HOUSE OF COMMONS LIBRARY

BRIEFING PAPER

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Suicide Prevention: Policy and Strategy

By Andrew Mackley

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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 cross-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 2016 it has included a commitment to reduce the rate of suicides in England by 10% by 2020/21, which the Government will measure against the rate of registered suicides in 2015.

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 the transport, social security, education, defence, media, and justice policy briefs.

Suicide rates

Section one of this briefing paper provides a statistical overview of suicide rates throughout the UK over time, using the latest data published by the Office of National Statistics in September 2019. This shows that in 2018 there were 6,507 recorded suicides in the United Kingdom. This number of deaths equates to an age-standardised suicide rate of 11.2 deaths per 100,000 population, which is a significant increase on previous years and the highest rate recorded since 2002. It is also, nevertheless, lower than rates recorded in the 1980s and 1990s.

National suicide prevention strategy

Section two provides an overview of suicide prevention policies and strategies in the UK, as well as their various updates; the latest of which from the UK Government is the Fourth Progress Report and Workplan for its Suicide Prevention Strategy for England, both published in January 2019.

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.

Since October 2018, there has been a designated Minister for Suicide Prevention in the Department of Health and Social Care who is responsible for leading "a national effort on suicide prevention".

Suicide prevention in different policy areas

Given the cross-Government nature of the UK Government's Strategy, which is also, to varying degrees, a feature of strategies developed by the devolved administrations, this briefing paper considers 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 and mental health support in the NHS Long Term Plan (published in January 2019) and other NHS England reports. It also covers local suicide prevention plans, and NHS support for high risk groups;
- **Education** – setting out suicide prevention measures taken by educational institutions, including schools and the mental health services they provide, as well as further and higher education institutions which have a legal duty under the *Equality Act 2010* to support their students, including those with mental illness conditions;
- **Employment** – outlining policies designed to keep people who suffer from mental health problems in work, including implementation of a Government strategy for support for people with health conditions in the workplace called 'Improving Lives', as well as a recent consultation on proposals to reduce ill health-related job loss;
- **Social security** – outlining support for benefit claimants with mental health problems, training and guidance for DWP staff, the risks in ESA and PIP assessments, and concerns expressed recently that people with mental health conditions may face certain difficulties or problems when navigating the new Universal Credit system;
- **Transport** – detailing suicide prevention measures for railways and roads undertaken by the British Transport Police (BTP) and the Department of Transport, as well as suicide prevention strategies developed by Samaritans, BTP, Network Rail, Highways England, and other parts of the transport sector;
- **Prisons** – outlining current prison service policy and health services for prisoners, Government policy to prevent suicide in prisons, as well as concerns about the levels of self-harm and suicides in prisons, and a recent Health and Social Care Committee report on the health of prisoners;
- **Media** – outlining issues connected to the reporting of suicide, as well as the role of the internet and social media;
- **Armed forces** – providing information on suicide in the UK regular armed forces, the new Ministry of Defence Mental Health and Wellbeing Strategy (launched in July 2017), concerns around suicide among veterans, as well as a recent Defence Committee inquiry into mental health in the armed forces; and
- **Coroners' conclusions** – explaining that until recently it was considered that the high criminal standard of proof was necessary for a coroner's conclusion of suicide – namely "beyond all reasonable doubt". In July 2018, however, the High Court held that cases decided previously did not state the law correctly, and that the lower civil standard of proof – "on the balance of probabilities" – applies for suicide conclusions. The Court of Appeal has upheld this decision; it is understood that permission to appeal to the Supreme Court has been granted.

Suicide prevention in the devolved nations

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

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

- **Scottish Government** – *Suicide Prevention Action Plan: Every Life Matters*, August 2018;
- **Welsh Government** – *Talk to me 2: Suicide and Self Harm Prevention Strategy for Wales 2015-2020*, June 2015; and
- **Northern Ireland Department of Health** – *Protect Life 2: Strategy for Preventing Suicide and Self Harm in Northern Ireland 2019-2024*, September 2019.

Further general reading

- House of Lords Library briefing LLN-2019-0124, *Suicide in the UK: Statistics and Prevention Strategies*, 1 October 2019
- Commons Library briefing CBP-8593, *Support for students with mental health issues in higher education in England*, 21 August 2019
- Commons Library briefing CBP-7196, *Children and young people's mental health – policy, CAMHS services, funding and education*, 16 July 2019
- Commons Library briefing CBP-7547, *Mental health policy in England*, 4 September 2018

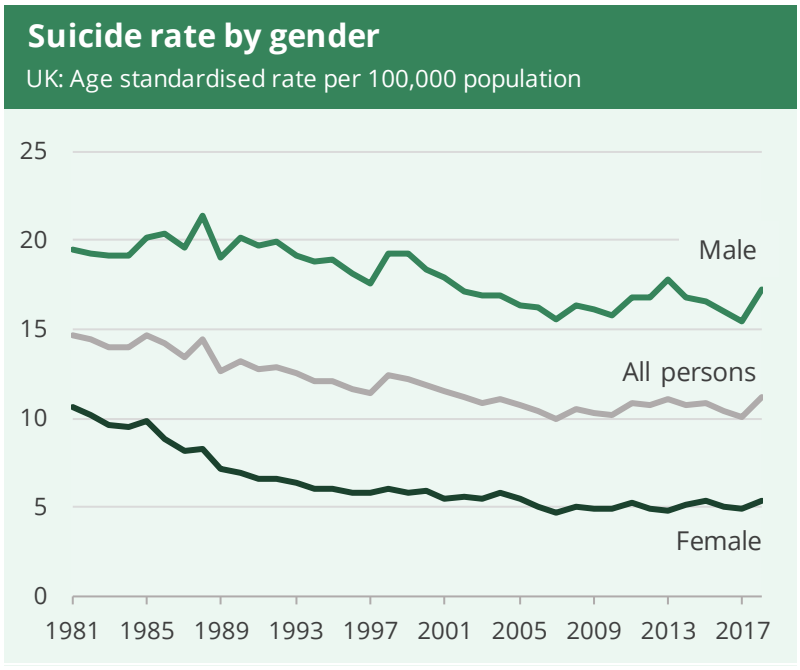
1. Suicide rates in the UK

1.1 Suicide rates by age, gender, and country

In 2018 there were 6,507 deaths in the United Kingdom where the cause was identified as suicide. This amounts to 11.2 deaths per 100,000 population. This is a significant increase on previous years, and is the highest rate recorded since 2002. Nevertheless, it is lower than rates recorded in the 1980s and 1990s – in 1981, the rate was 14.7 per 100,000 population.

In July 2018, the standard of proof used to determine whether a death is suicide was lowered in England & Wales. ONS states that this may have contributed to the increase in recorded suicides in 2018 – but they also note that rates had begun to rise in earlier quarters of 2018, before the change had been made.

Men are three times more likely than women to take their own lives, and this gender gap has grown in the past 35 years. The suicide rate among women in the UK has halved since 1981. The rate among men was 12% lower in 2018 than in 1981. However, the 2018 rise in suicide rates affected both genders to a similar degree, with both male and female rates rising by 10%. Information on suicides among transgender or gender dysphoric people is not generally available.[1]



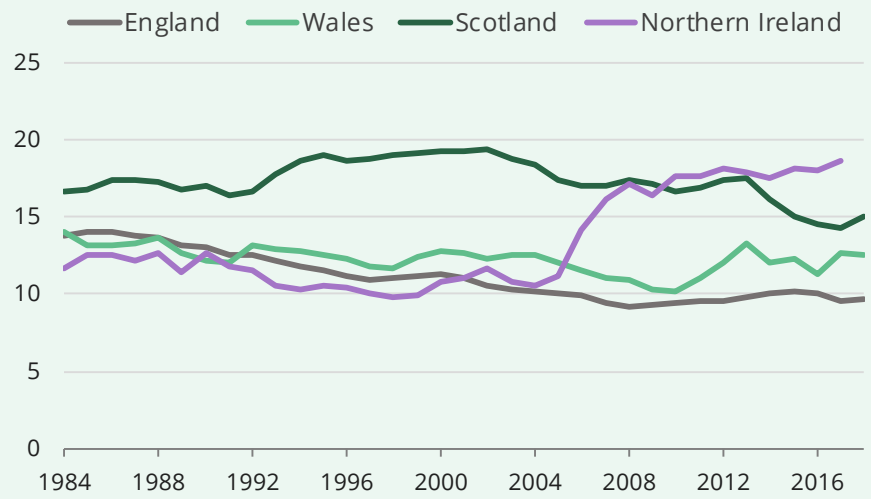
Source: ONS *Suicides in the United Kingdom: 2018 registrations*

[1] According to the ONS – in reply to a Freedom of Information request for the suicide rate for transgender/gender dysphoric persons – the information they hold on deaths, including on gender, is limited to what is recorded on the death certificate by a doctor, or to information about the cause and circumstances of the death provided by a coroner. For more information on this, see ONS, *Suicide rates and transgender persons*, 21 June 2018.

The suicide rate is higher in Northern Ireland than other UK countries. The chart below shows the three-year moving average suicide rate up to 2018 for England, Wales and Scotland, and trends up to 2017 for Northern Ireland. 2018 data for Northern Ireland has not yet been released.

Suicide rate in the four UK nations

Age-standardised rate per 100 000 population (3-year moving average)



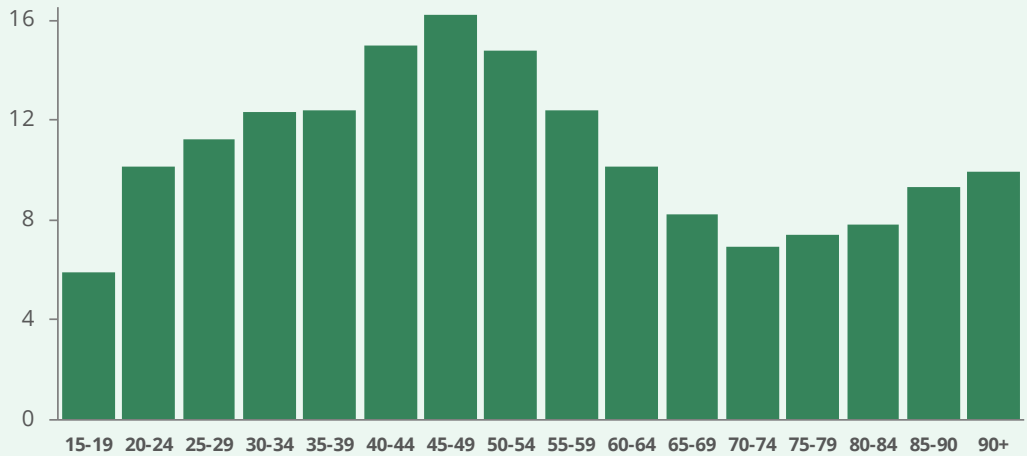
Note: The sharp increase between 2004 and 2006 in Northern Ireland coincides with a change to the Coroner's Service. See this Northern Ireland Assembly research paper for more information.

Source: ONS *Suicides in the United Kingdom: 2018 registrations*

The suicide rate is highest for those aged between 40 and 54. The rate among 45-49 year olds is around 50% higher than the overall average.

The suicide rate is highest among ages 40-54

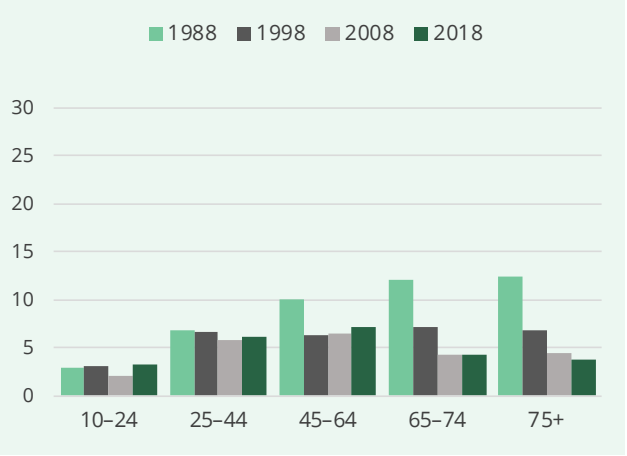
UK rate per 100,000 population, by 5-year age group, 2016-2018 average



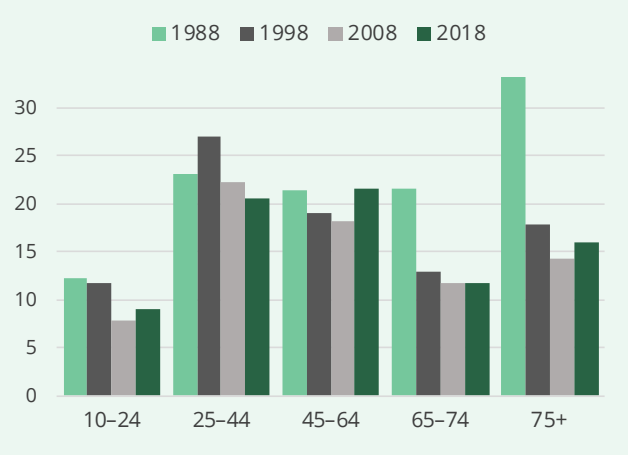
Source: ONS *Suicides in the United Kingdom: 2018 registrations*

The charts below show how the suicide rate has changed in the last 30 years for men and women of different ages. In both genders there were substantial falls between 1988 and 1998 among those aged 65 and above. Among women there was also a fall among those aged 45-64. Among genders there was a rise in the suicide rate among ages 10-24 between 2008 and 2018.

Female suicide rate over time by age group
UK rate per 100,000 population



Male suicide rate over time by age group
UK rate per 100,000 population



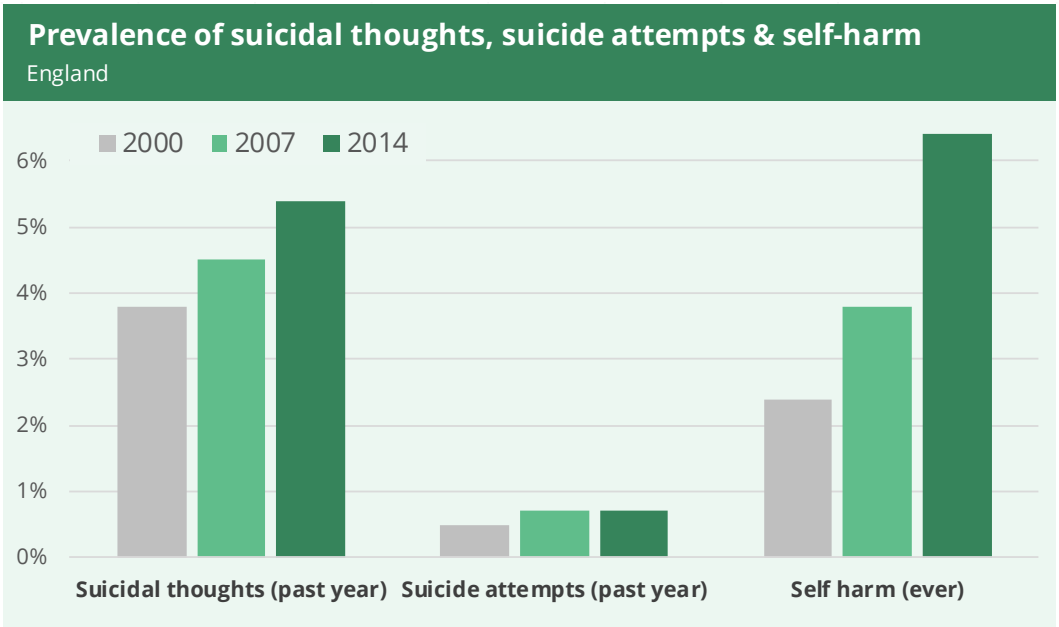
Source: ONS *Suicides in the United Kingdom: 2018 registrations*

1.2 Suicidal thoughts and self-harm in England

A survey of adult mental health in England has been carried out every seven years. The most recent Adult Psychiatric Morbidity Survey was carried out in 2014. 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.

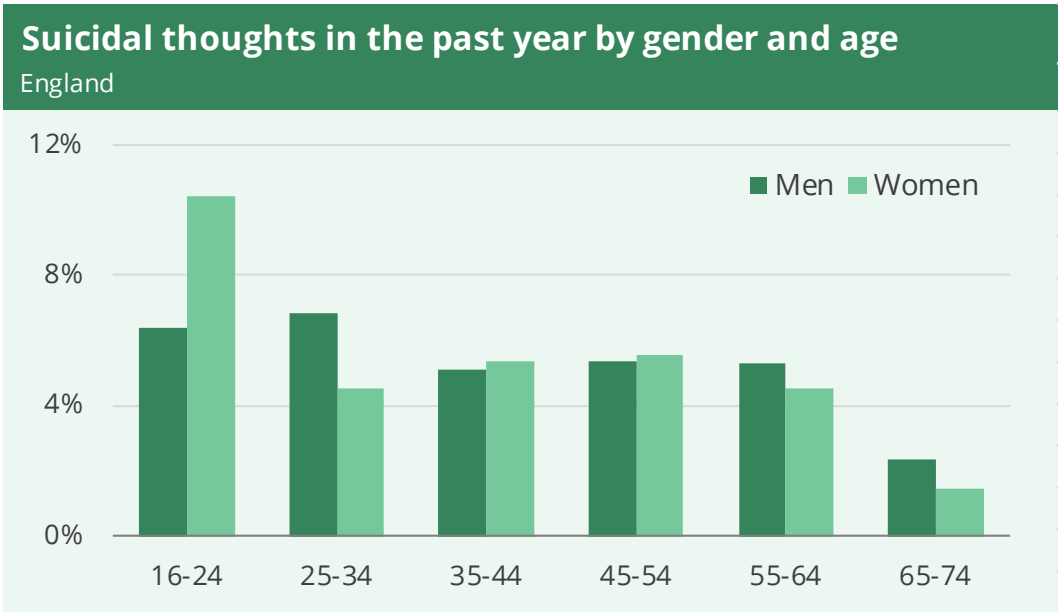
[2] NHS Digital, APMS, Suicidal Thoughts



Source: NHS Digital Adult Psychiatric Morbidity Survey 2017

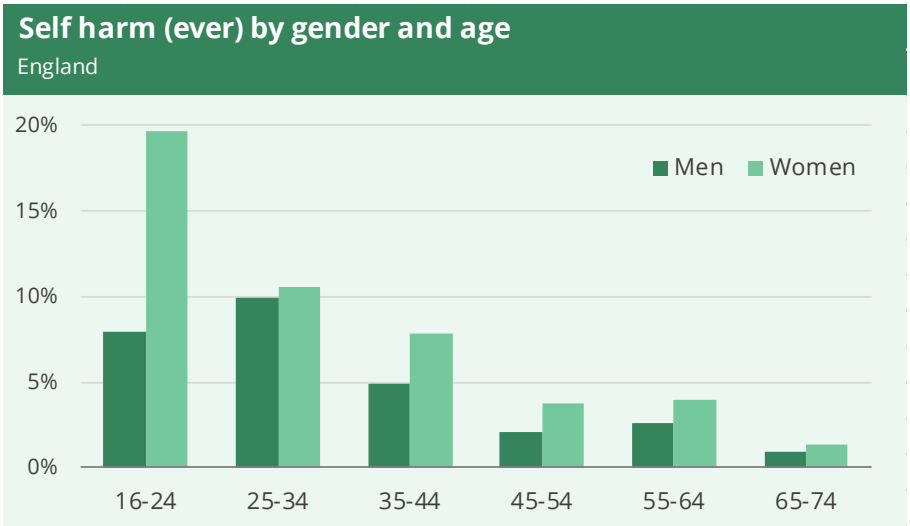
Some groups saw larger increases in suicidal thoughts and suicide attempts over the period – e.g. people aged 55-64.

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



Source: NHS Digital Adult Psychiatric Morbidity Survey 2017

Women aged 16-24 are more likely to report having ever self-harmed than any other age group, with almost 20% reporting self-harm. Among men, those aged 25-34 are most likely to report self-harm (10%).



Source: NHS Digital Adult Psychiatric Morbidity Survey 2017

1.3 Concerns around data on suicide

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

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

The situation developed in July 2018 when the High Court delivered a judgment which decided that the lower civil standard of proof – "on the balance of probabilities" – applies for suicide conclusions. The Court of Appeal has upheld this decision and it is understood that permission to appeal to the Supreme Court has been granted.

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

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

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

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 foreword 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, p3
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 in *Saving Lives* had been a reduction of 20% (or one fifth) 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, p2

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 reiterated the commitment from the Government to achieve a 10% reduction in suicides in England by 2020/21.[22]

Fourth Progress Report and Workplan (2019)

The Government published its "Fourth Progress Report" in January 2019, entitled *Preventing suicide in England: fourth progress report of the cross-government outcomes strategy to save lives*. This was accompanied by the Government's first cross-government suicide prevention workplan committing "every area of Government to taking action on suicide" and which sets out the actions being taken up until 2020 to implement the Strategy.[23]

The Fourth Report provided an update on the progress made on each of the areas highlighted for renewed focus on the Third Report. It clarified how it would monitor and measure the commitment to reduce suicides by 10% by 2020/21, stating that it was setting a baseline for the number of suicides registered in 2015 (4,820). It said it would measure success based on the suicide registrations for 2020 as published by the ONS in 2021, and calculated that in order to achieve its target, suicides would need to reduce by at least 482.[24]

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.[25]

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

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20 *Ibid*., p4
21 *Ibid*., para. 13, p9
22 *Ibid*., p5
23 HMG, *Cross-Government Suicide Prevention Workplan*, January 2019
24 HMG, *Preventing suicide in England: fourth progress report of the cross-government outcomes strategy to save lives*, January 2019, p9
25 Scottish Executive, *Choose Life: A National Strategy and Action Plan to Prevent Suicide in Scotland*, December 2002, p7

following the publication of "Choose Life" there had been a reduction in the suicide rate in Scotland of 18%.[26] The new strategy contained 11 Government "commitments" and was developed around five themes, lettered A-E:

a. "Responding to people in distress" – to engage better with people in distress, noting self-harm as a "clear risk factor for suicide" as well as a "phenomenon that we need to understand and address in its own right".

b. "Talking about suicide" – involving the development of an "engagement strategy to influence public perception about suicide and the stigma surrounding it", using social media and to encourage "sensitive and appropriate reporting" in the media.

c. "Improving the NHS response to suicide" – including working with Healthcare Improvement Scotland to support NHS Boards to make mental health services safer for people at risk of suicide.

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.[27]

On 9 August 2018, the Scottish Government published its new suicide prevention action plan, *Every Life Matters*. This was designed explicitly to continue the work from the previous strategy as well as "the strong downward trend in suicide rates in Scotland". In her foreword to this action plan, Clare Haughey, Minister for Mental Health, stated that the suicide rate in Scotland had fallen by 20% "between 2002-2006 and 2013-17", i.e. the two periods covered by the Scottish Government's previous strategies.[28]

This new Action Plan was the result of an engagement process which took place during March and April 2018, including five events organised by NHS Health Scotland. The resulting publication committed to a new target to reduce further "the suicide rate by 20% by 2022"[29] which it planned to achieve through the following actions:

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

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26 Scottish Government, *Suicide Prevention Strategy 2013-2016*, December 2013
27 *Ibid*., pp6-14
28 Scottish Government, *Suicide Prevention Action Plan: Every Life Matters*, August 2018, p2
29 *Ibid*., pp2-3

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

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

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

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

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

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

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

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

Action 10. The Scottish Government will work with the NSPLG and partners to develop appropriate reviews into all deaths by suicide, and ensure that the lessons from reviews are shared with NSPLG and partners and acted on.[30]

As a result of Action 1, the Scottish Government established a National Suicide Prevention Leadership Group (NSPLG). This developed a delivery plan for the ten actions in the Action Plan, which was published in December 2018 and updated in June 2019. It is supported by £3 million in funding over the course of the current Scottish Parliament (2016-2021).[31] In September 2019 it published its first annual report which made a series of eleven recommendations to Scottish Ministers and local authorities to help deliver the actions and realise the objectives in *Every Life Matters*.[32]

Wales

In 2009, the Welsh Assembly Government introduced *Talk to Me: The National Action Plan to Reduce Suicide and Self Harm in Wales 2009-*

30 *Ibid*., p4
31 Scottish Government, *National Suicide Prevention Leadership Group: delivery plan*, August 2019
32 National Suicide Prevention Leadership Group, *Making Suicide Prevention Everyone's Business: The first annual report of the National Suicide Prevention Leadership Group*, September 2019

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".[33] 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.[34]

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.[35] 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.[36] It prioritised certain high risk groups, in particular middle-aged men, which was a group highlighted as particularly vulnerable by a Samaritans campaign.[37] 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

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33 Welsh Assembly Government, *Talk to Me: The National Action Plan to Reduce Suicide and Self Harm in Wales 2009-2014*, October 2009, pp9 & 19
34 *Ibid*., p9
35 Welsh Government, *Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales*, October 2012
36 Welsh Government, *Talk to me 2: Suicide and Self Harm Prevention Strategy for Wales 2015-2020*, June 2015, para. 36, p15
37 *Ibid*. paras 57-60, pp19-20

understanding of suicide and self harm in Wales and guide action[38]

Northern Ireland

A suicide prevention strategy in Northern Ireland was developed in October 2006 by the then Department of Health, Social Service and Public Safety (DHSSPS), and was entitled *Protect Life: Northern Ireland Suicide Prevention Strategy and Action Plan, 2006-2011*. This outlined a strategy for the next five years which aimed to reduce the suicide rate in Northern Ireland by 15%. A particular focus was placed on reducing the number of suicides in young males, amongst other high risk groups, as well as addressing the rising rate of self-harm.[39] 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.[40]

Following further reviews, a draft of a new suicide prevention strategy was published in September 2016. Consultation began upon publication and closed on 4 November 2016.[41]

In September 2019, the Department of Health published *Protect Life 2: A Strategy for Preventing Suicide and Self Harm in Northern Ireland 2019-2024*. The stated aim of this strategy is to reduce the suicide rate in Northern Ireland by 10% by 2024, as well as to "ensure suicide prevention services and support are delivered appropriately in deprived areas where suicide and self-harm rates are highest". In particular, the 10% reduction target will be based on the 3-year rolling over annual rate of suicide for the period 2015/17 (16.5 deaths per 100,000 of population). If this target is achieved, therefore, the Strategy calculates that suicide rate will reduce at least to 14.9 deaths per 100,000.[42]

Furthermore, the *Protect Life 2* strategy has the following 10 objectives:

1. Ensure a collaborative, co-ordinated cross departmental approach to suicide prevention.

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38 *Ibid*., pp15-17

39 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

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

41 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

42 NIDH, *Protect Life 2: A Strategy for Preventing Suicide and Self Harm in Northern Ireland 2019-2024*, September 2019, p11

2. Improve awareness of suicide prevention and associated services.
3. Enhance responsible media reporting on suicide.
4. Enhance community capacity to prevent and respond to suicidal behaviour within local communities.
5. Reduce incidence of suicide amongst people under the care of mental health services.
6. Restrict access to the means of suicide.
7. Enhance the initial response to, and care and recovery of people who are suicidal.
8. Enhance services for people who self-harm, particularly for those who do so repeatedly.
9. Ensure the provision of effective support for those who are exposed to suicide or suicidal behaviour.
10. Strengthen the local evidence on suicide patterns, trends and risk, and on effective interventions to prevent suicide and self-harm.[43]

[43] *Ibid*., p16. The full rationale for these objectives are outlined in Appendix 1.

3. National and local approaches

3.1 National oversight in England

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

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

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

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

For further information on the NHS in England, see Commons Library briefing CBP 07206, *The Structure of the NHS in England*.

UK Government oversight

Each of the "areas for action" in the UK Government's 2012 Strategy were accompanied by suggested local and national approaches. While the strategy was clear that "[m]uch of the planning and work to prevent suicides will be carried out locally", it did come with a national implementation framework for *No health without mental health*, published at a similar time, which covered suicide and supported implementation of the prevention strategy. The Cabinet Sub-Committee on Public Health was charged by the Strategy with overseeing this, and the Cabinet Committee on Social Justice was given additional 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.[44]

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

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

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

> continue to have the lead role across government on suicide prevention.[45]

In October 2018, the then Prime Minister, Theresa May, announced that the then Minister for Mental Health, Jackie Doyle-Price, would be adding "Suicide Prevention" to her portfolio. The press release announcing this new ministerial position said:

> The Minister will lead a new national effort on suicide prevention, bringing together a ministerial taskforce and working with national and local government, experts in suicide and self-harm prevention, charities, clinicians and those personally affected by suicide.
>
> She will also ensure every local area has an effective suicide prevention plan in place, and look at how the latest technology can be used to identify those most at risk.[46]

The current Minister for Mental Health, Suicide Prevention and Patient Safety is Nadine Dorries, who was appointed in the Johnson Government in July 2019.

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.[47] 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".[48] 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.[49] It also recently published guidance for local commissioners on how and why they can deliver support after suicide.[50]

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45 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

46 'PM pledges action on suicide to mark World Mental Health Day', Gov.uk press release, 9 October 2019

47 HMG, *Preventing suicide in England: One year on – First annual report on the cross-government outcomes strategy to save lives*, January 2014, paras 7.5-7.6, p50

48 *Ibid*., p4

49 Public Health England, *Local Suicide Prevention Planning: A Practice Resource*, October 2016

50 Public Health England, *Support after a suicide: a guide to providing local services*, January 2017

NHS England

NHS England was charged with helping in realising the aims of the Strategy, through its role in commissioning primary care, specialised services, prison health, military health, and some public health services.[51]

NICE

The National Institute for Health and Care Excellence (NICE) was also tasked with providing quality standards, including those already in existence which are relevant to suicide prevention, such as alcohol dependence and depression in adults, as well as those in development, such as depression in children and young people, self-harm in adults and vulnerable groups, antenatal and postnatal mental health, and long-term care for people with complex needs.[52] For more on this, see Section 4 of this briefing paper 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, was tasked by the Strategy to "continue to provide leadership for implementation".[53] Its chair, Professor Louis Appleby, provided the preface to the report, and continues to provide a summary of progress in this area at the beginning of each new progress report.[54]

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.[55] 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.[56] 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.

In January 2019, it published its strategic framework for 2019-2021 which included sharing information and good practice, providing a collective voice to influence policy, and enabling greater collaboration across sectors.

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51 HMG, *Preventing suicide in England: A cross-government outcomes strategy to save lives*, 10 September 2012, paras 7.16-7.16, p51
52 *Ibid*., paras 7.17, pp51-2
53 *Ibid*., para. 7.24, p53
54 *Ibid*., p4
55 National Suicide Prevention Alliance, *Annual Review 2012-13*, July 2014, p6
56 'The Suicide Bereavement Support Partnership', Samaritans website, 17th June 2014 [accessed 7 December 2017]

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".[57] It highlighted five areas it believed ought to be key to the Government's considerations:

> (1) **Implementation**—a clear implementation programme underpinned by external scrutiny is required.
>
> (2) **Services to support people who are vulnerable to suicide**—this includes wider support for public mental health and wellbeing alongside the identification of and targeted support for 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.[58]

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.[59]

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:

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57 Health Committee, *Suicide Prevention: Interim Report, Fourth report of Session 2016-17*, 19 December 2016, HC 1087, para. 5, p4

58 *Ibid*., para. 7, pp4-5

59 Health Committee, *Suicide Prevention, Sixth report of Session 2016-17*, 16 March 2017, HC 1087, paras 10-11, p7

- **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".[60]
- **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.[61]

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 ensuring effective and consistent implementation across the country".[62] 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.[63]

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.[64]

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.[65]
- 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 Section 4 on health policy.[66]

What is now the Health and Social Care Committee held a one-off evidence session on 22 January 2019, to follow up on the Health

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60 *Ibid*., para. 92, p24
61 *Ibid*., para. 114, p29
62 *Ibid*,. para. 12, p7
63 *Ibid*., paras 27-28, p10
64 DH, *Government Response to the Health Select Committee's Inquiry into Suicide Prevention*, July 2017, Cm 9466, p6
65 *Ibid*., p3
66 *Ibid*., p3

Committee's 2017 inquiry on suicide prevention (see: Health and Social Care Committee, Suicide prevention: follow-up inquiry, January 2019).

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.[67] 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 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.[68]

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.[69]

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67 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.

68 HMG, *Preventing suicide in England: A cross-government outcomes strategy to save lives*, 10 September 2012, paras 37-39, p8

69 *Ibid*.

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.

This 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.[70] 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:

> …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.[71]

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.[72]

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.[73]

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". The Government accepted that the APPG's findings had been "unacceptable" but claimed this was improving. It also pointed to the fact that in November 2016, Public Health England undertook a survey to assess local authority suicide prevention plans which 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.[74]

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70 APPG on Suicide and Self-Harm, *The Future of Local Suicide Prevention Plans in England*, January 2013, *Ibid.*, paras 44-45, pp19-20

71 *Ibid.*, p5

72 *Ibid*.

73 APPG on Suicide and Self-Harm Prevention, *Inquiry into Local Suicide Prevention Plans in England*, January 2015, pp3-7

74 HMG, *Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives*, January 2017, para. 5, p7

The NHS Long Term Plan (January 2019) noted that all local areas across England now have multi-agency suicide prevention plans in place.[75] Further information on local prevention plans can be found in Section 4.2 of this briefing.

3.4 Oversight and implementation in the devolved nations

Scotland

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

NHS Health Scotland leads implementation of the Strategy through the National Programme for Suicide Prevention in Scotland. In this it organises national and local campaigns, provides guidance on the Choose Life website, and leads workforce development. It also provides leadership and direction for the local *Choose Life* coordinators who are appointed in each of Scotland's 32 local authority areas to help implement local suicide prevention action plans.[76] These local plans are designed to prevent suicide within communities by promoting awareness, delivering intervention activities, providing practical support for those affected by suicide, and collaborating with local bodies and agencies.[77]

The 2018 Action Plan established a National Prevention Leadership Group (NSPLG) in September 2018 which leads on the Scottish Government's suicide prevention "vision" and reports directly to Scottish Ministers.[78]

The Action Plan further commits the NSPLG to working with the Convention of Scottish Local Authorities (COSLA), which is the national association of Scottish councils. It will do this "on issues that sit within the competence of local government and integration authorities".[79] Its first annual report to the Scottish Government and COSLA was published in September 2019.[80]

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

75 NHS Long Term Plan, 7 January 2019
76 'National and local implementation', Choose Life website [accessed 18 December 2017]
77 'Local action plans', Choose Life website [accessed 7 September 2018]
78 Scottish Government, *National Suicide Prevention Leadership Group: delivery plan*, August 2019
79 Scottish Government, *Suicide Prevention Action Plan: Every Life Matters*, August 2018, p9
80 National Suicide Prevention Leadership Group, *Making Suicide Prevention Everyone's Business: The first annual report of the National Suicide Prevention Leadership Group*, September 2019

with UK Government departments to ensure a "collaborative approach" in order to fulfil the objectives.[81] Local authorities were given responsibility for local implementation in collaboration with local Health Boards, justice agencies, third sector agencies, and community organisations.[82]

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."[83] 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".[84]

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.[85]

The Health and Social Care and Sport Committee in the National Assembly for Wales conducted an inquiry on suicide prevention to examine "the extent of the problem of suicide in Wales and what can be done to address it". It focused on suicide prevention for people aged 15 and over in Wales and a report was published in December 2018. This made 31 recommendations which encouraged the Welsh Government to see suicide prevention as an "urgent priority". In particular, the Committee urged the National Advisory Group to adopt and implement a suicide prevention training framework across all public services "as an immediate priority".[86] The Welsh Government responded the following January and accepted all the Committee's recommendations, at least in principle.[87]

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

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81 Welsh Assembly Government, *Talk to Me: The National Action Plan to Reduce Suicide and Self Harm in Wales 2009-2014*, October 2009, p21
82 *Ibid*., pp21-22
83 Welsh Government, *Talk to me 2: Suicide and Self Harm Prevention Strategy for Wales 2015-2020*, June 2015, para. 51, p18
84 *Ibid*., para. 6, p6
85 *Ibid*., paras 51-55, pp18-19
86 Health, Social Care and Sport Committee, *Everybody's Business: A report on suicide prevention in Wales*, December 2018
87 Welsh Government, *Response to Everybody's Business*, January 2019

Government Departments" and "to enhance cross-Departmental cooperation".[88]

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.[89]

The new *Protect Life 2* strategy states that the Ministerial Co-ordination group on suicide prevention will continue to provide oversight, and that strategic oversight should will be led by the Northern Ireland Department of Health. It further states that a new "Protect Life 2 Implementation Steering Group" will "drive the delivery of the strategy through a more details implementation plan". It will also be supported by local implementation groups which will develop local action plans based on the *Protect Life 2* action plan, and which will oversee delivery of them.[90]

88 NIDHSSPH, *Protect Life – A Share Vision: The Northern Ireland Suicide Prevention Strategy 2012-March 2014*, June 2012, paras 5.2-5.4, p39
89 *Ibid*., para. 1.2, p7
90 NIDH, *Protect Life 2: A Strategy for Preventing Suicide and Self Harm in Northern Ireland 2019-2024*, September 2019, p62-65

4. Health services

This section sets out the work of health services to prevent suicide. For information on mental health policy in England more generally, see the Commons Library briefing paper *Mental health policy in England*, published in September 2018.

4.1 Reducing suicide rates

The *Five Year Forward View for Mental Health* was published in February 2016 by the independent Mental Health Taskforce. The report made recommendations on suicide prevention and reduction, including an objective to reduce suicides by 10% in England by 2020/21.[91]

NHS England accepted the recommendations of the report and agreed with the Government that to support the transformation of mental health services there would be an additional investment, including £25 million specifically on suicide prevention.[92]

In January 2018, the former Health Secretary Jeremy Hunt also announced a zero-suicide ambition for mental health inpatients.[93] This included a new requirement for NHS mental health organisations in England to draw up detailed plans to achieve zero suicides, starting with those in inpatient settings. The plans include:

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

The then Health Secretary said this would result in England becoming the first country in the world to roll out zero suicides as a national ambition.[94]

On 11 October 2018, the Department of Health and Social Care announced that £2 million of funding would be given to the Zero Suicide Alliance over the next two years. This money would go towards developing training, making safety improvements and ensuring that "lessons are learnt when suicides occur." More information can be found on the Zero Suicide Alliance website.

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91 NHS England, *Five Year Forward View for Mental Health*, February 2016, p13
92 NHS England, *Implementing the Five Year Forward View For Mental Health*, July 2016, pp35-36
93 Public Health England, Department of Health and Social Care [DHSC], *New Funding for Health and Social Care in England*, 16 May 2018
94 'Zero suicide is our simple but powerful NHS mission', *The Telegraph*, 31 January 2018 (an opinion piece written by Jeremy Hunt MP)

The NHS Long Term Plan, published in January 2019, noted that "…we are on track to deliver a 10% reduction in suicide rates by 2020/21".[95] The Plan also stated that reducing suicides will remain an NHS priority over the next decade, and set out measures to achieve this:

> With the support of partners in addressing this complex, system-wide challenge, we will provide full coverage across the country of the existing suicide reduction programme. Through an enhanced mental health crisis model, anyone experiencing a crisis will be able to call NHS 111 and have 24/7 access to mental health support as well as the services described earlier in this chapter. We will expand specialist perinatal mental health services so that more women who need it have access to the care they need from preconception to two years after the birth of their baby. We are investing in specialist community teams to help support children and young people with autism and their families, and integrated models of primary and community mental health care which will support adults with severe mental illnesses, and support for individuals who self-harm. [96]

The Fourth Progress Report on the Government's Suicide Prevention Strategy, published in January 2019, details what has been done to reduce deaths by suicide since the Third Progress Report, published in January 2017. Alongside this, the Department of Health and Social Care (DHSC) announced the publication of its first cross-government Suicide Prevention Workplan. This set out the actions being taken up to 2020 to carry out the Strategy. This was created in response to the 2017 Suicide Prevention Inquiry led by the Health Select Committee, which had called for a clearer implementation plan. In addition, what is now the Health and Social Care Committee held a one-off evidence session on 22 January 2019, to follow up on the Health Committee's 2017 inquiry on suicide prevention (Health and Social Care Committee, Suicide prevention: follow-up inquiry).

In September 2019, the National Institute of Health and Care Excellence (NICE) published a new Quality Standard (Suicide Prevention, QS189) covering ways to reduce suicide and help people bereaved or affected by suicide.

4.2 Local suicide prevention plans

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

> 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

95 NHS England, *NHS Long Term Plan*, 7 January 2019
96 *Ibid.,* para 3.105

> preventative interventions that target high-risk locations and support high-risk groups (including young people who self-harm) within their population, drawing on localised real time data. Updates should be provided in the Department of Health's annual report on suicide.[97]

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.[98] A PQ answered in July 2018 noted that "most" local authorities now have a suicide prevention plan, and that it is envisaged that all areas will have one by 2020/21.[99]

In May 2018, the Department of Health and Social Care, Public Health England and NHS England announced the first local areas that will receive funding from a £25 million investment over three years for suicide prevention. The funding has initially been allocated to areas that are worst affected by suicide.[100] It will include targeted prevention campaigns for men; psychological support for people with financial difficulties; better care after discharge; and improved self-harm services for all ages.[101]

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

> We welcome the fact that 95 per cent of local authorities have a suicide prevention plan in place or in development. However we are concerned that there is currently no detail about the quality of those plans. It is not enough simply to count the number of local authorities which report that they have a plan in place.[102]

The Health Committee called on the Government to set out a quality assurance process to assess and report on local plans. The Committee also recommended that Public Health England's suicide prevention planning guidance for local authorities should be developed into quality standards against which local suicide prevention plans should be assessed.[103]

In its response, the Government announced an assurance process to support local authorities to develop suicide prevention plans and ensure their regular review. [104] A PQ response noted that in October 2018, local authorities were invited to complete a self-assessment of their local plans. The self-assessment responses and the local plans will be analysed

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97 NHS England, *Five Year Forward View for Mental Health*, p77 (Recommendations for Government)

98 NHS England, *Implementing the Five Year Forward View for Mental Health*, July 2016

99 PQ 164869 [on Suicide], 24 July 2018 PQ 164869 [on Suicide], 24 July 2018

100 For the full list of areas, see NHS England, *Suicide prevention and reduction*, 16 May 2018

101 Public Health England and DHSC, New Funding for Health and Social Care in England, 16 May 2018

102 Health Committee, *Suicide Prevention, Sixth report of Session 2016-17*, 7 March 2017, HC 1087, para. 21

103 *Ibid*., paras 22-23

104 DH, *Government response to the Health Select Committee's Inquiry into Suicide Prevention*, Cm 9466, July 2017, p5

by an independent researcher and the results will be considered by an expert panel. The Government states that this process will help to identify areas for improvement for local plans and areas of best practice which can be shared across the local government sector. The results will also be used to inform a programme of mutual support over the next two to three years to enable local areas to learn from each other and to further develop their plans.[105] The NHS Long Term Plan noted that all local areas across England now have multi-agency suicide prevention plans in place.[106]

4.3 Support for mental health patients and other high-risk groups

The Third Progress Report of the Suicide Prevention Strategy, published in 2017, set an objective to target suicide prevention and help-seeking in high risk groups. The Strategy identified these as young and middle-aged men, people in the care of mental health services, people in contact with the criminal justice system, specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers, and people with a history of self-harm.[107]

The Third Progress Report also set out areas of work to reduce suicide among people in contact with mental health services, for whom it says suicides are the most preventable. It highlights that around one third of people who die by suicide have been under specialist mental health services in the preceding year, and two thirds have seen their GP. Additionally, just over half of people sought help following an attempted suicide from either their GP or hospital services.[108]

The NHS Long Term Plan included a commitment to design a new Mental Health Safety Improvement Programme, which will have a focus on suicide prevention and reduction for mental health inpatients. The Plan also committed to putting in place suicide bereavement support for families and staff working in mental health crisis services in every area of England, and to using decision-support tools and machine learning to deliver personalised care and predict risk of self-harm or suicide.[109]

The latest National Confidential Inquiry into Suicide and Safety in Mental Health report was published in October 2018. The Government has noted that it has a dedicated quality improvement programme to implement the findings from the National Confidential Inquiry, and learn from deaths in NHS settings, to prevent future suicides.[110]

Primary and community care

For primary care, the Government has highlighted improved training for GPs and their staff in suicide awareness and safety planning. The

105 PQ 190782 [Suicide] 19 November 2018
106 NHS England, *NHS Long Term Plan*, 7 January 2019
107 HMG, *Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives*, January 2017, p9
108 *Ibid*., para. 21
109 NHS England, *NHS Long Term Plan*, 7 January 2019, para 3.106
110 PQ 190782 [Suicide] 19 November 2018

General Medical Council and the Royal College of GPs provide training for GPs in suicide and self-harm.[111]

The Third Progress Report also highlighted 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 asked NICE to develop a new guideline – *Preventing suicides in community and custodial settings* (NG105) which was published in September 2018.[112]

Specialist services and support

For people in the care of specialist mental health services, the Third Progress Report noted a significant reduction in the number of inpatient suicides due to improvements in patient safety, but raises concerns about the rates of suicide for patients in contact with crisis home resolution teams. The Government is focusing on crisis care services in the community, including funding of £400 million to improve 24/7 treatment in communities as a safe and effective alternative to hospital and £247 million for mental health liaison services, where psychiatrists and counsellors are available in A&E units to assess, counsel and refer patients onto other mental health services if they show signs of self-harm or other psychological distress, by 2020/21.[113]

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.[114] In its inquiry, the Health Committee recommended that patients should receive support within three days. The Government said that NHS England will consider this recommendation in future scoping work.[115]

The final report of the Independent Review of the *Mental Health Act 1983* was published in December 2018 (*Modernising the Mental Health Act: Increasing choice, reducing compulsion*). Several of its recommendations are closely linked to the issue of suicide: for example, when patients are detained under the Mental Health Act 1983 or when a hospital is considering discharging a person at risk of suicide.

The Government welcomed the publication of the final report of the independent review and has said it will consider its recommendations in detail and respond in due course.[116]

Information sharing

The Information Sharing and Suicide Prevention Consensus Statement, published in January 2014, is intended to encourage health

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111 See DH, *Government response to the Health Select Committee's Inquiry into Suicide Prevention*, Cm, 9466, July 2017, p15

112 HMG, *Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives*, January 2017, pp12-13

113 *Ibid*., para 32, p14

114 NHS England, *Five Year Forward View for Mental Health Dashboard*, January to March 2017

115 DH, *Government response to the Health Select Committee's Inquiry into Suicide Prevention*, Cm 9466, July 2017, p18

116 See PQ 209277, 24 January 2019 and HCWS1149, 6 December 2018

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.[117] 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.[118]

Perinatal suicide prevention

The "*Mother and Babies: Reducing Risk Through Audits and Confidential Enquiries across the UK*" report – *Saving Lives, Improving Mothers' Care* – which was published in December 2015, highlighted that almost a quarter of women (23%) who died between six weeks and one year after pregnancy died from mental health related causes, and one in seven women died by suicide.[119] The Health Committee also noted concerns about the levels of perinatal suicide.[120]

NHS England's *Five Year Forward View for Mental Health* set out a target for at least 30,000 additional women each year to access evidence-based specialist perinatal mental health treatment by 2020/21. A PQ response in July 2019 noted that at least 9,000 additional women received specialist perinatal mental health treatment in 2018/19.[121]

The NHS Long Term Plan includes a commitment for a further 24,000 women to be able to access specialist perinatal mental health care by 2023/24. The Plan also noted that specialist care will also be available from preconception to 24 months after birth, which will provide an extra year of support.[122]

4.4 Devolved nations

Scotland

The Scottish Government's *Suicide Prevention Action Plan: Every life matters*, published in August 2018, commits the Scottish Government to fund the creation and implementation of refreshed mental health and suicide prevention training by May 2019, and develop a Scottish Crisis Care Agreement. A package of new resources to support workforce development in mental health improvement and suicide prevention launched in May 2019, as the first phase of work on developing training in this area.[123]

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117 Health Committee, *Suicide Prevention, Sixth report of Session 2016-17*, 7 March 2017, HC 1087, paras 21 and 95
118 DH, *Government response to the Health Select Committee's Inquiry into Suicide Prevention*, July 2017, pp21-22
119 MBRACE-UK, *Saving Lives, Improving Mothers' Care*, December 2015, pii
120 Health Committee, *Suicide Prevention, Sixth report of Session 2016-17*, 7 March 2017, HC 1087, para. 80, p21
121 PQ 276533, [Pregnancy: Mental Health Services] 17 July 2019
122 NHS England, *NHS Long Term Plan*, 7 January 2019
123 National Suicide Prevention Leadership Group, *Making Suicide Prevention Everyone's Business: The first annual report of the National Suicide Prevention Leadership Group*, September 2019, p12

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

To help fulfil these commitments and support implementation of the strategy more generally, NHS Health Scotland hosts the *Choose Life* programme which provides leadership and guidance to local suicide prevention coordinators around the Scotland, as well as training courses on suicide prevention action. It coordinates with other agencies closely involved in suicide prevention action in Scotland, including local authorities, NHS Boards, the Police and the voluntary sector.[124]

In March 2017 the Scottish Government published a 10-year Mental Health Strategy which is designed to complement current suicide prevention measures.[125]

Wales

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".[126]

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.[127]

The Strategy Action Plan commits to reviewing deaths through suicide in those known to mental health services, as well as those not known to

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[124] 'National and local implementation', Choose Life website [accessed 28 November 2017]
[125] Scottish Government, *Mental Health Strategy: 2017-2027*, March 2017, p28
[126] 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
[127] Welsh Government, *Talk to me 2: Suicide and Self Harm Prevention Action Plan for Wales 2015-2020*, June 2015, pp9-10

mental health services. This involves collaboration between Health Boards, Public Health Wales, the National Advisory Group, and local authorities.[128]

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. The Welsh Government has recently finished consulting on the latest iteration of its mental health delivery plan for 2019 to 2022.[129]

Northern Ireland

The *Protect Life 2* suicide prevention strategy for Northern Ireland, which was published in September 2019, is designed to work in coordination with mental health initiatives, such as the Regional Mental Health Care Pathway, *You in Mind*, which sets out the standards expected by all mental health and psychological therapy services in Northern Ireland.[130]

Objective 5 of the strategy in particular specifies a desire to "reduce incidence of suicide amongst people under the care of mental health services". It notes that there has been improvement within in-patient safety over recent years and that there is now "substantial scope for action in community mental health services to reduce the number of patients who take their own lives".

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).

128 *Ibid*., p13
129 Welsh Government, *Together for Mental Health Delivery Plan: 2019-2022 – consultation document*, July 2019
130 *Ibid*., p42

5. Education

5.1 Schools

Suicide Prevention in England

The 2012 Suicide Prevention Strategy for England identifies children and young people as a group for whom "a tailored approach to their mental health is necessary if their suicide risk is to be reduced."[131] 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;
- clear referral routes to specialist mental health services.[132]

The strategy adds that "appropriate training on suicide and self-harm should be available for staff working in schools and colleges".[133]

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

Personal, Social Health and Economic (PSHE) education is highlighted by the Suicide Prevention 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."[134]

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)*, last updated on 17 July 2019.

The Strategy notes that interventions at a community level after a suicide can help prevent copycat and suicide clusters and ensure support is available, and states that this approach may be used in schools, colleges and universities. It 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.[135]

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131 HMG, *Preventing Suicide in England: A cross-government outcomes strategy to save lives*, September 2012, p6.
132 *Ibid*., p22
133 *Ibid*., p17
134 *Ibid*.
135 *Ibid*, p41

Fourth Progress Report of the Suicide Prevention Strategy

The Fourth Progress Report of the Suicide Prevention Strategy for England was published in January 2019. The report noted the "key role" that schools and colleges have to play in "promoting good mental health for children and young people and in early intervention when problems arise."[136] It also highlighted Government proposals and actions in this area, including:

- Expanding pilots to establish single points of contact for mental health to more schools;[137]
- Incentivising schools and colleges to train Designated Senior Leads for Mental Health.
- Creating new Mental Health Support Teams to work in or close to schools.
- Publishing guidance for schools on preventing bullying and providing funding to tackle homophobic, biphobic and transphobic bullying in schools.

More information on these is provided in the relevant sections below.

Safeguarding in schools

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

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

> Where schools have immediate concerns about the risk of suicide, their safeguarding role is set out in our statutory guidance, Keeping Children Safe in Education. This emphasises that schools should have a designated senior lead, with responsibility for the handling of safeguarding concerns, in place. Where schools have immediate concerns about the risk of suicide, an immediate referral should be made to children's social care.[138]

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.[139]

Further information on the safeguarding responsibilities of schools in England is set out in the Library Briefing, *Safeguarding in English schools*, published in June 2018.

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136 HMG, *Preventing suicide in England: Fourth progress report of the cross-government outcomes strategy to save lives*, January 2019, p31.
137 *Ibid.*, p31. See Department for Education [DfE], *Mental health services and schools link pilot: evaluation*, 9 February 2017 for further information.
138 PQ 228146 [on Children: Suicide], 23 March 2015
139 DfE, *Keeping children safe in education: Statutory guidance for schools and colleges*, September 2019, p3

Identifying mental health issues

As well as outlining what schools should do in response to an immediate suicide concern, the PQ response cited above also noted the key role that schools have in identifying and supporting pupils with mental health conditions more generally. At the same time, however, the Government has acknowledged that teachers are not mental health professionals and, where more serious problems occur, it expects that pupils should receive additional support from CAMHS services, voluntary organisations and GP practices.[140]

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.[141]

In addition, the MindEd website, which was set up in 2014 and is funded by the Department of Health and Social Care, 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 guidance on counselling in schools, which provides schools with practical advice on setting up and improving counselling services for pupils.[142] The DfE has stated that it "recognises that school-based counselling by qualified practitioners can play an effective role in supporting mental health and wellbeing". It has also emphasised, however, that it is "up to schools to decide what support to provide for pupils based on their individual circumstances."[143] Schools are not required to report centrally on the counselling services they provide, but a survey published by the Government in 2017 indicated that 61% of schools offered counselling services, and 84% of secondary schools provided their pupils with access to counselling support.[144]

Initiatives to improve mental health in schools

In December 2017 the Government published a Green Paper on children and young people's mental health provision. The consultation outlined several proposals aimed at improving support for mental health in schools, including:

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140 PQ 111153 [on Schools: Counselling], 7 November 2017
141 DfE, *Mental health and behaviour in schools*, March 2016, p49
142 DfE, *Counselling in schools*, February 2016
143 PQ 279120 [on Pupils: Counselling], 24 July 2019
144 DfE, *Supporting Mental Health in Schools and Colleges*, August 2017, p29

- Incentivising schools to identify and train a Designated Senior Lead for Mental Health, with new training to help leads and staff deliver whole school approaches to promoting better mental health.
- Creating new Mental Health Support Teams to work with groups of schools and colleges, and work with Designated Senior Leads in addressing the problems of children with mild to moderate mental health problems, and provide a link to services for children with severe problems.
- 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.[145]

The Government's response to the consultation, published in July 2018, committed to taking forward all proposals in the Green Paper. It stated that the Government aimed to offer training to designated mental health leads to one fifth of schools from September 2019.[146] In July 2019, the DfE announced that it had begun recruiting a specialist provider to deliver the training.[147]

The response added that that the Government was "committed to providing mental health awareness training to every secondary school by 2019 and every primary school by 2022". In the first year, the response said, training had been provided to a member of staff in a third of secondary schools (1,000 schools), and by June 2019 it was aimed to have reached a further 1,000 schools.[148] In July 2019, the DfE announced that the training would be rolled out nationally to schools and colleges in phases over four years from September 2019.[149]

In December 2018, the Government announced 25 trailblazer areas where the first Mental Health Support Teams will be established. It is expected that each team will support up to 8,000 children in around 20 schools in their area. The teams began training in January 2019 and are expected to be fully operational by the end of 2019.[150] It is aimed that teams will be available to 20-25% of England by 2023, with the Government announcing the second wave of 124 teams in July 2019.[151]

Further information on mental health in schools, including the Green Paper proposals, is provided in Section 6 of the Library Briefing, *Children and young people's mental health – policy, CAMHS services, funding and education*, published in August 2018.

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145 PQ 901024 [on Mental Health Services: Children], 10 October 2017
146 Department of Health and Social Care and Department of Education, *Government Response to the Consultation on Transforming Children and Young People's Mental Health Provision: a Green Paper and Next Steps*, June 2018, p6.
147 National mental health programme between schools and NHS, DfE press release, 12 July 2019
148 *Ibid,* p34
149 DfE and DHSC, *NHS and schools in England will provide expert mental health support*, 20 December 2018.
150 *Ibid*; PQ 268557 [on Mental Health Services: Young People], 2 July 2019
151 PQ 268626 [on Schools: Mental Health Services], 2 July 2019; DfE and DHSC, *NHS and schools in England will provide expert mental health support*, 20 December 2018

Mental health education on the curriculum

The Relationships Education, Relationships and Sex Education and Health Education (England) Regulations 2019 provide for Health Education to be compulsory in schools from September 2020. Schools are encouraged to adopt the new curriculum early, from September 2019.

The statutory guidance for Relationships Education, Relationships and Sex Education (RSE) and Health Education, which was published in June 2019 following a consultation, includes guidance on mental wellbeing.

Further information is available in Section 2.3 of Library briefing, *Personal, social, health and economic education in schools (England)*.

Concerns over mental health provision in schools

Concerns have been raised that current provision of mental health support in schools is patchy. This was, for example, noted by the Care Quality Commission (CQC) in a review of CAMHS services in 2017. The CQC noted that when pupils can access high-quality counselling through their schools, it can be an effective form of early intervention. The CQC also said, however, that it is not always available, and that in some cases there are concerns about the quality of support on offer.[152]

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 2017 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 15, and recommended that the Government should review the effect of budget reductions on in-school mental health services.[153]

In its response to the joint report, the Government provided the results of a survey of mental health provision in schools showing, amongst other things, that 56% of primary maintained schools and 84% of maintained secondary schools offered counselling services. These figures have also been cited by the Government in more recent responses to parliamentary questions.[154] The response also stated that the 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."[155]

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

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

154 PQ 269133, 3 July 2019

155 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

The Government's position on increasing counselling services in schools was also set out in response to a parliamentary question in July 2019.

Bullying and mental health

Bullying has been identified as a common theme in suicide by young people and children. 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 it. The advice also outlines principles that underpin the most-effective anti-bullying strategies in schools.[156]

In September 2016 the Government Equalities Office announced a £3 million programme from 2016 to 2019 to prevent and address 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.[157] In November 2018 the programme was extended to 2020, with the allocation of an extra £1 million of funding.[158]

The Government Equalities Office has also published cyberbullying guidance and an online safety toolkit for schools. The Fourth Progress Report on the Suicide Prevention Strategy states that these resources "will help provide advice to schools on understanding, preventing and responding to cyberbullying."[159]

5.2 Further and Higher Education

This section provides a brief overview of this area. More detailed information is available in Library Briefing 8593, *Support for students with mental health conditions in higher education in England*.

Further and higher education institutions (HEIs) are generally accepted to have a common law duty of care to act reasonably to protect the health, safety and welfare of their students.[160] They also have duties under the *Equality Act 2010* to provide reasonable adjustments for students with disabilities, including those with mental health conditions.[161] However, HEIs and further education institutions are autonomous bodies and the way in which mental health provision is organised and delivered varies across the sector.

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.

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

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

158 £2.6 million to improve lives of LGBT people, Government Equalities Office, 4 November 2018

159 HMG, *Preventing suicide in England: Fourth progress report of the cross-government outcomes strategy to save lives*, January 2019, p32

160 See Universities UK, *Student mental wellbeing in higher education: Good practice guide*, February 2015, pp43-45, for more information.

161 PQ 14451 [on Students: Suicide], 10 November 2015

Most HEIs have a mental health policy which sets out the institution's approach to mental health services and provision for students. A number of HEIs have also introduced suicide prevention strategies. The University of Wolverhampton and the University of Cumbria, for example, employ Connecting with People and the Columbia Suicide Severity Rating Scale (C-SSRS) – these approaches are preventative and include training for students and staff.

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

- Wellbeing services to deliver low-intensity support and signpost to non-medical services;
- Counselling services targeted at students with moderate levels of mental distress; and
- Disability services targeted at students in receipt of disabled students' allowances or who experience mental illness which meets a clinical threshold for diagnosis.

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

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

Following a pilot, Samaritans is also exploring expansion of Step by Step, its suicide postvention service for schools, for the higher education sector.[162]

Government policy on preventing student suicide

The Fourth Progress Report of the Suicide Prevention Strategy noted the pressures faced by modern-day students – including workload, financial difficulties and the transition of moving away from home – and stated that "it is important that students receive the support they need to cope with these issues."[163] It then highlighted actions taken by the Government in this in this area, including:

- Analysing data on student suicides in England (see box 4).
- Supporting the launch of the Step Change framework for improving student mental health and wellbeing.
- Supporting the development of guidance for universities on preventing suicides.

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[162] HMG, *Preventing suicide in England: Fourth progress report of the cross-government outcomes strategy to save lives*, January 2019, p33

[163] *Ibid.*, p32

- Plans for a mental health charter.

More information on these is provided in the sections below. At outline of Government policy on student mental health more broadly was provided in response to a parliamentary question in May 2019.[164]

Guidance for universities on preventing student suicide

In September 2018, Universities UK (UUK) and PAPYRUS, a national charity dedicated to the prevention of young suicide, published Suicide Safer Universities, guidance for universities in preventing student suicides. The guidance states that suicide prevention, intervention and "postvention" should be connected as a specific strategy as a component of a university's overarching mental health strategy. The strategy, the guidance adds, should be created in partnership with staff, students, and external stakeholders, and should be developed into a multi-agency action plan detailing how, by who and when it will be implemented.[165]

The guidance also sets out best practice for universities in preventing student suicides, intervening when students get into difficulties, and responding to student suicides.[166] It ends with a checklist, setting out that universities should, among other things:

- Make suicide safety an institutional priority;
- Develop a suicide-safer strategy and action-plan as a distinct component of their overarching mental health strategy;
- Train suicide intervention and postvention teams, and train all student-facing staff in suicide awareness;
- Create strong links with local and national partners rom the health sector, voluntary sector, and local authorities; and
- Work together with schools, colleges and other universities in the area to ensure smooth transitions between educational settings.[167]

Box 4: ONS estimates of suicide among higher education students

Public Health England has worked with the ONS to link higher education record data to suicide data. The resulting experimental statistics were published by the ONS in June 2018 and estimate suicide among higher education students in England and Wales. They found that:

- The suicide rate for students in England and Wales in the 2016-17 academic year was 4.7 deaths per 100,000 students, equating to 95 suicides. This was higher than in most earlier years, although the small numbers per year make it difficult to identify statistically significant differences.
- Between the 2012-13 and 2015-16 academic years the suicide rate of higher education students in England and Wales was significantly lower than for the

164 PQ 256293 [on Students: Mental Health], 23 May 2019
165 Universities UK and PAPYRUS, *Suicide-safe universities*, September 2018, p15
166 *Ibid*., pp17-19
167 *Ibid*., p21

general population of similar ages (figures for the 2016-17 academic year were provisional).

- Male students had a significantly higher rate of suicide than female students.
- The number of suicides in the analysis was lower than in previous ONS estimates. This is likely because it focused on higher education students only, while previous estimates also covered further education students.[168]

Step Change Framework

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 states that universities should adopt mental health as a strategic priority and should implement a whole university approach with students and staff involved at all stages. It also gives guidance on leadership, data, staff, prevention, early intervention, support, transition and partnerships.

In a May 2018 report, *Minding Our Future*, Universities UK argued that student mental health needs to become a shared priority, with services redesigned to integrate university support with NHS care more effectively. The report stated that in some areas universities, NHS organisations and local authorities are starting to form local partnerships to develop mental health strategies to improve services for students. Universities UK would, the report said, work with health and education bodies to identify how they can be best supported by national policy.[169]

Mental health charter

In June 2018, the then Higher Education Minister, Sam Gyimah, hosted a 'mental health summit' with universities, students and support groups to discuss better support for students. At the summit, Mr Gyimah announced that a new University Mental Health Charter would be developed with charities and HEIs.[170]

In July 2018, the charity Student Minds announced that it would lead the development of the Charter in partnership with the UPP Foundation, the Office for Students (OfS), National Union of Students (NUS) and Universities UK.[171] The Charter will be a UK-wide scheme to recognise and reward institutions that demonstrate good practice, make student and staff mental health a university-wide priority and deliver improved mental health and wellbeing outcomes. The content of the Charter aims to be published on the Student Minds website in December 2019, before assessment development and piloting in 2020, with a view to launching the scheme later in 2020. Further information on the Charter

168 ONS, *Estimating suicide among higher education students, England and Wales: Experimental Statistics*, 25 June 2018
169 Universities UK, *Minding Our Future: Starting a conversation about the support of student mental health*, May 2018
170 New package of measures announced on student mental health, Department for Education press release, 28 June 2018
171 Student Minds launch University Mental Health Charter, Student Minds press release, 4 July 2018

is available on the Student Minds website at University Mental Health Charter FAQs.

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

- A Department for Education-led working group would be set up into the transition students face when going to university. In March 2019, the DfE announced that a new taskforce – the Education Transitions Network – had been set up to look at how students moving to university can be better supporting in their first year.[172]
- The Government would explore whether an opt-in requirement for universities could be considered, so they could have permission to share information on student mental health with parents or a trusted person.[173] A UUK task group is exploring how students' families can be better involved in mental health support while ensuring that the confidentiality rights of students are respected.[174] In June 2019, the Higher Education Policy Institute published their annual Student Academic Experience Survey 2019. The report questioned students about their wellbeing and asked if they would be happy for their institution to contact their parents if there were a concern about their mental health. 66% of students were happy for their parents to be contacted in the event of extreme circumstances; 18% were not happy for their parents to be contacted at all.[175]

Reports

Student mental health has been the focus of a number of reports in recent years, including:

- Higher Education Policy Institute, *Measuring well-being in higher education*, May 2019
- Insight Network, *University Student Mental Health Survey 2018*, March 2019
- Education Policy Institute, *Prevalence of mental health issues within the student-aged population,* 10 September 2018
- Universities UK, *Minding our future. Starting a conversation about the support of student mental health,* 11 May 2018
- IPPR, *Not by degrees: Improving student mental health in the UK's universities*, September 2017
- Association of Colleges, AoC survey on students with mental health conditions in Further Education, January 2017.
- Higher Education Policy Institute, *The invisible problem? Improving students' mental health,* September 2016

172 Government creates new student mental health taskforce, DfE press release, 7 March 2019
173 New package of measures announced on student mental health, DfE press release, 28 June 2018
174 Government creates new student mental health taskforce, DfE press release, 7 March 2019
175 HEPI, *Student Academic Experience Survey 2019*, June 2019, p42

5.3 Devolved nations

Scotland

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

The Plan commits to ensuring that "by the end of academic year 2019/20, every local authority will be offered training for teachers in mental health first aid, using a 'train the trainer' model to enable dissemination to all schools." It additionally notes that the higher and further sectors "are already engaging with relevant partners, including NUS Scotland, on how to develop further, their responses to the mental health needs of students."[176]

Information on the Scottish Government's approach to promoting mental health more generally is contained in the *Mental Health Strategy 2017-2027*. This strategy highlights the role of education in promoting mental health and states that "support from teachers and other school staff can be vital in helping ensure the mental wellbeing of children and young people." It adds that the Scottish Government will "empower and support local services to provide early access to effective supports and interventions at tiers 1 and 2 and to use specialist CAMHS expertise where it will be most effective."[177]

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

- Reviewing Personal and Social Education (PSE), the role of pastoral guidance in local authority schools, and services for counselling for children and young people; and
- Rolling out improved mental health training for those who support young people in educational settings.[178]

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

> Students of further and higher education face some unique challenges, but we want to ensure a consistent level of support for mental health across the country. These education settings also provide opportunities to help address stigma and discrimination, and support efforts towards self-management.
>
> Working with the NUS, we've supported their "Think Positive" project and we will work to explore how this can be developed

[176] Scottish Government, *Every Life Matters: Scotland's Suicide Prevention Action Plan*, August 2018, pp10 & 16
[177] Scottish Government, *Mental Health Strategy: 2017-2027*, March 2017, p8
[178] *Ibid*., p4

and built upon in the coming years, particularly for the most vulnerable students.[179]

Wales

The Welsh Government's current suicide prevention strategy – *Suicide and self harm prevention strategy for Wales 2015-2020* – highlights schools, further and higher education establishments as among the "priority places" where suicide prevention efforts should be focused.

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

- School-based suicide prevention programmes are designed to either reduce risk, and/or increase protective factors by: increasing knowledge and understanding of suicide; changing attitudes towards suicide; and increasing awareness of risk factors and encouraging help seeking behaviour;
- School based prevention programmes are not in routine use in Wales. There is some evidence that they have a short term impact but it is not known if these changes persist in the longer term; and that
- There is evidence that training for individuals who frequently come in to contact with people at risk of suicide, including teachers, increases confidence in recognising those who may be at risk of suicide and referring them appropriately for help. Whether or not such training has an impact on suicidal behaviour has however not yet been established.[180]

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.[181]

Northern Ireland

Northern Ireland's new suicide prevention strategy – *Protect Life 2 2019-2024* – was published in September 2019. The strategy highlights a number of actions taken under the previous suicide prevention strategy (Protect Life 2006-2016) aimed at younger age groups, including:

- Suicide prevention training for teachers;
- Guidance on responding to 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; and

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179 *Ibid*., p18
180 Welsh Government, *Suicide and self harm prevention strategy for Wales 2015-2020*, June 2015, pp24-5
181 *Ibid*., p25

- Broader guidance on suicide prevention in schools – Protecting Life in Schools – developed as part of the "iMatter" programme and published in March 2016.

On the approach to suicide prevention in schools, the strategy states:

> Evidence indicates that an approach which emphasises broader positive mental health and incorporates training in coping skills is most effective for the school setting. In this regard, suicide prevention in schools is focussed on strengthening pupils' self-esteem and emotional resilience, preventing bullying, raising understanding of the importance of positive mental health, provision of an independent counselling service, and (where an incident has occurred) ensuring that appropriate crisis response plans are activated and skilled staff in place.[182]

Regarding future developments, the strategy states that the Department of Education, the Department of Health, the Public Health Agency and the Education Authority have started work on developing "a joined up framework across government for supporting the emotional health and wellbeing of children and young people." It adds that this will include further consideration of child focussed interventions, building on what is already in place through the "iMatter" programme.[183]

On further and higher education, the strategy cites evidence that students are "experiencing increasing levels of stress, anxiety, mental illness, and suicidal behaviour" and states that the need for more preventative action has been recognised. It adds that "there is a growing appreciation of the need for a whole university / college approach to mental health and wellbeing" and cites the development of the UK-wide University Mental Health Charter (see Section 1.2 above).[184]

The strategy outlines the key objectives and associated actions underpinning the strategy. A number of actions explicitly refer to schools, and further and higher education institutions:

> 1.4 Develop a joined up framework across government to support the wellbeing of children and young people in educational settings and beyond. This will include the development and implementation of policies and guidance which promote emotional resilience in educational settings.
>
> […]
>
> 4.5 Encourage universities, colleges, schools and training organisations to promote a culture of help-seeking behaviour and suicide prevention awareness among their students and trainees.
>
> […]
>
> 9.9 Support for school staff to help them provide effective support to children & young people affected by suicide or suicidal behaviours at home.[185]

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[182] NIDH, *Protect Life 2: A Strategy for Preventing Suicide and Self Harm in Northern Ireland 2019-2024*, September 2019, pp36-7.
[183] *Ibid*, p37
[184] *Ibid*., p47
[185] *Ibid.*, pp57-8 & 60-1

A more detailed, timetabled implementation plan will be developed by the Public Health Agency working with a newly formed Protect Life 2 Strategy Steering Group.[186]

[186] *Ibid.*, p55

6. Employment

6.1 Suicide rates by occupation

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

- Men working in the lowest-skilled occupations had a 44% higher risk of suicide than men as a whole;
- Risk of suicide among men who were labourers was 3 times higher than men as a whole;
- For women, the risk of suicide among professionals was 24% higher than for women as a whole – this is mostly explained by high risk of suicide among female nurses;
- Carers, both men and women, had higher risk of suicide than average; and
- Managers, directors and senior officials – the highest paid occupation group – had the lowest risk of suicide.[187]

6.2 Employment policy and mental illness

The Government acknowledges that unemployment rates for people with mental health issues remains high and that those who are unemployed can face additional challenges that lead to poorer mental health.[188] It also recognises that there are complex reasons for increased suicide risks in different occupations and that there is a need for support for employers.[189] The Department for Work and Pensions and the Department for Health and Social Care are working together through the joint Work and Health Unit (WHU) to explore how more people living with mental health problems can be supported to find or stay in work.

Thriving at work (the Stevenson/Farmer Review)

On 9 January 2017, the then Prime Minister, Theresa May, 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".[190] The review report - *Thriving at Work: the Stevenson / Farmer review of mental health and employers* - was published on 26 October 2017. It 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

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

188 HMG, *Preventing suicide in England: Fourth progress report of the cross-government outcomes strategy to save lives*, January 2019, para. 2.44.

189 *Ibid*., para. 1.41.

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

> 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:
>
> - Produce, implement and communicate a mental health at work plan
> - Develop mental health awareness among employees
> - Encourage open conversations about mental health and the support available when employees are struggling
> - Provide your employees with good working conditions
> - Promote effective people management
> - Routinely monitor employee mental health and wellbeing.[191]

Improving Lives: The Future of Work, Health and Disability

On 30 November 2017, the Government published *Improving Lives: The Future of Work, Health and Disability*, a response to the Green Paper published in October 2016. The paper set out a 10-year strategy focussing on three areas: welfare, the workplace and healthcare. Its vision for the workplace was explained in the following terms:

> In the workplace setting we want employers who have the support and confidence to recruit and retain disabled people and people with long-term health conditions, and to create healthy workplaces where people can thrive and progress.[192]

The paper supported, in full, all of the recommendations made by the *Thriving at work*. With respect to employers, the paper focussed on four key issues:

- Improving advice and support for employers of all sizes;
- Increasing transparency;
- Reforming Statutory Sick Pay; and
- Ensuring the right incentives and expectations are in place for employers.[193]

The WHU is overseeing the implementation of the recommendations.

Implementation of *Improving Lives*

As part of the strategy to improve advice for employers, the WHU, along with Public Health England (PHE), is supporting Mental Health at Work, a website launched by the mental health charity Mind and the Royal Foundation in September 2018. The website provides information and resources on mental health issues for employers. PHE has also

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191 Department for Work and Pensions [DWP] and DH, *Thriving at Work: the Stevenson / Farmer review of mental health and employers*, October 2017, p. 8.
192 DWP and DH, *Improving Lives: The Future of Work, Health and Disability*, Cm 9526, November 2017, p. 14.
193 *Ibid*., para. 28. See also Chapter 2 (pp. 24-34).

partnered with Business in the Community, a charity, to create a toolkit for employers on reducing the risk of suicide.[194]

In November 2018, the WHU published a voluntary framework for employers to report on steps they are taking to support disabled employees and ensure wellbeing in the workplace.[195] This is part of the strategy for improving transparency. The stated rationale is that "transparency and reporting are effective levers in driving the culture change required to build a more inclusive society."[196] The reporting framework is designed for employers with over 250 workers, although it can be applied by employers of any size. No statistics are held on the number of employers that are carrying out transparency reporting although the Government has said that it will be publishing a report on the implementation of the framework in October 2019.[197]

In January 2019, Paul Farmer, CEO of Mind and co-author of *Thriving at work*, published a blog post on the Mental Health at Work website assessing the progress that has been made in implementing the recommendations in his report. The blog states that "things are moving in the right direction". He also noted that progress was still needed on certain issues, including the reform of Statutory Sick Pay and the Government's proposal to expand the scope of the *Equality Act 2010* to cover more people with mental health problems.[198]

Health is everyone's business

On 18 July 2019, the Government published *Health is everyone's business*, a consultation on proposals to reduce ill health-related job loss.[199] The proposals in the consultation form part of the implementation of *Improving Lives* in the workplace setting. The key proposals include:

1. Making changes to the legal framework to encourage employers to support employees with health issues affecting work, and to intervene early during a period of sickness absence;
2. Reforming Statutory Sick Pay so that it is better enforced, more flexible and covers the lowest paid employees;
3. Improving occupational health provision by considering ways of reducing the costs, increasing market capacity and improving the value and quality of services, especially for small employers and self-employed people;
4. Improving employers' and self-employed people's access to good advice and support, ensuring that all employers

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194 PHE and Business in the Community, *Reducing the risk of suicide: a toolkit for employers*, March 2017.
195 DWP and DHSC, *Voluntary Reporting on Disability, Mental Health and Wellbeing*, November 2018.
196 *Ibid*., p. 3.
197 PQ 290364 [on Employment: Disability] 02 October 2019 and PQ 290900 [on Department for Work and Pensions: Disability and Health] 03 October 2019.
198 Paul Farmer, *What progress has been made when it comes to Thriving at Work?*, Mental Health at Work, 17 January 2019.
199 HMG, *Health is everyone's business: Proposals to reduce ill health-related job loss*, CP 134, July 2019.

> understand and are able to act on their responsibilities to their employees. [200]

Right to request workplace modifications

One of the main proposals is the creation of a new right to request workplace modification.

Currently, under the *Equality Act 2010*, employers have a duty to make reasonable adjustments for employees who have a disability.[201] This duty only applies where the employee has a disability as defined by section 6 of the Act:

> (1) A person (P) has a disability if—
>
> (a) P has a physical or mental impairment, and
>
> (b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.

The consultation recognises that there are workers with health conditions who may not fall within this definition. The Government is seeking views on whether to introduce a right to request workplace modifications that would apply to a broader range of workers.[202] The paper sets out a number of potential eligibility tests, ranging from workers who have taken long-term sickness absences (four weeks or more) to a worker returning from a sickness absence of any length. It also suggests that unlike the existing duty to make reasonable adjustments, employers could refuse to make modifications in certain cases. The new right could be modelled on the right to request flexible working where employers can refuse requests on certain grounds listed in statute.[203]

Reform of statutory sick pay

The need for reform of statutory sick pay (SSP) was first raised in the Green Paper in 2016. Reforming SSP was one of the recommendations in *Thriving at work* and was accepted by the Government in *Improving lives*.

Currently, eligibility for SSP is limited to employees who earn above the Lower Earnings Limit (£118 per week). SSP is paid when an employee has a period of incapacity from work (defined as a period of sickness lasting four or more consecutive days). It is payable from the fourth qualifying day of sickness absence ('qualifying day' usually means the employee's contracted working days). SSP is available for up to 28 weeks in a three-year period and is paid at the rate of £94.25 per week. Payment of SSP ends when an employee returns to work.[204]

The consultation contains a number of proposals for reforming SSP, including:

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200 *Ibid*., para. 12.
201 *Equality Act 2010*, sections 20-22.
202 HMG, *Health is everyone's business: Proposals to reduce ill health-related job loss*, CP 134, July 2019, paras 48-64.
203 See *Employment Rights Act 1996*, section 80G.
204 See, Commons Library briefing CBP-7245, *Key Employment Rights,* 23 November 2018, Section 24.

- Allowing SSP to continue during phased returns to work (i.e. wages and SSP paid *pro rata*);
- Extending SSP to employees who earn under the Lower Earnings Limit;
- Removing the concept of qualifying days;
- Charging a new single labour market enforcement body with the enforcement of SSP;
- Increasing the penalty (currently £3,000) for the non-payment of SSP following a HMRC or Employment Tribunal decision on liability; and
- Adopting a targeted rebate of SSP for SMEs.[205]

The consultation closed on 7 October 2019.

[205] HMG, *Health is everyone's business: Proposals to reduce ill health-related job loss*, CP 134, July 2019, paras 78-123.

7. Social security

7.1 Benefit claimants and mental health

At February 2019, of the 2.07 million claimants of Employment and Support Allowance (an income replacement benefit for people with health conditions and disabilities), 1.05 million (51%) were recorded as having a mental or behavioural disorder as their main disabling condition. As of July 2019, of the 2.20 million claimants of Personal Independence Payment (which helps claimants with the extra costs of disability and is replacing Disability Living Allowance for people of working age), around 769,000 (35%) had a mental or behavioural disorder as their main disabling condition.[206]

In both benefits, the proportion of claimants whose main disabling condition is a mental and behavioural disorder is highest among the youngest age groups. 68% of ESA claimants and 67% of PIP claimants in the under-35 age category have a mental or behavioural disorder as their main condition.[207]

The Department for Work and Pensions (DWP) does not publish statistics on how many claimants have a mental or behavioural disorder *in addition* to another condition which is their main disabling condition. Therefore, the total numbers of ESA and PIP claimants with a mental or behavioural disorder will be greater than those above.

Since 2012, the DWP has been undertaking internal reviews (around 20-25 a year[208]) in cases where it is alleged the Department's actions are linked to the death of a benefit recipient. Government's Suicide Prevention Strategy states that these "Internal Process Reviews" (formerly known as "Peer Reviews") are "a tool for staff to look at the handling of a specific case":

> The purpose is to scrutinise Department for Work and Pensions handling of particular cases to identify whether processes have been properly followed and if appropriate, identify recommendations for changes to the process. It is a mechanism aimed at ensuring we learn lessons and take appropriate action, rather than about apportioning blame.[209]

Following a ruling of the Information Tribunal in May 2016[210], the DWP published redacted copies of 49 Internal Process Reviews.[211] A further Freedom of Information (FoI) response in September 2018 – following a request submitted by Disability News Service (DNS) – gives information on reviews conducted since April 2016 and recommendations made.[212]

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206 Source: DWP Stat-Xplore
207 *Ibid*.
208 HC Deb 4 July 2019 cc1353-9
209 HMG, *Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives*, January 2017, para. 94
210 *John Pring v IC & Department of Work & Pensions (Freedom of Information Act 2000)* [2016] UKFTT 2015_0237 (GRC) (20 April 2016)
211 See DWP, Peer reviews of handling of benefit claims, 12 May 2016
212 DWP FoI response VTR 2897, 17 September 2018

7.2 Training and guidance for DWP staff

The DWP states that it has systems in place to ensure that Jobcentre staff can identify people at risk of suicide or self-harm and refer them to appropriate local sources of help, but it does not collate records of how many such referrals are made.[213]

It further states that it provides "substantial and specific instructions to staff on how to support vulnerable people throughout their benefit journey."[214] 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.[215] 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.

An overview of the DWP's approach is given in the Fourth Progress Report on the Government's Suicide Prevention Strategy, published in January 2019.[216] More detailed information – including the DWP's 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 – was released in November 2017 in response to an FoI request.[217] Guidance for DWP staff on handling situations where claimants say they intend to harm or kill themselves is also given in the Universal Credit Full Service Guidance chapter Suicide and self-harm.[218]

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 (the DWP refers to these as "core visits") – where staff make attempts to contact the person before a decision is made to impose a sanction or terminate a claim.

In a PQ response 2016, DWP said that it had no intention to publish the internal guidance on safeguards "as it is for Departmental use only."[219]

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

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

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

216 HMG, *Preventing suicide in England: Fourth progress report of the cross-government outcomes strategy to save lives*, January 2019, paras 2.44-2.51

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

218 DWP, *Universal Credit Full Service Guidance: Suicide and self-harm*, Version 2.0, current March 2019

219 See PQs 42575 [on Personal Independence Payment: Mental Illness], 42576 [on Jobseeker's Allowance: Mental Illness], 42577 [on Employment and Support

The Royal Greenwich Welfare Rights Service has produced a detailed Benefit Safeguards Briefing[220] 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.

Despite policies and protocols that should be in place, there have been calls on the DWP to do more to identify vulnerable claimants, to strengthen safeguards and to apply them consistently.[221] In response to a case in 2017[222] where the DWP was found not to have followed its own procedures when it stopped a woman's benefits after she missed a Work Capability Assessment, and she took her own life 15 days later, a petition was presented to Parliament calling for, among other things, an independent inquiry to investigate the DWP's "failings" in relation to benefit-related deaths, "including whether there has been misconduct by civil servants or Ministers."[223] The petition, which closed on 15 September 2019, received 55,784 signatures. In its response, the Government said that it "apologised unreservedly" for the failings in this particular case, but had no plans to hold an inquiry into deaths relating to actions taken by the DWP.

In her latest annual report on DWP complaints, published on 12 September, the Independent Case Examiner, Joanna Wallace, voiced concern about the number of instances where the DWP had not followed safeguarding procedures aimed at protecting vulnerable claimants. While acknowledging that many of the Department's policies and procedures recognised the need for safeguarding, Ms Wallace added:

> …too often this year I have seen cases where those steps have not been followed. I don't wait until my annual report to raise concerns and have been doing so during the year, particularly with regard to DWP's services to working age people. Very recent discussions reassure me that real action is being taken to make sure these vulnerability safeguards do work effectively – and also that my concerns about meeting vulnerable customers' needs are shared at the highest levels in DWP. It is an important matter and I will continue to pay close attention to it in the coming year.[224]

An internal review of the Department's safeguarding policy and guidance for staff – covering "all areas of DWP delivery activities" – is currently underway and is due to report in autumn 2019.[225]

Allowance: Mental Illness], and 42578 [on Universal Credit: Mental Illness], 21 July 2016

220 Available on the Rightsnet website, last updated October 2017

221 See Owen Stevens, UC and complex needs, CPAG Welfare Rights Bulletin 271, August 2019

222 See Benefits officials' apology after mum's suicide, *BBC News*, 10 June 2019

223 See Justice for Jodey Whiting: Independent inquiry into deaths linked to the DWP

224 DWP complaints: Annual report by the Independent Case Examiner 2018 to 2019, 12 September 2019, p4

225 HC Deb 4 July 2019 c1355

7.3 ESA and PIP assessments

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

The Work Capability Assessment and "substantial risk"

There are provisions in legislation under which people not scoring sufficient points in the Work Capability Assessment (WCA) – would otherwise be found "fit for work" – can nevertheless be treated as having a limited capability for work, or for work-related activity, as appropriate, if "exceptional circumstances" apply. This includes where 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 or limited capability for work-related activity.

The rules on "substantial risk" in relation to mental health are set out in Appendix 6 of the CDHA's Revised WCA Handbook.[226] Revised guidance on substantial risk was issued by DWP in 2015 and implemented in early 2016. The Revised WCA Handbook states:

> The main change is that the focus on suicide has been reduced and the question of substantial risk placed in the context of work-related activity (WRA). The Department's approach is that tailored WRA may be appropriate for most people with mental health conditions, including for people with suicidal thoughts.[227]

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

Assessment procedures

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

> If an individual has a mental health condition or there is any indication that a claimant has suicidal thoughts or intentions, assessors are trained to explore the person's circumstances

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[226] Centre for Health and Disability Assessments, *Revised WCA Handbook*, MED-ESAAR2011/2012HB~001, updated 7 February 2019

[227] *Ibid*., para. 3.8.2.1

> 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.[228]

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

Work and Pensions Committee inquiry

In September 2017 the Work and Pensions Committee launched an inquiry examining the effectiveness of assessment processes used to determine eligibility for PIP and ESA.[229] In November 2017 *The Guardian* reported that the Committee had been "deluged by people sharing stories about being denied disability benefits or battles to keep their entitlements."[230] An online forum launched to allow people to share their experiences received nearly 4,000 individual submissions, the most ever received by a select committee inquiry. 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.
- Assessors overlooking disabilities or illnesses that are not immediately visible.

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

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

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228 PQ 193 [on Social Security Benefits: Mental Illness], 27 June 2017
229 See PIP and ESA Assessments inquiry, Work and Pensions Committee website
230 Inquiry into disability benefits 'deluged' by tales of despair, *The Guardian*, 27 November 2017

- Claimants regularly report that their concerns are not taken seriously by assessors and that their statements are routinely ignored.
- Assessors often do not have the necessary knowledge or expertise to assess the impact of mental health problems.
- The nature of face to face assessments leading claimants to break down due to the distress it causes them, only for the written report to state that the claimant coped well.
- People finding the whole claims, assessment and appeals process confusing and threatening, with detrimental effects in their mental health.
- Instances where the assessment process has led to people being hospitalised, have their medication increased, or attempt to take their own lives.
- Dissatisfaction with the "Mandatory Reconsideration" process for challenging decisions, which many claimants viewed as a tool to dissuade people going to appeal.
- Claimants or those supporting them are not taking their claim to appeal because of the distress the process had caused them up to that point, and/or being overwhelmed at the thought of going through the appeals process.
- Although some people expressed dissatisfaction with the appeals process, the most common view was that the appeals stage was the first time when the full range of information presented as part of the assessment process had been properly considered.
- Appeals Tribunals expressing surprise at the high levels of disabilities among people with mental health conditions who had been initially assessed as not eligible for PIP.[231]

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

In December 2017, Rethink Mental Illness published a report, 'It's broken her': Assessments for disability benefits and mental health. Drawing on findings from a series of interviews and a focus group-style discussion with people with personal experience of the Work Capability Assessment and of mental illness which took place in January 2017, and an online survey conducted in April 2017 which had over 650 respondents, the report found that assessments can be "traumatising and anxiety-inducing" for the following reasons:[232]

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231 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

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

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

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

- Major reform of the PIP and ESA assessments to reduce the distress caused to people affected by mental illness and better reflect the realities of living with mental health conditions.
- Exempt claimants from face-to-face assessments where clear medical evidence exists that they have severe forms of mental illness, and where assessments are necessary claimants should be 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.[233]

The Work and Pensions Committee's report – together with a separate report detailing claimant experiences of PIP and ESA assessments – was published in February 2018.[234] The Committee found that failings in the end to end processes had contributed to a lack of trust in both benefits and undermined confidence among claimants. It made a series of recommendations covering, amongst other things, the recording of assessments, the supply and use of evidence, the clarity of communications, and guidance in relation to home assessments and the role of companions at assessments. The Committee did not make any specific recommendations regarding the assessment of people with mental health conditions, but in light of evidence received from claimants and from organisations it said that the Department for Work and Pensions should demonstrate that it was "alert to the risk to mental health posed by parts of the application processes and seek to offset this." Accordingly, it recommended that:

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

[233] *Ibid*., p18
[234] Word and Pensions Committee, *PIP and ESA assessments*, HC 829 2017-19, 14 February 2018; Work and Pensions Committee, *PIP and ESA assessments: claimant experiences*, HC 355 2017-19, 9 February 2018

> application forms, identifying how they can be made more claimant-friendly and less distressing for claimants to fill in.[235]

In its response published on 18 April 2018, the Government said that it would commission research from external contractors to cover whether any aspects of ESA and PIP claim forms have the potential to cause distress, to identify what changes should be made, and to test the revised forms with applicants. This work would commence in summer 2018 and a report would be published in 2019.[236]

All assessors carrying out Work Capability Assessments were given face to face training on "exploring self-harm and suicidal ideation" in May 2018. The training, which was quality assured by the Royal College of Psychiatrists, was designed to enhance assessors' skills in sensitively exploring these subjects when undertaking assessments.[237]

Reassessing ESA and PIP claimants

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

In September 2017 the Department for Work and Pensions announced criteria for "switching off" reassessments for ESA claimants in the Support Group with severe, lifelong disabilities illnesses or health conditions who are unlikely ever to be able to work. In order to qualify, the person's condition must be permanent, there must be no realistic prospect of recovery, and the condition must be unambiguous. Examples given in DWP guidance do not include any mental health conditions, although the guidance states the lists are not exhaustive.[238]

In June 2018 the Government announced that people awarded the highest level of support under PIP whose "needs are expected to stay the same or increase" would be given "ongoing" PIP awards and would only have to face a "light touch" review every 10 years.[239] DWP is working with stakeholders to design the light touch review process.

Further information is given in Commons Library briefing CBP-7820, ESA and PIP reassessments, 10 May 2019

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235 Word and Pensions Committee, *PIP and ESA assessments*, HC 829 2017-19, 14 February 2018, para. 21

236 DWP, *PIP and ESA assessments: Government Response to the Committee's Seventh Report of 2017–19*, HC 986 2017-18

237 HMG, *Preventing suicide in England: fourth progress report of the cross-government outcomes strategy to save lives*, January 2019, paras 2.49

238 Centre for Health and Disability Assessments, Revised WCA Handbook, 7 February 2019, Appendix 8

239 Government to end unnecessary PIP reviews for people with most severe health conditions' DWP press release, 18 June 2018

7.4 Conditionality and sanctions

A benefit sanction – withdrawal of benefit or a reduction in the amount of benefit paid for a certain period – may be imposed if a claimant is deemed not to have complied with a condition for receiving the benefit in question. Further information on the conditionality and sanction regimes for Jobseeker's Allowance, Employment and Support Allowance and Universal Credit claimants can be found in Commons Library briefing CBP-7813, *Benefit Claimants Sanctions (Required Assessment) Bill 2016-17*, 30 November 2016.

In response to a PQ in 2014 on what assessment the DWP had made of the effect of benefit sanctions on the mental health of claimants, the then Minister of State for Employment Alok Sharma said:

> No assessment has been made on the impact of benefit sanctions on the mental health of claimants.
>
> We engage at a personal and individual level with all of our claimants and are committed to tailoring support for specific individual needs, including agreeing realistic and structured steps to encourage claimants into the labour market. These conditionality requirements are regularly reviewed to ensure that they remain appropriate for the claimant.
>
> When considering whether a sanction is appropriate, a Decision Maker will take all the claimant's individual circumstances, including any health conditions or disabilities and any evidence of good reason, into account before deciding whether a sanction is warranted.[240]

A recent major research programme concluded, however, that welfare conditionality was "largely ineffective in facilitating people's entry into or progression within the paid labour market over time." Instead, it found that for a significant number of respondents, conditionality "triggered a sustained range of negative behaviour changes and outcomes" which included, amongst other things, disengagement, increased poverty or destitution, and exacerbated mental health conditions.[241]

On 12 April 2018 the Work and Pensions Committee launched an inquiry into Benefit sanctions. Amongst other things, the inquiry considered the evidence base for the impact of sanctions, and the robustness of the evidence base for the current use of sanctions as a means of achieving policy objectives.

In its subsequent report published on 6 November 2018, the Committee noted that witnesses had stressed the "disproportionate impact of both the threat, and application of sanctions on disabled claimants' well-being:[242]

> Among others, the British Psychological Society highlighted the particularly damaging effect the threat of sanctions can have on claimants with mental ill health. It stated, "the threat of sanctions

240 PQ 166197 [on Social Security Benefits: Disqualification], 24 July 2018
241 Department of Social Policy and Social Work, University of York, *Final findings report: Welfare Conditionality Project 2013-2018*, 9 July 2018
242 Work and Pensions Committee, *Benefit Sanctions*, HC 955 2017-19, November 2018, para. 55

> can trigger or exacerbate mental health conditions", which was reflected in a YouGov survey of over 2,000 people in contact with secondary mental health services. It found that 29% of those who had considered taking their own life mentioned the fear of losing welfare benefits. Mind, the mental health charity, described the "significant amount of anxiety" experienced by people with mental health problems "as they attempt to navigate the system in good faith".[243]

The Committee concluded that the Government had presented no evidence that conditionality and sanctions were improving employment outcomes for disabled people and those with health conditions. It recommended that the Government immediately stop imposing conditionality and sanctions on anyone found to have limited capability for work, or who presents a valid doctor's note stating they cannot work. Instead, it should work with experts to develop a programme of voluntary employment support for those who can get into work.[244]

In its response published in February 2019, the DWP said that it would explore the possibility of a general policy not to apply conditionality to people waiting for a Work Capability Assessment, although the decision would be left to individual Work Coaches. It did not accept the recommendation to exempt claimants found fit for work who continue to present a fit note, however, as this would "undermine the WCA process and create a loophole whereby claimants could avoid conditionality indefinitely despite being 'fit for work'."[245] It emphasised that Work Coaches had he discretion to tailor work-related requirements to individuals' needs and abilities, based on what was considered reasonable in light of their health condition.[246]

In a Written Ministerial Statement on 9 May 2019, the then Secretary of State for Work and Pensions, Amber Rudd, said that three-year sanctions (which may be imposed on JSA or Universal Credit claimants for repeated failures to comply with work-related requirements), while rarely used, were "counter-productive and ultimately undermine our goal of supporting people into work." The maximum sanction period is therefore to reduce to six months by the end of the year. Ms Rudd also announced that the DWP was carrying out a further evaluation of the effectiveness of UC sanctions at supporting claimants to search for work, and would consider what other improvements could be made in light of this.[247]

7.5 Universal Credit

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

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243 *Ibid*.
244 *Ibid*., para. 63
245 DWP, *Benefit sanctions: Government Response to the Committee's Nineteenth Report of Session 2017-19*, HC 1949 2017-19, 11 February 2019, para. 36
246 *Ibid*., paras 38, 40
247 Labour Market Policy Update: Written statement HCWS1545, 9 May 2019

Charities and pressure groups are concerned that vulnerable people with mental health conditions may face particular problems navigating the Universal Credit system.[248] Concern includes, amongst other things, people's ability to cope with single monthly payments in arrears, making and managing claims online, and the possibility that people may be subject to inappropriate "conditionality" requirements. While there are arrangements to identify people who might need help to make and manage a claim for UC, or who should be offered additional support, organisations believe that such safeguards as exist are inadequate, leaving open the risk that vulnerable people who struggle to engage with the system will be left without a source of income. They also point out that the removal of "implicit consent" in UC makes it harder for advisers and support workers to advocate for their clients.[249]

The Universal Credit Full Service has been available in all parts of the UK since December 2018. Existing benefit and tax credit claimants who have not moved onto UC following a change in their circumstances will transfer to UC by a process known as "managed migration." Over two million households are expected to move onto UC by managed migration, of which around 745,000 will have been claiming Employment and Support Allowance.[250]

A managed migration pilot – "Move to UC" – which will involve around 10,000 claimants in the Harrogate area began in July 2019.[251] In light of the lessons learned from this, the DWP will then seek parliamentary approval for the main phase of managed migration, which is expected to get underway in late 2020 and be completed by December 2023.

Initial plans for managed migration were set out in draft regulations published in June 2018, which were the subject of a public consultation launched by the Social Security Advisor Committee.[252] A key concern of stakeholder organisations was that the proposed approach placed the burdens of arranging the move to UC, and the financial risks associated with it, almost entirely on claimants themselves. Many were worried that vulnerable people who fail to engage with the Universal Credit system could lose their financial support completely.

The mental health charity Mind was particularly concerned that the requirements for people to have read and understood communications about managed migration, to contact the DWP within a given

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

249 Where implicit consent is accepted, a third party can deal with the DWP on behalf of a claimant in the absence of valid written authority, or where the claimant is not present at the time to confirm their consent verbally. In the UC Full Service, the claimant must provide explicit consent before information can be disclosed to a representative – although an exception has been made for Members of Parliament. For further information see the DWP UC Full Service guidance on Consent and disclosure, Version 15.0, current March 2019

250 DWP, *Explanatory Memorandum for the draft Universal Credit (Managed Migration) Amendment Regulations 2018*, 1 June 2018, p29

251 For details see the DWP, *LA Welfare Direct Bulletin 7/2019 lite*, 20 September 2019

252 *Draft Universal Credit (Managed Migration) Regulations 2018: SSAC report and government statement*, November 2018

timeframe, and to articulate their case for an extension of the deadline to make claim, did not provide necessary safeguards for people at greatest risk. It suggested two alternative approaches to managed migration. The first would involve calculating a person's entitlement to UC automatically, using information already held by DWP on "legacy" benefit systems. The second would retain the requirement for the individual to make a claim for UC, but would remove the power to terminate the person's existing benefits until they have moved to UC. Mind argued that either approach, or a combination of both, would ensure that benefit payments are not interrupted throughout the process, which it believes is a "minimum requirement for managed migration if it is to avoid creating hardship."[253]

The DWP has resisted suggestions that it transfer claimants directly to Universal Credit, or "pre-populate" UC forms using information it already holds on individuals, citing concerns about data quality.[254] It did however announce other changes to the managed migration rules including:

- extending the minimum notice period that legacy benefit claimants receive before they are required to claim for Universal Credit from one month to three months; and
- a one month "grace period" for all claimants, so that if a person misses the deadline to apply for UC but applies within a month of that deadline, they remain entitled to transitional protection (under the original plans, this would have possible only in very limited circumstances.

The regulations also allow for the three-month period to be extended in individual cases, "…if analysis shows that certain claimants require more time, e.g. someone who is vulnerable or has complex needs."[255]

The DWP has said that in the managed migration pilot it does not intend to use its powers to terminate legacy benefits where a claimant has not made a UC claim, emphasising that its priority is "to ensure that claimants do not fall through the net during the process."[256]

As part of managed migration pilot the DWP is also testing a new approach to assisting vulnerable claimants and those with complex needs – "Who knows me?" – based on the hypothesis that organisations with an existing relationship with the claimant are best placed to support them through the move to Universal Credit.[257]

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253 Mind, *Universal Credit managed migration: Mind's response to the SSAC consultation*, August 2018

254 See the Work and Pensions Committee, *Universal Credit: managed migration*, HC 1762 2017-19, 22 November 2018; and the Government's response (HC 1901 2017-19, 23 January 2019)

255 DWP, *Explanatory Memorandum to the Universal Credit (Managed Migration Pilot and Miscellaneous Amendments Regulations 2019* (SI 2019/1152), para 7.2

256 DWP, *Universal Credit: tests for managed migration: Government Response*, HC 2499 2017-19, 5 July 2019, p2

257 See the letter from Neil Couling, UC Programme SRO, to Frank Field MP, 11 June 2019

7.6 Devolved nations

Northern Ireland

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

There are concerns that claimants in Northern Ireland will face a "cliff edge" if the mitigation package is not renewed, with thousands of households experiencing sharp falls in their incomes and some losing hundreds of pounds per month. A recent joint report by the Northern Ireland Affairs and Work and Pensions Committees today urges the Secretary of State for Northern Ireland to commit to legislation to extend the mitigation package beyond March 2020.[258] The Government has not yet given its response to the report.

Scotland

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

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

- A redesigned application process involving significantly fewer face to face assessments, which will be carried out by qualified assessors employed by Social Security Scotland rather than private sector contractors, and audio-recorded as standard.
- Moving the burden of collecting information from the client to Social Security Scotland. Case Managers will assume responsibility for gathering information from various sources suggested by the individual - such as family members, nurse specialists, charity support worker.
- Only in circumstances in which there is no other practicable way to make a decision about entitlement to assistance will an individual be required to attend an assessment.

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[258] Work and Pensions and the Northern Ireland Affairs Committees, *Welfare policy in Northern Ireland*, HC 2100 2017-19, 9 September 2019

- All awards will be made on a rolling basis, with no set date for an award ending.
- Reviews of awards will be "light-touch" and, as far as possible, minimise stress.
- In cases where there is no likelihood of improvement there will be at least five years between light-touch reviews.
- Awards will have a maximum period of 10 years between light-touch Reviews.[259]

In addition, participation in the devolved employment programmes in Scotland – now known as Fair Start Scotland – are voluntary, i.e. a person cannot be sanctioned if they refuse to participate.

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

> Within our social security agency we will equip our people to confidently handle and talk about mental health generally, including suicide awareness and prevention. Working with partners, we will develop and utilise a range of learning opportunities that fully equip social security agency staff to have a wider awareness of the challenges and circumstances the person may be facing; to possess a knowledge of the systems and support functions that are available; and importantly, to be skilled in having sensitive conversations including suicide awareness.[260]

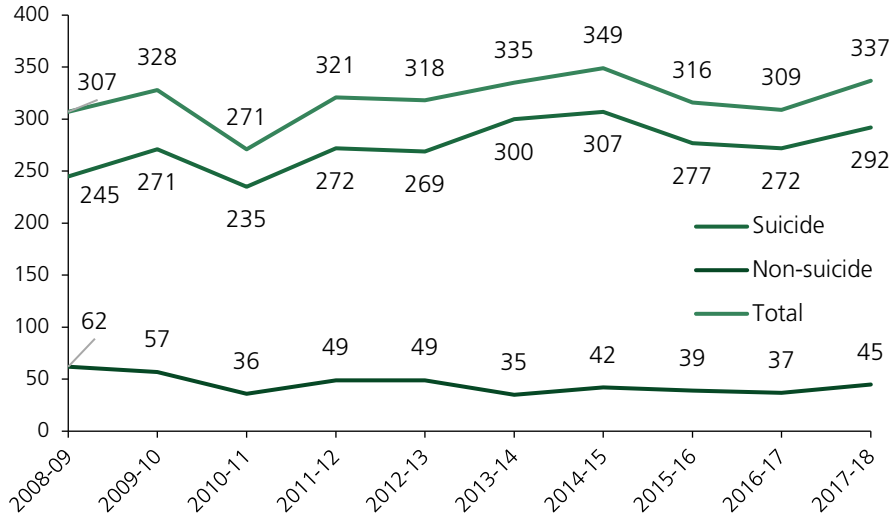
[259] Scottish Government, *Social security: policy position papers*, 28 February 2019
[260] Scottish Government, *Suicide Prevention Action Plan: Every Life Matters*, August 2018, p4

8. Transport

8.1 Railways

Suicide accounts for most fatalities on the railway: there were 337 public fatalities in 2017-18 (an increase of 9.1% from 2016-17), of which 292 were suicide or suspected suicide fatalities (an increase of 7.4% from 2016-17). 249 of the suicide related fatalities occurred on the mainline and 43 on the London Underground.[261] Such fatalities are higher than were realised a decade ago but have not shown any discernible trend since 2013-14.

Public fatalities on the railways[262]



Apart from the obvious human cost, there are additional costs for the railway from suicide, with an average additional operating cost of £198,000 per event, which at current rates total £60 million per year.[263]

British Transport Police

The British Transport Police (BTP) provide a police 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 BTP are on the frontline when it comes to preventing and responding to suicide on the railways. In 2015/16, the BTP dealt with some 9,381 mental health crisis and suicide-related incidents. These people are often removed from a place of danger and in most cases

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261 ORR, *Rail Safety Statistics – 2017-18 Annual Statistical Release*, 25 September 2018
262 *Ibid*.
263 BTP, *From Criss to Care – A strategy for supporting people in mental health crisis and preventing suicide on the railway, 2016-2019*, August 2016

detained under Section 136 of the *Mental Health Act 1983* or *Section 297 of the Mental Health (Care and Treatment) (Scotland) Act 2003*.[264]

One of the notable ways the BTP works in this area is by employing Suicide Prevention and Mental Health teams that bring together police officers and staff and psychiatric medical professionals. They signpost people to support and put in place suicide prevention plans for those who are vulnerable. They also provide support to families of those who have tried to harm themselves. For example, as explained by the BTP:[265]

> In London, we have introduced a foot patrol by a police officer and an NHS psychiatric nurse working together. Under the pilot scheme, they patrol the network aiming to identify people who are in crisis or vulnerable and need support. They also respond to calls to help other frontline officers dealing with people in crisis. This has helped to avoid inappropriate detentions under mental health legislation and ensure the right decisions are made to support the individual and protect them from harm.

Each year these teams will case manage over 2000 people who have presented on the railway in suicidal circumstances. This process has proved very successful with a very low return fatality rate of only 0.6%.[266]

BTP's approach to suicide is outlined in their document '*From Criss to Care – A strategy for supporting people in mental health crisis and preventing suicide on the railway, 2016-2019*', published in August 2016. The three strategic aims in the strategy are to:

1 prevent suicide occurring on Great Britain's railways;

2 support vulnerable people and those in mental health crisis on the railway; and

3 effectively manage the impacts of suicide on the railway.

It has several more detailed actions in the strategy around the core themes of the national suicide prevention strategy, including to:

- capture relevant data and analyse it to understand the vulnerability of people, places and times;
- work with local authorities to contribute to and support local Suicide Prevention Plans.
- provide post-event site visits to advise on preventative location-based options;
- work with the rail industry to identify national priority locations for suicide prevention engineering and community outreach activity;

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264 BTP, *From Criss to Care – A strategy for supporting people in mental health crisis and preventing suicide on the railway, 2016-2019*, August 2016

265 BTP, Preventing suicide on the railway [accessed 9 September 2019]

266 National Suicide Prevention Alliance, British Transport Police [accessed 9 September 2019]

- provide effective intervention and case management through use of statutory powers, the Suicide Prevention Plan process and joint BTP and Health Suicide Prevention and Mental Health teams;
- provide a professional response to suicidal incidents, which aims to protect life and minimise disruption; and
- provide effective training for BTP officers and staff through a suite of internal and external products.[267]

Partnership working

During 2017/18, BTP police officers and colleagues in local police forces, together with rail staff and members of the public, made 1,917 life-saving interventions (up from 1,837 in 2016-17), physically preventing people from taking or attempting to take their life on the rail network.[268] According to the BTP:

> Every suicide, including those that happen on the railway, costs the UK economy an estimated £1.7m. The lifesaving interventions made in 2017/18 represent a potential saving to the nation of some £3b and of some £390m, in operational costs and penalty payments to the rail industry.[269]

Much of the improvement and success in suicide prevention on the railway is down to partnership working. Samaritans is the main organisation that works with the railway industry to improve practice in relation to suicide education and training, prevention and "postvention" (dealing with the aftermath of incidents). Samaritans specifically:

- supports local railway stations to help those affected by potentially traumatic incidents;
- delivers training to people managers within the rail industry;
- attend stations to meet with local people, raise awareness of Samaritans' services and talk to anyone who may need support; and
- works with the rail industry to help prevent rail suicides. This work includes delivery of a suicide prevention course to frontline rail staff. There are 16,000 railway employees and stakeholders who are now trained in suicide prevention techniques, meaning that one in six employees are now able to support those who come to the railway in emotional crisis.[270]

Network Rail, which own and manages the country's railway infrastructure, also works closely with the BTP and Samaritans. In 2016, the BTP, Network Rail and Samaritans' suicide prevention partnership won the Charity Times Corporate Social Responsibility Project of the Year award.

BTP launched the Small Talk Saves Lives campaign in November 2017 with Samaritans and Network Rail and train operating companies. The

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267 BTP, *From Criss to Care – A strategy for supporting people in mental health crisis and preventing suicide on the railway, 2016-2019*, August 2016
268 BTP, *A Force for the future – Annual Report 2017/18*, 5 October 2018
269 *Ibid*., p25
270 Samaritans, *Supporting local railway stations* [accessed 9 September 2019]

first campaign of its type on the railway, aims to give commuters the confidence to trust their own instincts and intervene if they see someone vulnerable who may be at risk of suicide on or around the rail network, and to talk to them to interrupt their suicidal thoughts.[271] The second phase of the campaign launched in April 2018, with phase three launching in November 2018.

Department for Transport

The Third Progress Report of the Government's Suicide Prevention Strategy (2017) noted the Department of Transport (DfT)'s support for these suicide prevention measures, with the main initiative of the Department to incorporate the aims of the British Transport Police's Suicide Prevention Strategy and the railway Suicide Prevention Duty Holders Group's Nine-Point Plan into train operating franchise agreements as the minimum standard which train operators must meet.[272]

It further noted the DfT's work on suicide prevention on the railways, including 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.[273]

The Fourth Progress Report of the Strategy, published in noted that the DfT had established a suicide prevention awareness group in 2018, which:

> …brings together agencies from across the transport sector to work together in reducing transport-related suicides. This group comprises of members from a range of agencies including Network Rail, Highways England, British Transport Police, Transport for London, RNLI and the Maritime and Coastguard Agency.[274]

The report also noted that the DfT had, since the publication of the Third Progress Report, introduced provisions into train operator franchise agreements which require them to produce a suicide prevention strategy, working in collaboration with the British Transport Police, Network Rail and Samaritans to reduce instances of suicide on the railway.[275]

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271 Network Rail, *Suicide prevention campaigns* [accesses 9 September 2019]
272 HMG, *Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives*, January 2017, paras 109-5, pp27-8
273 *Ibid*., pp27-8
274 HMG, *Preventing suicide in England: Fourth progress report of the cross-government outcomes strategy to save lives*, January 2019, p40
275 *Ibid*.

8.2 Roads

Samaritans has extended its involvement with the transport sector by working with the Parliamentary Advisory Council for Transport Safety (PACTS) to produce a report into road suicide, which was launched in a special PACTS conference in October 2017. This report shows that roads, vehicles and road infrastructure are being used by individuals seeking to end their lives. The report revealed that there are likely to be around 50 deaths each year by suicide on UK roads. It provides evidence that this is likely an underestimate of the true number:

> Highways England has estimated that there were between 15 and 41 suicides per year on England's road network in the period 2001 to 2014. It is not possible to give a precise figure but, based on various sources, PACTS estimates that an average of over 50 deaths by suicide per year occur on the roads in the UK. The number of suicide attempts is also not known with any precision. However, depending on definition, it is vastly in excess of the number of deaths.[276]

The report noted that the issue of suicide on UK roads is under-researched, with data and awareness generally poor. The report went on to make several recommendations in this area, including:

- clarification of ministerial responsibilities and identification of road-related suicide in official guidance;
- changes to the standard of proof required for a suicide conclusion by coroners (as previously recommended by the House of Commons Health Select Committee), and improved reporting by coroners;
- standardised incident recording by the police and others in cases where suicide or attempted suicide is suspected;
- closer working on this issue by public health, highways, emergency services and voluntary sectors; and
- a review of how suicides are recorded and retained in road casualty reports (STATS19).[277]

Samaritans has also worked with Highways England to better understand suicide on the road network and explore ways of addressing it. In November 2017, Highways England published its Suicide Prevention Strategy which sets out how it will continue to contribute to the cross-government National Suicide Prevention Strategy through reducing the number of suicides and attempted suicides on the road network. It outlined several actions that it said would help it deliver its vision to prevent, intervene and provide postvention where necessary, including to:

- embedding the Suicide Prevention Strategy within Highways England, its supply chain and service providers;

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276 PACTS, *Suicides on UK Roads – Lifting the Lid*, October 2017
277 'PACTS launches new report: 'Suicide on UK roads – Lifting the Lid', PACTS press notice, 18 October 2017

- ensure effective internal working within Highways England through the development of an enhanced capability and the establishment of a Suicide Prevention Working Group;
- improve the collation, analysis and sharing of data to ensure they deliver more effective and inclusive suicide prevention plans;
- publish an Annual Suicide Prevention Report (starting in June 2018), evaluating progress, identifying future areas of work and generating a cycle of continuous improvement;
- work collaboratively with partners to further develop guidance on crisis intervention techniques and ensure that plans adopt a broad and inclusive approach;
- review and improve procedures and processes to support those affected by suicide and other traumatic events.[278]

[278] Highways England, *Suicide prevention strategy – Our approach*, November 2017

9. Prisons

9.1 Statistics

The Ministry of Justice (MoJ) publishes a quarterly report on safety in custody statistics for England and Wales which includes data on self-inflicted deaths and self-harm.

The most recent update, published in July 2019, states that in the 12 months to June 2019 there were 86 apparent self-inflicted deaths in the latest year (a rate of 1.0 per 1,000 prisoners), up 6% from 81 the previous year.[279]

In addition, the following self-harm figures were recorded in the 12 months to March 2019:

- 57,968 reported incidents of self-harm (a rate of 699 per 1,000 prisoners), up 24% from the previous year.
- The number of individuals self-harming increased by 6% in the 12 months to March 2019, to 12,539, and the average number of self-harm incidents per individual increased from 4.0 to 4.6.[280]

The Office for National Statistics (ONS) published a release on suicide in prison custody in England and Wales: 2008 to 2016 in July 2019 which found that:

> Male prisoners were at an increased risk of dying by suicide compared with the general male population; the risk of male prisoners dying by suicide was 3.7 times higher than the general male population during the nine-year period.[281]

However, the release notes that that while the ONS's analysis accounts for some risk factors that are overrepresented in the prison population (age and sex), it does not reflect others (for example, a history of mental health problems or substance misuse). As a result, the comparison should not, it says, be seen as indicating that there is an increased risk of suicide associated specifically with prison custody.

9.2 Prison service policy

The Prison Service Instruction (PSI) Safer Custody, issued by HM Prison and Probation Service to all prisons in England and Wales, details actions which must be taken by prisons to try to reduce incidents of self-harm and deaths in custody. It states that staff must identify prisoners at risk of self-harm and/or suicide. Prisoners at risk of harm to self must be managed using the Assessment, Care in Custody and Teamwork (ACCT) procedures set out in the PSI.

NICE has published a guideline – *Preventing suicide in community and custodial settings* – aimed at, amongst others, those working in prisons.

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279 Ministry of Justice and National Statistics bulletin, *Safety in Custody Statistics Bulletin England and Wales: Deaths in prison custody to June 2019; Assaults and Self-harm to March 2019*, 25 July 2019

280 *Ibid*.

281 Office for National Statistics, *Drug-related deaths and suicide in prison custody in England and Wales: 2008 to 2016*, 25 July 2019

9.3 Recent comment

HM Inspectorate of Prisons

In his Annual Report 2018-19, the Chief Inspector of Prisons said that levels of self-harm were disturbingly high and self-inflicted deaths tragically increased by nearly one-fifth on the previous year.

> Self-harm had increased in two-thirds of the adult male prisons we inspected this year, and we made main recommendations about serious deficiencies in suicide and selfharm prevention measures at 14 of them.[282]

The report states that at more than half of inspected adult male prisons, the quality of support for prisoners in crisis, delivered through ACCT case management, was weak.

The Chief Inspector called for an independent external inquiry on self-inflicted deaths in prisons:

> At a press conference to launch the report, Clarke said: "Is it time, after years and years and years of the same faults, same mistakes, same admissions leading to self-inflicted deaths, is it time for there to be an independent external inquiry into this whole subject?"
>
> "It is no exaggeration to say it is a scandal. People in the care of the state are dying unnecessarily in preventable circumstances."[283]

Independent Monitoring Boards

Dame Anne Owens, Chair of the Independent Monitoring Boards; giving oral evidence to the Justice Committee in July 2019 expressed surprise that there is much less public and ministerial concern about deaths in prisons when contrasted with deaths in police custody. She said:

> I well recall that, when they [deaths in police custody] went up from an average of 15 a year to 17, the then Home Secretary, now Prime Minister, called for an independent inquiry led by the former Lord Advocate of Scotland to find out what was going on. At the same time, suicides in prisons rose to 119. Obviously, the Prison Service was very concerned about that, but I do not think there is commensurate concern, which seems to me to be a problem.[284]

The Prisons and Probation Ombudsman

The Prison and Probation Ombudsman (PPO) carries out independent investigations into deaths and complaints in custody. The PPO's Annual Report 2017-18, published in October 2018, commented on ACCT, the Prison Service care planning system used to support prisoners at risk of suicide or self-harm, stating that it was not used properly in many cases:

> The purpose of ACCT is to try to assess the level of risk, to identify and implement actions that may reduce the risk, and to determine how best to monitor and supervise the prisoner. As in previous years, we continued to see many cases where staff did not follow national instructions and did not complete ACCT procedures

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282 HM Inspectorate of Prisons, *Annual Report 2018-19*, HC 2469, July 2019, p25
283 'Prison suicide rate is a scandal, says HM chief inspector', *The Guardian*, 9 July 2019
284 Justice Committee, *Oral evidence: Prison governance*, HC 2128, 16 July 2019, Q366

> properly, which meant that prisoners did not receive appropriate support to reduce their risk of suicide and self-harm. Although we repeatedly identify where lessons could be learned – including improving ACCT caremaps, identifying triggers, taking a multidisciplinary approach and ensuring that staff are properly trained – we continued to see failings in all these areas.[285]

The PPO expressed a hope that increased staffing levels would make it possible to improve the implementation of ACCT. The Annual Report questioned whether ACCT is fit for purpose:

> When we make critical findings, we are often told that the pressures on prisons and shortages of staff mean that the ACCT procedures cannot be properly resourced. While we have much sympathy for hard-pressed prison staff, this situation is simply not acceptable. If the current suicide prevention procedures cannot be resourced, they cannot be said to be fit for purpose.

Health and Social Care Committee

The Health and Social Care Committee's October 2018 report on Prisoner Health called on the Government to work to reduce incidences of self-harm and suicide in prisons:

> 88. There are well known risks relating to suicide and self-harm for people in prison. While rates of self-inflicted deaths in prisons have fallen since reaching a peak in 2016, there is no room for complacency as incidences of self-harm remain at a record high. We expect to see a concerted effort from Government to reduce suicide and self-harm in prison, supported by ambitious targets and a clear and credible plan for achieving them. The newly identified role of a minister with responsibility for suicide prevention is welcome, but we expect the Government within its response to report on how this role will extend to suicides and self-harm within prisons and on release.[286]

9.4 Government position

In January 2019, the Government response to the Health and Social Care Committee's report, noted the appointment of the UK's first Minister for Suicide Prevention in October 2018 and the establishment of a National Suicide Prevention Strategy Delivery Group to oversee implementation of the first cross-Government Suicide Prevention Workplan and concluded that

> …these, together with other measures in the prison safety programme, constitute a clear and credible plan for reducing the number of self-inflicted deaths and incidents of self-harm in prisons.[287]

The Ministry of Justice set out in answer to a PQ in July 2019 steps it was taking to address self-harm and suicide in prisons:

> The Government is taking unprecedented action to improve safety in prisons, including redoubling our efforts to prevent self-inflicted deaths and to reduce the levels of self-harm. We have recruited over 4,700 more prison officers since October 2016, and we now

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285 Prison and Probation Ombudsman, *Annual Report 2017-18*, Cm 9708, October 2018, p25

286 Health and Social Care Committee, *Prisoner Health*, HC963, 22 October 2018

287 HMG, *Government Response to the Health and Social Care Committee's Inquiry into Prison Health*, January 2019, p35

> have the greatest number in post since early 2012. This is allowing us to implement the key worker role, allowing staff dedicated time to provide support to individual prisoners.
>
> We are improving support for prisoners in their early days in custody and working to improve the multi-disciplinary ACCT case management process for those at risk of suicide or self-harm.
>
> We have rolled out a revised and improved Introduction to Suicide and Self-harm Prevention course. This is being completed by all new staff and as refresher training by all existing staff. Nearly 25,000 staff have already begun this training and over 14,000 have completed all six modules.[288]

9.5 Devolved nations

Scotland

The Scottish Prison Service, together with NHS Health Scotland and other organisations has published *Talk to Me: Prevention of Suicide in Prison Strategy 2016-2021*. The key aims of the strategy are:

> …to assume a shared responsibility for the care of those 'At Risk' of suicide; to work together to provide a person centred care pathway based on an individual's needs, strengths and assets and promote a supportive environment where people in our custody can ask for help.

Northern Ireland

The Northern Ireland Prison Service has published *a Suicide and Self harm prevention policy*, updated in 2013. It aims:

> …to identify vulnerable prisoners at risk of self harm or suicide, and provide the necessary support and care to minimise the harm an individual may cause to himself or herself throughout their time in custody.

[288] PQ 263189 [on Prisons: Self-harm and Suicide], 11 June 2019

10. Media

Suicidal behaviour can be prompted by the way suicide is reported in the media.[289] The risk can increase when a story describes the suicide method, uses a graphic or dramatic headline or image, and repeatedly or extensively sensationalises a death.[290]

The Government's Suicide Prevention Strategy, published in 2012, noted "two key aspects to supporting the media in delivering sensitive approaches to suicide and suicidal behaviour":

- promoting the responsible reporting and portrayal of suicide and suicidal behaviour in the media; and
- continuing to support the internet industry to remove content that encourages suicide and provide ready access to suicide prevention services.[291]

The Samaritans have published Media Guidelines for Reporting Suicide.

The National Union of Journalists has also published guidance (March 2015) on the responsible reporting of mental health, mental illness and suicide.

10.1 Press

There are two press regulators. Many titles have signed up to the Independent Press Standards Organisation (IPSO). The IPSO Editors' Code of Practice includes this on 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.[292]

There may be exceptions to this clause (and others in the Code) where they can be demonstrated to be in the public interest.

According to an April 2017 IPSO blog, since September 2014, IPSO has upheld one complaint and resolved three between publication and complainant on the reporting of suicide.[293]

A smaller number of publications have joined IMPRESS. The IMPRESS Standards Code includes this on reporting suicide:

> 9.1 When reporting on suicide or self-harm, publishers must not provide excessive details of the method used or speculate on the motives.

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289 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

290 Recommendations for reporting on suicide, Reporting on Suicide website [accessed 10 September 2019]

291 HMG, *Preventing suicide in England: a cross-government outcomes strategy to save lives*, September 2012, p43

292 IPSO, *Editors' Code of Practice*, January 2018, clause 5

293 Niall Duffy, *How the UK press takes reporting of suicide seriously*, IPSO Blog, 27 April 2017

10.2 Broadcasting

Ofcom's Broadcasting Code (January 2019) sets out the rules for programmes broadcast on television and radio in the UK.

Section 2 of the Code covers "Harm and Offence" and includes this on violence, dangerous behaviour and suicide:

> 2.4 Programmes must not include material (whether in individual programmes or in programmes taken together) which, taking into account the context, condones or glamorises violent, dangerous or seriously antisocial behaviour and is likely to encourage others to copy such behaviour.
>
> (See Rules 1.11 to 1.13 in Section One: Protecting the Under-Eighteens.)
>
> 2.5 Methods of suicide and self-harm must not be included in programmes except where they are editorially justified and are also justified by the context.
>
> (See Rule 1.13 in Section One: Protecting the Under-Eighteens.)

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

> 1.11 Violence, its after-effects and descriptions of violence, whether verbal or physical, must be appropriately limited in programmes broadcast before the watershed (in the case of television), when children are particularly likely to be listening (in the case of radio) or when content is likely to be accessed by children (in the case of BBC ODPS) and must also be justified by the context.
>
> 1.12 Violence, whether verbal or physical, that is easily imitable by children in a manner that is harmful or dangerous:
>
> - must not be featured in programmes made primarily for children unless there is strong editorial justification;
> - must not be broadcast before the watershed (in the case of television), when children are particularly likely to be listening (in the case of radio), or when content is likely to be accessed by children (in the case of BBC ODPS), unless there is editorial justification.
>
> 1.13 Dangerous behaviour, or the portrayal of dangerous behaviour, that is likely to be easily imitable by children in a manner that is harmful:
>
> - must not be featured in programmes made primarily for children unless there is strong editorial justification;
> - must not be broadcast before the watershed (in the case of television), when children are particularly likely to be listening (in the case of radio), or when content is likely to be accessed by children (in the case of BBC ODPS), unless there is editorial justification.

Ofcom publishes guidance notes on its Code. These include:

- *Guidance notes: Section two - Harm and offence*, July 2017
- *Guidance notes: Section one - Protecting the under-eighteens*, March 2015

General guidance (April 2017) on the Code states that compliance is the responsibility of individual broadcasters.

10.3 Social media and the internet

In a 2008 report, Tanya Byron recommended that the application of the law to the encouragement of suicide should be clarified.[294]

The *Coroners and Justice Act 2009* 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.[295] Under section 2(1) of the 1961 Act (as amended), it is an offence to conduct an act capable of encouraging or assisting the suicide or attempted suicide of another person with the intention to so encourage 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.[296]

The impact of social media

The Government's Second Progress Report on its Suicide Prevention Strategy noted the "limited systematic evidence" on the influence of social media on self-harm and suicidal behaviour.[297] The report set out these "emerging findings" on the role of social media in the aftermath of youth suicides:

- Suicidal tweeters show a high degree of reciprocal connectivity (i.e. they follow each other), when compared with other studies of the connectivity of Twitter users, suggesting a community of interest.
- A retweet graph shows that users who post suicidal statements are connected to users who are not, suggesting a potential for information cascade and possibly contagion of suicidal statements.
- The reaction on Twitter to the Hayley Cropper Coronation Street suicide storyline was mostly information/support and debate about the morality of assisted dying, rather than statements of suicidal feelings.
- Tweets about actual youth suicide cases are far more numerous than newspaper reports and far more numerous than tweets about young people dying in road traffic accidents, which suggests that suicide is especially newsworthy in social media. In newspapers there is no

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294 Tanya Byron, *Safer children in a digital world: the Report of the Byron Review*, March 2008, para. 15

295 Ministry of Justice, *Encouraging or assisting suicide: implementation of section 59 of the Coroners and Justice Act 2009*, Circular 2010/03, 28 January 2010

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

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

> significant difference between the two types of death, in terms of number of reports per case.
>
> 14. A lot of work has already been done by industry and government to equip parents and schools in keeping children and young people safe online. Given the global and changing nature of the internet, continuing that joint approach to better awareness through education is much more likely to be effective than an approach based solely on technical solutions.[298]

Online harms white paper

The Government's Online harms white paper, published in April 2019, sets out how it intends to tackle a range of harmful content online, including "encouraging or assisting suicide."[299]

The Government's plans include a new statutory duty of care to make social media companies take more responsibility for the safety of their users and for tackling the harm caused by content or activity on their services. An independent regulator will oversee and enforce compliance with the duty. A consultation on the Government's proposals closed on 1 July 2019. The Government is analysing the responses.

The strategy includes these findings relating to the internet and self-harm and suicide:

> Threat:
>
> In a survey of young adults, 22.5% reported self-harm and suicide-related internet use, including 8.2% and 7.5% who had actively searched for information about self-harm and suicide respectively.
>
> - Amongst those who had harmed with suicidal intent, 70% reported self-harm and suicide-related internet use.
> - The prevalence of using the internet to view related content has also been found to be higher in children than adults. One study of those presenting to hospital following self-harm found that 26% of children had viewed self-harm and suicide content, compared to 8.4% of adults.
>
> Impact:
>
> - The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) analysed the characteristics of 595 children and young people (aged under 20) who had died by suicide in the UK between 2014 and 2016.
> - The NCISH found that suicide-related internet use (i.e. searching the internet for information on suicide methods) was reported for almost a quarter (23%) of these children and young people.[300]

Chapter 7 of the strategy sets out what companies will need to do to fulfil the duty of care. On self-harm and suicide, it states:

> 7.34 Companies will be required to take robust action to address harmful suicidal and self-harm content that provides graphic details of suicide methods and self-harming, including

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298 *Ibid*., p10
299 HMG, *Online harms white paper*, April 2019, p31
300 *Ibid*., pp19-20, footnotes removed

encouragement of self-harm and suicide. Services must also respond quickly to identify and remove content which is illegal or violates terms of use, and act swiftly and proportionately when this content is reported to them by users.

7.35 Some of the areas we expect the regulator to include in a code of practice are:

- Steps to ensure that vulnerable users and users who actively search for or have been exposed to this content, including content that encourages eating disorders, are directed to, and able to access, adequate support.
- Ensuring that companies work with experts in suicide prevention to ensure that their policies and practices are designed to protect the most vulnerable (and to ensure that moderators receive appropriate training).
- Steps companies should take to ensure that their services are safe by design, including tools to help users avoid material or behaviour which encourages suicide or self-harm, and measures to block content and block, mute and stay hidden from other users.
- Guidance about how to ensure it is easy for users to understand these tools, and the company's terms of use in relation to these harms, when they sign up to use the service.
- Processes to stop algorithms promoting self-harm or suicide content to users.
- Measures to ensure that reporting processes and processes for moderating content and activity are transparent and effective at tackling the encouragement of self-harm and suicide and measures to ensure that users are kept up to date with the progress of their report.
- Steps services should take to ensure they engage sufficiently with civil society groups and law enforcement, so that moderators are educated about what constitutes self-harm or suicide encouragement and how it can be prevented and tackled.
- Steps companies should take to ensure harm is tackled rapidly, such as removing content which is illegal or violates acceptable use, and blocking users responsible for activity which violates terms and conditions, as well as steps that services can take to ensure that these measures are conducted sensitively.
- Processes companies should have in place to ensure that users can appeal the removal of content or other responses, in order to protect users' rights online.
- Steps to prevent banned users creating new accounts to continue to encourage suicide or self-harm.[301]

10.4 Health Committee report (March 2017)

In its March 2017 report on suicide prevention, the Health Select Committee said that it was concerned about the level of non-adherence

[301] *Ibid*., pp72-3

to the guidelines on media reporting of suicide. The Committee recognised the "excellent work" of Samaritans but said that it was "concerned that there appears to be no accountability or responsibility for monitoring adherence to the guidelines."[302]

The Committee recommended, among other things, that there needed to be a nominated person within Government or Public Health England who was "ultimately responsible for ensuring that the Government has a firm grasp of the current media situation and for supporting Samaritans and other organisations and individuals."[303]

The Committee recommended that the IPSO Editors' Code of Practice should be amended so that "excessive detail" became "unnecessary detail". It also recommended strengthening Ofcom's Broadcasting Code to "ensure that detailed description or portrayal of suicide methods, including particular locations where suicide could be easily imitated, are not permissible."[304]

Government response

The Government's response to the Committee's report was published in July 2017. Pages 27-32 deal with the Committee's recommendations on the role of the media. The Government began by stating that it was "committed to a free and open press and does not interfere with what the press does and does not publish".[305] It then noted, amongst other things, the role of the Samaritans:

> (…) The Cross-Government Suicide Prevention Strategy sets out the importance of responsible media reporting of suicide. We have supported the Samaritans over many years, which has built strong relationships with the broadcast, print and online media and has developed guidelines for the responsible reporting of suicide. The National Lead at Public Health England works closely with the Samaritans to share information and to highlight needs for proactive engagement, for example emerging clusters and high profile inquests. Whilst there has been great progress in how the media reports suicide, sadly we still see examples of poor reporting. Our stakeholders continue to look at ways in which they can work proactively with the media to improve this.[306]

The Government said that the Committee's recommendations on the Editors' Code and the Broadcasting Code were matters for IPSO and Ofcom.[307]

Chapter 5 of the Government's Fourth Progress Report on its Suicide Prevention Strategy also looked at the Health Committee's recommendations and noted:

> To respond to the HSC's [Health Select Committee] recommendations, Public Health England, DHSC, Samaritans and the Chair of NSPSAG have worked together to agree a protocol

302 Health Committee, *Suicide prevention*, 16 March 2017, HC 1087 2016-17, para 120
303 *Ibid*., para. 124
304 *Ibid*., paras 128-33
305 DH, *Government response to the Health Select Committee's inquiry into suicide prevention*, Cm 9466, July 2017, p27
306 *Ibid*., p27
307 *Ibid*., p30

> for action if there are national public health concerns around an emerging cluster, high profile online challenge or high profile or novel method. This ensures that Directors of Public Health, PHE Centre leads and key stakeholders are reached with briefing and advice.
>
> Samaritans continues to work with online providers to look at how to maximise positive opportunities online and minimise harmful content. The University of Bristol has worked in partnership with Samaritans to complete ground-breaking research into suicide and the online environment. Funded by the Department of Health and Social Care, it provides unique insights into why people use the internet when they are feeling suicidal, its impact and what we can do to make the online environment 'safer'…[308]

10.5 Devolved nations

Scotland

The Scottish Government's Suicide Prevention Strategy for 2013-16 referred to the need to encourage "sensitive and appropriate reporting" in the media:

> We will work closely with NHS Health Scotland…and other agencies to develop and implement an engagement strategy to influence public perception about suicide and the stigma surrounding it and will use social media, in addition to other communication channels, to communicate key messages about suicide and its prevention.
>
> We know that media reporting of suicide can increase the number of suicides in a locality. The quality and nature of that reporting can be a factor and we have worked with the National Union of Journalists (NUJ) to develop guidelines and deliver training on sensitive and appropriate reporting. We will continue to work with the NUJ and others to encourage the implementation of media guidelines and challenge inappropriate reporting when it occurs…[309]

The Scottish Government's Suicide Prevention Action Plan, published in August 2018, states that the National Suicide Prevention Leadership Group will work with partners "to develop and support the delivery of innovations in digital technology that improve suicide prevention":

> If used positively, the internet and other technologies can be used to influence suicide prevention both locally and nationally. This could include providing online support to people who may be at risk of suicide, raising awareness of sources of support, facilitating individuals' ability to manage themselves and develop resilience, and encouraging safe use of the internet.
>
> We need to maximise the positive influence of social media and its potential for key messaging, working with NHS24, NHS Health Scotland and other interested partners to develop a strong online

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[308] HMG, *Preventing suicide in England: Fourth progress report of the cross-government outcomes strategy to save lives*, January 2019, pp46-7

[309] Scottish Government, *Suicide Prevention Strategy 2013-2016*, 2013, p9

suicide prevention presence across Scotland that caters for all ages.[310]

Wales

The Welsh Government's Suicide Prevention Plan for 2015-20 includes an objective to: "Support the media in responsible reporting and portrayal of suicide and suicidal behaviour."[311]

Northern Ireland

The Northern Ireland Department of Health's *Protect Life 2* strategy, published in September 2019, includes an objective to: "Enhance responsible media reporting on suicide."[312]

[310] Scottish Government, *Suicide Prevention Action Plan: Every Life Matters*, August 2018, p14
[311] Welsh Government, *Talk to me 2: suicide and self harm prevention strategy for Wales 2015-2020*, June 2015, p16
[312] NIDH, *Protect Life 2: A Strategy for Preventing Suicide and Self Harm in Northern Ireland 2019-2024*, September 2019, pp66-7

11. Armed forces

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

The UK regular armed forces have seen a declining trend in male suicide rates since the 1990s. For the 20-year period 1999-2018 the male suicide rate was 8 per 100,000.
The MOD publishes annual statistics on suicide and open verdict deaths in the UK regular armed forces. Analysis of the twenty-year period between 1999 and 2018 shows:

- The male suicide rate for the UK regular armed forces was statistically significantly lower than the UK general population;
- The overall UK regular armed forces male suicide rate was 8 per 100,000 personnel at risk, with the Army had the highest rate (10 per 100,000) and the RAF the lowest (5 per 100,000);
- There were 310 suicides and open verdicts among UK regular armed forces personnel: 292 among males and 18 among females.

The MOD says: "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 since the 1990s and for the latest twenty-year period (1998-2019), the rate of suicide in young Army males was the same as the rate in males of the same age in the UK general population.[313]

There has been a declining trend in male suicide rates in the armed forces since the 1990s.

The Ministry of Defence has in recent years focussed on the mental health of regular and reserve personnel and it is now a priority for the Department.[314] Suicide and self-harm is one of the four core areas of the Mental Health Steering Group.[315]

The Defence Committee has published two reports on mental health and the armed forces during the 2017-19 session.

11.1 A new strategy

The MOD launched a new Mental Health and Wellbeing Strategy in July 2017. While this 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.[316]

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313 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 2018*, 28 March 2019

314 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)

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

316 Further information on mental health support given to Veterans can be found in Library briefing paper CBP07693, *Support for UK Veterans*, June 2018, Section 4

Further information mental health in the armed forces can be found in a briefing note by the Parliamentary Office of Science and Technology: *Psychological health of military personnel*, published on 3 February 2016.

11.2 The numbers

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

The statistical analysis provides some clues as to why suicide among the male regular personnel is lower than the general population: higher than usual levels of fitness and lower levels of ill-health; strong group loyalty; and bonding and mutual dependence encouraged at all levels in the Services.[317]

11.3 Suicide among Veterans

The MOD does not routinely 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).[318] The head of research at the Samaritans wrote a blog on "suicide in the UK armed forces" on the back of the grant award. The MOD says it is compiling a Veterans register and has established a Veterans' Board to address the specific needs of veterans.[319]

The Defence Committee highlighted the lack of authoritative statistics on suicide amongst veterans. They noted ITV had produced a figure that "at least 71 serving personnel/veterans unfortunately took their own lives in 2018. Even as a rough estimate this gives a good idea of the scale of the problem".[320] The Health Minister, Jackie Doyle-Price MP, told the Committee the Government could do better on tracking suicide rates among veterans.[321]

MPs discussed Veteran Suicide in a debate on 3 April 2019. Tobias Ellwood, the Parliamentary Under-Secretary of State for Defence, referred to the national suicide prevention strategy and having a Minister responsible for suicide prevention. He also identified the

317 '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

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

319 HC Deb 10 July 2017 c6

320 Defence Committee, *Mental Health and the Armed Forces, Part Two: The Provision of Care*, HC 1481 2017-19, 25 February 2019

321 Defence Committee, *Mental Health and the Armed Forces, Part One: The scale of mental health issues*, HC 813 2017-19, 25 July 2018, qq182

'Falklands war' cohort as those he is most concerned about because "they are stoic and still have that stigma – not wanting to put their hand up".[322]

Veterans Gateway provides resources and support on a range of issues including mental health and those feeling suicidal.

Post-operational suicide rates

In terms of post-operational rates of suicide, Defence Minister Tobias Ellwood said the MOD's own studies into deaths occurring among veterans of the 1990/91 Gulf war the 1982 Falklands campaign showed "that there was no excess in the rates of suicide in these groups of veterans and is lower than comparative rates in the civilian population."[323]

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.[324]

New study launched

In October 2018, the MOD launched a new study into the causes of death of military personnel who deployed on combat operations in Iraq and Afghanistan between 2001 and 2014. The MOD said the research will match the MOD's service database with corresponding NHS records to track causes of death and compare findings with the general population and personnel who served during the same period outside Iraq or Afghanistan.[325] The results of the study have not yet been published.

11.4 Defence Committee reports

The Defence Committee produced two reports on mental health in the armed forces during the current session (2017 to present). The first report, published in July 2018, assessed the scale of mental health issues.

The Committee was concerned by the lack of national data on veteran suicides and recommended the MOD improve data collection.[326] The Committee published their second report, on the provision of mental

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322 HC Deb 3 April 2019 c455WH
323 PQ347 [on Veterans: Suicide], 30 June 2017
324 HL3467 [on Armed Forces: Suicide], 30 November 2016
325 "New study into Iraq and Afghanistan veterans launched", Ministry of Defence, 22 October 2018
326 Defence Committee, *Mental Health and the Armed Forces, Part One: The scale of mental health issues*, HC 813 2017-19, 25 July 2018, para 45

health care, in February 2019. The Committee recommended the MOD considers options for regular statistical releases on veteran suicides.[327]

[327] Defence Committee, *Mental Health and the Armed Forces, Part Two: The Provision of Care, HC 1481 2017-19*, 25 February 2019, para 114

12. Coroners' conclusions

In England and Wales, deaths caused by suicide are investigated by a coroner.

12.1 Statutory requirements

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

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

- The deceased died a violent or unnatural death;
- The cause of the death is unknown; or
- The deceased died while in custody or state detention.[328]

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

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

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

At the end of the inquest, the coroner – or the jury if there is one - must make a 'determination' of the matters set out in section 5 and a 'finding' about the details required for registration of the death.[329] 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.

Another Commons Library briefing paper, Coroners' investigations and inquests, provides information about coroners and their work.[330]

12.2 Conclusions

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

Conclusions can be short-form or narrative. It is for the coroner to decide which is more appropriate to the case in question. The coroner

328 *Coroners and Justice Act 2009*, section 1
329 *Ibid.*, section 10
330 Commons Library briefing SN03981, *Coroners' investigations and inquests*, 7 May 2019

can also, in addition to a short-form conclusion, make a brief narrative conclusion to explain the reasons for the determination.

The outcome of an inquest is recorded in the Record of Inquest (Form 2) which is set out in the Schedule to the Coroners (Inquests) Rules 2013.[331] The notes to Form 2 list the short form conclusions, one of which is suicide.

12.3 Chief Coroner guidance

The first Chief Coroner published guidance, Conclusions: short-form and narrative.[332] This advises that, wherever possible, coroners should conclude with a short-form conclusion:

> This has the advantage of being simple, accessible for bereaved families and public alike, and also clear for statistical purposes.[333]

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

- it encourages coroners not to avoid a conclusion of suicide where appropriate;[334]
- it requires coroners to make express reference in each case of possible suicide to the two elements which need to be proved: that the deceased took his/her own life; and that the deceased intended to do so (or, put together, 'he/she intentionally took his/her own life'); and
- it suggests wording to alleviate the impact of the conclusion of suicide, where proved.

12.4 Suicide conclusions: coroner statistics

The Ministry of Justice publishes annual coroner statistics. The most recent annual bulletin, published in May 2019, presents statistics of deaths reported to coroners in England and Wales in 2018. This notes that the proportion of conclusions recorded as suicide has remained broadly constant for a number of years, though with a recent rise, and that there are some regional variations:

> The proportion of conclusions recorded as suicide has remained broadly constant over the past ten years, generally at around 11-12%. However, in 2018, it accounted for 14% of all inquest conclusions, up from 11% of all conclusions in 2017. This proportion in 2018 varies from 3% in Portsmouth and South East Hampshire area to 34% in East Sussex.[335]

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331 *The Coroners (Inquests) Rules 2013* (SI 2013/1616)
332 Chief Coroner, *Conclusions: Short-Form and Narrative, Guidance No 17*, 30 January 2015, revised 14 January 2016
333 *Ibid*., para. 26
334 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)"
335 Ministry of Justice, *Coroners Statistics Annual 2018 England and Wales*, 9 May 2019, pp11-12

12.5 The standard of proof for a conclusion of suicide

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

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

This position is reflected in Note (iii) to Form 2,[336] which deals with the standard of proof at inquests generally. It distinguishes conclusions of suicide and unlawful killing from all other conclusions:

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

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

In 2018, the High Court held that previously decided cases did not correctly state the law, and that the lower civil standard of proof applies for suicide conclusions.

In 2019, the Court of Appeal confirmed that the civil standard of proof is to be applied for both narrative and short-form conclusions of suicide.

Background to current position

Previous case law

Previously the courts had considered that the criminal standard of proof was required for a coroner's conclusion of suicide. For example, in a 2013 case, Mrs Justice Lang DBE provided this reasoning for the "beyond reasonable doubt" requirement:

> 35. …a high standard is deliberately set in order to ensure that such serious findings are only made on the basis of absolutely clear and compelling evidence. See: R v West London Coroner, Ex Parte Gray [1988] 1 QB 467 at 477 (Watkins LJ). In that case, the Court explained the need for the high standard of proof as being because suicide is regarded as "a drastic action which often leaves in its wake serious social, economic and other consequences."
>
> (…)
>
> 37. In summary, the approach of the Courts to suicide verdicts reflects (a) the fact that a finding of suicide is a serious matter which can cause serious distress and stigma, and other adverse consequences; and (b) the complexities of human psychology which can cause people to harm themselves seriously or to put

[336] See Section 12.2 of this briefing paper

> themselves in very dangerous positions without the clear intention to end their lives.[337]

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

> At least since 1984 it has been consistently held in England that the standard of proof in suicide cases should be the same as in criminal prosecutions, i.e. beyond reasonable doubt, although there is no crime involved and an inquest is not a criminal trial (or any sort of trial). The comparative difficulty in obtaining a conclusion of suicide may well mean that official statistics significantly underestimate the occurrence of suicide.
>
> All other definite conclusions (except unlawful killing) operate on the civil standard i.e. the balance of probabilities. This logically means that if the coroner (or jury) is satisfied *on the balance of probabilities* that it was suicide, but is not satisfied *beyond reasonable doubt*, the conclusion must be an open one…[338]

Previous calls for change

A number of calls were made for the standard of proof for suicide conclusions to be lowered, including:

- 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.[339]

  In its interim report published in December 2016,[340] and in its full report, published in March 2017,[341] the Committee recommended that the standard of proof for conclusions of death by suicide should be changed to the civil standard of proof, rather than the criminal standard of proof.

  In its response to the Committee's report, the Government said that it was considering whether the standard of proof should be lowered.[342]

- PAPYRUS, the charity for the prevention of young suicide, called for a change in the way coroners' reach conclusions in cases of suicide.[343]

- An EDM tabled by Norman Lamb on 8 February 2017, Suicide and the criminal standard of proof, gained twelve signatures.[344]

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337 R (Lagos) v HM Coroner for City of London [2013] EWHC 423 (Admin)
338 Paul Matthews, *Jervis on Coroners*, 13th ed,, 2014, paras 13.70-71 (footnotes omitted)
339 Health Committee, *Suicide prevention: interim report, Fourth Report of Session 2016-17*, 13 December 2016, HC 1087, para. 28
340 *Ibid.*, para. 31
341 Health Committee, *Suicide prevention, Sixth Report of Session 2016-17*, 7 March 2017, HC 1087, para 151
342 DH, *Government response to the Health Select Committee's inquiry into suicide prevention*, Cm 9466, July 2017
343 'Campaign to change the law', PAPYRUS [accessed 6 September 2018]
344 Early day motion 930 of 2016-17

2017: Inquest conclusion

In 2017, the Senior Coroner for South Oxfordshire (the Coroner) held an inquest into the death of JM who had been found hanging in his prison cell.

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

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

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

2018: High Court judicial review decision

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

On 26 July 2018, the High Court delivered its judgment in the judicial review, R (Maughan) v HM Senior Coroner Oxfordshire and others.[345] The Court disagreed that the criminal standard of proof had to be applied:

> Given the nature and function of a modern inquest, it seems to us that there is today no relationship or analogy between coroner's proceedings and criminal proceedings which can in principle justify applying in coroner's proceedings the criminal standard of proof.[346]

The Court decided that, contrary to previously decided cases and guidance, the correct standard of proof for the conclusion of suicide, whether in short or narrative form, should be the civil standard, and dismissed the claim:

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

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345 (R (Maughan) v HM Senior Coroner Oxfordshire and others [2018] EWHC 1955 (Admin)

346 *Ibid*., para. 38

> mind that such a conclusion should only be reached if there is sufficient evidence to justify it.
>
> 76. It follows that there was nothing wrong with the coroner's directions to the jury in this case and that the jury's conclusion was lawful. The claim must therefore be dismissed.

2019: Court of Appeal decision

The deceased's brother appealed to the Court of Appeal. The appeal was dismissed.[347] Lord Justice Davis concluded:

> 97.In the result, I conclude that, in cases of suicide, the standard of proof to be applied throughout at inquests, and including both short-form conclusions and narrative conclusions, is the civil standard of proof. Since, in the present case, that is how the Coroner instructed the jury as to the narrative conclusion which they might reach, the present challenge by the appellant cannot be accepted.

It is understood that the deceased's brother has been granted permission to appeal to the Supreme Court.

12.6 The position in Northern Ireland

Northern Ireland has its own coroner legislation. However, in 2018, in judicial review proceedings, the High Court of Justice in Northern Ireland confirmed that, although not obliged to do so, it would follow the decision in Maughan (see above).[348]

The case concerned a challenge to a Coroner's preliminary ruling that one of the questions which the jury would be invited to answer was whether the deceased died by his own act (i.e. by suicide). By his preliminary ruling, the Coroner decided that the jury would be directed to answer this question by the application of the civil standard of proof, namely the balance of probabilities. The Applicant contended that the appropriate standard of proof was the criminal one, namely proof beyond reasonable doubt, and that in making the ruling, the Coroner erred in law.

McCloskey J held:

> I am unable to diagnose any flaw in the reasoning or conclusion of the Divisional Court in the Maughan case. Though not binding on this court, the decision is so carefully and persuasively reasoned that, in common with the Coroner, I propose to follow it. None of the grounds of challenge has been substantiated. The application for judicial review is dismissed accordingly.[349]

12.7 The position in Scotland

Fatal Accident Inquiries

Unlike in England, Wales and Northern Ireland, Scotland does not have a system of coroners' inquests. The responsibility for the investigation of any death in Scotland (and sometimes of a Scottish resident outside

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347 R (Maughan) v Senior Coroner for Oxfordshire [2019] EWCA Civ 809
348 In the matter of Steponaviciene's Application [2018] NIQB
349 *Ibid*., para. 67

the UK) that requires further explanation rests with the Crown Office and Procurator Fiscal Service (COPFS).

In the vast majority of deaths, a COPFS investigation will conclude the matter. However, a Fatal Accident Inquiry (FAI) may be instructed in certain circumstances.[350]

Information about FAIs is available at:

- COPFS, Our role in investigating deaths;
- Scottish Government, Fatal Accident Inquiries: follow up review, 7 August 2019.

A FAI must take place when someone dies in legal custody or a death is caused by an accident at work. FAIs can be held in other circumstances if it is thought to be in the public interest. The aim is to prevent future deaths or injuries. Sheriffs may make recommendations covering precautions which could have resulted in the death being avoided.[351]

The evidential standard for facts to be proven for FAIs is the civil standard of proof – the balance of probabilities.[352]

Suicide cases

All deaths where the circumstances are thought to have been as a result of intentional self-harm must be reported to the Procurator Fiscal. The COPFS states that one of the principal reasons for this is to exclude that the death is suspicious in nature. In most such deaths, the Procurator Fiscal will instruct a post mortem examination.[353]

There will not always be a FAI in cases of suicide. A guide published by the Scottish charity, SAMH (the Scottish Association for Mental Health), After a Suicide, provides further information:

> The Procurator Fiscal (referred to here as the Fiscal) is a lawyer who works for Scotland's prosecution service. The Fiscal is responsible for investigating all sudden, suspicious, accidental and unexplained deaths and any death occurring in circumstances which give rise to serious public concern. The Fiscal must enquire into any death where the circumstances point to suicide. The Fiscal has legal responsibility for the deceased person until the death certificate is issued and the deceased person is released to the person arranging the funeral.
>
> (…)
>
> The Fiscal will investigate the cause and circumstances and will then decide whether any further investigation is needed. This may involve instructing a post mortem, to be carried out by a forensic pathologist. The Fiscal is responsible for directing the level and type of post mortem examination, subject to advice from investigating police officers, medical experts and other expert advisers.

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350 Personal communication from SPICe, 23 September 2019
351 Personal communication from SPICe, 23 September 2019
352 Explanatory Notes, *Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016*, 14 January 2016, para. 61
353 COPFS, *Information for bereaved relatives The role of the Procurator Fiscal in the investigation of deaths*, p6

The purpose of the Fiscal's investigation is to decide whether there is a need for criminal proceedings or if a Fatal Accident Inquiry should be held. This decision may depend on the results of toxicological examinations.

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