duty of care to act reasonably to protect the health, safety and welfare of their students.[138]

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 parliamentary question 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 "each 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*."[139]

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
- 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.

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137 PQ 14451 [on Students: Suicide], 10 November 2015
138 See Universities UK, *Student mental wellbeing in higher education: Good practice guide*, February 2015, pp43-45, for more information.
139 PQ 109171 [on Universities: Mental Health Services], 31 October 2017

- Student Minds: a charity which carries out research and campaigns on mental health issues. It trains volunteers and supports student-led societies across campuses.
- Students Against Depression: a website offering advice, information, guidance and resources to those suffering from depression and suicidal thinking.

Guidance on supporting student mental health

In February 2015, Universities UK, the representative body of university vice chancellors, 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.
- Liaison between internal and external, voluntary and statutory agencies.

It notes that each institution is different and the use of the guidance will depend on the nature of the student cohort and the particular challenges the institution may face.[140]

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.[141] 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.[142]

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.[143]

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

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[140] Universities UK, *Student mental wellbeing in higher education: good practice guide*, February 2015, p5
[141] *Ibid*., p45
[142] *Ibid*.
[143] 'Mental Health in Higher Education', Universities UK (accessed 3 January 2018)

higher education are increasing and are high relative to other sections 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).[144]

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.[145]

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."[146]

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."

144 Institute for Public Policy Research, *Not by Degrees: Improving Student Mental Health in the UK's Universities*, September 2017
145 *Ibid*.
146 *Ibid*.

- 74% of those surveyed had referred students experiencing mental health crises to A&E in the last year.
- The AoC called for colleges and local mental health services to "develop better working relationships" and asked colleges to prioritise student wellbeing.[147] 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.[148]

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.[149]

5.3 Devolved nations

Scotland

In the Scottish Government's most recent suicide prevention strategy – Suicide Prevention Strategy 2013-2016 – the foreword noted that "building resilience and mental and emotional wellbeing in schools" was part of the "broader focus of activities not directly related to suicide prevention but which, if taken forward effectively, contributes to reducing the overall rate of suicide."[150]

It was expected that "a short series of pre-engagement events" would take place in autumn 2017 to "help inform the development of a new suicide prevention action plan."[151]

Information on the Scottish Government's approach to promoting mental health more generally is contained in the Mental Health Strategy 2017-2027. The 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

147 'Colleges forced to refer students with mental health issues directly to A&E', Association of Colleges, 7 February 2017
148 Department of Health and Department for Education, *Transforming Children and Young People's Mental Health Provision: a Green Paper*, December 2017, p34.
149 *Ibid*., p34.
150 Scottish Government, *Suicide Prevention 2013-2016*, December 2013, p1
151 'Reducing Suicide and Self Harm', Scottish Government website (accessed 31 October 2017)

and interventions at tiers 1 and 2 and to use specialist CAMHS expertise where it will be most effective."[152]

The 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.
- Rolling out improved mental health training for those who support young people in educational settings.[153]

The strategy 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.[154]

Wales

The Welsh Government's most recent 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.
- 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.
- 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.[155]

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[152] Scottish Government, *Mental Health Strategy: 2017-2027*, March 2017, p8
[153] *Ibid*., p4
[154] *Ibid*., p18
[155] Welsh Government, *Suicide and self harm prevention strategy for Wales 2015-2020*, June 2015, pp24-5

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.[156]

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.[157]

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*.[158]

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."[159]

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

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156 *Ibid*., p25

157 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)

158 NIDH, *Protect Life 2: A Draft Strategy for Suicide Prevention in the North of Ireland*, September 2016, pp94-105

159 *Ibid.*, p104

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."[160]

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.[161]

[160] *Ibid*., pp104-5
[161] *Ibid*., p46

6. Employment and social security

6.1 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.[162] The Department for Work and Pensions and the Department for Health 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.[163]

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".[164] This includes:

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

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

[163] PQ 6691 [on Unemployed People: Mental Health], 7 September 2017

[164] Department of Work and Pensions [DWP] and DH, *Improving Life: The Future of Work, Health and Disability*, Cm 9526, November 2017

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".[165] 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[166]

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
>
> 5. Promote effective people management
>
> 6. Routinely monitor employee mental health and wellbeing.[167]

6.2 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.[168]

Since 2012, the Department for Work and Pensions 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":

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165 'Prime Minister unveils plans to transform mental health support', Gov.uk, 6 January 2017

166 DWP and DH, *Thriving at Work: a review of mental health and employers*, October 2017, p23

167 *Ibid*., p8

168 Source: DWP Stat-Xplore

> 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.[169]

Following a ruling of the Information Tribunal[170], in May 2016 DWP published redacted copies of 49 Peer Reviews.[171]

6.3 Training and guidance for DWP staff

The Department for Work and Pensions 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 nor collate records of how many such referrals are made.[172]

The Department states that it provides "substantial and specific instructions to staff on how to support vulnerable people throughout their benefit journey."[173] 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.[174] A "six point plan" 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 Department'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 on 17 November in response to a Freedom of Information request.[175]

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.

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

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

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

172 PQ 67873 [on Unemployed People: Mental Health], 20 March 2017; PQ 71177 [on Unemployed People: Mental Health], 25 April 2017

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

174 PQ 53958 [on Department for Work and Pensions: Staff], 24 November 2016

175 DWP ref: FoI 4521 – available at the *whatdotheyknow.com website*

In response to Parliamentary Questions in 2016, DWP said that it had no intention to publish the internal guidance on safeguards "as it is for Departmental use only."[176] The Royal Greenwich Welfare Rights Service has produced a detailed Benefit Safeguards Briefing[177] 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.

6.4 ESA and PIP assessments

The Department for Work and Pensions 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 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* [178] 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.[179] Revised

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[176] See PQs 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

[177] Available on the *Rightsnet website*, last updated October 2017

[178] SI 2008/794, as amended

[179] MED-ESAAR2011/2012HB~001, revised 1 August 2017

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.[180]

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 response to a parliamentary question 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 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.[181]

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

Work and Pensions Committee inquiry

On 27 September 2017 the Work and Pensions Committee launched an inquiry looking at the effectiveness of assessment processes used to determine eligibility for PIP and ESA.[182] The deadline for written submissions was 10 November.

On 27 November *The Guardian* reported that the Committee had been "deluged by people sharing stories about being denied disability benefits or battles to keep their entitlements."[183] It quoted the

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180 *Ibid*., para. 3.8.2.1
181 PQ 193 [on Social Security Benefits: Mental Illness], 27 June 2017
182 See: 'PIP and ESA Assessments inquiry', Work and Pensions Committee website (accessed 3 January 2018)
183 'Inquiry into disability benefits 'deluged' by tales of despair', *The Guardian*, 27 November 2017

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 issues 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.
- 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.
- Then 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, had 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 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.[184]

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 finds that assessments can be "traumatising and anxiety-inducing" for the following reasons:[185]

- "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.
- Delays in Mandatory Reconsideration and appeals mean that claimants may have to wait many months for the correct result.

The report concludes that the current PIP and ESA assessment procedures "inherently discriminate against people with mental illnesses." It sets out a number of policy recommendations to "dramatically improve the benefits system for people with mental illnesses." These include (original emphasis):

- **A major reform of the PIP assessment and the WCA is needed.** This should result in both assessments reducing the distress caused to people affected by mental illness and that better reflect the realities of living with a condition of this type. Such reform would reduce the need for appeals and the associated costs to the DWP and HM Courts & Tribunals Service (HMCTS).

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184 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

185 Rethink Mental Illness, *'It's broken her': Assessments for disability benefits and mental health*, December 2017, p7

- **The Government should review the way in which people with mental illness are assessed.** Where clear medical evidence exists that claimants have severe forms of mental illness, they should be exempt from face-to-face assessments. Where face-to-face assessments are necessary, claimants should be encouraged to seek support from carers, friends or family members.
- **All assessors and DWP decision makers should be appropriately trained in mental health.** The scandal of inappropriately trained and experienced assessors making critical decisions about the lives of people affected by mental illness must end.[186]

[186] *Ibid*., p18

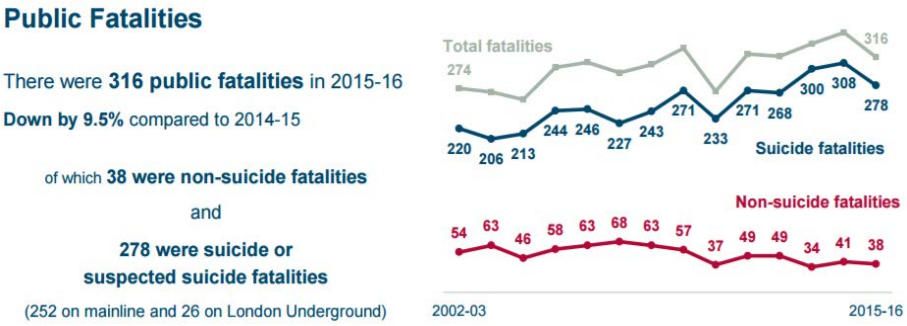
7. Railways

7.1 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.[187]

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.[188]



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.[189] 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.[190]

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187 British Transport Police Authority, *Strategic Plan 2013-2019*, September 2013
188 Samaritans, *Suicide statistics report 2017*, p28
189 Transport Committee, *Rail safety: written evidence submitted by the British Transport Police*, October 2016, para 8.4
190 BTP, *Policing your journey: Annual Report 2015/16*, August 2016, p18

7.2 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.[191]

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.[192]

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.

7.3 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".[193]

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

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191 *Ibid*., p2

192 Transport Committee, *Rail safety 2016-17*, 6 March 2017, HC 694 Q58 [Ruth Sutherland]

193 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.[194]

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.[195]

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

[195] *Ibid*., pp27-8

8. Prisons

8.1 Statistics

The Ministry of Justice (MoJ) publishes a quarterly report on safety in custody statistics for England and Wales. The most recent update, published on 26 October 2017, found that in the 12 months to September 2017 there were:

- 300 deaths in prison custody (a rate of 3.5 deaths per 1,000 prisoners), a decrease of 24 (7%) compared to the same period of the previous year;
- 77 apparent self-inflicted deaths (a rate of 0.9 per 1,000 prisoners) down 30% from 110 in the previous 12 month period;
- 190 deaths due to natural causes, an increase of 4 from the previous year;
- 3 apparent homicides, down from 5; and
- 30 other deaths, 25 of which are "awaiting further information" prior to being classified.[196]

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.[197]

Self-harm

In addition, the following self-harm figures were recorded in the 12 months to June 2017:

- 41,103 reported incidents of self-harm, an increase of 12% from the previous year representing a record high level;
- There was a rate of 482 self-harm incidents per 1,000 prisoners;
- 10,994 prisoners self-harmed, up 4% from the previous year;
- 2,833 hospital attendances, up 9% from the previous year.
- However, the proportion of self-harm incidents requiring hospital attendance has remained generally consistent in recent years at around 7%.[198]

8.2 Prison service policy

HM Prisons & Probations Service issue rules, regulations and guidelines for prisons in England and Wales via Prison Service Instructions (PSIs) and Prison Service Orders (PSOs). The PSI into 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:

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196 Ministry of Justice [MoJ] and National Statistics bulletin, *Safety in Custody Statistics Bulletin England and Wales: Deaths in prison custody to September 2017; Assaults and Self-harm to June 2017*, 26 October 2017

197 MoJ and National Statistics, *Deaths in prison custody 1978 to 2016*, 27 July 2017

198 *Ibid*.

- 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
- Having in place a learning strategy to improve local delivery of safer custody and prevent/reduce future incidents of self-harm.[199]

8.3 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.[200] 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 committing suicide were found to have had mental health needs, according to the Prisons and Probation Ombudsman.[201]

8.4 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.[202]

On its web page summarising the report, the NAO argued that the "Government needs to address the rising rates of suicide and self-harm in prisons as a matter of urgency".[203] It highlighted the lack of data on how many people in prison have mental health problems, and recommended that Her Majesty's Prisons and Probations Service, NHS England and Public Health England need to collect better data to understand how they are meeting their objectives.

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199 MoJ, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, PSI 64/2011, 13 September 2013

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

201 Prisons and Probation Ombudsman, *Learning from PPO investigations: Prisoner mental health*, January 2016, p12

202 National Audit Office, *Mental health in prisons*, 29 June 2017

203 *Ibid*.

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.[204]

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".[205] 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 2015-16 annual report, the Prisons and Probation Ombudsman commented on the rise in self-inflicted deaths in prisons, calling the rise of self-inflicted deaths "shocking":

> My tenure has coincided with a difficult period for prisons and probation. One consequence of this has been that demand for independent investigation of deaths and complaints remains unremittingly high. Over the past year, deaths in custody have risen sharply, with a shocking 34% rise in self-inflicted deaths, steadily rising numbers of deaths from natural causes and the highest number of homicides since my office was established. The number of complaints from prisoners also remains very high.

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[204] National Audit Office, *Mental health in prisons*, 29 June 2017, Key Finding 12
[205] Howard League for Penal Reform, *2016 becomes worst year ever recorded for suicides in prisons*, 28 November 2016

> […] Unfortunately, I have been saying many of the same things for much of my time in office. While resources and staffing in prisons are undeniably stretched, it is disappointing how often – after invariably accepting my recommendation – prisons struggle to sustain the improvement I call for. Improving safety and fairness is less about identifying new learning and more about implementing the learning already available. Ensuring real and lasting improvement in safety and fairness needs to be a focus of the new prison reform agenda.[206]

Joint Committee on Human Rights (JCHR)

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, JCHR made legislative recommendations "to address the shocking rise in self-harm and suicide in prisons".[207] 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 levels[208]

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206 Prisons and Probation Ombudsman, *Annual report 2015-16*, Cm 9329, September 2016, p7

207 Joint Committee on Human Rights, *Government must address crisis of self-inflicted deaths in prisons*, 2 May 2017

208 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

8.5 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.[209] The white paper acknowledged the recent increase in self-inflicted deaths and self-harm incidents:

> 170. Prison safety has declined since 2012. Levels of total assaults across the prison estate and assaults on staff are the highest on record, and are continuing to rise. Comparing the 12 months to June 2016 with the calendar year 2012:
>
> 1. total assaults in prisons increased by 64%;
>
> 2. assaults on staff rose by 99%; and
>
> 3. the number of self-harm incidents increased by 57%.
>
> 171. In the 12 months to September 2016, there were 107 self-inflicted deaths in custody, a 75% increase on the 61 self-inflicted deaths during 2012. [210]

The white paper gave an explanation of the increase in violence, self-harm and self-inflicted death. It highlighted 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.[211] In addition, it also acknowledged that more frontline staff were needed to address prison safety.

The white paper set out a series of reform proposals, some requiring legislation. For more detail on the white paper, see the Commons Library briefing Prison Reform: Recent Developments.

Additional funding and increase in prison officers

At the 2016 Conservative Party Conference, the then newly appointed Justice Secretary, Liz Truss, announced an additional £14 million to recruit 400 prison officers.[212] 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".[213] 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.[214]

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209 MoJ, *Prison Safety and Reform*, Cm 9350, November 2016
210 *Ibid.*, p40
211 *Ibid*.
212 Conservative Party, *Truss: Prisons: Places of Safety and Reform*, 4 October 2016
213 Autumn Statement 2016: Philip Hammond's speech
214 HM Treasury, *Policy paper: Autumn Statement 2016*, 23 November 2016, section 6.3

Mental health training for prison staff

Answering a parliamentary question which asked about suicide of prisoners in 2017, Sam Gyimah, Under Secretary of State for Prisons and Probation, said:

> Every death in custody is a tragedy and we are redoubling our efforts to make prisons places of safety for those at risk. We have put in place a range of measures to support prisoners who are at risk of self-harm or suicide, especially in the first 24 hours when they are at their most vulnerable. We are also 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.[215]

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.[216]

8.6 Devolved administrations

Scotland

In 2017, there were 27 deaths in custody in Scottish prisons.[217]

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".[218] The new strategy, *Talk to Me*, was published in November 2015 and came into effect on 5 December 2015.[219] 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.[220]

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.[221] 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

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215 PQ 9658 [on Prisoners: Suicide], 13 September 2017
216 PQ 8540 [on Prisoners: Mental Illness], 11 September 2017
217 'Prisoner Deaths: Deaths in Prison Custody 2017', Scottish Prison Service (accessed 27 November 2017)
218 Scottish Prison Service, *Talk to Me: Prevention of suicide in prison strategy 2016-2021*, November 2015
219 'Talk to me' Strategy', Scottish Prison Service, (accessed 27 November 2017)
220 'Sugden: almost half of NI's prisoners have addictions', *BBC News*, 21 November 2016
221 Criminal Justice Inspection Northern Ireland, *An unannounced visit to review the progress against the 2015 recommendations*, 22 August 2017

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".[222]

[222] *Ibid*.

9. Media

9.1 Reporting of suicide

A significant body of evidence has established that certain ways in which the media reports suicides can provoke suicidal behaviours.[223] The risk has been noted to increase when the media story describes the suicide method explicitly, uses a graphic or dramatic headline or image, and repeatedly or extensively sensationalises a death.[224] Responsible media reporting on suicides is recognised worldwide as a public health approach to improve suicide prevention.[225]

Independent Press Standards Organisation (IPSO)

IPSO is the independent regulator for the newspaper and magazine industry in the UK. IPSO's Editors' Code of Practice is a set of rules that media organisations regulated by IPSO have agreed to follow. Initially in 2006 (and extended in 2016), the Code was amended to include a clause on the reporting of suicide:[226]

> **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.[227]

Since September 2014, IPSO said it had upheld only one complaint and resolved three between publication and complainant on the reporting of suicide.[228]

Government action

One of the key areas of the Government's Suicide Prevention Strategy for England is to support the media "in delivering sensitive approaches to suicide and suicidal behaviour" by:

- 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.

Local responsibility for the coordination and implementation of the strategy is the responsibility of local authorities, supported by public

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223 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), which found that the majority of studies support an association between media reporting and suicidality. Only four studies in the systematic review found no significant associations and these were all conducted prior to 1990.

224 'Recommendations for reporting on suicide', Reporting on Suicide (accessed 16 October 2017)

225 The World Health Organisation published a guide in 2000 for media professionals; other similar guides have been published for example by the Suicide Prevention Resource Center (USA) and

226 IPSO Blog, '*How the UK press takes reporting of suicide seriously*', 27 April 2017

227 'Editors' Code of Practice', IPSO (accessed 16 October 2017)

228 IPSO Blog, '*How the UK press takes reporting of suicide seriously*', 27 April 2017

guidance issued by Public Health England.[229] On its national media aims, the Government said it planned to achieve these by working with the charity Samaritans, who already have an established role in monitoring media coverage of suicide.[230]

The third annual progress report of the Strategy focused on the work that Samaritans was undertaking, including:

- Samaritans work with the Independent Press Standards Organisation in implementing responsible reporting of suicide (see below);
- Samaritans work with Google UK which means Samaritan contact numbers appear above Google search results on suicide and self-harm.[231]

Health Committee inquiry into suicide prevention

In its report on suicide prevention, the Health Committee criticised the lack of accountability in the Government's aim to promote responsible media reporting.[232] Public Health England told the Committee that it was not part of their role to counter irresponsible reporting, and they did not know whose role it was.[233] The Committee recommended that there needed to be 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".[234]

The Committee also recommended a change in regulation, including altering the IPSO Editors' Code of Practice so the term "excessive detail" became "unnecessary detail", and a strengthening of the Ofcom Broadcasting Code.[235]

In response, the Government said it was "committed to a free and open press" and would not interfere with what the press chooses to publish, adding:

> 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

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229 HMG, *Preventing suicide in England: a cross-government outcomes strategy to save lives*, 10 September 2012, p11
230 Samaritans, Media guidelines for the reporting of suicide June 2017
231 HMG, *Preventing suicide in England: Third Progress report of the cross-government outcomes strategy to save lives*, January 2017, p31
232 Health Committee, *Suicide prevention, Sixth Report of Session 2016-17*, 7 March 2017, HC 1087, chapter 7
233 *Ibid*., para. 120
234 *Ibid*., para.124
235 *Ibid*., paras 128-133

> reporting. Our stakeholders continue to look at ways in which they can work proactively with the media to improve this.[236]

Addressing the Health Committee's recommendations to change the IPSO Editors' Code and the Ofcom Broadcasting Code, the Government said that this was a matter for each institution and was not the responsibility of Government to determine.[237]

9.2 The internet and social media

The legal framework

In 2008, the report of the Byron Review, an independent review into the risks of children online, recommended that the application of the law to the encouragement of suicide should be clarified.[238] The *Coroners and Justice Act 2009*, which came into force on 1 February 2010, 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.[239]

Under section 2(1) of the *Suicide Act 1961* (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 of 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.[240]

The impact of the internet and social media

In the second annual progress report of the Government's Suicide Prevention Strategy for England, the Government stated that, despite concern over the impact of the internet on suicidal behaviours, the evidence was mixed:

> 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

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236 DH, *Government response to the Health Select Committee's inquiry into suicide prevention*, Cm 9466, July 2017, p27
237 *Ibid*., p30
238 Byron Review, *Safer children in a digital world: the Report of the Byron Review*, March 2008, para. 15
239 MoJ, *Encouraging or assisting suicide: implementation of section 59 of the Coroners and Justice Act 2009*, Circular 2010/03, 28 January 2010
240 Crown Prosecution Service, *Policy for prosecutors in respect of cases of encouraging or assisting suicide*, February 2010 (updated October 2014), para. 20

A global review of existing studies found that there were contradictory findings on whether the internet exerted a positive or negative influence. Internet forums were found by some studies to support and connect socially isolated young people, whereas other studies found that those who sought out information about self-harm and suicide were exposed to violent imagery and were more likely to act out what they had encountered online.[241]

The Internet Safety Strategy

In February 2017, the Government announced a "major new drive" on internet safety, with the aim of "ensuring the UK becomes the safest place in the world for young people to go online". A green paper, published on 11 October 2017, seeks views on the Government's plans. The strategy is part of the Government's wider Digital Charter, proposals for which were set out in the Queen's Speech.[242]

A key part of the Government's plan is the issuing of the voluntary code of practice to social media platforms, required by section 103 of the *Digital Economy Act 2017*. The green paper is consulting on whether guidance should be issued on a broader range than originally conceived.

A report was commissioned as part of the strategy to provide "up to date evidence of how young people are using the internet, the dangers they face, and the gaps that exist in keeping them safe".[243] On self-harm and suicide, the study found that:

- According to a 2011 survey, 7% of children have seen sites relating to self-harm and 5% have seen sites relating to suicides;
- Seeing negative user-generated content, such as those related to self-harm or suicide, is the third most common risk online for children aged 11-16;
- Some of the primary causes of 'suicidal ideation' are cyberbullying, grooming and online abuse, and emotional and behavioural difficulties; and
- 13 of 22 individuals who had survived 'near fatal' suicide attempts' interviewed in a 2012 study reported using the internet for information.[244]

Websites that promote or encourage suicide or self-harm

On 4 July 2017, the Department of Health was asked what plans it had "to restrict access to websites that promote or encourage suicide or self-harm". It replied:

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241 K. Daine et al, *The Power of the Web: A systematic review of studies of the influence of the internet on self-harm and suicide among young people*, 20 October 2013

242 Prime Minister's Office, Queen's Speech Background Briefing, 21 June 2017 (Digital Charter p59-61)

243 'Government launches major new drive on internet safety', Department for Digital, Culture, Media & Sport on Gov.uk, 27 February 2017

244 S Livingstone et al, *Children's online activities, risks and safety: a literature review by the UKCCIS Evidence Group*, October 2017, section 11.4

> The Department does not hold information on the number of websites promoting, encouraging or selling products that assist suicide and self-harm.
>
> People or organisations that provide information or sell products online must operate within the law. It is illegal to assist a suicide. The law does not differentiate between criminal offences committed online or anywhere else; it is the action that is illegal.
>
> The Government works with the online sector and other stakeholders to address issues of safety online and the impact of potentially harmful content.
>
> We expect websites including social media companies to respond quickly to reports of harmful content and abusive behaviour on their networks. This includes having easy to use reporting tools, robust processes in place to respond promptly when issues are reported, and suspending or terminating the accounts of those who do not comply with acceptable use policies.[245]

9.3 Devolved administrations

Scotland

The Scottish Government committed to encouraging sensitive reporting of suicide online and in social media in its suicide prevention strategy, *Suicide Prevention Strategy 2013-16*:

> "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.

Wales

Similarly, the Welsh Government has included an objective to encouraging sensitive and responsible reporting in its suicide prevention plan, *Talk to me 2*:

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

Northern Ireland

Protect Life 2, Northern Ireland's draft strategy for its new suicide prevention plan, currently suggests that Objective 8 will be "Enhance responsible media reporting on suicide":

> Appropriate media reporting of suicide can make a positive contribution to public understanding of suicide, and to the promotion of help-seeking behaviour and suicide prevention. Inappropriate media reporting causes considerable stress and trauma to those bereaved by suicide and can lead to 'copycat' behaviour, especially among young people and those already at risk.

The NI Department of Health has analysed consultation responses, and published a report in February 2017; the next stage would be an amended report and executive approval.[246]

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245 PQ 2872 [on Suicide: Internet] 12 July 2017

246 NIDH, *Protect Life 2: a draft strategy for suicide prevention in the north of Ireland – consultation analysis report*, February 2017, para 14.1-2

10. Armed forces

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

The suicide rate among males aged 16-59 years in the UK general population in 2015 (latest data available) was 19 per 100,000 compared to a UK Armed Forces rate of 4 per 100,000 in 2016. Analysis of the twenty year period between 1997 and 2016 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 having the highest rate (10 per 100,000) and the RAF the lowest (6 per 100,000).
- There were 325 suicides and open verdicts among UK regular armed forces personnel: 308 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 five-year period, there was no significant difference in suicides among young Army males compared to males of the same age in the UK general population.[247]

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.[248] Suicide and self-harm is one of the four core areas of the Mental Health Steering Group.[249]

The Defence Committee announced a new inquiry on armed forces and veterans mental health in January 2018.

10.1 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.[250]

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.

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247 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 2016*, 30 March 2016

248 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)

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

250 Further information on mental health support given to Veterans can be found in Library briefing paper *Support for UK Veterans*, CBP07693, section 4

10.2 The numbers

The Strategy states that the armed forces has 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.[251]

10.3 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).[252] 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 establishing a Veterans' Board to address the specific needs of veterans.[253]

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."[254]

When asked specifically about the rate of suicide among personnel who have seen active service in Afghanistan and Iraq, the Ministry of Defence 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.[255]

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251 '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

252 '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

253 HC Deb 10 July 2017 c6

254 PQ347 [on Veterans: Suicide], 30 June 2017

255 HL3467 [on Armed Forces: Suicide], 30 November 2016

11. Coroners' conclusions

Box 6: Standard of proof required for a coroner's conclusion of suicide

The standard of proof required in England and Wales for the short form conclusions of "unlawful killing" and "suicide" is the criminal standard of proof - "beyond reasonable doubt". For all other short-form conclusions the standard of proof is the civil standard of proof -"on the balance of probabilities".
Therefore, in order to return a conclusion of suicide, the coroner (or jury) must be certain that the deceased intended their own death, and that they did an act with that intention which caused their death.
There is a considerable body of case law on the required standard of proof for a coroner's conclusion of suicide.
There have been calls for the Government to lower the standard of proof to the balance of probabilities rather than beyond reasonable doubt. Proponents for lowering the standard of proof suggest this will improve the quality of data on suicides.
The Commons Library briefing paper 03981, *Coroners' investigations and inquests*, provides information about coroners and their work.

11.1 Coroners' investigations and inquests

Part 1 of the *Coroners and Justice Act 2009* 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.[256]

Section 5 sets out the matters to be ascertained by the coroner as being:

- 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.

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.[257] 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.

The Coroners and Justice Act 2009 and the 2013 Coroner Rules and Regulations no longer use the word 'verdict' for the finding at the end of an inquest. The word 'conclusion', rather than verdict, is now used. In essence the conclusion sets out "how the deceased came by his or her death".

[256] *Coroners and Justice Act 2009*, section 1
[257] *Coroners and Justice Act 2009*, section 10

Conclusions of a coroners' inquest can be short-form or narrative.[258] It is for the coroner to decide whether a short-form or a narrative conclusion 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 Schedule to the Coroners (Inquests) Rules 2013 includes Form 2 which the coroner (or jury if there is one) must use to record the determination and any findings required under **section 10.**[259] The notes to Form 2 list the short form conclusions.

In 2016, 91% of inquests received a short-form conclusion, and the remaining 9% were narrative conclusions.[260]

11.2 Chief Coroner guidance on conclusions

The Chief Coroner has published guidance, Conclusions: short-form and narrative.[261] Paragraph 56 deals with the standard of proof at inquests generally. It refers to Note (iii) to Form 2 which is as follows:

> 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.

A footnote notes 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".[262]

The Chief Coroner advises that, wherever possible, coroners should conclude with a short-form conclusion adding:

> This has the advantage of being simple, accessible for bereaved families and public alike, and also clear for statistical purposes.[263]

Paragraphs 60 to 63 deal specifically with the suicide conclusion. The Chief Coroner makes three points, encouraging coroners not to avoid a conclusion of suicide where appropriate:

> 61. First, the conclusion of suicide should not be avoided by coroners simply out of sympathy for family relatives or for any other reason. Parliament has decided that suicide should remain as a short-form conclusion. The word 'suicide' is expressly used in the Rules: see Note (i), Form 2, Schedule, Coroners (Inquests) Rules 2013. It is therefore the coroner's judicial duty, when suicide is proved on the evidence, to record the conclusion of suicide according to the law and the findings which justify it. It would be wrong, for example, to record an 'open' conclusion when the evidence is clear.[264]

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258 Coroners (Inquests) Rules 2013, SI 2013/1616, Schedule, Form 2
259 *Ibid*.
260 Office for National Statistics, *Suicides in Great Britain: 2016 registrations*, 7 September 2017
261 Chief Coroner, *Guidance No.17: Conclusions: Short-form and narrative*, 30 January 2015
262 *Ibid*., p11, footnote 44
263 *Ibid*., para. 26
264 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)"

> 62. Secondly, coroners should make express reference in each case of possible suicide to the two elements which need to be proved: (i) [the deceased] took his/her own life; and (ii) [the deceased] intended to do so (or, put together, 'he/she intentionally took his/her own life'). Both elements must be proved to the criminal standard of proof.[265] Suicide must never be presumed.[266] Where suicide is not found the coroner should explain why, for example:
>
> > 'Looking at the two elements which must be proved to the higher standard of proof before a conclusion of suicide can be recorded, I am satisfied that [the deceased] took his own life, but I am not satisfied that he intended to do so. I cannot be sure about it. It is in my judgment more likely than not that he had that intention, but on the evidence looked at as a whole I cannot rule out that this was a terrible accident. For those reasons my conclusion is not suicide or accident but an open conclusion.'
>
> Or as Pill LJ concluded in Hopper:[267]
>
> > 'The facts and circumstances in this case did not, in my judgment, point irresistibly to the existence of a suicidal intent. The possibility that the discharge of the gun was accidental could not be excluded as a reasonable possibility.'
>
> 63. Thirdly, coroners may wish to alleviate the impact of the conclusion of suicide where proved with a form of words such as:
>
> > 'Those findings of fact lead me therefore to the following inevitable conclusion. I am satisfied to the relevant standard of proof that [the deceased] took his own life and intended to do so. For the purposes of the law I must therefore record the formal conclusion as suicide.'
>
> There is usually no longer any need to add the words 'whilst the balance of his mind was disturbed'.

11.3 Case law and the rationale for the standard of proof

A body of case law has built up on 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."
>
> […]

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265 Footnote to text: "See R (Lagos) v HM Coroner for City of London [2013] EWHC 423 (Admin)"

266 Footnote to text; "R v City of London Coroner, ex parte Barber [1975] 1 WLR 1310"

267 Footnote to text: "R v Essex Coroner ex parte Hopper ILR 23 May 1988"

> 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.[268]

A textbook on coroners (Jervis on Coroners) sets out this information about the requirement for the criminal standard of proof:

> 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 probabilities* that it was suicide, but is not satisfied *beyond reasonable doubt*, the conclusion must be an open one…[269]

Another textbook on coroners includes further information about the standard of proof for a suicide conclusion:

> 17.45 Until the Suicide Act 1961, suicide or 'felo de se' (self-murder) was a crime at common law. Although the person who commits or attempts to commit suicide is no longer subject to the sanctions of the criminal law, suicide continues to constitute a crime when a person enters into a suicide pact, or aids and abets the suicide of another person. The original punishment for suicide included the forfeiture of property. Today, a conclusion of suicide has implications for a person's life insurance. The social and religious prohibitions on self-harm mean that suicide continues to embody a significant stigma and adds a degree of turmoil to the grief of the family of the deceased.[270]
>
> 17.46 It is for this reason that the courts have maintained the high criminal standard of proof in relation to suicide conclusions – it has been emphasised on several occasions that the strict evidential requirements of the pre-1961 law relating to suicide should still be binding. In *R v City of London Coroner ex p Barber,* [[1975] 1 WLR 1310] Lord Widgery emphasised that 'the possibility of suicide may be there for all to see, but it must not be presumed merely because it seems on the face of it to be such a likely explanation'. [*R v City of London Coroner ex p Barber,* [1975] 1 WLR 1310 at 1313] Therefore, suicide cannot be presumed...Such a serious finding can be made only on the basis of absolutely clear and compelling evidence...[271]

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

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

270 Footnote to text: "For the broader legal and moral issues pertaining to suicide see Georges Minois, *History of suicide: voluntary death in western culture*, 1995

271 Leslie Thomas, Adam Straw, Daniel Machover and Danny Friedman QC, *Inquests A Practitioner's Guide*, 2014, p319

11.4 Impact on statistics

The Office for National Statistics (ONS) definition of suicide is as follows:

> …all deaths from intentional self-harm for persons aged 10 and over, and deaths where the intent was undetermined for those aged 15 and over. This definition was revised in January 2016 and further information on the impact can be found in the 2014 suicide registrations bulletin.
>
> Deaths from an event of undetermined intent in 10 to 14 year-olds are not included because although for older teenagers and adults we assume that in these deaths the harm was self-inflicted, for younger children it is not clear whether this assumption is appropriate. Deaths from an event of undetermined intent cannot be applied to children due to the possibility that these deaths were caused by unverifiable accidents, neglect or abuse.[272]

The 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 2016, 52.8% of narrative conclusions were coded as resulting from an external cause of death (as opposed to a disease).[273]

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.[274]

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.[275]

11.5 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.[276]

In its interim report published in December 2016, the Committee recommended that the standard of proof for conclusions of death by

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272 Office for National Statistics, *Statistical bulletin: suicides in Great Britain: 2016 registrations*, 7 September 2017
273 *Ibid*., section 8: 'Narrative conclusions in England and Wales'
274 *Ibid*.
275 'Thousands of suicides hidden to comfort grief-stricken families', *The Times*, 6 January 2017 (subscription required – accessed 12 October 2017)
276 Health Committee, *Suicide prevention: interim report, Fourth Report of Session 2016-17*, 13 December 2016, HC 1087, para. 28

suicide should be changed to the civil standard of proof, rather than the criminal standard of proof.[277]

In its full report, published in March 2017, the Committee repeated its recommendation about the change in the standard of proof.[278] 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.[279]

The Committee recommended that improvements were needed in the way narrative conclusions are recorded by coroners to improve data accuracy for suicides.[280]

In its response to the Committee's report, the Government said that it was considering whether the standard of proof should be lowered.[281]

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.[282] Norman Lamb MP, a patron of PAPYRUS, tabled an Early Day Motion on 8 February 2017 which had 12 signatures:

> 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.[283]

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277 *Ibid.*, para. 31
278 Health Committee, *Suicide prevention, Sixth Report of Session 2016-17*, 7 March 2017, HC 1087, para 151
279 *Ibid.*, para. 155
280 *Ibid.*, paras 161-164
281 DH, *Government response to the Health Select Committee's inquiry into suicide prevention*, Cm 9466, July 2017
282 'Campaign to change the law', PAPYRUS (accessed 12 October 2017)
283 Early day motion 930 of 2016-17

11.6 Devolved nations

Scotland

Unlike England, Wales, and Northern Ireland, there is no system of coroners' inquest in Scotland. The Lord Advocate is responsible for investigating any death in Scotland which requires further explanation, such as accidental, unexpected, sudden or suspicious deaths. Procurators Fiscal, a type of lawyer, act on the instructions of the Lord Advocate.[284] Similar to a coroner, the Fiscal is responsible for determining whether further investigation is needed.

The National Records of Scotland (NRS) classify deaths as a probable suicide if the underlying cause was classified as "intentional self-harm" or "event of undetermined intent". The NRS explains:

> The figures will therefore be higher than would be the case if (say) one counted only those deaths which had been confirmed as suicide following the completion of the relevant legal processes.[285]

Essentially, NRS does not wait until a Procurator Fiscal investigation has necessarily concluded, but will change the classification of a particular death as more information becomes available. However, it cannot be changed once NRS 'freezes' its data for the calendar year.[286] In effect this means Scotland has more deaths coded as probable suicides compared to the rest of the UK.

Northern Ireland

As in England and Wales, deaths which are sudden, violent or unnatural are referred to the coroner. Unlike in England and Wales, however, inquests are discretionary rather than mandatory, and the standard of proof applied at a coroner's inquest in Northern Ireland is the civil standard – on the balance of probabilities.[287]

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284 'Our role in investigating deaths', Crown Office & Procurator Fiscal Service (accessed 27 November 2017)

285 'How NRS classifies deaths for statistical purposes as (probable) suicides', National Records of Scotland (accessed 27 November 2017)

286 *Ibid*.

287 See, for example, *Before the Coroner for Northern Ireland Mr Joseph McCrisken: The Inquest touching upon the death of Mr Bernard Watt*, 27 April 2017, para 11

BRIEFING PAPER

Number CBP 08221

5 February 2018

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