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Research Briefing

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Suicide prevention: Policy and strategy

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Contents

Summary

Warning: This briefing discusses suicide and self-harm, which some readers may find distressing.

Suicide rates in the UK

In 2021, England had the lowest rate of suicide in the UK. The age-standardised mortality rates across the UK in 2021 were:

- 10.5 deaths per 100,000 people in England
- 12.3 deaths per 100,000 people in Wales
- 14.0 deaths per 100,000 people in Scotland
- 14.3 deaths per 100,000 people in Northern Ireland

Long-term trends in suicide have varied in different parts of the UK:

- The suicide rate in England declined between 1981 and 2021. Most of this fall occurred before 2000.
    - The NHS five year forward view for mental health (2016) included a commitment to reduce the rate of suicides in England by 10% by 2020 compared to 2015 levels. The NHS Long Term plan (2019) suggested this target would be met but there has been no statistically significant change in the rate of suicides in England since 2015.
- Since the 1980s there has been a general downward trend in Wales, although over the past decade rates of suicide have increased.
- The suicide rate in Scotland has been consistently higher than in any other part of the UK. Since 2002, the rate of suicide has generally decreased, although there has been a slight increase in recent years.
- There has been little change in the rate of suicide in Northern Ireland since 2015. Figures before this are not comparable.

Suicide prevention strategies in the UK

England

In 2022, the Department for Health and Social Care held a call for evidence and a consultation on a Mental health and wellbeing plan: discussion paper, intended to inform a new mental health strategy and a separate suicide prevention strategy for England. In January 2023, it was announced that mental health would be incorporated into a new Major conditions strategy, instead of a stand-alone plan, and a separate suicide prevention strategy will be published later in 2023.

The current strategy in England, Preventing suicide in England: A cross-government outcomes strategy to save lives, was published in 2012. A Cross-government suicide prevention workplan was published in 2019.

Scotland

The current strategy in Scotland, Creating hope together: Suicide prevention strategy 2022 to 2032, was published in 2022. A Suicide prevention action plan 2022 to 2025 was published alongside.

Wales

The latest strategy in Wales, Talk to me 2: Suicide and self harm prevention strategy for Wales 2015-2022, was published in 2015. A review of the strategy, alongside the Welsh Government's mental health strategy, was published in 2023.

Northern Ireland

The current strategy in Northern Ireland, Protect life 2: Strategy for preventing suicide and self harm in Northern Ireland 2019-2024, was published in 2019. It includes an aim to reduce the suicide rate in Northern Ireland by 10% by 2024.

Suicide prevention in different policy areas (England)

Suicide prevention requires action across many areas of policy that are devolved in the UK, such as health and education. A summary of suicide prevention actions in different policy areas in England is set out below. Information on Scotland, Wales and Northern Ireland can be found in the relevant briefing sections.

Healthcare

The NHS Long term plan and subsequent Mental health implementation plan commit to achieving 100% coverage of crisis care via NHS 111 by 2023/24. In 2021 the Government announced £150 million of funding for crisis mental health facilities and patient safety in mental health units. In January 2023, it was announced £7 million of the funding would be allocated to new mental health ambulances. £143 million would go towards 150 new projects, including schemes providing alternatives to A&E.

The Government has said a national investigation of mental health in-patient services will commence in October 2023. This will include investigating how service providers learn from deaths and translate learning into improvement. The NHS Mental Health Safety Improvement Programme includes a focus on suicide prevention and reduction for mental health inpatients.

In the 2023 Spring Budget, the Government announced a £10 million grant fund for suicide prevention VSCE organisations across 2023 to 2025.

Education

Since September 2020, health education has been a statutory part of the curriculum in primary and secondary schools in England. The Government has published statutory guidance on relationships and sex education (RSE) and health education, including recognising and discussing mental health concerns.

The Government is supporting mental health in educational settings by offering funding to train a Senior Mental Health Lead in each school and college and rolling out Mental Health Support Teams in schools.

Employment

The Department for Work and Pensions (DWP) and the Department for Health and Social Care have worked together through the joint Work and Health Unit to explore how more people living with mental health problems can be supported to find or stay in work. One such scheme is the Access to Work Mental Health Support Service, which provides support to manage mental health at work. This may include a tailored plan to help someone get or stay in a job, or one-to-one sessions with a mental health professional.

In 2017, the Thriving at work: the Stevenson/Farmer review of mental health and employers made recommendations on core standards for workplace mental health. The Government's response, Improving lives: The future of work, health and disability, accepted the recommendations. In 2019, the Government consulted on proposals to reduce job loss due to ill health, including extending the right to request workplace modifications to a broader range of workers, but this was not taken forward. The Government also

considered reforming Statutory Sick Pay, but said it is not the right time for such changes.

Social security

The DWP reviews cases where it is alleged the department's actions are linked to the death of a benefit claimant or have caused 'serious harm', including attempted suicide. Stakeholders have expressed concerns the process and number of reviews "don't reflect anything like the real scale of harm". The DWP says it has taken a number of steps to improve how it responds to "those who live complex lives".

In April 2022, the Equality and Human Rights Commission (EHRC) announced it was taking action to require the DWP to improve its treatment customers with mental health impairments and learning disabilities. The EHRC and DWP have said they are drawing up a legally binding agreement, committing the DWP to action plan to meet the needs of these groups.

Major proposals to reform benefits for disabled people were set out in the Government's Health and Disability White Paper, published alongside the Spring Budget on 15 March 2023.

Transport

The Department for Transport convenes a variety of regular meetings and groups on suicide prevention, such as a suicide prevention awareness group bringing together agencies within the sector to work together to reduce transport-related suicides. The British Transport Police also work to prevent suicides through actions such as capturing real time data and training rail industry partners.

The rail industry has its own suicide prevention programme, in partnership with the Samaritans and the BTP. National Highways (formerly called Highways England) published a Suicide prevention strategy in 2022.

Prisons

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

The Ministry of Justice has developed safety training for staff which includes suicide and self-harm prevention, a suicide prevention learning tool developed in partnership with the Samaritans, and guidance distributed nationally on supporting someone who is self-harming.

Media

The way suicide is covered in the media can an impact suicide rates. Depictions of methods and excessive reporting can lead to imitational behaviour. Press, media outlets and broadcasters should follow guidance on reporting deaths by suicide set out by their regulators.

There are growing concerns around the impact of social media on young people's mental health, particularly in relation to self-harm and suicide. The Government's plans to tackle harmful content online, including content related to suicide and self-harm, are set out in the Online Safety Bill. Key aims are to increase user safety online and to improve users' ability to keep themselves safe online. All regulated services would have to protect users from illegal content. There would be additional duties for services likely to be accessed by children.

Armed forces

The Armed Forces published a Suicide prevention strategy and action plan in April 2023. It was prompted in part by an upward trend in death by suicide in the armed forces. The Ministry of Defence made suicide prevention one of its priority themes in the Defence People Health and Wellbeing Strategy - 2022 to 2027, along with wellbeing and resilience.

The provision of veterans' healthcare is primarily the responsibility of the NHS. In March 2021 the Government launched the Operation Courage service, creating a single point to access mental health services for veterans.

Coroners' conclusions

In England and Wales, deaths which appear to have been caused by suicide are investigated by a coroner as set out in Part 1 of the Coroners and Justice Act 2009.

The level of certainty for a conclusion of suicide is the same as the civil standard of proof, that is, the balance of probabilities. This is a lower threshold than the standard of proof applied in the criminal courts – which is being sure, or "beyond all reasonable doubt".

On 7 June 2022, The Lord Bishop of St Albans introduced into the House of Lords the Coroners (Determination of Suicide) Bill, a Private Member's Bill that would require a coroner to record an opinion as to the relevant causative factors in a suicide after the conclusion of an inquest. The Government said it would not be able to support the Bill as it would lead to an inappropriate extension to the coroner's jurisdiction.

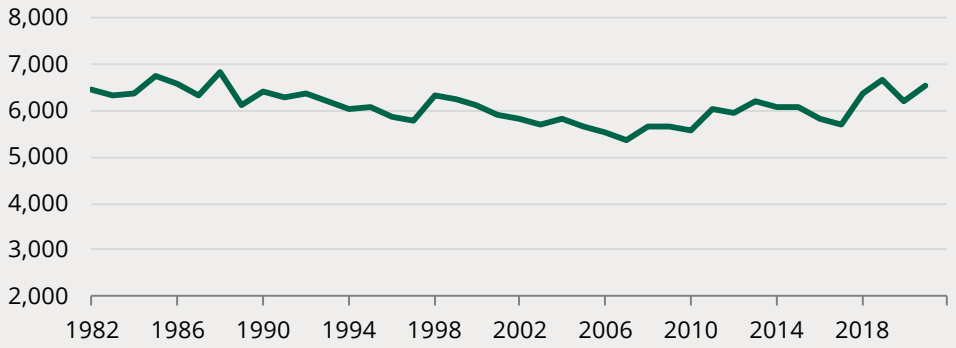
1 Suicide rates in the UK

In 2021 there were 6,556 deaths registered in the UK where the cause was recorded as suicide.[1]

The charts below show trends since 1981 in both the number of suicides and the age-standardised mortality rate from suicide. The mortality rate accounts for changes in population size and structure. For example, while the number of suicides registered in England in 2020 was 11% higher than in 2005, the suicide rate was similar, because the population has increased.

Suicide in the UK since 1981

Number of deaths by year of registration



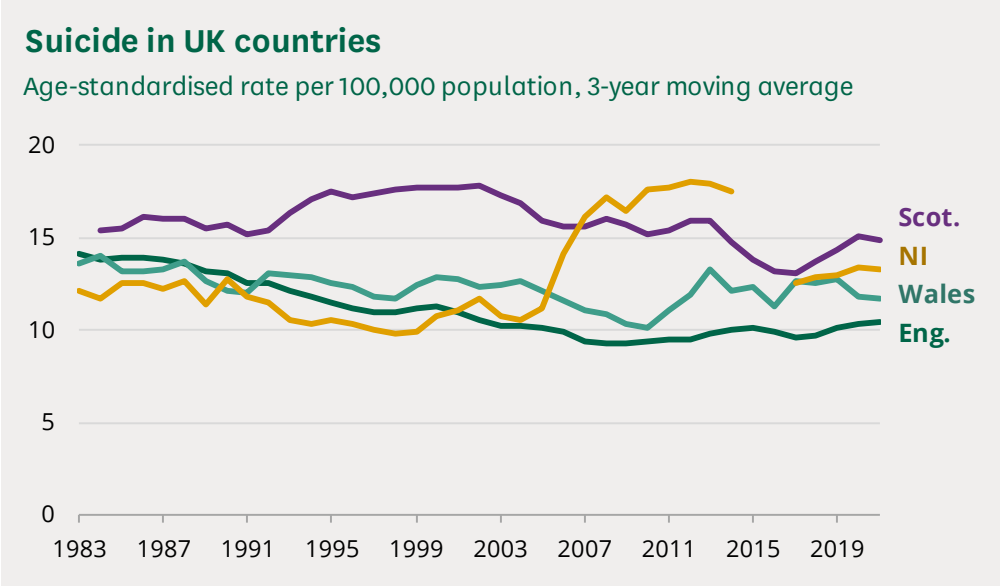
Sources: ONS, Suicides in England and Wales tables, Table 1; Public Health Scotland, Suicide statistics for Scotland, Table 1; NISRA, Suicide Statistics 2021, Tables 1 and 3

The suicide rate in England declined by 28% between 1981 and 2021 (see chart below). Most of this fall occurred before 2000. Trends in Scotland, Wales, and Northern Ireland have varied.

Figures for Northern Ireland were revised as a result of the Review of Suicide Statistics Northern Ireland (2022). As a result, figures from 2015 onwards are not comparable with previous years. This is shown as a gap in the orange line on the chart above. The increase in the mid-2000s corresponds with the centralisation of the Coroner's Service in Northern Ireland, which resulted in the clearing of long-standing cases.

In July 2018, the standard of proof used to determine whether a death is suicide was lowered in England and Wales. The Office for National Statistics has published analysis of this change.

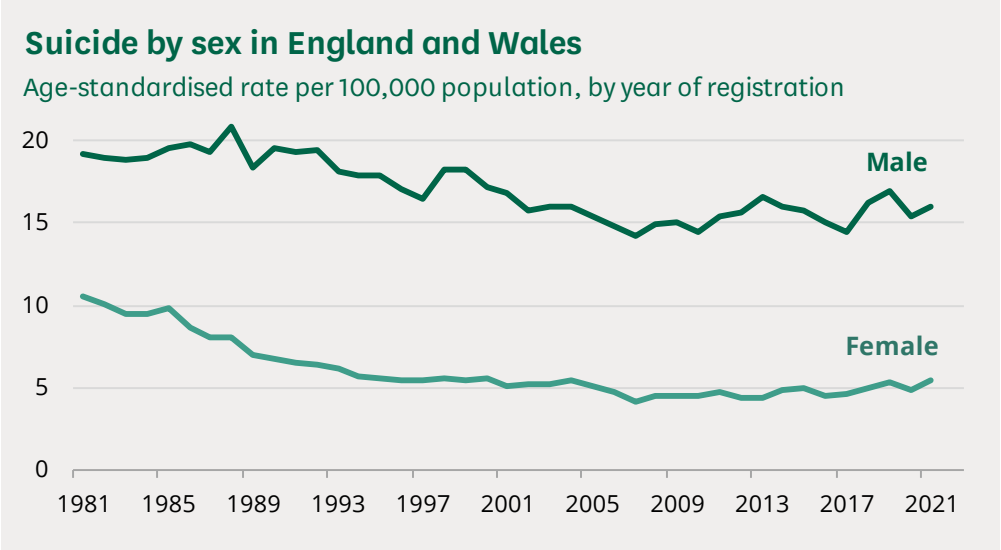
[1] ONS, Suicides in England and Wales tables, Table 1; Public Health Scotland, Suicide statistics for Scotland, Table 1; NISRA, Suicide Statistics 2021, Tables 1 and 3



Sources: ONS, Suicides in England and Wales tables, Table 1; Public Health Scotland, Suicide statistics for Scotland, Table 1; NISRA, Suicide Statistics, Tables 1 and 3

1.1 Suicide by sex and age

Men are three times more likely than women to take their own lives and this gap has grown in the past 35 years. The suicide rate among women has approximately halved since 1981. By comparison, the rate among men has reduced by 17%.

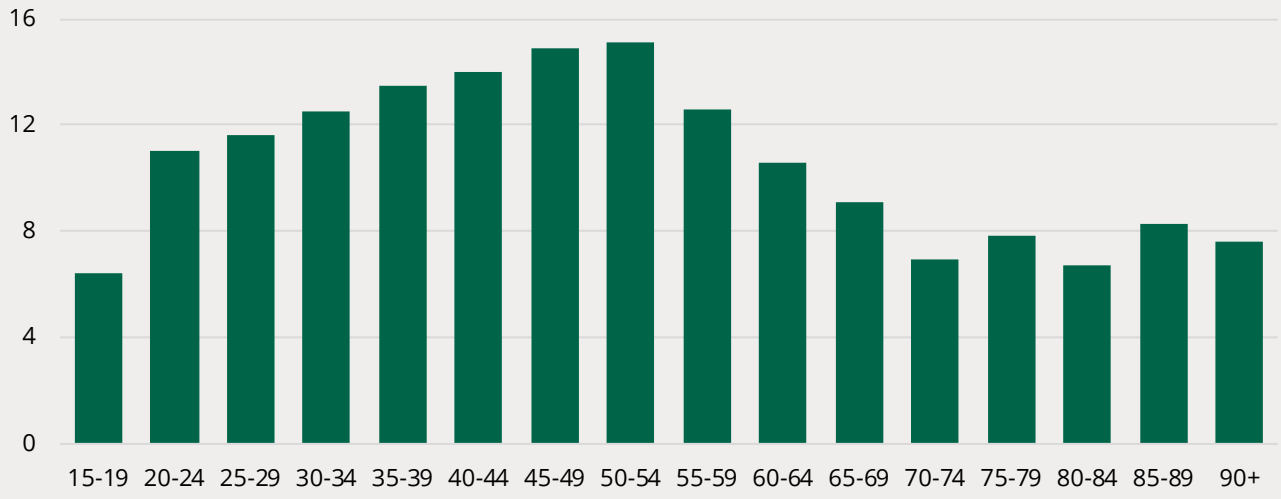


Source: ONS, Suicides in England and Wales tables, Table 1

Risk of suicide in England and Wales is highest among people aged between 45 and 54 and lowest among people aged under 20 and over 70. The chart below shows data for five-year age groups in 2021.

Suicide by age group, England and Wales

Age-specific rate per 100,000 population, 2021



Source: ONS, Suicides in England and Wales tables, Table 5

1.2 Suicide during the pandemic

The most recent data on suicide by date of occurrence is for 2020.[2] It indicates that the number of suicides occurring in 2020 in England and Wales was 5,277 – lower than the number in 2019 (5,674).

The ONS has released data analysing suicides occurring between April and December 2020.[3] During that period, the suicide rate was lower than in the same period in 2019 and 2018, and similar to 2017. The ONS notes that while the data is not yet complete due to registration delays, late registrations will not fully explain the decrease in suicides.

1.3 Suicidal thoughts and self-harm

A survey of adult mental health is commissioned by the NHS in England is carried out every seven years. The most recent Adult Psychiatric Morbidity Survey was carried out in 2014. It included questions on suicidal thoughts, self-harm and suicide attempts, which are "strongly associated with mental illness".[4] The findings were as follows:

2 ONS, Suicide occurrences, England and Wales, 2020, 6 September 2022

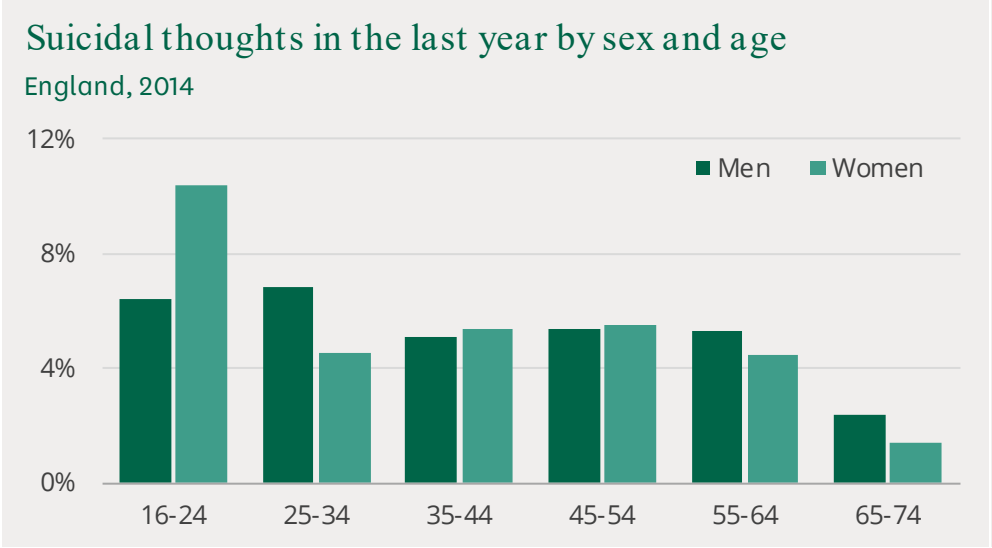
3 ONS, Deaths from suicide that occurred in England and Wales: April to December 2020, 14 April 2022

4 NHS Digital, Adult Psychiatric Morbidity Survey: 2014, Chapter 12 – Suicidal thoughts, p2

- 5.4% of people surveyed in 2014 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 (0.5%).

Source: NHS Digital, Adult Psychiatric Morbidity Survey: 2014, Table 12.2

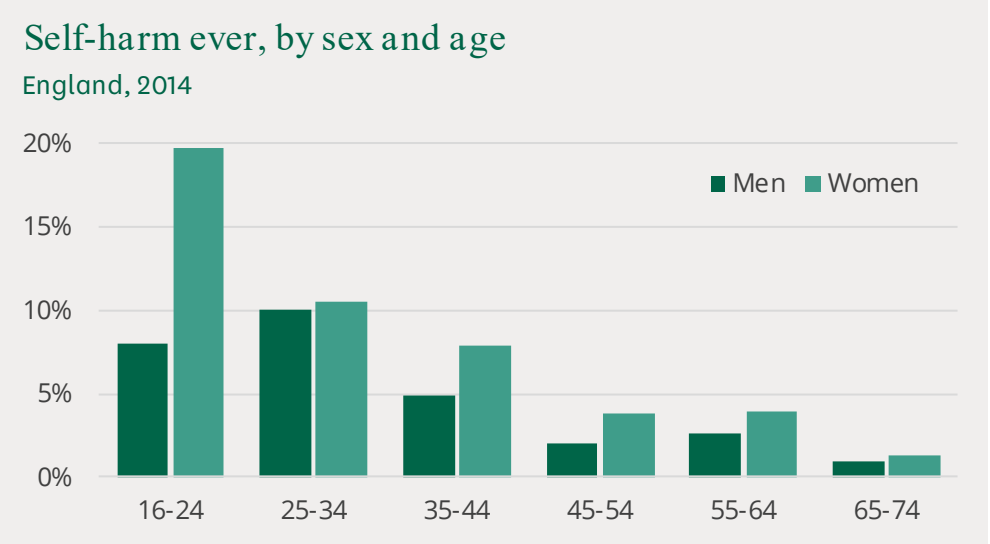
Among women, suicidal thoughts in the past year were most common among those aged 16–24 (10%). Among men, rates were highest for those aged between 16 and 24 and those aged between 25 to 34 (6 to 7%).



Source: NHS Digital, Adult Psychiatric Morbidity Survey: 2014, Table 12.2

Women aged 16–24 were much 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 were most likely to report self-harm (10%).

According to NHS data, there were just under 94,000 hospital admissions due to intentional self-harm in 2021/22.[5]



Source: NHS Digital, Adult Psychiatric Morbidity Survey: 2014, Table 12.2

[5] Office for Health Improvement and Disparities, Public Health Profiles: Emergency hospital admissions for intentional self-harm 2021/22

2 Suicide prevention policy in England

2.1 National suicide prevention strategy 2012

The national suicide prevention strategy, Preventing suicide in England: A cross-government outcomes strategy to save lives, was first published in 2012.[6] Its key aims were to reduce the suicide rate in the general population in England and improve support for those bereaved or affected by suicide.

It initially specified six areas for action. A seventh area was added in a progress report in 2017:

1. Reduce the risk of suicide in key high-risk groups.
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.[7]
7. Reduce rates of self-harm as a key indicator of suicide risk.[8]

The Department of Health and Social Care published five progress reports on the strategy between 2014 and 2021. Each report set out current trends, progress to date and future actions.

The most recent report, the Fifth progress report was published in March 2021.[9] It set out additional government support and funding for suicide prevention to address pressures caused by the pandemic.

6 Department of Health, Preventing Suicide in England: A cross-government outcomes strategy to save lives, 10 September 2012
7 As above, p6
8 Department of Health and Social Care, Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives, January 2017
9 Department of Health and Social Care, Suicide prevention in England: fifth progress report, 27 March 2021

Local suicide prevention plans

The Government's 2012 suicide prevention strategy said that by April 2013, suicide prevention would become an "integral part of local authorities' new responsibilities for leading on local public health and health improvement."[10]

Guidance for local authorities on developing multi-agency suicide prevention plans was published by Public Health England[11] in 2014 and last updated in September 2020.[12] The guidance says local plans should work towards the seven areas for action identified in the suicide prevention strategy, as well as priorities for action based on local data.

The guidance also includes information on developing local real-time 'suicide surveillance systems', also known as real time data, led by police or coroners. Real-time notification of suspected suicides facilitates public health responses such as identifying clusters and trends, as well as timely support for those bereaved.[13]

The recommended priorities for short term action were:

- Reducing risk in men
- Preventing and responding to self-harm
- Mental health of children and young people
- Treatment of depression in primary care
- Acute mental health care
- Tackling high frequency locations
- Reducing isolation
- Bereavement support.[14]

In the Five year forward view for mental health (2017), establishing local suicide prevention plans is a key action.[15]

In May 2018, the Department of Health and Social Care, Public Health England and NHS England announced a £25 million investment over three years for local suicide prevention schemes.[16] The funding was initially

10 Department of Health, Preventing suicide in England: A cross-government outcomes strategy to save lives, 10 September 2012, p8

11 In October 2021 Public Health England was abolished. Its functions were transferred to the UK Health Security Agency, the Office for Health Improvement and Disparities and NHS England.

12 Public Health England, Suicide prevention: developing a local action plan, updated September 2020

13 As above, p32

14 As above, pp8-9

15 Independent Mental Health Taskforce, The Five year forward view for mental health, February 2016, p27

16 NHS England, Suicide prevention and reduction, 16 May 2018

allocated to areas worst affected by suicide.[17] Plans for the funding included targeted prevention campaigns for men; psychological support for people with financial difficulties; better care after discharge; and improved self-harm services for all ages.[18]

The NHS Long Term Plan (2019) reported all areas as having implemented multi-agency suicide prevention plans.[19]

In 2019, the Samaritans, a charity and mental health support service, and the University of Exeter published an independent progress report, Local Suicide Prevention Planning in England.[20] The report was produced through work with local authorities to self-assess their plans. It found that while most local authorities had included the recommended priorities for action in their plans, not all areas had translated these plans into actions.[21] Recommendations from the report focused on effective delivery through sharing successful initiatives between local authorities.[22]

In September 2019, the National Institute of Health and Care Excellence (NICE) published a new quality standard on suicide prevention covering:

- Multi-agency suicide prevention partnerships
- Reducing access to methods of suicide
- Media reporting of suicide
- Involving family, carers and friends
- Supporting people bereaved or affected by suicide.[23]

The Government reports it provided over £550,000 to the Local Government Association in 2021/22 to fund a support programme to help local authorities strengthen their suicide prevention plans.[24]

Health Committee inquiry into suicide prevention

In 2016, the Health Committee published an interim report on suicide prevention[25] which was intended to inform the Government's third progress

17 For full list of areas see NHS England, Suicide prevention and reduction, 16 May 2018
18 Public Health England, New Funding for Health and Social Care in England, 16 May 2018
19 NHS England, The NHS Long Term Plan,7 January 2019, para 3.104
20 Samaritans and University of Exeter, Local suicide prevention planning in England: An independent progress report, Tom Chadwick, Christabel Owens and Jacqui Morrissey, May 2019
21 As above, p6
22 As above, p78
23 NICE, Suicide Prevention, QS189, September 2019
24 PQ 185532 [on Suicide: Mental health services], 23 May 2023
25 Health Committee, Suicide prevention, 19 Dec 2016, HC 300 2016-17

report on the suicide prevention plan.[26] The Committee made recommendations in five areas:

- Implementation
- Targeted and universal support services for people vulnerable to suicide
- Sharing information
- Improving data
- Media guidelines.[27]

The third progress report was published in January 2017. It welcomed the Committee's interim report and committed to a range of further work, including a more robust implementation programme.[28]

The Committee published its full report in March 2017, in which it urged the Government to publish details of the new implementation plan as soon as possible, alongside other recommendations.[29]

2.2 Five Year Forward View for Mental Health 2016

The Five Year Forward View for Mental Health was published in February 2016 by the independent Mental Health Taskforce.[30] The report recognised rising suicide rates in England and included recommendations for the Government and NHS England on the prevention and reduction of suicide, such as the improvement of crisis services.

It also included an objective to reduce suicides by 10% in England by 2020/21.[31] This objective was also included in the NHS Long Term Plan but was not achieved (see section 1.4 below).

The recommendations were accepted by NHS England and additional investment was agreed, including £25 million specifically on suicide prevention to support the transformation of mental health services.[32]

26 As above, para 8
27 As above, para 7
28 DHSC, Suicide prevention: third annual report, 9 Jan 2017
29 Health Committee, Suicide prevention final report, 16 March 2017, HC1087 2016-17
30 NHS England, Five year forward view for mental health, February 2016
31 As above, p13
32 NHS England, Implementing the five year forward view for mental health, July 2016, pp35-36

2.3 Cross-government suicide prevention workplan 2019

In January 2019, the Government published a Cross-government suicide prevention workplan alongside the Fourth national suicide prevention strategy progress report.[33] The workplan commits every area of government to acting on suicide and sets out deliverables and timescales against which the key commitments in the strategy are monitored.

The Government also established a National Suicide Prevention Strategy Delivery Group to track, monitor, and regularly report on implementation of the workplan to the National Suicide Prevention Strategy Advisory Group.[34]

The workplan was produced in response to a recommendation from the Health Committee's inquiry into suicide prevention (see section 2.1), which called for a clear implementation strategy with strong national leadership, clear accountability, and regular and transparent external scrutiny.[35]

The workplan set out key actions to address suicide, including:

- Ensuring the effectiveness of every local authority suicide prevention plan;
- Ensuring every mental health trust had a zero-suicide ambition plan for mental health inpatients by the end of 2019;
- Implementing the Prison Safety Programme across the prison estate; and
- Improving data collection at local and national level, and harnessing technology to identify those most at risk of suicide and self-harm.[36]

The workplan says the drive to improve data on deaths by suicides includes development of a real-time suicide surveillance system.[37] The fifth progress report on the suicide prevention strategy (2021), said Public Health England[38] received £1.2 million for 2021 to 2022 as part of the Spending Review settlement to "support roll-out of a national real-time suicide surveillance system."[39]

In June 2023, Parliamentary Under-Secretary (Department of Health and Social Care), Maria Caulfield, said a national system developed by the Office

33 Department of Health and Social Care, Cross-government suicide prevention workplan, January 2019
34 As above, p3
35 Health Committee, Suicide prevention, 16 March 2017, 'Conclusions and recommendations'
36 Department of Health and Social Care, Cross-government suicide prevention workplan, January 2019, p7
37 As above, P9
38 In October 2021 Public Health England was abolished. Its functions were transferred to the UK Health Security Agency, the Office for Health Improvement and Disparities and NHS England.
39 Department of Health and Social Care, Suicide prevention in England: fifth progress report, 27 March 2021, p22

for Health Improvement and Disparities, local areas and the National Police Chief's Council is in a testing phase and routine reporting is expected by the end of 2023.[40]

2.4 NHS Long Term Plan 2019

The NHS Long Term Plan (January 2019) set out key ambitions for the health service over the next ten years, including making suicide reduction an NHS priority.[41]

The plan acknowledged areas of success, such as a significant reduction in the number of male suicides and the implementation of a multi-agency suicide prevention plan in every local area. It also said the NHS was on track to deliver a 10% reduction in suicide rates by 2020/21.[42] The latest data available shows there was no statistically significant change in suicide rates in England between 2015 and 2021.[43]

The Government subsequently announced it would invest £57 million in suicide prevention as set out in the NHS Mental Health Implementation Plan (July 2019), which covers 2019/20 to2023/24.[44] This includes investment in all areas of the country by 2023/24 to support local suicide prevention and establish suicide bereavement support services.[45]

The implementation plan provides a breakdown in funding per year for suicide prevention activity, alongside other areas of specific investment for mental health. It sets out how funding allocations for suicide reduction programmes will be targeted, based on rates of suicide in each local area.[46]

2.5 Covid-19 mental health and wellbeing recovery action plan 2021

The Covid-19 mental health and wellbeing recovery action plan (March 2021) set out a cross-government and holistic approach to promoting mental health and supporting people living with mental illness to recover and live well. While the plan had a general focus on the effect of the pandemic on mental health, the Government gave specific consideration to suicide.

40 PQ 185612 [on Suicide], 12 June 2023
41 NHS England, NHS Long Term Plan, 7 January 2019
42 As above, p72
43 ONS, Suicides in England and Wales, 6 September 2022, Table 2
44 NHS England, NHS mental health implementation plan, 23 July 2019
45 As above, p38
46 As above, p38

This included providing £5 million to support suicide prevention voluntary and community sector organisations in 2021/22 and encouraging government frontline workers and volunteers to complete suicide prevention awareness training.[47]

2.6 Mental health and wellbeing plan consultation 2022

In April 2022, the Government published a Mental health and wellbeing plan: discussion paper for consultation, intended to inform a new mental health and wellbeing plan and a separate suicide prevention strategy.[48]

In January 2023, it was announced that mental health would be incorporated into a new 'major conditions strategy' instead of a stand-alone plan. A separate suicide prevention strategy will be published later in 2023.[49]

The results of the consultation were published in May 2023. The Department of Health and Social Care said the main themes in response to the question "what is the most important thing we need to address in order to prevent suicide?" were:

- access to services
- addressing poverty
- breaking down stigma
- crisis support
- early intervention
- funding for services
- holistic, personal support
- identifying and addressing the risk of suicide
- impact of school on mental health
- impact of tech and social media on mental health
- improved continuity of care

47 HM Government, COVID-19 mental health and wellbeing recovery action plan, 27 March 2021, p13

48 Department of Health and Social Care, Mental health and wellbeing plan: discussion paper, April 2022

49 HCWS514 [written statement on Government action on major conditions and diseases], 24 January 2023

- join-up of services
- prevention
- support for parents
- support for vulnerable groups
- support in the community
- the impact of social media
- training, education and increased awareness
- understanding and addressing the wider determinants of mental health
- voluntary sector support[50]

The department said it had worked with voluntary sector partners to conduct focus groups with people with lived experience of suicide and self-harm. Key themes from this engagement are listed as:

- education and awareness raising to reduce stigma
- improving access and quality of care, and consistency of services
- better crisis support services
- personalisation of care and support for individuals experiencing suicidal feelings
- targeted support for, and awareness-raising among, higher-risk groups[51]

The department said the new suicide prevention strategy will update the 2012 strategy and the results of the consultation have been used to inform priorities and actions.

50 Department of Health and Social Care, Mental health and wellbeing plan: discussion paper and call for evidence, 17 May 2023

51 As above

3 Suicide prevention policy in Scotland, Wales and Northern Ireland

3.1 Scotland

The Scottish Government published Choose life: A national strategy and action plan to prevent suicide in Scotland, in 2002.[52]

In 2013, this was replaced by the Suicide prevention strategy 2013-16.[53]

In 2018, the Scottish Government published Suicide prevention action plan: Every life matters.[54]

In 2022, the Scottish Government published Creating hope together: Suicide prevention strategy 2022 to 2032. The strategy sets out four long term outcomes:

1. The environment we live in promotes conditions which protect against suicide risk – this includes our psychological, social, cultural, economic and physical environment.

2. Our communities have a clear understanding of suicide, risk factors and its prevention – so that people and organisations are more able to respond in helpful and informed ways when they, or others, need support.

3. Everyone affected by suicide is able to access high quality, compassionate, appropriate and timely support – which promotes wellbeing and recovery. This applies to all children, young people and adults who experience suicidal thoughts and behaviour, anyone who cares for them, and anyone affected by suicide in other ways.

4. Our approach to suicide prevention is well planned and delivered, through close collaboration between national, local and sectoral partners. Our work is designed with lived experience insight, practice, data, research and intelligence. We improve our approach through regular monitoring, evaluation and review.[55]

[52] Scottish Government, Choose life: a national strategy and action plan to prevent suicide in Scotland, 2002

[53] Scottish Government, Suicide Prevention Strategy 2013 - 2016, 3 December 2013

[54] Scottish Government, Suicide prevention action plan: Every life matters, 9 August 2018

[55] Scottish Government, Creating hope together: Suicide prevention strategy 2022 to 2032, 29 September 2022

Alongside the strategy, the Scottish Government published a three year Action plan for 2022 to 2025.[56]

3.2 Wales

In 2009, the Welsh Government published Talk to me: The national action plan to reduce suicide and self-harm in Wales 2009-2014.[57]

The strategy was updated in 2015. Talk to me 2: Suicide and self-harm prevention strategy for Wales 2015-2022, outlined six strategic objectives:

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.

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

3. Information and support for those bereaved or affected by suicide and self-harm.

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

5. Reduce access to the means of suicide.

6. Continue to promote and support learning, information and monitoring systems and research to improve our understanding of suicide and self-harm in Wales and guide action.[58]

3.3 Northern Ireland

In 2006, the Northern Ireland Executive published Protect life 1: Northern Ireland suicide prevention strategy and action plan.[59]

In September 2019, the Executive published Protect life 2: A strategy for preventing suicide and self harm in Northern Ireland 2019-2024.[60] The aim of the strategy is to reduce the suicide rate in Northern Ireland by 10% by 2024,

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56 Scottish Government, Creating hope together: suicide prevention action plan 2022 to 2025, 29 September 2022

57 Welsh Government, Talk to me: The national action plan to reduce suicide and self harm in Wales 2009-2014, 2009

58 Welsh Government, Talk to me 2: Suicide and self harm prevention strategy for Wales 2015-2022, July 2015, pp15-17

59 Northern Ireland Executive, Protect life 1: Northern Ireland suicide prevention strategy and action plan, 2006

60 Department of Health Northern Ireland, Protect life 2: A strategy for preventing suicide and self harm in Northern Ireland 2019-2024, September 2019

as well as to ensure suicide prevention services and support are delivered appropriately in deprived areas where suicide and self-harm rates are highest.[61]

The Protect life 2 strategy has 10 key objectives:

1. Ensure a collaborative, co-ordinated cross departmental approach to suicide prevention.
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.[62]

[61] Department of Health Northern Ireland, Protect life 2: A strategy for preventing suicide and self harm in Northern Ireland 2019-2024, September 2019, p2

[62] As above, p16

4 Healthcare and suicide prevention

This section covers work on suicide prevention within the health service. For information on mental health policy in England more generally, see the Commons Library briefing Mental health policy in England.[63]

4.1 Mental health and suicide

The National confidential inquiry into suicide and safety in mental health (NCISH) is an ongoing study collecting data on suicides in the UK since 1996. This data is used to inform national policies and clinical guidance.

Until 2018, NCISH research focused on deaths by suicide of people under the care of, or recently discharged from, mental health services. Based on this evidence, the NCISH produces safety recommendations and toolkits for safer mental health services. Since 2018 the scope of the NCISH has expanded to include those not in contact with mental health services.

The NCISH 2023 report said rates of suicide in "patients" (people in contact with mental health services within 12 months of suicide) across the UK are "relatively stable."[64] The report included the following observations on mental health patients and suicide between 2010 and 2020:

- There are commons factors among patients who died by suicide, for example:
  - The majority (64%) of patients had a history of self-harm
  - Almost half had a history of alcohol misuse
  - Over a third had a history of drug misuse
  - High rates of socio-economic adversity and isolation.
- The increase in suicides among children and young people is reflected in the patient population.
- Patients are at high risk during inpatient admission and recent discharge from hospital.

63 House of Commons Library, Mental health policy in England, CBP-7547

64 National Confidential Inquiry into Suicide and Safety in Mental Health, Annual report 2023: UK patient and general population data 2010-2020, March 2023, p8

- Suicides among people diagnosed with a personality disorder are increasing, particularly among women.
- Clinicians should be aware of prejudice and high rates of trauma experienced by lesbian, gay, bisexual and trans[65] groups.
- Across all age groups, suicide-related internet usage is a feature of suicide by mental health patients.[66]

Suicide prevention policy and mental health

The fifth progress report on the suicide prevention strategy in England highlighted that "there is approximately a 10-fold increase in risk of suicide for people under mental health care for mental illness."[67] The report also identified that around half of people who die by suicide have experienced self-harm, with the risk of suicide peaking within the first year of self-harm taking place.[68]

The fifth progress report considered how the Covid-19 pandemic exacerbated risk factors for death by suicide. For those with existing mental health conditions, disruption to mental health services and a switch to telephone or online working affected their ability to access support.[69] Despite this, the report said, based on current data, there was no indication the pandemic caused a spike in deaths by suicide.[70]

Actions from the fifth progress report to prevent suicide among people with mental health conditions include:

- Implementing the Mental Health Safety Improvement Programme (see below).
- A national quality improvement programme for local multi-agency suicide prevention plans.
- Expansion of suicide safety plans in inpatient and community settings.
- Testing the new Community Mental Health Framework in early implementer sites (see below).

65 "Trans" is used in the report as a term to encompass transgender, transsexual and non-binary people

66 National Confidential Inquiry into Suicide and Safety in Mental Health, Annual report 2023: UK patient and general population data 2010-2020, March 2023, pp5-7

67 Department of Health and Social Care, Suicide prevention in England: fifth progress report, 27 March 2021, p15

68 As above, p14

69 As above, p20

70 As above, p20

- Delivery of a 'green' social prescribing project for people with, and at risk of, mental ill health.[71]

Zero-suicide ambition for mental health inpatients

In January 2018, then Health Secretary Jeremy Hunt announced a 'zero-suicide ambition' for mental health patients treated in hospitals.[72] This included a new requirement for NHS mental health organisations in England to draw up detailed plans to achieve zero suicides, including mechanisms for reporting inpatient suicides.

£2 million investment over 2018 to 2020 was announced for the Zero Suicide Alliance to help achieve this ambition.[73] The Alliance is a registered charity that delivers suicide awareness and prevention training to NHS Trusts. This funding was in addition to the £25 million in suicide prevention funding first announced in 2016.

The NCISH 2023 report said the estimated number of inpatient suicides in the UK has declined since 2015, however this has slowed in recent years. Between 2010 and 2020, over a third of mental health inpatients who died by suicide died on the ward, half were on agreed leave from the ward, and 13% had left the ward without agreement or did not return as agreed.[74]

Patient safety improvements

The NHS Long Term Plan committed the NHS to implementing the Mental Health Safety Improvement Programme as part of the NHS Patient Safety Strategy.[75] This programme includes a focus on suicide prevention and reduction for mental health inpatients. It provides bespoke support to mental health trusts on their individual safety priorities, as well as support with common challenges across local systems.

In February 2021, the NHS Patient Safety Strategy was updated to include more detailed goals for the reduction of self-harm and suicide in inpatient mental health settings.[76] These included achieving the following actions by the first quarter of 2021/22:

- Identifying the interventions that reduce absence without leave (AWOL) and interventions that reduce suicide and deliberate self-harm while on leave;

71 Department of Health and Social Care, Suicide prevention in England: fifth progress report, 27 March 2021, pp35-39

72 Public Health England, Department of Health and Social Care, New funding for health and social care in England, 16 May 2018

73 Department of Health and Social Care, £2 million investment to help NHS achieve zero inpatient suicide ambition, 11 October 2018

74 National Confidential Inquiry into Suicide and Safety in Mental Health, Annual report 2023: UK patient and general population data 2010-2020, March 2023, p5

75 NHS England, The NHS patient safety strategy, July 2019

76 NHS England, NHS patient safety strategy: 2021 update, February 2021

- Scoping the incidence and understanding of suicide and deliberate self-harm in non-mental health acute settings; and

- Supporting the assessment of ligature points and other environmental self-harm risks for inpatient mental health services.[77]

In August 2022, NHS England published a new Patient Safety Incident Response Framework (PSIRF), to replace the Serious Incident Framework. The framework sets out the processes following a safety incident, such as a death by suicide, and how lessons should be used to improve patient safety.[78] Secondary care providers (for example, hospitals and community healthcare providers) are expected to transition to PSIRF by autumn 2023.

In February 2023, the Government said there would be a "rapid review into patient safety in mental health inpatient settings in England", focusing on how data and evidence are used to identify patient safety risks.[79] A report was expected in spring 2023.[80]

In June 2023, the report of an independent rapid review into data on mental health inpatient settings in England, chaired by Dr Geraldine Strathdee made recommendations on how data is collected, processed and used in order to improve patient safety during the inpatient pathway.[81]

The Government announced in June 2023 that the Healthcare Safety Investigation Branch will launch a national investigation of mental health in-patient services in October 2023. This will include investigating how service providers learn from deaths and translate learning into improvement.[82]

Further information on patient safety is available in The structure of the NHS in England, Commons Library briefing.[83]

Crisis care

The NHS Long term plan and subsequent Mental health implementation plan commit to achieving 100% coverage of crisis care via NHS 111 by 2023/24, including:

- 24/7 Crisis Resolution Home Treatment teams for all adults in England by 2020/21.

77 NHS England and NHS Improvement, NHS Patient Safety Strategy: 2021 update, 11 February 2021, p23

78 NHS England, Patient Safety Incident Response Framework and supporting guidance, 16 August, 2022

79 HCWS512 [on Mental health update], 23 January 2023

80 Department of Health and Social Care, Terms of reference for rapid review into data on mental health inpatient settings, 14 February 2023

81 Independent report chaired by Dr Geraldine Strathdee, Rapid review into data on mental health inpatient settings: final report and recommendations, 28 June 2023

82 HC Deb 28 June 2023, c294

83 The structure of the NHS in England, Commons Library briefing CBP-7206

- 24/7 crisis provision for all children and young people including assessment, brief response and intensive home treatment by 2023/24.
- Mental health liaison services in all acute hospitals, with half meeting the "core 24" (available 24/7) service standard by 2020/21 and 70% by 2023/24.
- A range of crisis alternatives to A&E or admission to hospital, such as crisis houses.
- Training ambulance staff in mental health, introducing mental health transport vehicles and integrating mental health professionnals into ambulance control rooms.
- Reviewing waiting time standards including for crisis support.[84]

NHS England published an update on progress against these commitments:

- Every mental health trust has a 24/7 crisis line for all ages.
- Close to 100% of adult crisis teams are operating 24/7.
- All emergency departments offer a mental health liaison service or in-reach support from the crisis team.
- 61% of liaison services meet "core 24 or equivalent" standards.
- Crisis services for children and young people are "on track" to meet the 100% coverage target by 2023/24.[85]

NHS England has consulted on potential new waiting time standards, including for crisis care, which received widespread support.[86] They are developing proposals for implementing the new standards for consideration by the Government.[87]

In the 2021 Autumn budget and spending review, the Government announced £150 million of funding for "NHS mental health facilities linked to A&E and to enhance patient safety in mental health units."[88]

In January 2023, the Government said £7 million of the funding would be allocated to new mental health ambulances. The remaining £143 million will go towards 150 new projects, including crisis line upgrades, improving

84 NHS England, NHS mental health implementation plan 2019/20 – 2023/24, 23 July 2019, pp30-31
85 NHS England, NHS mental health dashboard, (Accessed 22 May 2023)
86 NHS England, Mental health clinically-led review of standards consultation response, 22 February 2022
87 PQ HL7376 [on Mental health services: Children and young people], 2 Mary 2023
88 HM Treasury, Autumn Budget and Spending Review 2021, 27 October 2021, p94

community mental health facilities and schemes providing alternatives to A&E.[89]

Community mental health services

It was previously recommended that 95% of patients discharged from inpatient mental health hospitals should be followed up in the community by a professional within seven days.[90]

However, a 2019 report by the National Confidential Inquiry into Suicide and Safety in Mental Health found the highest risk of death by suicide in this group was in the first two to three days following discharge.[91]

Subsequently a new target to follow up 80% of all adult patients within 72 hours of discharge was introduced and became a national standard in the NHS Standard Contract.[92] NHS Digital collects and publishes data on this target and the results are published in the NHS Mental Health Dashboard.[93] According to analysis by the Nuffield Trust, this target has not yet been met nationally. In 2021 76% of adults discharged form inpatient care were followed up in 72 hours.[94]

In 2020/21, in light of the impact of the Covid-19 pandemic on patients accessing their usual support systems, the Government allocated £50 million to mental health post-discharge support.[95]

NHS England and NHS Improvement and the National Collaborating Centre for Mental Health have developed a new Community mental health framework, to modernise and improve services for people living with severe mental illnesses in the community.[96]

Information sharing

In 2014, the Information sharing and suicide prevention consensus statement was published to encourage health professionals to share information about someone at risk of suicide with family members and friends.[97] However, the Health Committee's 2016-17 inquiry raised concerns that the statement was

89 Department of Health and Social Care press release, Mental health services boosted by £150 million government funding, 23 January 2023

90 NHS England, NHS Standard Contract 2019/20 Particulars (Full Length), 7 March 2019, p44. Applicable to patients under the Care Programme Approach only.

91 NCISH, Annual report 2019: England, Northern Ireland, Scotland and Wales, December 2019

92 NHS England, Full-length NHS Standard Contract 2020/21 Particulars, 10 March 2020

93 NHS England, NHS Mental Health Dashboard (formerly the Five Year Forward View for Mental Health Dashboard).

94 The Nuffield Trust, Follow-up care for adults with mental health problems, updated 27 March 2023

95 Guidance on additional 2020/21 winter funding for post-discharge support for mental health patients, NHS England and NHS improvement, 30 November 2020, p2

96 NHS England and NHS Improvement and the National Collaborating Central for Mental Health, The community mental health framework for adults and older adults, September 2019

97 Department of Health, Information sharing and suicide prevention consensus statement, January 2014

not widely used, and recommended action to increase awareness and train staff on the tool.[98]

In August 2021, a new Consensus statement for information sharing and suicide prevention replaced the original guidance.[99] The Zero Suicide Alliance has also published information for professionals on using the consensus statement.[100]

Most people who die by suicide have attended an appointment with their GP in the preceding year.[101] Primary care therefore provides important opportunities to identify people who are at risk of suicide and refer them for more support.

Health Education England, the National Collaborating Centre for Mental Health and University College London have produced overlapping self-harm and suicide prevention competency frameworks for professionals working with children and young people, adults and older adults, and the public.[102]

Suicide prevention during and after pregnancy

The latest report of the confidential enquiry on maternal deaths and morbidity, Saving lives, improving mothers' care (November 2022), covers the years 2018 to 2020.[103] The report says suicide continues to be the leading cause of maternal death in the first year after giving birth.[104] There was also a statistically significant increase in the rate of suicide during pregnancy and up to six weeks after pregnancy in the UK in 2020, compared to 2017 to 2019.[105]

Although few women who died by suicide had a formal mental health diagnosis, many had a history of trauma.[106] At least half of the women who died by suicide had a background of multiple adversity.[107]

98 Health Committee, Suicide Prevention, 7 March 2017, HC 1087 2016-17, para 95

99 Department of Health and Social Care, Consensus statement for information sharing and suicide prevention, August 2021

100 DHSC, SHARE: consent, confidentiality and information sharing in mental healthcare and suicide prevention, published 26 Aug 2021

101 University of Manchester, Suicide in primary care – 2002-2011 National Confidential Enquiry into Suicide and Homicide by People with Mental Illness (NCISH) (PDF), 2014. Referred to in Department of Health and Social Care, Preventing suicide in England: fourth progress report of the cross-government outcomes strategy to save lives, January 2019, p15

102 Health Education England, National Collaborating Centre for Mental Health. University College London, Self-harm and Suicide Prevention Competence Framework (Accessed 22 May 2023)

103 Maternal, Newborn and Infant Clinical Outcome Review Programme, Maternal, Newborn and Infant Clinical Outcome Review Programme: Saving Lives, Improving Mothers' Care Report 2022, 10 November 2022

104 As above, p2

105 As above, p11

106 As above, p12

107 As above, p12

The report highlights the important role of specialist perinatal mental health services in supporting women directly and advising other services. It makes several recommendations including recognising severe insomnia, a history of trauma, cultural stigma and fear of child removal in the assessment of risk.[108]

NHS England's Five Year Forward View for Mental Health set a target for at least 30,000 additional women each year to access evidence-based specialist perinatal mental health treatment by 2020/21.[109]

The NHS Mental Health Implementation Plan 2019/20-2023/24 built on this ambition, aiming for a further 66,000 women to be able to access specialist perinatal mental health care by 2023/24. The plan said specialist care would be available from preconception to 24 months after birth.[110]

The implementation plan said every local area in England had a specialist mental health perinatal mental health service.[111] However, NHS England said "access is below the planned growth trajectory" with access at 49,130 women in the third quarter of 2022/23.[112]

4.2 Support for other high-risk groups

The Suicide prevention strategy for England, and subsequent progress reports, set an objective to target suicide prevention and help-seeking in high risk groups including:

- Young and middle-aged men
- People in the care of mental health services (see above)
- People in contact with the criminal justice system
- Specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers
- People with a history of self-harm.[113]

The fifth progress report addresses these groups in the context of the Covid-19 pandemic and highlights the effects of lockdown on vulnerable groups. The report includes children and young people as a high-risk group,

108 Maternal, Newborn and Infant Clinical Outcome Review Programme, Maternal, Newborn and Infant Clinical Outcome Review Programme: Saving Lives, Improving Mothers' Care Report 2022, 10 November 2022, p10

109 NHS England, Five year forward view for mental health, February 2016, p71

110 NHS England, NHS Mental Health Implementation Plan 2019/20–2023/24, July 2019, p17

111 As above, p3

112 NHS England, NHS mental health dashboard (Accessed 23 May 2023)

113 Department of Health and Social Care, Suicide prevention strategy for England, September 2012, p13

noting that rates of suicide and self-harm among people under 25 are rising.[114]

Healthcare actions from the Fifth Report for high-risk groups include:

- Ongoing creation of mental health support teams for schools/colleges.
- Health Education England have worked with MindEd to produce online training modules aimed at children and young people in relation to suicide and deliberate self-harm prevention.
- Implementation of a dedicated programme of work to understand the scale of the issue of nurse suicides and support the system.
- NHS England and NHS Improvement have put in place a package of support for NHS staff available at people.nhs.uk
- Development of a new Health and Justice Information Service linking prison healthcare systems to healthcare systems in the community, and to prison systems.
- Specialist gambling clinics established in major cities, including a pilot young person's clinic in London.[115]

4.3 The role of the voluntary, community and social enterprise sector

The Government's suicide prevention strategy, workplan and related progress reports all set out the need for close collaboration between the Government, the NHS and voluntary, community and social enterprise (VCSE) organisations.

The Fifth Progress Report recognises "the important role that the VCS sector plays in our response to supporting people's wellbeing during and following the pandemic."[116]

In November 2021, the Government launched a £5 million support fund for suicide prevention services provided by the VCSE sector. The press release said some VCSE services had experienced a 20% increase in demand over the previous year and quoted then Minister for Mental Health, Gillian Keegan as saying:

> The entire suicide prevention voluntary sector has played a crucial role in providing people with the help and support they need throughout the

[114] Department of Health and Social Care, Suicide prevention in England: fifth progress report, 27 March 2021, p14
[115] As above, pp 32-69
[116] As above, p23

> pandemic and I encourage them to apply for this funding so we can continue to support our communities.[117]

In the 2023 Spring Budget, the Government announced a £10 million grant fund for suicide prevention VSCE organisations across 2023 to 2025.[118]

4.4 Health and suicide prevention in Scotland, Wales and Northern Ireland

Scotland

The Scottish Government's 2022 to 2032 suicide prevention strategy and 2022 to 2025 action plan include a range of commitments across health policy, including to:

- Focus on the causes of suicide including trauma.
- Recognise the impact of discrimination on the mental health of marginalised groups.
- Target training at people who work in sectors and settings that play a role in preventing suicide, including health and care settings.
- Consider how training on suicide prevention can be embedded in pre-registration training for health and care professionals.
- Improve patient safety in health and care settings.
- Continue rolling out Distress Brief Intervention across local areas and pilot its use with under 16s.
- Work with partners such as the Scottish Recovery Network to build peer support capability.
- Consider how professionals in primary care settings can identify and support people at risk of suicide.
- Mental health services adopt recommendations by the National Confidential Inquiry into Suicide and Safety in Mental Health into their safety planning.[119]

The Scottish Government's Suicide Prevention Action Plan: Every Life Matters (August 2018), committed the Scottish Government to fund refreshed mental

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117 Department of Health and Social Care press release, £5 million launched to support suicide prevention services, 26 November 2021

118 HM Treasury, Spring Budget 2023, 15 March 2023, para 4.24

119 Scottish Government, Creating hope together: suicide prevention action plan 2022 to 2025, 29 September 2022

health and suicide prevention training, and develop a Scottish Crisis Care Agreement.[120] 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.[121]

In March 2017 the Scottish Government published a 10-year Mental Health Strategy which is designed to complement current suicide prevention measures.[122]

Wales

The second objective in the latest Welsh Government's suicide prevention strategy, Talk to me 2: Suicide and self harm prevention strategy for Wales 2015-2022, is "to deliver appropriate responses to personal crises, early intervention and management of suicide and self-harm."[123] In particular, this commits the Welsh Government to the mantra "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."[124]

The strategy recommends GPs have appropriate suicide prevention education and says emergency staff "must have the necessary knowledge, skills and attitudes to recognise, assess, signpost, manage and initiate appropriate follow up for those with whom they come into contact and who are in distress."[125]

The Strategy action plan also commits to reviewing deaths through suicide in those known and unknown to mental health services. This involves collaboration between Health Boards, Public Health Wales, the National Advisory Group, and local authorities.[126]

The Welsh Government published its mental health strategy, Together for mental health, in October 2012.[127] The strategy is supported by a delivery plan, last updated in November 2021, to include actions in response to the Covid-19 pandemic.[128] The updated plan includes a new action "to review deaths by suicide and self-harm (0-25 year olds) as part of the Child Death Review process and to improve timely access to data supporting interventions."[129]

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120 Population Health Directorate, Scottish Government, Suicide prevention action plan: Every life matters, August 2018

121 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

122 Population Health Directorate, Scottish Government, Mental health strategy 2017-2027, March 2017

123 Welsh Government, Talk to me 2: Suicide and self harm prevention strategy for Wales 2015-2022, 2015, p15

124 As above. pp15-16

125 As above, pp15-16 and 22-23

126 As above, p13

127 Welsh Government, Together for mental health, October 2012

128 Welsh Government, Mental health delivery plan 2019 to 2022, updated November 2021

129 As above, p22

Northern Ireland

The Protect Life 2 Suicide Prevention Strategy for Northern Ireland (September 2019) is designed to work in coordination with mental health initiatives such as the Regional Mental Health Care Pathway, You in Mind. This sets out the standards expected by all mental health and psychological therapy services in Northern Ireland.[130]

The fifth objective of the strategy specifies a desire to "reduce incidence of suicide amongst people under the care of mental health services."[131] It noted an improvement within inpatient safety and "substantial scope for action in community mental health services to reduce the number of patients who take their own lives."[132]

Northern Ireland's Mental Health Strategy 2021-2031 (June 2021) includes as an outcome "a workforce who have training in meeting the needs of particular high risk groups, suicide prevention skills and trauma informed practice."[133]

More information on suicide in Northern Ireland can be found in this Northern Ireland Assembly Research and Information Service briefing on Suicide: Northern Ireland (PDF).[134]

130 Heath and Social Care Northern Ireland, Regional Mental Care Pathway, October 2014
131 Department of Health Northern Ireland, The Protect life 2 suicide prevention strategy, September 2019, p67
132 As above, p67
133 Department of Health Northern Ireland, Mental Health Strategy 2021-2031 , 29 June 2021, p83
134 Northern Ireland Assembly Research and Information Service NIAR 379-29, Suicide: Northern Ireland (PDF)

5 Education and suicide prevention

5.1 Schools and suicide prevention in England

Data on suicide for children and young people

In 2021, and in England:

- There were 14 registered deaths by suicide of young people aged 10 to 14. The absolute number is too small to calculate a reliable rate for this age group.
- There were 198 registered deaths by suicide of young people aged 15 to 19. The suicide rate among this group was estimated at 6.2 per 100,000 people.[135,136]

Suicide awareness in the school curriculum

Since September 2020, health education has been a statutory part of the curriculum in primary and secondary schools in England. More information on this can be found in the Library briefing on relationships and sex education in schools (England).

The Government has published statutory guidance on relationships and sex education (RSE) and health education. This sets out what pupils should know about mental wellbeing by the end of primary and secondary school, including:

- Discussing mental health conditions
- Recognising early signs of mental wellbeing concerns, and
- Knowing where to seek help.

The guidance does not explicitly include teaching on suicide awareness, though it says that students may bring up the topic of suicide:

[135] The National Statistics definition of suicide does not include any deaths among children aged under 10. It includes all deaths from intentional self-harm for persons aged 10 years and over and deaths caused by injury or poisoning where the intent was undetermined for those aged 15 years and over. Deaths from an event of undetermined intent in 10- to- 14-year-olds are also not included in suicide statistics.

[136] Office for National Statistics, Suicides in England and Wales, table 6, published 6 September 2022

> There are some important points for teachers in terms of how they approach this content and how they consider their planning. When teaching the new subjects, schools should be aware that children may raise topics including self-harm and suicide. In talking about this content in the classroom, teachers must be aware of the risks of encouraging or making suicide seem a more viable option for pupils and avoid material being instructive rather than preventative. To avoid this, they should take care to avoid giving instructions or methods of self-harm or suicide and avoid using emotive language, videos or images. Teacher Guidance: preparing to teach about mental health and emotional wellbeing provides useful support for teachers in handling this material.[137]

Further guidance, issued by the PHSE Association (funded by the Department for Education), Mental health and emotional wellbeing teacher guidance (updated 2021) provides additional information on teaching about self-harm and suicide. The guidance focuses on things to avoid in any sessions covering suicide, such as distressing images, and detailed information on methods. It also says extra care should be taken to signpost pupils to sources of support.

Government review of relationships, sex and health education (RSHE)

The Government has committed to carrying out a review of the revised RSHE curriculum. On 8 March 2023, Prime Minister Rishi Sunak said the Government was bringing forward a review of RSHE statutory guidance, and would start a consultation as soon as possible.[138]

In response to a parliamentary question, Schools Minister Nick Gibb said suicide awareness and prevention would be considered in the review:

> All pupils in schools are taught about mental health as part of the relationships, sex and health Education (RSHE) curriculum, which the Department has made mandatory in 2020 to ensure that all pupils are taught about important topics. Schools can teach older pupils about suicide in an age appropriate and sensitive way.
>
> Ministers are aware of the interest in the inclusion of suicide prevention material in the RSHE curriculum and have written to key campaigners about this important topic.
>
> [...]
>
> The Department is taking a comprehensive, evidence based approach in deciding what should be included and suicide prevention will be considered in the review.[139]

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137 Department for Education, Relationships education, relationships and sex education (RSE) and health education, Statutory guidance, July 2019, p42

138 HC Deb 8 March 2023 c298

139 PQ 141648 [on Relationships and sex education: Suicide], 15 February 2023

Nick Gibb reaffirmed the commitment to consider suicide prevention as part of the review, when responding to a Westminster Hall debate on suicide prevention in the curriculum on 13 March 2023.[140]

Safeguarding in schools

Suicide prevention is closely linked to safeguarding. The Department for Education revised its main safeguarding guidance for providers, Keeping children safe in education, in September 2022. There is broader guidance for those working in health, social services, the police and other agencies: Working together to safeguard children, last updated in December 2020.

Identifying mental health issues

Guidance published by the Department for Education (DfE) advises 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 Child and Adolescent Mental Health Services (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.
- 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 working 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 practical advice on setting up and improving counselling services for pupils.[142] The Government says it "recognises that school-based counselling by qualified practitioners can play an effective role in supporting mental health and wellbeing".[143]

Government policy to improve mental health in schools

Current government initiatives to support mental health in schools include:

140 HC Deb 13 March 2023 c237WH
141 Department for Education, Mental health and behaviour in schools, 2018
142 Department for Education, Counselling in schools, February 2016
143 PQ 279120 [on: Pupils: Counselling], 24 July 2019

- Offering £1,200 funding for a senior school or college staff member to undertake senior mental health lead training, to each setting.
- Increasing the number of Mental Health Support Teams working with schools, to around 500 by 2024. Established from 2018 onwards, these teams provide direct support to pupils with mild to moderate mental health problems, and to schools and colleges in developing whole-setting approaches.
- Providing an online training module for RSHE teachers on mental wellbeing.

Further information on mental health in schools is provided in section 4 of the Library briefing, Children and young people's mental health – policy, CAMHS services, funding and education.

Evaluation of children and young people's mental health 'trailblazer' areas

The National Institute for Health and Care Research (NIHR) has evaluated the development of Mental Health Support Teams in 25 'trailblazer' areas. Its final report was published in January 2023. Key findings included:

- Substantial progress had been made in challenging circumstances.
- There were challenges retaining key staff (education mental health practitioners).
- Education settings welcomed additional mental health support.
- However, there were concerns about students who had problems more significant than 'mild to moderate', but who couldn't access more specialised help.[144]
- One aim of the Mental Health Support Teams is to work on whole-school and whole-college approaches, but in general, trailblazer sites reported "spending more time supporting children with mental health problems" and some had a strong clinical focus.[145]

May 2023 data on Mental Health Support Teams rollout

Figures published by the DfE on 16 May 2023 gave a snapshot of progress on the rollout of Mental Health Support Teams, and training for school and college leads:

144 Ellins J, and others, Early evaluation of the Children and Young People's Mental Health Trailblazer programme: a rapid mixed-methods study. Southampton: NIHR Health and Social Care Delivery Research Topic Report, January 2023, p4

145 As above, p4

- 3.4 million students in schools and colleges, or around 35% of all school and college students, were covered by Mental Health Support Team in 2022/23.
- 28% of schools and colleges were covered by a Mental Health Support Team.
- Each team in operation by March 2023 covered 8,500 learners and 17 schools and colleges, on average.
- Coverage varied by region. Taking into account teams operational by March 2023, 22% of schools and colleges in the East of England and the Midlands were covered, compared to 34% in the North West and South West.
- 58% of eligible settings had applied for the £1,200 grant to train a senior mental health lead.
- Take-up of this grant funding varied by school phase, with 73% of secondary schools applying, compared to 59% of primary schools, and 66% of special schools.[146]

Bullying and mental health

Bullying has been identified as a common theme in the suicide of young people and children. The DfE publishes advice for schools 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 outlines principles underpinning the most-effective anti-bullying strategies in schools.[147]

The Government says it is providing over £2 million of funding between August 2021 and March 2024 to five anti-bullying organisations working with schools.[148]

The Government Equalities Office has published cyberbullying guidance and an online safety toolkit for schools.

146 Department for Education, Transparency data, Transforming children and young people's mental health provision, data release, 16 May 2023, pp 7,8,11 and 19

147 Department for Education, Preventing and tackling bullying, July 2017

148 PQ 177914 [on Schools: Bullying], 21 April 2023

5.2 Schools and suicide prevention in Scotland, Wales and Northern Ireland

Scotland

Statistics on suicide among children and young people

In 2021, in Scotland:

- The number and rate of death by suicide for those aged 14 and under is not published.
- There were 73 registered deaths by probable suicide among young people aged 15 to 24, with a rate of 11.7 per 100,000 people.[149]

Policy

September 2022's Suicide prevention strategy: Creating hope together for Scotland, and associated action plan, commits to:

- Further embedding the Mental Health and Wellbeing framework and the Children and Young People's Mental Health and Wellbeing professional learning resource.
- Improving and developing evidence-informed teaching and learning resources on mental health, self-harm and suicide prevention.

Under an earlier suicide prevention strategy, NHS Education for Scotland and Public Health Scotland were asked to develop educational resources for use in schools, colleges and other settings. By October 2022:

- There were over 65,500 views of the Ask, Tell, Respond adult animations, and 8,000 views of the children's version of the same, with the animations being used widely across the country.
- Twelve of the 19 Higher Educational Institutions and 12 of the 27 Further Education colleges in Scotland access and use the resources within their programmes.[150]

Information on the Scottish Government's approach to promoting mental health more generally is contained in the Mental health strategy 2017-2027. The strategy highlights the role of education in promoting mental health and says "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

149 Public Health Scotland, Suicide statistics for Scotland, Update of trends for the year 2021, table 1, 2 August 2022

150 NHS Education for Scotland, Education for suicide prevention in demand: strong uptake for educational resources, 10 October 2022

early access to effective supports and interventions at tiers 1 and 2 and to use specialist CAMHS expertise where it will be most effective."[151]

Of the 40 initial actions in the strategy, a number focused on education, including:

- Reviewing personal and social education, the role of pastoral guidance in local authority schools, and services for counselling for children and young people.
- Rolling out improved mental health training for those who support young people in educational settings.[152]

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

> Students of further and higher education face some unique challenges, but we want to ensure a consistent level of support for mental health across the country. These education settings also provide opportunities to help address stigma and discrimination, and support efforts towards self-management.
>
> Working with the NUS, we've supported their "Think Positive" project and we will work to explore how this can be developed and built upon in the coming years, particularly for the most vulnerable students.[153]

Wales

Statistics on suicide among children and young people

In 2021, in Wales:

- There were no registered deaths by suicide in the 10 to 14 age group.
- There were 17 registered deaths by suicide among young people aged 15 to 24. The small absolute number of deaths means a reliable rate cannot be calculated.[154]

Policy

The Suicide and self-harm prevention strategy for Wales 2015-2022 highlighted schools and further and higher education establishments as among the "priority places" where suicide prevention efforts should be focused.

In a section focussing on education settings, it highlights some initial positive evidence from school-based suicide prevention programmes:

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151 Scottish Government, Mental health strategy: 2017-2027, March 2017, p8

152 As above, p4

153 As above, p18

154 Office for National Statistics, Suicides in England and Wales, table 7, published 6 September 2022

> School based prevention programmes are designed to either reduce risk, and or increase protective factors. They aim to increase knowledge and understanding of suicide, change attitudes towards suicide, increase awareness of risk factors and encourage help seeking behaviour.
>
> Within Wales, school based prevention programmes are not in routine use. There is some evidence from randomised controlled trials that such interventions have a short term impact, particularly on knowledge and attitudes. It is not known if these changes persist in the longer term or whether they have an impact on suicidal behaviour and help seeking.
>
> There is evidence that training for individuals who frequently come in to contact with people at risk of suicide and self harm, including teachers, increases confidence in recognising those who may be at risk of suicide and referring them appropriately for help. Whether or not such training has an impact on suicidal behaviour has however not yet been established.[155]

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."[156]

It states this counselling provision might "contribute to suicide and self-harm prevention efforts, being suitably placed and accessible to children and young people in crisis." It adds that the importance of emotional support is also acknowledged by colleges of further and higher education.[157]

In 2019, the Welsh Government published guidance for education and youth professionals on responding to self- harm and thoughts of suicide.

Further guidance published in 2021 helps schools to develop a whole-school approach to emotional and mental well-being.

Northern Ireland

Statistics on suicide among children and young people

In 2021 in Northern Ireland there were 16 registered deaths by suicide in children and young people aged 20 or under. Suicide rates by age group are not published.[158]

Policy

Northern Ireland's suicide prevention strategy, Protect life 2 2019-2024, highlights actions taken under the previous suicide prevention strategy (Protect Life 2006-2016) aimed at younger people, including:

- Suicide prevention training for teachers.

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155 Welsh Government, Suicide and self harm prevention strategy for Wales 2015-2022, October 2020, p25

156 As above

157 As above

158 Northern Ireland Statistics and Research Agency, Suicide statistics 2021, 30 November 2022

- 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.
- 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.[159]

Regarding future developments, the strategy states 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." [160]

It says this will include further consideration of child focussed interventions, building on what is already in place through the iMatter programme.[161]

5.3 Further and higher education

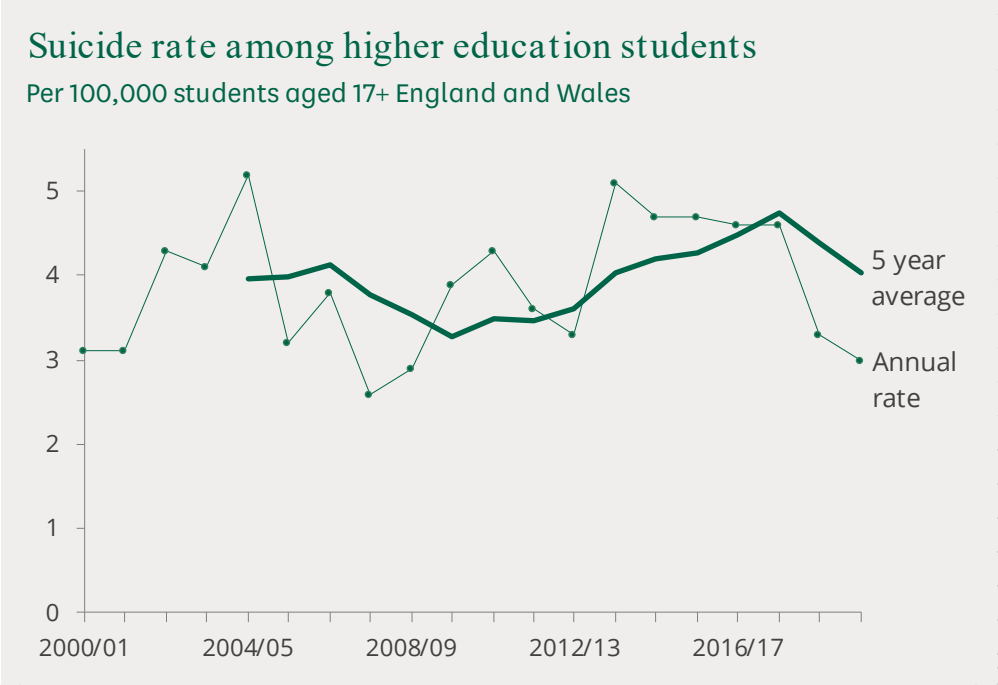
This section provides a brief overview of suicide prevention in the further and higher education sector. More detailed information on student mental health is available in the Library briefing Student mental health in England: Statistics, policy, and guidance.[162]

While there is a strong connection between poor mental health and suicide or self-harm, the ability to identify students who are at risk of suicide is difficult. A 2017 report revealed only 12% of students who died by suicide were reported to be seeing student counselling services.[163]

159 Northern Ireland Department of Health, Protect life 2: A strategy for preventing suicide and self harm in Northern Ireland 2019-2024, September 2019, pp36-7
160 As above, p37
161 As above
162 Commons Library briefing, CPB-8593, Student mental health in England: Statistics, policy, and guidance
163 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH), Suicide by children and young people, July 2017, p3

In 2018, the Office for National Statistics (ONS) published a report estimating the number of suicides among higher education students in England and Wales between 2000 and 2017.[164] It updated this in 2022 with data covering the period from 2017 to 2020.[165]

The reports found substantial year-on-year variations in suicide rates among students. There was some evidence that the overall rate increased in the decade to 2017/18, but fell in 2018/19 and 2019/20. The chart below looks at trends in the suicide rate since 2000/01 and gives a five-year rolling average to help identify underlying trends.



Sources: ONS, Estimating suicide among higher education students, England and Wales: Experimental Statistics, June 2018; ONS, Estimating suicide among higher education students, England and Wales: Experimental Statistics: 2017 to 2020Sources: ONS, Estimating suicide among higher education students, England and Wales: Experimental Statistics, June 2018; ONS, Estimating suicide among higher education students, England and Wales: Experimental Statistics: 2017 to 2020

A total of 1,554 students died by suicide between July 2000 and July 2020. The suicide rate for students in England and Wales in the 2019/20 academic year was 3.0 deaths per 100,000 students (64 suicides). This was the lowest rate for a decade. According to the ONS, the relatively small annual numbers mean it is difficult to identify statistically significant differences over time. [166]

[164] ONS, Estimating suicide among higher education students, England and Wales: Experimental Statistics, June 2018

[165] ONS, Estimating suicide among higher education students, England and Wales: Experimental Statistics: 2017 to 2020, May 2022

[166] ONS, Estimating suicide among higher education students, England and Wales: Experimental Statistics, June 2018; ONS, Estimating suicide among higher education students, England and Wales: Experimental Statistics: 2017 to 2020

The suicide rate among higher education students across the years covered was significantly lower than among the general population of the same age. For the three years 2017/18 to 2019/20, the rate among the general population aged 24 and under was 2.7 times higher than for higher education students. This applies when the data are broken down by age group and by gender. Other findings covering the three most recent years include:

- Of the 319 students who died by suicide, 202 (63%) were male and 117 (37%) were female.
- The suicide rate for male students was significantly higher at 5.6 per 100,000 students compared to 2.5 per 100,000 for females.
- The rate was generally higher among older students.
- White students had a higher suicide rate than Black and Asian students, but the differences were not statistically significant.
- Among younger students (aged 24 and under) the suicide rate was significantly higher among first year students.[167]

Government policy on student mental health

The Government has said it believes the most effective way to support student mental health is through a "two-pronged approach" of funding services and working with mental health experts and the sector to implement best practice.[168] It has also said "preventing suicide and self-harm in our student populations is a key priority."[169]

The Fifth progress report on preventing suicide in England (2021) said the Government was currently coordinating two approaches to improving mental health among university students.[170] These included:

- Supporting Public Health England[171] and Universities UK to develop a serious incident framework for use following a student's death. The aim would be to ensure incidents are identified correctly, investigated thoroughly, and learned from to reduce reoccurrence.
- Setting up Student Mental Health Collaboratives to improve coordination of care between universities and the NHS, investigate potential barriers to accessing support, and develop a clinical risk assessment tool which can be rolled out across the UK. So far, collaboratives have been

167 ONS, Estimating suicide among higher education students, England and Wales: Experimental Statistics: 2017 to 2020

168 PQ 181273 [Higher Education: Health and Safety] 25 April 2023

169 Department for Education Hub blog, How we're supporting students with their mental health, 9 March 2023

170 HMG, Preventing suicide in England: Fifth progress report of the cross-government outcomes strategy to save lives, March 2021, p61

171 In October 2021 Public Health England was abolished. Its functions were transferred to the UK Health Security Agency, the Office for Health Improvement and Disparities and NHS England.

established across an initial five university sites in Bristol, Liverpool, Manchester, London (UCL), and Sheffield.

In June 2021, the then Minister of State for Universities, Michelle Donelan, and the President of Universities UK, Steve West, co-hosted a roundtable on suicide prevention in the higher education sector.[172] The event brought together government departments, sector bodies, charities, higher education providers, and several bereaved family members. The Minister said she expected all higher education providers to have suicide prevention strategies in place.

The Government has said that while it is "determined to provide students with the best mental health support possible at university", it does not believe a statutory duty of care for higher education providers is the most effective way to improve outcomes for students.[173]

During a Westminster Hall debate in June 2023 on a petition calling for a statutory duty of care in higher education, the Minister for Skills, Apprenticeships, and Higher Education, Robert Halfon, announced his intention to commission a national review of university student deaths.[174]

The Office for Students

The Office for Students (OfS), which regulates higher education in England, does not directly regulate student welfare or support systems at individual universities and colleges. Instead, as part of its role in ensuring all students are supported to access, succeed in, and progress from higher education, the OfS's mental health work covers three broad areas:

- Providing funding for higher education providers to develop "practical and innovative approaches and solutions".
- Challenging providers to address gaps in outcomes between different groups of students through its access and participation regulation.
- Working with a range of partners to develop and disseminate sector-wide effective practice.[175]

The role of further and higher education providers

Further education providers which admit students under the age of 18 must comply with the same safeguarding regulations as schools. There has been considerable debate in recent years as to whether universities have a similar duty of care to their students.

172 Office for Students blog, Working together on suicide prevention in higher education, 10 September 2021

173 PQ 181273 [Higher Education: Health and Safety] 25 April 2023

174 HC Deb 5 June 2023 [Higher Education Students: Statutory Duty of Care] cc236-40WH

175 Office for Students, Student mental health, Our role, October 2020

Abrahart v University of Bristol

The Government has often asserted that universities have a duty of care to their students,[176] but in March 2023 it also acknowledged "the existence and application of a duty of care between HE [higher education] providers and students has not been widely tested in the courts".[177]

This acknowledgement followed the May 2022 court judgment in the case of *Abrahart v University of Bristol* (PDF). Natasha Abrahart was studying physics at the University of Bristol when she was diagnosed with chronic social anxiety. She died by suicide in April 2018 on the day she was due to give an assessed oral presentation in a lecture hall to students and staff.

Natasha Abrahart's parents took the university to court arguing their daughter was a victim of disability discrimination under the Equality Act 2010 and that the university had breached its duty of care to their daughter under the law of negligence. The judge found there is "no statute or precedent" concerning a duty of care owed by a university to a student to take reasonable steps to avoid and not to cause injury, including psychiatric injury, and harm.[178]

Nevertheless, some sector bodies and legal firms maintain a general legal duty of care not to cause harm by careless acts or omissions does exist in certain circumstances, but that this cannot reasonably be expected to apply to all aspects of a university's relationships with its students.[179] There also exist established legal duties to which universities must adhere arising from health and safety and equalities legislation.[180]

Debate on a statutory duty of care in higher education

On 5 June 2023, the Commons considered a petition calling for a statutory duty of care for higher education students.[181]

Opening the debate, Nick Fletcher (Conservative) said "a statutory duty of care would ensure that all parties knew where they stood".[182] Mary Foy (Labour) also said she supported the petition because it was a "fair, just and reasonable" response to the issue of protecting students. She said:

> A general duty of care is too vague and does not provide clarity or consistency. A statutory duty of care would change that and give students and their parents peace of mind that they were protected.[183]

176 PQ 56624 [on Students: Long covid], 25 October 2021
177 PQ 174398 [on Higher education: Standards], 31 March 2023
178 *Abrahart v University of Bristol* [2022] (PDF), paras 143-44
179 Universities UK, Creating a statutory duty of care for students, 19 April 2023; Shakespeare Martineau, Student suicide - why new laws are not the answer, 22 November 2022
180 See the Commons Library briefing Student mental health in England: Statistics, policy, and guidance for more information.
181 HC Deb 5 June 2023 [Higher Education Students: Statutory Duty of Care]
182 HC Deb 5 June 2023 [Higher Education Students: Statutory Duty of Care] c218WH
183 HC Deb 5 June 2023 [Higher Education Students: Statutory Duty of Care] c223WH

Helen Grant (Conservative) said inconsistencies across the higher education sector in how universities support students struggling with poor mental health had let to "a care and wellbeing lottery for students in the UCAS application process."[184] She argued a statutory duty of care would set a standard for what higher education providers might reasonably be expected to do.

Speaking for the Government, the Minister for Skills, Apprenticeships, and Higher Education, Robert Halfon, highlighted the funding it had provided to the Office for Students and the wider funding made available for NHS mental health services. He also announced a new higher education mental health implementation taskforce to be chaired by the student support champion, Professor Edward Peck, and a national review of university student deaths to be carried out by an independent organisation.[185]

More information on whether universities have a duty of care to students is available in section two of the Library briefing Student mental health in England: Statistics, policy, and guidance.[186]

University support

Most higher education providers have mental health policies setting out their mental health services and provision for students, as well as suicide prevention strategies. The most common model of mental health provision within providers involves three separate services:

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

There are also several student-led initiatives offering mental health support, including, Nightline, Student Minds, and Students Against Depression.[187]

A 2023 survey of 4,000 UK students by the Tab, a student news site, and Campaign Against Living Miserably (CALM), a suicide prevention charity, found just 12% of respondents think their university handles the issue of mental health well.[188]

184 HC Deb 5 June 2023 [Higher Education Students: Statutory Duty of Care] c225WH

185 HC Deb 5 June 2023 [Higher Education Students: Statutory Duty of Care] cc236-40WH

186 Commons Library briefing, CPB-8593, Student mental health in England: Statistics, policy, and guidance

187 See also Samaritans, Universities.

188 "'They made me feel invalid': Shocking new figures show scale of student mental health crisis", The Tab, 2 May 2023

Calls for transparency on suicide rates

Following the death of Harry Armstrong Evans, who died by suicide in 2021 after suffering a mental health crisis at the University of Exeter,[189] his parents, launched a campaign to require universities to record or publish their student suicide rates. A parliamentary petition called for:

- Coroners to inform universities when the suicide of an enrolled student is registered.
- Universities to publish annually the suicide rate of enrolled students.
- New powers to place universities into 'special measures' where suicide rates exceed that of the national average.[190]

The 2023 survey of 4,000 UK students by the Tab and CALM found 88% of respondents wished their university was more transparent about suicide numbers.[191]

In response to the petition, Universities UK, which represents 140 universities in England, Scotland, Wales, and Northern Ireland, said coroner decisions are already in the public domain and so it would be "inappropriate" for universities also to publish this information.[192]

Guidance for universities on preventing student suicide

Suicide-safer Universities

In September 2018, Universities UK (UUK) and PAPYRUS, a national charity dedicated to the prevention of young suicide, published guidance called Suicide-safer Universities. In October 2022, Universities UK supplemented the main guidance with recommendations on sharing information with trusted contacts, supporting placement students, and what to do after a student suicide.

The main guidance provides a framework to help university staff understand student suicide, mitigate risk, and intervene when students get into difficulties.[193] The guidance states suicide prevention, intervention, and "postvention" should be connected in a university's overarching mental health strategy. The strategy should be created in partnership with staff,

189 "University failed to support Harry Armstrong Evans, inquest told", BBC News, 31 October 2022 (accessed 3 May 2022)

190 UK Government and Parliament petition, Introduce new rules regarding the suicide of higher education students, 8 November 2022

191 "'They made me feel invalid': Shocking new figures show scale of student mental health crisis", The Tab, 2 May 2023

192 Universities UK, Creating a statutory duty of care for students, 19 April 2023, pp6-7

193 Universities UK and PAPYRUS, Suicide-safer universities, September 2018

students, and external stakeholders, and should be developed into a multi-agency action plan detailing how, by who, and when it will be implemented.[194]

Stepchange framework

Universities UK's Stepchange framework was introduced in 2017 and relaunched in March 2020 as Stepchange: Mentally healthy universities. It is a strategic framework for a 'whole university approach' to mental health and wellbeing, which calls on universities to see mental health as foundational to all aspects of university life, for all students and all staff.[195] The framework was co-developed with the University Mental Health Charter, see below.

University Mental Health Charter

In December 2019, the University Mental Health Charter was published. It is a set of principles universities can commit to working towards to improve the mental health and wellbeing of their communities.

The charter was developed by Student Minds in partnership with the UPP Foundation (which offers grants to universities, charities, and other higher education bodies), the Office for Students, National Union of Students and Universities UK. It provides principles to support universities to adopt a 'whole university' approach to mental health and wellbeing. The framework includes 18 themes including, the transition into university life, learning, teaching, and assessment, support services, and residential accommodation.

194 Universities UK and PAPYRUS, Suicide-safer universities, Main guidance for university leaders, September 2018, p15

195 Universities UK, Stepchange: Mentally healthy universities, updated February 2023

6 Employment and suicide prevention

6.1 Suicide rates by occupation

In 2017, the Office for National Statistics (ONS) released a study of suicide rates by occupation which was based on deaths registered in England between 2011 and 2015. This found that men and women who were aged between 20 and 64 had a higher risk of suicide if they were working in certain occupations .[196]

Some of the main findings were as follows:

- Men who worked in the 'lowest skilled' occupations had a 44% higher risk of suicide than the average across all men. The risk among men in skilled trades was 35% higher and the risk of suicide among men who were labourers was three times higher.
- For women, the risk of suicide among professionals was 24% higher than the average across all women – this is mostly explained by a higher risk of suicide among female nurses.
- Carers, both men and women, had higher risk of suicide than average.
- Managers, directors and senior officials – the highest paid occupation group – had the lowest risk of suicide.

More timely statistics on suicide by occupation were published by the ONS in September 2022. These did not provide updated figures showing the risk of suicide by occupation but did provide a time series showing the number of suicides between 2011 and 2021.[197]

Statistics had previously been published in September 2021 which provided the number of suicides between 2011 and 2020. The ONS reported in these statistics that "occupational differences in suicide have been consistent across time".[198]

196 Office for National Statistics, Suicide by occupation, England: 2011 to 2015, 17 March 2017
197 Office for National Statistics, Suicide by occupation, England and Wales, 2011 to 2021 registrations, 6 September 2022
198 Office for National Statistics, Suicide by occupation, England and Wales, 2011 to 2020 registrations, 7 September 2021

6.2 Employment policy and mental health

The Government has acknowledged that unemployment rates for people with mental health issues remain high and those who are unemployed can face additional challenges leading to poorer mental health.[199] It recognises there are complex reasons for increased suicide risks in different occupations and that employers need support.[200]

The Department for Work and Pensions and the Department for Health and Social Care have worked together through the joint Work and Health Unit to explore how more people living with mental health problems can be supported to find or stay in work.[201]

An overview of some of the employment support schemes that are in place to support people with mental health issues is provided in the Library briefing Disabled people in employment. This includes the Access to Work Mental Health Support Service which provides support to manage mental health at work. This may include a tailored plan to help someone get or stay in a job, or one-to-one sessions with a mental health professional.[202]

Since 2017, various government reports and reviews have put in place additional employment support for people with mental health issues, summarised below. In addition, the Government published the March 2023 Transforming Support white paper following a consultation linked to the July 2021 Shaping future support: the health and disability green paper, although these did not put in place any substantial new support for those with mental health issues.

Thriving at work (the Stevenson/Farmer Review) 2017

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".[203]

The review report, Thriving at work: the Stevenson/Farmer review of mental health and employers, was published on 26 October 2017. It contained several recommendations for employers, the public sector and government aimed at implementing "mental health core standards", which are explained as follows:

> The mental health core standards should provide a framework for workplace mental health and we have designed them in a way that they can be tailored to

199 DHSC, Suicide prevention: fourth annual report, January 2019, para 2.44
200 As above, para 1.41
201 GOV.UK, Work and Health Unit
202 GOV.UK, Access to Work: get support if you have a disability or health condition
203 GOV.UK, Prime Minister unveils plans to transform mental health support, 6 January 2017

> suit a variety of workplaces and be implemented by even the smallest employers. We believe all employers can and should:
>
> 1. Produce, implement and communicate a mental health at work plan
> 2. Develop mental health awareness among employees
> 3. Encourage open conversations about mental health and the support available when employees are struggling
> 4. Provide your employees with good working conditions
> 5. Promote effective people management
> 6. Routinely monitor employee mental health and wellbeing.[204]

Improving lives: The future of work, health and disability 2017

On 30 November 2017, the Government published Improving lives: The future of work, health and disability, a response to the Thriving at Work review. It set out a 10-year strategy focussing on: 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.[205]

The paper supported all the recommendations made by the Thriving at Work review. With respect to employers, the paper focused 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.[206]

The Work and Health Unit is overseeing the implementation of the recommendations.

Implementing the Improving lives strategy

As part of the strategy to improve advice for employers, the Work and Health Unit is supporting Mental Health at Work, a website launched by the mental

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[204] DWP and DH, Thriving at Work: the Stevenson / Farmer review of mental health and employers, October 2017, p8

[205] DWP and DH, Improving lives: The future of work, health and disability (PDF), Cm 9526, November 2017, p14

[206] See above, para 28. See also Chapter 2 (pp 24-34)

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 partnered with Business in the Community, a charity, to create a toolkit for employers on reducing the risk of suicide.[207]

In the Improving Lives strategy, the Government committed to developing a framework for voluntary reporting on disability and mental health, following a recommendation for such a framework in the Improving Lives review. In November 2018, the Work and Health Unit published a voluntary framework for employers to report on steps they are taking to support disabled employees and ensure wellbeing in the workplace.[208] This aims to support employers to have greater transparency around physical and mental health within the workplace. The Government's rationale for the framework is that "transparency and reporting are effective levers in driving the culture change required to build a more inclusive society."[209]

The reporting framework is designed for employers with over 250 workers, although smaller organisations may also use it. Employers are not required to notify the Government if they are using the framework, which means the Government does not know the total number of employers who are reporting on it.[210]

From November 2019, a requirement to use the reporting framework was added to the steps that an employer needs to take to be a "disability confident leader".[211] All employers who apply for to be a disability confident leader, including those with less than 250 employees, will need to confirm that they are recording information on disability, mental health and wellbeing within the workplace, or how they intend to do so over the following year. Around 500 employers were disability confident leaders in June 2023. The Library briefing, Disabled people in employment provides an overview of the Disability Confident scheme.

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 progress made in implementing the report's recommendations. He said: "things are moving in the right direction" but noted 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 (see below for developments on these issues).[212]

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207 PHE and Business in the Community, Suicide Prevention Toolkit, 29 October 2019

208 DWP and DHSC, Voluntary Reporting on Disability, Mental Health and Wellbeing, November 2018.

209 As above, p3

210 PQ HL3219 [on Employment: Disability] 5 May 2020

211 As above

212 Paul Farmer, What progress has been made when it comes to Thriving at Work?, Mental Health at Work, 17 January 2019

Health is everyone's business 2019

On 18 July 2019, the Government published Health is everyone's business, a consultation on proposals to reduce job loss due to ill health.[213] The key proposals included:[214]

- 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.
- Reforming Statutory Sick Pay so that it is better enforced, more flexible and covers the lowest paid employees.
- 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.
- Improving employers' and self-employed people's access to good advice and support, ensuring that all employers understand and can act on their responsibilities to their employees.

The consultation outcome was published in July 2021.[215]

Right to request workplace modifications

One of the main proposals in Health is everyone's business was the creation of a new right to request workplace modifications.

Currently, under the Equality Act 2010, employers have a duty to make reasonable adjustments for employees who have a disability.[216] 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.[217]

The consultation recognised there are workers with health conditions who may not fall within this definition. The Government sought views on whether to

213 HMG, Health is everyone's business: Proposals to reduce ill health-related job loss, CP 134, July 2019
214 As above, para 12.
215 DWP and DHSC, Health is everyone's business: proposals to reduce ill health-related job loss, 4 October 2021
216 Equality Act 2010, sections 20-22.
217 As above, section 6

introduce a right to request workplace modifications that would apply to a broader range of workers.[218]

In the consultation outcome, the Government said it would not proceed with the introduction of the right to request such modifications. This was in response to concerns raised including a view that it would undermine existing workplace protections and risk greater confusion in an already complex area.[219]

Instead, the Government said it would consider what it could do to raise awareness and understanding among employers and employees of their existing rights and responsibilities. This involves increasing the visibility of the Access to Work scheme and making it a "quicker and more efficient service".[220]

In September 2022, the Government started trialling a new online service, Support with employee health and disability, to provide guidance to employers and managers on how to better support employees with disabilities or health issues, including understanding their legal obligations.[221]

Reform of Statutory Sick Pay

The need for reform of Statutory Sick Pay (SSP) was first raised in the Work, Health and Disability green paper in 2016. Reforming SSP was one of the recommendations in the Thriving at work report and was accepted by the Government in the Improving lives strategy.

Currently, eligibility for SSP is limited to employees who earn above the Lower Earnings Limit (£123 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 £109.40 per week. Payment of SSP ends when an employee returns to work.[222]

The consultation contained several proposals for reforming SSP, including:[223]

- Allowing SSP to continue during phased returns to work (wages and SSP paid pro rata).

218 HMG, Health is everyone's business: Proposals to reduce ill health-related job loss (PDF), CP 134, July 2019, paras 48-64.

219 DWP and DHSC, Government response: Health is everyone's business (PDF), July 2021, pp20-21

220 DWP and DHSC, Government response: Health is everyone's business (PDF), July 2021, pp21-22

221 DWP, Support with employee health and disability, Gov.uk, [accessed 9 May 2023 – as of this date the page remains in Beta testing mode].

222 See Statutory Sick Pay, Commons Library briefing CBP-9435, 27 May 2022

223 HMG, Health is everyone's business: Proposals to reduce ill health-related job loss (PDF), CP 134, July 2019, paras 78-123.

- 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.
- Adopting a targeted rebate of SSP for small and medium enterprises (SMEs).

In Health is everyone's business, the Government said respondents were broadly supportive of most of these proposals, but the questions posed in the consultation required further consideration. It also said it was "not the right time to introduce changes to the sick pay system".[224]

In April 2023, Tom Pursglove, Minister for Disabled People, Health and Work, responding to a written question from SNP MP Martyn Day, reiterated the view that it was not the right time to introduce changes to SSP but added "The Government is continuing to keep the SSP system under review."[225]

6.3 Employment support in Scotland, Wales and Northern Ireland

Scotland

In its Mental Health Strategy 2017-2027, the Scottish Government included an action to work with employees "on how they can act to protect and improve mental health, and support employees experiencing poor mental health".[226]

An update on progress made towards this action was provided in the second annual progress report published in November 2019:

> We know the mental health benefits of working in mentally healthy workplaces. Along with See Me's targeted work programme, NHS Health Scotland continues to lead on activities to support employers and employees through its Work Positive and Healthy Working Lives Programmes and in partnership with public and private sector employers, is developing a framework of key standards that will demonstrate how employers are supporting a mentally flourishing workplace. Also, in recognition of the importance the Scottish Government places on staff wellbeing and resilience, particularly for those who are called upon to offer assistance in moments of crisis and trauma, we are providing funding of £138,000 to extend the Lifelines

[224] DWP and DHSC, Government response: Health is everyone's business (PDF), July 2021, pp27-29
[225] PQ180542 [on Statutory Sick Pay], 14 April 2023
[226] Scottish Government, Mental health strategy 2017-2027, March 2017, action 36

> Scotland wellbeing programme to cover emergency responders in Police, Ambulance and Fire Services.
>
> As part of our commitment to achieve a coordinated and aligned employability and health pathway for those with mental health problems, given in "A Fairer Scotland for Disabled People: Employment Action Plan" Scottish Government will evaluate the employment support provided to those who suffer mental ill-health and make improvement to Fair Start Scotland, which will include reviewing how individual placement and support is delivered within Scotland.[227]

The third and latest update on progress was published in March 2021. This did not provide any further update on this action, with the onset of the pandemic meaning that the Scottish Government has prioritised other actions within the strategy.[228]

Wales

The Welsh Government reported on how it will provide employment support to people with mental health conditions in the Mental health delivery plan 2019 to 2022. Action 1.2 explained the programmes to be used to achieve this:

> Welsh Government (Health and Social Services) to support people with mental health conditions into employment or to remain in work through delivery of a health-led employment support programme which consists of the Out of Work Peer Mentoring Service, the In-Work Support Service and an Individual Placement Support pilot.[229]

The Out of Work Service provides peer monitoring to people who are in mental ill health.[230] The service is aimed at young people who are not in education, employment or training (NEET), or those aged 25 and over who have been unemployed for longer than twelve months. This support is mainly provided by experienced peer mentors who have "lived experience of recovery".

The In-Work Support Service provides therapy services to help manage mental health problems in work. Free support and training are also provided to businesses in the private and third sector who help employers identify the wellbeing needs to the workforce.[231]

Both services were extended in April 2022 until 2025.[232]

A twelve-month pilot of the I Can Work project was launched in July 2019, which is based on the principles of Individual Placement Support programme. This programme, which is funded by the Welsh Government, provides intensive support to help people with mental health issues to find and remain

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227 Scottish Government, Mental health strategy 2017-2027: second progress report, 26 November 2019, p29

228 Scottish Government, Mental health strategy: third annual progress report, 15 March 2021

229 Welsh Government, Together for Mental Health Delivery Plan: 2019-22, 24 January 2020, p19

230 Business Wales Skills Gateway, Out of Work Service (accessed 24 May 2023)

231 Business Wales Skills Gateway, In-Work Support Service (accessed 24 May 2023)

232 Welsh Government, Nearly £8m in funding to extend employment support services, 13 April 2022

in employment. It also provides support to employers. The pilot was extended by another six months in July 2020.[233] In March 2021, the Welsh Government announced that the pilot had been successful, and that funding would be provided to extend this project in North Wales.[234]

Northern Ireland

The Northern Ireland Government published its Mental Health Strategy in December 2021.[235] The strategy included information on employment support provided to support people with physical and mental health conditions:

> Through Work Coaches, the Department for Communities (DfC) works in collaboration with contracted and specialist local providers to support people with physical and mental health conditions. Support is provided through the Workable (NI), Access to Work (NI), European Social Fund projects and the Condition Management Programme (CMP) to help people realise the ambition to work and achieve mental health improvement and stability. DfC delivers CMP in collaboration with the Department of Health. It is a work-focused, rehabilitation programme, aimed at improving the employability of our people by supporting them to understand and manage their health condition(s), including mental health, to enable them to progress towards, move into and stay in employment.
>
> DfC is in the process of standing up a suite of new programmes to improve the employment prospects of those impacted by the COVID-19 pandemic. This will include a specifc focus on our youth and those with health and disability support needs who are particularly vulnerable in the labour market and subsequently at risk for longer term health and wellbeing issues. The Department also has a team of Work Psychologists who are responsible for leading on the work and health agenda and developing the capacity of our front line teams to support people with mental ill-health.[236]

233 NHS Wales, Unique employment support programme extended amid concern over the economic and mental health impacts of the COVID-19 pandemic

234 Welsh Government, Nearly £8m in funding to extend employment support services, 13 April 2022

235 NI Department of Health, Mental Health Strategy 2021-2031, 29 June 2021

236 As above, p33

7 Social security and suicide prevention

7.1 Benefit claimants and mental health

In November 2022, of the 1.65 million claimants of Employment and Support Allowance (ESA) – an income replacement benefit for people with health conditions and disabilities – 813,000 (49%) were recorded as having a mental or behavioural disorder as their main disabling condition.

As of January 2023, of the 3.26 million claimants of Personal Independence Payment (PIP) – which helps claimants with the extra costs of disability – around 1.18 million (36%) had a mental or behavioural disorder as their main disabling condition.[237]

For both benefits, the proportion of claimants whose main disabling condition is a mental and behavioural disorder is highest among the youngest age groups. 66% of ESA claimants and 69% of PIP claimants in the under-35 age category have a mental or behavioural disorder as their main condition.[238]

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

The department also does not yet publish a breakdown of the main disabling conditions of Universal Credit claimants who have been found to have limited capability for work or work-related activity. Therefore, it is not possible to know how many of these claimants have a mental or behavioural disorder.

7.2 Reviewing cases and processes

Since 2012, the DWP has been undertaking reviews of cases where it is alleged the department's actions are linked to the death of a benefit claimant. These internal process reviews' (IPRs; formerly known as 'peer reviews') are now also undertaken in cases involving 'serious harm' (including attempted suicide). The department explains:

237 Source: DWP Stat-Xplore

238 As above

> Internal Process Reviews (IPRs) are internal retrospective investigations, focussed on organisational learning – they are not published or shared externally. When deciding whether to undertake an IPR, we look at the information available to us and consider it against the criteria outlined below such as Safeguarding Adults Boards or inquests. Information pertinent to commencing an IPR can arise internally, from an external agency or professional, or from the claimant themselves or their family. Whilst there is no formal route for external agencies to recommend that we undertake an IPR, we continuously engage with these stakeholders (on a local and organisational level) and remain alert to individual cases that would merit investigation.
>
> IPRs are conducted in all cases where:
>
> - a customer has suffered serious harm, has died (including by suicide), or where we have reason to believe there has been an attempted suicide
> - AND there is a suggestion or allegation that the Department's actions or omissions may have negatively contributed to the customer's circumstances.
> - OR the Department is asked to participate in a local authority-led Safeguarding Adults Board or is named as an Interested Person at an Inquest (regardless of whether there is an allegation against the Department).[239]

Further information on IRPs is given in a National Audit Office (NAO) report published in February 2020.[240] The NAO found, among other things:

- The DWP had investigated 69 deaths in the previous six years, although it was "highly unlikely" that this represented the total number of cases it could have looked at.
- The DWP did not have robust records of all contact from coroners, and some contacts may not have resulted in an IPR being initiated.
- DWP guidance had not always been clear about when a case should be investigated, and not all staff were aware that the guidance existed.
- There was no tracking or monitoring of the status of IPR recommendations, and as a result the DWP did not know whether suggested improvements were implemented.
- The DWP did not seek to identify trends or themes from IPRs, and so "systemic issues which might be brought to light through these reviews could be missed".[241]

239 PQ 133187 [on Public Bodies: Injuries and Death], 8 March 2022

240 NAO, Information held by the Department for Work & Pensions on deaths by suicide of benefit claimants, HC 92 2019-20, 7 February 2020

241 As above

The NAO report also touched on measures the DWP was taking to improve its processes. This included establishing of a new unit within the department responsible for activities including:

- Improving the 'coroner focal point', which aims to provide a single point of entry for coroner communications with the DWP, including those related to suicide deaths. Improvements included making sure all coroners were aware of focal point and of the circumstances where they should report a death to the department and revamping internal guidance so that DWP staff were aware of the coroner focal point and can direct any enquiries accordingly.

- A new Serious Case Panel to consider "the most serious systemic issues which have been identified from IPRs and cases from the Department's Independent Case Examiner", and to make recommendations and help to assign accountability at the most senior levels for ensuring sustainable improvements are implemented, so that the department learns how to avoid similar issues in the future.

- A review of the IPR process, with the aim of strengthening the process and the department's response to serious cases, including suicides, which would focus on identifying cases, maximising learning, and prevention.[242]

Further information on these initiatives, and on subsequent developments including the newly established DWP 'Service Excellence Directorate' and the department's 'Excellence Plan' can be found in:

- The transcript of a Work and Pensions oral evidence session on 22 July 2020 (PDF).

- Letters from DWP ministers and officials to the Chair of the Work and Pensions Committee, Sir Stephen Timms, dated 20 March 2020 (PDF), 29 September 2020 (PDF), and 31 January 2023 (PDF).

- An article by Owen Stevens, "Holes in the safety net: benefits and claimant deaths", in the August 2021 Child Poverty Action Group's Welfare Rights Bulletin.

- Recent DWP Annual Report and Accounts.[243]

Between July 2019 and June 2022, the DWP started 179 IPRs (140 concerning death, and 39 serious harm). Over the same period, 151 IPRs were completed (120 concerning death, and 31 serious harm).[244] Between April 2022 and March 2023, 89 IPR referrals were received by the DWP, of which 60 met the criteria

242 NAO, Information held by the Department for Work & Pensions on deaths by suicide of benefit claimants, HC 92 2019-20, 7 February 2020

243 See pp73-77 of the Annual Report & Accounts for 2020-21; pp96-97 and pp139-140 of the Annual Report & Accounts for 2021-22; and pp64-66 of the Annual Report & Accounts for 2022-23.

244 PQ 27621 [on Social Security Benefits: Injuries and Death], 5 July 2022

for to be taken forward for a full IPR. 50 involved deaths, and 10 involved serious harm.[245]

A written answer in March 2022[246] on what had originally prompted cases being referred for review said that of completed IPRs since 2020:

- 45% had originated from the DWP's complaints process.
- 14% were flagged by frontline DWP staff.
- 11% were flagged by external agencies or professionals.
- 7% were flagged by a coroner's office.
- 6% were flagged by the DWP press office.
- 1% were flagged by the Independent Case Examiner.

The remaining 16% of cases were "not fitting the above categories, referred by non-frontline DWP staff".[247]

A DWP freedom of information response of 26 April 2023 to the Child Poverty Action Group's Owen Stevens gives lists recommendations made in IPRs up to April 2021, and gives information on progress in implementing those recommendations.[248]

Calls for independent investigation of cases of death or serious harm

In a report published in July 2021, Rethink Mental Illness said it suspected figures on the number of IPRs represented only "the tip of the iceberg" regarding deaths and serious harm. Rethink said that the DWP's existing processes for investigating deaths and serious harm were "piecemeal, opaque and inadequate" and that it was unclear whether they had recommended, let alone delivered, systemic policy or culture change within the department.[249] Rethink called on the Government to:

- Establish a full public inquiry into benefit related deaths and cases of serious harm.
- Set up an independent body to investigate future cases of death or serious harm in the benefits system.

245 DWP, Annual Report & Accounts for 2022-23, pp64-65

246 PQ 132264 [on Social Security Benefits], 14 March 2022

247 As above

248 DWP ref: FOI2023/24124. Available at whatdotheyknow.com

249 Rethink Mental Illness, Tip of the Iceberg? Deaths and Serious Harm in the Benefits System, July 2021, pp6, 16

In a follow-up report in March 2022, Rethink said little had changed to address its concerns. A small sample survey suggested the DWP was not instigating IPRs as often as it should be and was failing to investigate many cases of serious harm that did not involve a death.

It said many cases of serious harm did not get reported to the DWP because of a lack of awareness about the process and a lack of trust in the department, and that the DWP's definition of serious harm used by is unclear. It also added that cases where people's negative experiences fell below the DWP's threshold of serious harm nevertheless raised wider concerns about the adverse effect of the benefits system on mental health and whether enough was being done to address this.[250]

In addition to reiterating its call for a full public inquiry and an independent body to investigate cases of death or serious harm, Rethink called on the DWP to make six immediate changes:

- Inform claimants, their appointees and (where there has been a death) the next of kin when an IPR is taking place, of any recommendations made, and of progress on delivering those recommendations.
- Publish annual reports on IPRs conducted.
- Establish a simple process by which incidents of suspected death or serious harm associated with the benefits system can be reported.
- Write to all claimants and professionals working with claimants setting out the IPR process.
- Provide a clearer definition of what constitutes 'serious harm'.
- Monitor the ratio of investigations involving serious harm to those involving deaths, to see how effectively incidents are being identified.

A joint statement issued alongside the report from organisations including the British Association of Social Workers, Child Poverty Action Group, Mind, the National Association of Welfare Rights Advisers and Turn2us said that while DWP maintained it had a "no wrong door" policy and the number of investigations of suspected serious harm was increasing, it still did not reflect the real scale of harm.

Reiterating Rethink's calls for independent investigations and a public inquiry, the statement said that in the meantime the DWP "must urgently create a clear route for professionals to raise concerns around deaths and serious harm with confidence these will be investigated, and a way for individuals and their families to do the same."[251]

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250 Rethink Mental Illness, "We're just numbers to them" – The DWP's failure to investigate death and serious harm, 22 March 2022

251 Rethink Mental Illness, Joint statement with care and benefits advice sector, 22 March 2022

In a joint letter to the Secretary of State for Work and Pensions on 13 October 2022, MPs representing the SNP, the Liberal Democrats, Plaid Cymru and the Green Party called for a public inquiry into serious harm and deaths linked to the social security system, and for an independent process for investigating individual cases. The letter also urged the Secretary of State to implement the interim recommendations made by Rethink Mental Illness.[252]

7.3 Training and guidance for DWP staff

There have been calls on the DWP to do more to ensure it has in place necessary policies and protocols to identify vulnerable claimants, to strengthen safeguards, and to apply them consistently.[253] Following a 2017 case,[254] where the DWP was found not to have followed its own procedures by stopping a woman's benefits after she missed a Work Capability Assessment and took her own life 15 days later, an e-petition was presented to Parliament.

The petition called 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."[255] The petition, which closed on 15 September 2019, received 55,784 signatures. In its response, the Government said 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.[256]

Information on this and other high profile cases involving deaths of benefit claimants can be found in an article in the CPAG Welfare Rights Bulletin[257], and in the July 2021 Rethink Mental Illness report.[258]

Steps taken by DWP

Details of the steps taken by the DWP to "improve how we respond to those with complex lives" can be found in the letter of 20 March 2020 from the Secretary of State to the Chair of the Work and Pensions Committee (PDF), from the Committee's evidence session of 22 July 2020 (PDF), and the follow-up letter to the Committee (PDF) on 29 September 2020. Actions include:

252 See Rethink Mental Illness, Cross-party MP letter to Stop Benefit Deaths, 13 October 2022
253 See Stevens O, "UC and complex needs", Welfare Rights Bulletin, August 2019
254 See "Benefits officials' apology after mum's suicide", BBC News, 10 June 2019
255 E-petition 243337, Justice for Jodey Whiting: Independent inquiry into deaths linked to the DWP, 15 March 2019
256 As above
257 Stevens O, "Holes in the safety net: benefits and claimant deaths", Welfare Rights Bulletin, August 2021
258 Rethink Mental Illness, Tip of the Iceberg? Deaths and Serious Harm in the Benefits System, July 2021

- The introduction of mental health training for Universal Credit work coaches in late 2017 to better equip them "to identify customers' mental health issues or vulnerability, and take appropriate action to support them". By 28 February 2022, 20,076 es (74%) had completed the mental health training, and overall 38,823 DWP staff in customer contact roles had received the training.[259]

- Recruiting 37 'safeguarding leaders' (now called Advanced Customer Support Senior Leaders or ACSSLs) across the country to "work across all services and with key partners, to support and deliver a consistent service to vulnerable customers" (see annex C to the Secretary of State's letter to the Committee of 29 September 2020 (PDF) for a full job description). In March 2022 the department said that 36 ACSSLs had been appointed across Great Britain, but by May 2023 the number in post had fallen to 30.[260]

- Every Jobcentre has a 'complex needs toolkit' containing links to local support for a range of complex needs so that staff can signpost claimants to specialist organisations best able to support them.

- Local leaders carry out case conferencing on complex cases "to try to resolve issues in the best interests of the customer, often working with other agencies or local organisations".

- Establishing the DWP 'Customer Experience Directorate' in 2019 to take a cross-cutting approach "to address issues that recur across working-age, disability and retirement-age benefits and to identify where consistency could be improved".

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 six-point plan is in annex B to the Secretary of State's letter of 29 September 2020 (PDF), and forms part of the wider 'Keeping Safe' training all customer-facing DWP staff must complete. Guidance for DWP staff on handling situations where claimants say they intend to harm or kill themselves is also given in a Universal Credit guidance chapter.[261]

The DWP also has 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 or assessment, fails to return a questionnaire, 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

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259 PQ 134019 [on Jobcentres: Training], 8 March 2022. For more recent developments regarding mental health training for DWP staff see PQ 165204 [on Jobcentres: Training], 14 March 2023

260 PQ 134018 [on Department for Work and Pensions: Staff], 9 March 2023; PQ 184595 [on Social Security Benefits], 17 May 2023

261 Suicide or self-harm DWP Six Point Plan Framework (PDF), Version 10.0, current April 2023

decision is made to impose a sanction or terminate a claim. The DWP's revised guidance on core visits is in annex A to the Secretary of State's letter of 29 September 2020 (PDF). In her letter, the then Secretary of State explained:

> ...in cases of concern, a decision to stop a payment will only be made after we have tried every reasonable route – including the escalation process to Safeguarding Leads. Relevant staff have been made aware of the need to follow the updated guidance through an implementation update. While the Department does not have a duty of care or statutory safeguarding duty, escalating can help to direct our claimants to the most appropriate body to meet their needs.[262]

The DWP's Universal Credit guidance used to include a chapter on safeguarding[263], but this has now been replaced by a chapter on protecting claimants at risk.[264] While the structure and content of the chapter are very similar to before, almost all uses of the term 'safeguarding' have been removed.

The DWP also no longer refers to 'Senior Safeguarding leaders' – they are now known as 'Advanced Customer Support Senior Leaders' (ACSSLs). Further information on the role of ACSSLs, and on the 'Advanced Customer Support Team' established in 2020 to drive forwards "work directed at supporting vulnerable and at-risk customers", can be found in the DWP's Annual Report & Accounts for 2020-21.[265] This includes introducing a "pause" before stopping a claimant's benefit, to give time to identify whether they have "advanced support needs":

> Where it is identified that a customer has advanced support needs, we have introduced case conferencing, bringing together colleagues to take a holistic view of the customer circumstances before taking next steps. This could include referral to the ACSSLs who work with external agencies to facilitate join-up of support to the most vulnerable customers. We have also introduced a clear and visible route for escalation where additional support is required for colleagues before a decision is made, introducing safety points into the process.[266]

DWP staff used to rely on a system of 'pinned notes' – in essence, electronic 'post-it' notes – to record claimants' vulnerabilities or support needs on the Universal Credit system. Concerns have been voiced about the pinned notes system, including by the NAO, which in July 2020 said the DWP needed to improve its understanding of vulnerable claimants and how best to support them to ensure that no one slipped through the net.[267]

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262 DWP, Letter from The Rt Hon Therese Coffey MP to Work and Pensions Select Committee (PDF), 29 September 2020, p2

263 Safeguarding (PDF), Version 3.0, current April 2021

264 Protecting claimants at risk (PDF), Version 7.0, current April 2023

265 DWP, Annual Report & Accounts 2020-21, HC 422 2019-21, 15 July 2021, pp73-77

266 As above, p74

267 NAO, Universal Credit: getting to first payment, HC 376 2019-21, 10 July 2020

Giving evidence to a joint session of the Commons Work and Pensions Committee and Lords Economic Affairs Committee on 9 March 2021, the then Minister for Welfare Delivery, Will Quince, conceded that the lack of a 'marker' to track vulnerable claimants through the Universal Credit system was "a deficit". However, the Minister said work was progressing "at pace" in the DWP to develop a 'claimant profiles' system to track vulnerable and disadvantaged people through the Universal Credit system, which he hoped would go live in the first half of 2021.[268]

Equality and Human Rights Commission intervention

In April 2022, the Equality and Human Rights Commission (EHRC) announced it was taking action to require the DWP to improve its treatment of disabled benefit claimants. This was in response to "serious concerns about failures to meet the needs of its customers with mental health impairments and learning disabilities".[269]

The commission said disability campaigners had raised concerns with it about deaths of vulnerable DWP customers, and that in February 2021 the All Party Parliamentary Group on Health had recommended it "undertake an investigation into the deaths of vulnerable claimants, by suicide and other causes between 2008 and 2020".

The commission had examined whether the DWP was making reasonable adjustments to its processes for people with mental health conditions and learning difficulties, as required by the Equality Act 2010, and throughout 2021 had questioned DWP officials about concerns that its legal obligations were not being met. The DWP had outlined steps being taken to address problems identified, but the commission concluded that, given the seriousness of the issues, further action was necessary.

It was therefore drawing up a legally-binding agreement with the DWP, under powers in section 23 of the Equality Act 2006, to commit the department to an action plan to meet the needs of people with mental health impairments and learning disabilities. The commission said that DWP officials were working cooperatively with it to address its concerns, and that it expected the agreement to be in place "likely by summer 2022".[270]

At the time of writing (11 August 2023), an agreement has still not been signed. The DWP's Permanent Secretary Peter Schofield said in a letter to the Work and Pensions Committee on 31 January 2023 (PDF) that officials were "working closely and constructively with the EHRC and have entered a phase of advanced discussions" and that there was "momentum leading us and EHRC to believe we can conclude an agreement within a reasonable time."

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268 HL Economic Affairs Committee and HC Work and Pensions Committee evidence session (285KB, PDF), 9 March 2021, Q21

269 EHRC taking action to improve the treatment of disabled benefit claimants, EHRC press release, 19 April 2022

270 As above

7.4 Work Capability 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 Work Capability Assessments (WCAs) for Employment and Support Allowance (ESA) and Universal Credit.

Assessments for Personal Independence Payment (PIP) are delivered in Great Britain under three separate regional contracts. Atos holds two of the contracts, and it operates as Independent Assessment Services. Capita holds the third contract, which covers Wales and central England.

Rethink Mental Illness 2017 report

In December 2017, Rethink Mental Illness published a report, 'It's broken her': Assessments for disability benefits and mental health (PDF). Drawing on findings from a series of interviews, focus group-style discussions with people with personal experience of assessments and of mental illness, and an online survey, the report found assessments could be "traumatising and anxiety-inducing" for the following reasons:[271]

- "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 was "extremely burdensome, often expensive, and time-consuming".
- Staff who perform assessments frequently had a poor understanding of mental illnesses.
- Delays in mandatory reconsideration (the process of challenging a benefits decision) and appeals meant some claimants had to wait many months for the correct result.

The Rethink report concluded that the WCA and PIP assessment procedures "inherently discriminate against people with mental illnesses." It set out a series of policy recommendations including:

- Major reform of assessments to reduce the distress caused to people affected by mental illness and better reflect the realities of living with mental health conditions.

[271] Rethink Mental Illness, 'It's broken her': Assessments for disability benefits and mental health (1,321 KB, PDF), December 2017, p7

- 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.[272]

Work and Pensions Committee reports

In 2017 the Work and Pensions Committee launched an inquiry examining the effectiveness of both the WCA and the PIP assessment. The committee's report – together with a separate report detailing claimant experiences pf assessments – was published in February 2018.[273] In evidence to committee, claimants, disability bodies, welfare rights groups, and others flagged up various issues including:

- The activities and descriptors used in the WCA and in the PIP assessment were not "fit for purpose", being weighted towards physical health conditions and disabilities, and discriminating against those with mental health conditions.

- The structure and content of assessments (both written and face-to-face) did not always allow claimants to express accurately the impact of their condition.

- Neither assessment appropriately captured fluctuating conditions.

- Some people found the whole claims, assessment, and appeals process difficult, stressful, confusing and/or threatening, with in some cases detrimental effects on their health.

- Instances where it was claimed the assessment process had led to people being hospitalised, having their medication increased, or attempting to take their own lives.

- Claimants reported that their concerns were not taken seriously by assessors, or that their statements were ignored.

- Concerns that assessors often did not have sufficient knowledge or expertise to assess the impact of certain conditions, including mental health problems.

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272 Rethink Mental Illness, 'It's broken her': Assessments for disability benefits and mental health (1,321 KB, PDF), December 2017, p18

273 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

- Written reports not always accurately reflecting the claimant's recollection of what happened at the assessment.
- Dissatisfaction with the mandatory reconsideration process, which many claimants viewed as a tool to dissuade people from going to appeal.
- Claimants not challenging a decision through appeal because of the distress the process had already 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.

The committee said that failings in the assessment and decision-making processes for both ESA and PIP had resulted in the "pervasive lack of trust" that risked undermining the entire operation of both benefits.

April 2023 Work and Pensions Committee report

In its subsequent report, Health assessments for benefits, published on 14 April 2023[274], the current Work and Pensions Committee found that, despite some improvements since 2018, many of the problems highlighted by its predecessor committee remained, and that important changes to improve trust and transparency had not been made.

Key themes emerging from more than 8,500 responses to a survey, carried out by the committee, of people who had been through the WCA and/or PIP assessment process, or who had supported friends, family or clients through them, included:

- Factual errors in reports;
- Difficultly completing forms, in particular the stress and anxiety caused;
- Lack of knowledge of conditions from assessors;
- The effectiveness and impact on claimant of the Mandatory Reconsideration and appeal processes;
- Inconsistent support and access arrangements at all stages;
- Poor communication from DWP at all stages, including issuing communications in formats which people cannot use;
- Delays and consequent financial and health impacts; and

[274] HC 128 2022-23

- Over-frequent requirements to re-apply, particularly in circumstances where no improvement in the claimant's condition may reasonably be expected.[275]

The committee noted the Government's longer-term plans to abolish the WCA (see below), but said in the meantime retaining the status quo was not an option. It called on the Government to introduce a series of "quick and easy wins to improve trust, drive down the high rate of decisions reversed on appeal and reduce waiting times", including:

- Allowing claimants to choose between remote or in-person assessments.
- Default recording assessments, with claimants able to opt out.
- Extending deadlines for returning forms.
- Targets to reduce assessment waiting times, and payments to people forced to wait beyond the targets.
- Sending claimants their assessment reports.

The committee also recommended that, prior to making any long-term changes to the assessment process, including abolishing the WCA, there should be an external assessment of the potential physical and mental health effects of the proposed changes on claimants.[276]

Proposals to abolish the Work Capability Assessment

Major proposals to reform benefits for disabled people were set out in the Government's Health and Disability White Paper, published alongside the Spring Budget on 15 March 2023.

The Government proposes to abolish the Work Capability Assessment (WCA), which currently helps determine whether someone is eligible for Employment and Support Allowance (ESA) and/or the Limited Capability for Work-Related Activity (LCWRA) element of Universal Credit (UC), and what if any work-related requirements may be imposed on them. The LCWRA element would be replaced by a new "health element" in UC, available to UC claimants who also get Personal Independence Payment (PIP).

What if any work-related requirements would apply would be determined on a case-by-case basis through a "new personalised health conditionality approach", with DWP work coaches given discretion to decide what is appropriate for the individual.

The central case for change made in the white paper is that many claimants want to work, but fear doing so may result in them no longer being

275 HC 128 2022-23, Annex 1, para 5

276 As above, para 28

considered as having limited capability for work (LCW)/LCWRA and losing their entitlement to benefit following reassessment.

In addition, the Government has noted that multiple assessments can cause anxiety and distress, and that there is "unnecessary duplication" between PIP assessments and WCAs.[277]

Responses to the proposals

While many disabled people's organisations welcomed the Government's announcement of its intention to abolish the WCA, many also have concerns.

These include making the PIP assessment the sole gateway to additional support. Mind said that findings from recent research it had conducted[278] highlighted that PIP assessments "share many of the same issues as WCAs do, and are often more problematic", noting:

> 69% of people with mental health problems who experienced PIP assessments were left feeling their mental health had declined, compared to 62% for the WCA, and 46% of people felt their PIP assessor did not understand mental health problems, compared to 36% assessed under a WCA.[279]

Disability Rights UK said using PIP as a passport to the UC health element was "extremely problematic", adding:

> All the issues relating to the lack of accuracy of WCA assessments, apply equally to PIP - perhaps unsurprisingly given five weeks of online virtual training for Health Care Professionals.
>
> Tragically, the PIP assessment process has also resulted in the deaths of disabled people.
>
> The success rate for new PIP claims is only 50%, whereas the success rate of those who appeal PIP decisions is around 70%.[280]

Disabled people's organisations are also concerned that, under the proposed system, people who would have met the criteria for LCWRA, but who don't qualify for PIP, would lose support completely (although the Government said that LCWRA claimants not also getting PIP at the point they move to the new system and whose circumstances remain unchanged would receive transitional protection).

In relation to mental health, a particular concern is that the white paper did not include proposals to introduce for PIP equivalent provisions to the WCA "substantial risk" rules. At present, people not scoring sufficient points in the

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277 DWP, Transforming Support: The Health and Disability White Paper, CP 807, 16 March 2023, paras 134-141

278 Mind, Reassessing assessments: How people with mental health problems can help fix the broken benefits system, March 2023

279 Mind, Scrapping Work Capability Assessments could lead to even more broken benefits system, 16 March 2023

280 Disability Rights UK, DR UK says: Chancellor, we need rights not discretion, 17 March 2023

WCA can nevertheless be treated as having a limited capability for work, or for work-related activity, if exceptional circumstances apply. This includes where there would be a "substantial risk" to the mental or physical health of any person were they found not to have LCW or LCWRA.[281]

Disabled people's organisations are also worried that giving DWP work coaches more discretion to decide work-related requirements could result in people being subject to inappropriate conditionality requirements, and potentially benefit sanctions.

Commenting on the white paper proposals, Disability Rights UK said scrapping the WCA and leaving individual jobcentre work coaches to decide what should be required of the claimant and the extent to which sanctions would be imposed was "a move from a system based on rights, to one based on discretion". It added: "Will unqualified work coaches be better at making decisions on whether someone is fit for work rather than Maximus Health Care Professionals undertaking WCAs?" Disability Rights UK also noted proposals elsewhere in the Spring Budget "strengthening the way the sanctions regime is applied."[282]

Similar concerns were voiced by Mind, which commented: "The effectiveness of sanctions has no evidence base, and they have been disproportionately used on people with mental health problems, leaving some in destitution."[283]

The Government intends to introduce a bill in the next Parliament to implement the reforms. The changes would be introduced initially for new claimants only, starting from no earlier than 2026/27. Rollout would then take at least three years, after which existing claimants would move on to the new system.

Further information on the proposals in the white paper and on reactions to them can be found in the Commons Library briefing Proposals to abolish the Work Capability Assessment.

Other benefits assessment reforms

Alongside the proposals in chapter 4 of the white paper to abolish the Work Capability Assessment and replace the UC limited capability for work-related activity element with a new UC health element, chapter 3 of the white paper sets out proposals to enable disabled people, people with physical and/or mental health conditions and their carers to "have a better experience when applying for and receiving health and disability benefits".

281 Further background to substantial risk can be found in WCAinfo, Substantial risk (LCWRA), accessed 28 April 2023; and Simon Osborne, 'Substantial risk' and the WCA, CPAG, December 2021

282 DR UK says: Chancellor, we need rights not discretion, 17 March 2023; see also Health and Disability White Paper: support not sanctions needed, says DR UK, 15 March 2023

283 Mind, Scrapping Work Capability Assessments could lead to even more broken benefits system, 16 March 2023

Many of these build on work already underway as part of the DWP's Health Transformation Programme, which aims to make the health assessment process simpler, more user-friendly, easier to navigate and more joined-up for claimants, while delivering better value for money for taxpayers. Some of the proposals were also trailed in Shaping Future Support: The Health and Disability Green Paper, published by the DWP in July 2021.[284]

Repeat assessments and a Severe Disability Group

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

In September 2017 the DWP announced criteria for "switching off" reassessments for ESA Support Group claimants (and UC claimants with LCWRA) with severe, lifelong disabilities illnesses or health conditions who are unlikely ever to be able to work. 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.[285]

In June 2018, the Government announced 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.[286] DWP said it would work with stakeholders to design the light touch review process.[287]

In a report published in October 2020,[288] Mind said people in very vulnerable circumstances are forced to recount traumatic experiences at every stage of the assessment process, and frequent use of face-to-face assessments can make people more unwell. While noting some people could now have reassessments switched off, it argued there was a lack of transparency over the process. Mind wants to see the Government "end the cycle of repeat assessments by giving disabled people clear routes to apply for long-term or indefinite awards", including the right to challenge and appeal short-term awards.[289]

284 DWP, Shaping future support: the health and disability green paper, July 2021
285 DWP, WCA Handbook, updated 20 December 2022, Appendix 8
286 DWP press release, Government to end unnecessary PIP reviews for people with most severe health conditions, 18 June 2018
287 See Commons Library briefing CBP-7820, ESA and PIP reassessments
288 Mind, People, Not Tick Boxes: Our call to reform the disability benefits system, 7 October 2020
289 As above, p5

The July 2021 Health and Disability Green Paper said that reducing the number of repeat assessments disabled people must go through where a significant change in their condition is unlikely remained a "key priority" for the Government.[290] However, it said that the DWP would not introduce a minimum PIP award length of 18 months – as had been proposed in the Conservative Party's 2019 general election manifesto[291]. Instead, the Government had decided that "better triaging and testing of the Severe Disability Group" would deliver on the commitment to reduce the number of unnecessary repeat assessments more effectively.[292] Mind said it was "very disappointed" that the DWP was not introducing minimum 18-month PIP awards[293].

The Health and Disability White Paper published in March 2023 said that the DWP had been working with an expert group of specialist health professionals to draw up a set of draft criteria focusing on claimants who have conditions which are "severely disabling, lifelong and with no realistic prospect of recovery". Testing of the Severe Disability Group – claimants who would "benefit from a simplified process without ever needing to complete a detailed application form or go through an assessment" – began in Autumn 2022.[294]

Specialist assessors

At present, assessors undertaking Work Capability Assessments and PIP assessments do not specialise in certain health conditions, but are expected to be able to assess the functional capabilities of people across the whole spectrum of health conditions and disabilities.

The Health and Disability White Paper published in March 2023 stated that the DWP will continue to develop assessors' skills and that, starting this year, would begin testing matching people's primary health condition to a specialist assessor. In a written answer on 19 April 2023, the Minister for Disabled People, Health and Work, Tom Pursglove, said that as part of this, assessors would take part in training to specialise in the functional impacts of specific health conditions.[295]

An integrated Health Assessment Service

In March 2019 the DWP launched a "Health Transformation Programme" to develop "a new integrated Health Assessment Service", supported by a single digital system, for both PIP assessments and WCAs.[296] The department's

290 DWP, Shaping Future Support: The Health and Disability Green Paper, CP 470, 20 July 2021, para 184
291 Costings document: The Conservative and Unionist Party Manifesto 2019, November 2019, pp4-5
292 DWP, Shaping Future Support: The Health and Disability Green Paper, CP 470, 20 July 2021, para 187
293 Written evidence from Mind to the Work and Pensions Committee, HAB0040, November 2021, para 21
294 DWP, Transforming Support: The Health and Disability White Paper, CP 807, March 2023, paras 127-128
295 PQ 177845 [on Employment: Chronic illnesses and disability], 19 April 2023
296 HCWS1376 5 March 2019

ambition in launching this programme was to make the assessment process "simpler, more user-friendly, easier to navigate and more joined-up for claimants, whilst delivering better value for money for taxpayers".[297]

The DWP began developing the new service, on a small scale initially, in a location called the "Health Transformation Area" (HTA). It explained:

> The HTA will enable us to test, adapt and learn from new ideas and processes. This approach will allow us to continually improve the new service and systems in a controlled way. We then plan to roll out improvements gradually at a greater scale.[298]

The first HTA location, in North London, was launched on 21 April 2021. The HTA was subsequently expanded to parts of Birmingham, and the DWP plans to expand to other parts of the country in the future.

Ideas the DWP is seeking to explore in the HTA, and as part of the wider Health Transformation Programme, include:

- Different ways of conducting assessments, including the scope for "triaging" claims so that people only have face-to-face assessments where absolutely necessary.
- Lessons from "forced changes" to assessment processes during the coronavirus pandemic, including the greater use of telephone and video assessments.
- How to make it easier for claimants to understand the evidence they need to provide, and why.
- Where people give consent, reusing medical evidence the Department already holds on them, to provide a more "joined up" claimant experience and reduce the burden of having to provide the same information multiple times.
- How to make claimants aware of the range of support available to them both from the DWP and more widely.[299]

The department expects the programme to run until at least 2028.[300]

Further updates on the Health Transformation Programme were given in the March 2023 Health and Disability White Paper (see section 3 below).

A DWP written answer on 30 January 2023 said that, as part of the Health Transformation Programme, procurement of new "Functional Assessment

297 Department for Work and Pensions, Written evidence for the Work and Pensions Committee Health Assessments for Benefits inquiry, HAB0079, November 2021, p1

298 As above, p7

299 As above, pp8-9. See also Department for Work and Pensions, Shaping Future Support: The Health and Disability Green Paper, CP 470, 20 July 2021, chapter 3

300 National Audit Office, The Health Transformation Programme, 2022

Service contracts" was underway. The new contracts would bring together current WCA and PIP assessments under single geographic contracts, to form a building block for the new integrated Health Assessment Service.[301]

In a written answer on 15 May 2023, the Minister for Disabled People, Health and Work, Tom Pursglove, announced that Functional Assessment Service contracts had been awarded for four out of give geographical areas, and would run from 2024 to 2029.[302] The successful bidders are:

- Lot 1 (North England and Scotland): Maximus UK Services Limited
- Lot 2 (Midlands and Wales): Capita Business Services Limited
- Lot 4 (South East England, London and East Anglia): Ingeus UK Limited
- Lot 5 (Northern Ireland): Capita Business Services Limited

The contract for Lot 3 (South West England) has not yet been awarded.

Further information on plans for the integrated Health Assessment Service, and on improvements to claims and assessment processes the Government hopes to achieve with the introduction of the new service, is given in section 3 of the Commons Library briefing Proposals to abolish the Work Capability Assessment.

7.5 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 a Commons Library briefing, Department for Work and Pensions policy on benefit sanctions.[303]

When asked in 2014 what assessment the DWP had made of the effect of benefit sanctions on the mental health of claimants

In a written answer in July 2018, the then Minister of State for Employment Alok Sharma said that no assessment had been made by the DWP of the impact of benefit sanctions on the mental health of claimants. He added:

> 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.

301 PQ 131273 [on Personal Independence Payment and Work Capability Assessments], 30 January 2023
302 HCWS 807 [on Health Transformation Programme], 25 May 2023
303 Commons Library Debate Pack CDP-2022-0230, 12 December 2022

> 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.[304]

A major five-year research programme conducted by the University of York Department of Social Policy and Social Work questioned the effectiveness of conditionality. 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.[305]

In a report in October 2020, Mind said established evidence showed the threat of sanctions "does not help disabled people move closer to work". People with mental health problems had said the pressure of attending Jobcentre appointments could become "unmanageable, damaging their health and moving them further away from work".

Mind also argues sanctions affect the culture of the employment support system, requiring Jobcentre staff to prioritise carrying out compulsory appointments and giving them insufficient time to listen to people with mental health problems and to build trust. Mind believes the Government should end the use of sanctions for disabled people and for anyone awaiting benefit assessments.[306]

Work and Pensions Committee inquiry 2018

In 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 use of sanctions as a means of achieving policy objectives.

In its 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":

> 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 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

304 PQ 166197 [on Social Security Benefits: Disqualification], 24 July 2018

305 University of York Department of Social Policy and Social Work, Final findings report: Welfare Conditionality Project 2013-2018, 9 July 2018

306 Mind, People, Not Tick Boxes: Our call to reform the disability benefits system, 7 October 2020

> amount of anxiety" experienced by people with mental health problems "as they attempt to navigate the system in good faith".[307]

The committee concluded the Government had presented no evidence of conditionality and sanctions improving employment outcomes for disabled people and those with health conditions. It recommended 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.[308]

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 WCA, 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'."[309] It emphasised that work coaches had the discretion to tailor work-related requirements to individuals' needs and abilities, based on what was considered reasonable in light of their health condition.[310]

In a Written Ministerial Statement on 9 May 2019, then-Secretary of State for Work and Pensions, Amber Rudd, said three-year sanctions (which could be imposed on JSA or UC 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 was therefore reduced to six months in November 2019. Ms Rudd also announced 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.[311]

The DWP initially said it would publish the sanctions evaluation report, but later said it did not plan to publish it "as we were unable to assess the deterrent effect and therefore this research doesn't present a comprehensive picture of sanctions".[312] Following a series of freedom of information requests and Information Commissioner's Office rulings, the DWP published the report, together with a "context note", in April 2023.[313]

Key findings from the evaluation include:

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307 Work and Pensions Committee, Benefit Sanctions, November 2018, HC 955 2017-19, para 55

308 As above, para 63

309 DWP, Benefit sanctions: Government Response to the Committee's Nineteenth Report of Session 2017-19, 11 February 2019, HC 1949 2017-19, para 36

310 As above, paras 38, 40

311 HCWS1545, 9 May 2019

312 PQ 77445 [Social Security Benefits: Disqualification], 24 November 2021

313 DWP, The Impact of Benefit Sanctions on Employment Outcomes: draft report, 6 April 2023

- Sanctions reduce the duration of a claimant spell on UC. This is driven by increased exit rates into non-PAYE employment (including self-employment) or economic inactivity (including full-time education). Exit rates into PAYE employment decrease.

- Sanctions have a small negative impact on the rate at which claimants exit the UC "intensive" regime into a state where they are earning, either on or off UC.

- Taken together, these results suggest that the impact of a sanction is to decrease the rate of exit into higher paid work, while the exit rate into some kind of work is not greatly affected.

- Upon exiting "UC intensive", sanctioned claimants earn on average £34 per month less than non-sanctioned claimants over a 6-month period. This is driven by lower earnings while employed, rather than fewer months spent in employment.

- In contrast to the aggregate results, there is no evidence that sanctioned claimants with a health condition, with a partner, caring, or male face earn less than non-sanctioned claimants in the 6 months after exiting 'UC Intensive'. However, sanctioned claimants under the age of 26 fare worse than average, earning £43 per month less than non-sanctioned claimants in the same age group.

The report states:

> In summary, a sanction leads the average claimant to exit less quickly into PAYE earnings and to earn less upon exiting. In a narrow sense, this constitutes a negative impact of a sanction on claimant finances. However, this excludes the wider role of a sanction, which acts to incentivise compliance with a conditionality regime that encourages work search and earnings increases.
>
> The negative financial effect reported should therefore be balanced against the likely positive deterrent effect that the sanction regime has by incentivising claimant attendance, an effect which will be experienced by all claimants subject to conditionality, regardless of whether they are sanctioned.[314]

Further information on the report is given in a commentary by Dr David Webster of the University of Glasgow.[315]

7.6 Scotland

The Scotland Act 2016 devolved significant welfare powers to the Scottish Parliament. Amongst other things, the Act transferred responsibility for benefits to help with the extra costs of disability. New benefits will replace the

[314] DWP, The Impact of Benefit Sanctions on Employment Outcomes: draft report, 6 April 2023, p4

[315] David Webster, The Impact of Benefit Sanctions on Employment Outcomes: Commentary on the draft report, 13 April 2023

existing extra-costs benefits for claimants in Scotland (Disability Living Allowance (DLA), Personal Independence Payment (PIP), and Attendance Allowance). Adult Disability Payment (ADP) replaced PIP for new claims from 29 August 2022, and existing PIP claimants in Scotland will transfer to the new benefit.

The Scottish Parliament now also 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."[316]

In relation to disability benefits, the Scottish Government said its system would entail:

- A redesigned application process involving significantly fewer face to face assessments, 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 claimant 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.
- 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.[317]

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

Further information on what people should expect from the new social security system in Scotland, on the principles underpinning it, and on "how we

316 See Commons Library briefing CBP-9048, Social security powers in the UK

317 Scottish Government, Social security: policy position papers, 28 February 2019; and Social Security policy position paper - disability benefit applications: how decisions are made, 23 October 2020

will make sure that we are taking a human rights based approach to what we do and how we will demonstrate dignity, fairness and respect in all our actions" can be found in the Social Security Scotland document Our Charter.

The Scottish Government's suicide prevention action plan, Creating Hope Together, states that in relation to social security it will-

> ...work with Social Security Scotland to support embedding Time, Space and Compassion as part of their approach to working with – and supporting – members of the public who may be at higher risk of suicide in line with the Social Security Scotland Charter. This will include providing learning for staff to be able to recognise those who may be at higher risk of suicide and ensure they have knowledge, skills and confidence to support the person at the time of interaction, and know how to signpost to further support or escalate concerns to ensure someone's safety.[318]

[318] Scottish Government, Creating Hope Together: Scotland's Suicide Prevention Action Plan 2022-2025, 29 September 2022, Annex A

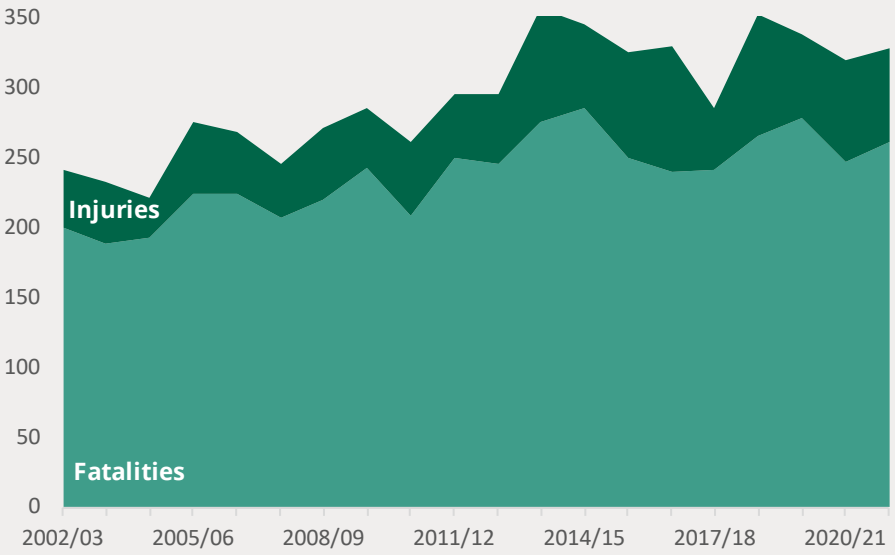
8 Transport and suicide prevention

8.1 Railways

Suicide statistics

Suicide accounts for most fatalities on the railways in Great Britain: there were 313 public and passenger fatalities in 2021/22, of which 285 were suicide or suspected suicide fatalities. Of the suicide-related fatalities in 2021/22, 261 occurred on the mainline and 24 on the London Underground. There were a further 112 injuries on the railways that were thought to be suicide attempts. The number of suicide attempts on the railways has remained around 280 to 360 per year since 2011-12.[319]

Suicide or suspected suicide fatalities and injuries on mainline railways, Great Britain



Source: ORR, Rail safety statistics, (Tables 5275)

Each week, British Transport Police (BTP) officers make over 40 potentially lifesaving interventions on average across the rail network in Great Britain.[320] In 2021/22, the BTP recorded over 2,400 lifesaving interventions across the network, a 20% increase on 2020/21. The BTP reported 275 suicides in 2021/22,

[319] ORR, Rail Safety Statistics – 2020-21, 30 September 2021

[320] National Suicide Prevention Alliance, British Transport Police [accessed on 17 April 2023]. The British Transport Police do not operate in Northern Ireland

a figure roughly similar to previous years, and estimated that for every life lost on the railway, there are eight incidents reported as a lifesaving intervention.[321]

In 2020/21, the BTP received 10,469 calls to public safety and welfare incidents, which included incidents involving people experiencing a mental health crisis.[322]

The Office of Rail and Road (ORR), the rail regulator in Great Britain, estimated that the average whole-industry financial cost of one suicide is in the region of approximately £275,000 and that in 2020/21, 357,888 delay minutes on the Great British rail network were attributed to suicide events.[323]

In Northern Ireland there were 9 recorded suspected suicides between 2016 and 2021 on Northern Ireland's rail network.[324]

Relevant organisations

Department for Transport

The Department for Transport (DfT) has a leadership role within the Great British rail industry with respect to suicide prevention, and convenes a variety of regular meetings and groups on the issue.[325] For example, the DfT established a suicide prevention awareness group in 2018 which brings together agencies within the sector – including Network Rail, the British Transport Police, Transport for London, Highways England, Maritime and Coastguard Agency and the RNLI – to work together to reduce transport-related suicides.[326] In November 2020, the DfT hosted a workshop on behalf of the transport sector on suicide prevention. The workshop:

> ...covered an introduction to the concept of 'dissuasion' and assessment of its potential for reducing suicides across the transport network. Participants discussed research in the field through discouraging suicidal behaviour and making the transport network less appealing as a place for those in suicidal crisis to take their lives.[327]

Since 2017, the DfT has introduced provisions into its franchising agreements with train operators, which have required them to produce suicide prevention

321 BTP, Annual report and accounts 2021/22 (PDF), 6 October 2022, p17

322 As above, p13. Where lifesaving interventions are required, those involved, in most cases, are then detained under the Mental Health Act for their own safety. National Suicide Prevention Alliance, British Transport Police [accessed on 20 December 2021]

323 Office of Rail and Road, Pulling together for better mental health in the rail industry, 9 May 2022

324 Department for Infrastructure, Rail Safety Authority - Annual safety performance report 2021, 8 February 2023

325 PQ 25657 [Railways: suicide] on 20 March 2020

326 HM Government, Preventing suicide in England: Fourth progress report of the cross-government outcomes strategy to save lives, January 2019

327 HM Government, Preventing suicide in England: Fifth progress report of the cross-government outcomes strategy to save lives, March 2021

strategies, working in collaboration with the BTP, Network Rail and the Samaritans.[328]

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.[329] The BTP is also responsible for policing the London Underground System and most tram networks across Great Britain. [330]

BTP's specialist policing approach is based on keeping passengers and staff safe and minimising disruption. To help prevent and respond to suicides on the railway, the BTP:

- capture real time information and data, to inform national learning and tactical responses
- refer and signpost people who may be at risk to relevant health, social care and voluntary sector agencies
- can investigate deaths by suicide and conduct post-event site visits and report on ways to prevent or remove suicide risks through changes in design
- provide support to those who are bereaved or affected by suicide
- provide support and advice to rail industry partners, training materials, standards, central policy and national guidance
- suppress unnecessary communications about suicides and moderate public announcements, news and social media reports to ensure they are in line with national guidance[331]

The BTP employs two suicide prevention and mental health teams in England and Wales, which have NHS psychiatric nurses embedded within them providing professional advice and support. These teams create suicide prevention plans for people who have presented on the railway in suicidal circumstances, and deal with around 2000 such people each year. The NHS resources in these teams are funded by Network Rail, Transport for London and NHS England.[332]

328 HM Government, Preventing suicide in England: Fifth progress report of the cross-government outcomes strategy to save lives, March 2021

329 British Transport Police, About Us [accessed 25 April 2023]

330 Including the Docklands Light Railway, the Midland Metro tram system, Croydon Tramlink, Sunderland Metro, Glasgow Subway and Emirates AirLine. British Transport Police, About Us [accessed 25 April 2023]

331 National Suicide Prevention Alliance, British Transport Police [accessed on 17 April 2023]

332 As above

BTP has a team in Scotland called the Concern Hub which deals with all suicidal presentations and follow the same Suicide Prevention Plan process, although they do not have embedded NHS staff working with them.[333]

Network Rail and train operators

The rail industry has its own suicide prevention programme, in partnership with the Samaritans and the BTP. The programme is overseen by the Suicide Prevention Programme Board (SPPB), a steering group with representatives from train operators, Network Rail and the British Transport Police. The SPPB aims to reduce the:

- Potential for suicide on the rail network
- Impact of suicide events on staff and customers through trauma management and support; and
- Disruption and delay caused by fatalities.[334]

The programme consists of a range of proactive and reactive measures.[335] For example, the programme:

- trains those who work for the railway to spot and support people who may be at risk of suicide. According to Network Rail, 20,000 railway employees have received training to intervene in suicide attempts.[336]
- deploys measures which can mitigate suicide attempts, such as "fencing to prevent access to the tracks at high-risk locations."[337]
- contributes to national strategies and guidance; and
- commissions bespoke research into suicides on the railway.[338]

Office of Rail and Road (ORR)

The Office of Rail and Road (ORR) is the health and safety regulator for rail in Great Britain, and has a number of powers under the Health and Safety at Work Act 1974.[339] The ORR can carry out investigations of fatalities on the railway, including suicides, to see if there have been any breaches of health

333 National Suicide Prevention Alliance, British Transport Police [accessed on 17 April 2023]
334 Rail Suicide Prevention, Governance [accessed on 2 December 2021]
335 Rail Suicide Prevention, Preventing railway suicides [accessed on 2 December 2021]
336 Network Rail, Suicide prevention on the railway [accessed on 25 April 2023]
337 As above
338 As above
339 Office of Rail and Road, Health and safety investigation and enforcement powers [accessed on 17 April 2023]

and safety law.[340] The ORR also compiles and publishes statistics on fatalities (including suicides) on the railways.[341]

Northern Ireland

The ORR is not the safety regulator for the railway in Northern Ireland, although it does perform certain regulatory functions there.[342] In Northern Ireland, the Department for Infrastructure (DfI) acts as the safety regulator, monitors the work of Translink, the main transport provider for Northern Ireland. The DfI also publishes annual safety performance reports.[343]

Unlike the British Transport Police in Great Britain, there is no separate specialist transport police service in Northern Ireland. Instead, the Police Service of Northern Ireland (PNSI) work in partnership with Translink, the main transport provider for Northern Ireland. The two bodies, in September 2020, established a Safe Transport Team, whereby police officers work alongside Translink personnel.[344] For more information about how the PSNI police mental health related incidents see Policing and mental health related incidents.[345]

Action to prevent suicides on the railway

The rail industry has partnered with charities, such as the Samaritans, to run suicide prevention campaigns. Small Talk Saves Lives, for example, is a joint campaign between the British Transport Police, Network Rail, train operators and the Samaritans, which on encourages the public to support someone experiencing an emotional crisis on the railway. The campaign, which launched in 2017, is based on research from Middlesex University. The campaign aims to enable passengers to:

> ... notice what may be warning signs, such as someone standing alone and isolated, looking distant or withdrawn, staying on the platform a long time without boarding a train or displaying something out of the ordinary in their behaviour or appearance.[346]

The campaign encourages rail travellers to be confident enough to approach such people and start a conversation with them, potentially interrupting what could be suicidal thoughts.

340 Office of Rail and Road, ORR policy & process for investigation of fatalities including suspected suicides and trespass related deaths (PDF), December 2018
341 ORR, Rail safety [accessed on 17 April 2023]
342 ORR, Northern Ireland regulation [accessed on 20 December 2021]
343 Department for Infrastructure, About Rail Safety Authority [accessed 17 April 2023]
344 Police Service of Northern Ireland and Translink launch joint partnership to implement Safe Transport Team, Police Service of Northern Ireland, 29 September 2020
345 PSNI, Policing and mental health related incidents [accessed on 20 December 2021]
346 Network Rail, Small Talk Saves Lives [accessed on 2 December 2021]

The main train operating company in Scotland, ScotRail,[347] has recently been recognised for its work on mental health and suicide prevention. On 31 March 2023, ScotRail received the Employer of the Year for First Aid Excellence at the Scottish First Aid Awards, for a programme of work including:

- Trauma Support Training for the frontline ScotRail management team to ensure staff who may be involved in, or witness to, a traumatic event receive the appropriate support
- The appointment of a Safeguarding Manager to help look out for vulnerable people who may be travelling on the rail network
- The introduction of a 'Travel Safe Team', who work closely with British Transport Police to support customers and colleagues in the promotion of a safe railway environment, both on train and in stations
- The training of 60 mental health first aiders across Scotland.[348]

8.2 Roads

Suicide statistics

There is no official record of the number of suicides and attempted suicides taking place on roads in the UK every year. In October 2017, Samaritans worked with the Parliamentary Advisory Council for Transport Safety (PACTS) to produce a report into road suicide.[349] This report shows that roads, vehicles and road infrastructure are being used by individuals seeking to end their lives, and that there are likely to be around 50 deaths each year by suicide on UK roads. It provides evidence that this is likely to be 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.[350]

347 ScotRail has been publicly owned by Scottish Minister since April 2022. ScotRail, About ScotRail [accessed 17 April 2023]

348 ScotRail Press Release, ScotRail honoured at Scottish First Aid Awards, 6 April 2023

349 The Parliamentary Advisory Council for Transport Safety (PACTS) is a registered charity and supports the All-Party Parliamentary Group for Transport Safety. Its charitable objective is "To protect human life through the promotion of transport safety for the public benefit". See PACTS, About Us [Accessed 25 April 2023]; PACTS, Suicides on UK Roads – Lifting the Lid, October 2017

350 PACTS, Suicides on UK Roads – Lifting the Lid, October 2017

The report noted 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 the Government's road casualty reports (STATS19).[351]

Relevant organisations

National Highways

National Highways (formerly called Highways England) is responsible for England's Strategic Road Network, which includes all motorways and major A-roads.[352] In November 2017, National Highways (then called Highways England) published its Suicide Prevention Strategy, which set out how it would continue to contribute to the cross-government national suicide prevention strategy by reducing the number of suicides and attempted suicides on the road network.[353]

It outlined several actions it said would help it deliver its vision to prevent, intervene and provide 'postvention' where necessary, including to:

- embed the Suicide Prevention Strategy within Highways England, its supply chain and service providers;
- ensure effective internal working within Highways England through the development of an enhanced capability and the establishment of a Suicide Prevention Working Group;

351 'PACTS launches new report: 'Suicide on UK roads – Lifting the Lid'', PACTS press notice, 18 October 2017

352 Motorways and trunk roads in Scotland roads are managed by Transport Scotland on behalf of the Scottish Government. See Transport Scotland, Roads [Accessed 17 April 2023]
Motorways and trunk roads in Wales are managed by the Welsh Government. See Welsh Government, Managing our roads [Accessed 17 April 2023]

353 Department of Health and Social Care, Suicide prevention strategy for England, 10 September 2012

- 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.[354]

A commitment to publish annual suicide prevention reports ceased in 2019, although National Highways has committed to publish commentary on suicide prevention as part of their standard annual reports.[355]

In their 2021 Annual Report it noted it has:

- committed over £1.6 million to its suicide prevention strategy since the beginning of the second road period (which covers 2020-25)
- installed crisis signage at 100 priority locations across the country partnership with the Samaritans.
- stated an aim to halve suicides on their roads by 2025, through its 'Home safe and well' approach.[356]

In their 2022 Suicide Prevention strategy document, National Highways said more work was needed to "develop metrics that more accurately monitor our progress" especially around statistics on suicide on the strategic road network:

> As a first step it is essential that we work to fully understand the number of suicides and attempted suicides on our roads and monitor any trends. We will collect baseline data and define clear data sets for monitoring suicides on the Strategic Road Network. We will also compare our data with wider national trends in suicide prevention to provide a framework for measuring performance.[357]

Scotland, Wales, Northern Ireland and local authorities

The Welsh and Scottish Governments are responsible for their motorways and major A-roads. Smaller roads across Great Britain are the responsibility of

354 Highways England, Suicide prevention strategy – Our approach (3.8MB, PDF), November 2017
355 Kent Online Highways England stops publishing Annual Suicide Reports less than two years into scheme 10 September 2019
356 Highways England Annual Report and Accounts 2021, 15 July 2021
357 National Highways Suicide prevention strategy Our approach (PDF), 2022 [accessed 17 April 2023]

local highway authorities.[358] All roads in Northern Ireland are managed by the Department for Infrastructure.[359]

Devolved administrations have their own strategies and action plans in place on suicide prevention, which emphasise the importance of partnership working between different public services. However, they make little reference to the specific role transport or road agencies play in helping to prevent suicide. [360]

Local authorities in Great Britain have similar powers to National Highways, such as providing suicide prevention signs at 'high-risk' locations such as bridges.[361]

[358] Highway authorities are usually county councils or unitary councils

[359] Department for Infrastructure Roads - an overview [Accessed 5 May 2022]

[360] Scottish Government, Creating Hope Together: suicide prevention strategy 2022 to 2032, September 2022; Welsh Government, Suicide and self harm prevention strategy 2015 to 2022, 2 October 2020; NI Department of Health, Protect Life 2, Suicide prevention strategy, September 2019

[361] PQ UIN 56572 [On Bridges: Suicide] tabled on 15 October 2021

9 Suicide prevention in prisons

9.1 Statistics

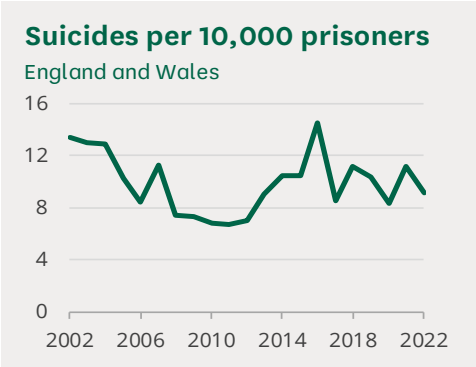
The Ministry of Justice (MoJ) publishes quarterly figures the number of suicides in prisons in England and Wales on a quarterly basis.[362]

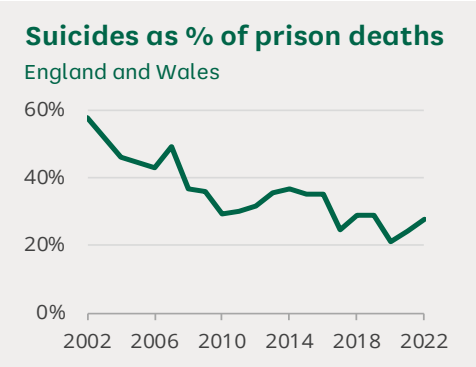
In 2022, there were 74 suicides in prison custody in England and Wales. This represented a rate of 9.2 suicides per 10,000 prison population, a reduction on the 2021 rate of 11.2.[363]

The 2022 figures are provisional. Given that cause of death is not always apparent, the most recent quarters of data usually contain cases which are still awaiting the coroner's decision as to cause or manner of death. There were 33 deaths recorded as awaiting further information in 2022.

The chart below shows the number of suicides relative to the size of the prison population in each year since 2002.[364] The lowest relative number was around 7 per 10,000 prisoners (2008-2012) and the highest 15 per 10,000 prisoners in 2016. Suicide rates were rising between 2012 and 2016 but have tended to decline since, albeit with some fluctuation.

Over the same period, the proportion of prison deaths attributed to suicide has declined by 30 percentage points: down from 58% of all deaths in 2002 to 28% in 2022.





362 Ministry of Justice, Safety in custody statistics. These capture self-inflicted deaths, which are broadly the same as suicides but which may include some cases in which it was not a person's intention to take their own life.

363 As above. 'Deaths data tool'; Ministry of Justice, Offender management statistics quarterly

364 This is relative to the average annual prison population. It does not capture the total number of individuals in custody at any point throughout the year but is an indicator of the daily average.

Source: Ministry of Justice, Safety in custody statistics

Only a small number of suicides occur among female prisoners (an average of five per year over the past 20 years), so the overall prison suicide rate broadly mirrors the male rate. The low number of prison suicides among women prevents meaningful consideration of separate female prisoner suicide rates.

The rate of suicides among male prisoners is higher than that in the male general population. An Office for National Statistics (ONS) study of deaths between 2008 and 2019 found that the risk of male prisoners dying by suicide was 3.9 times higher than the general male population between 2008 and 2019.[365]

This may be due to the demographic and socio-economic profile of prisoners being different to the general population (younger, higher prevalence of mental health problems or substance misuse, etc). It is not clear from the statistics what part, if any, incarceration itself plays on the likelihood of suicide.

Prison suicide statistics for Scotland are not routinely compiled, although a list of all deaths in custody can be found on the website of the Scottish Prison Service.[366]

The Northern Ireland Department of Justice does not publish regular statistics on prison suicide; however, it has disclosed figures periodically in response to requests.[367]

9.2 Policy

The Prison Service Instruction (PSI) Safer Custody, issued by HM Prison and Probation Service (HMPPS) 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.[368] It says 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.

The MoJ, in answer to a PQ in March 2023, set out other steps it was taking to address self-harm and suicide in prisons, including safety training for staff which includes suicide and self-harm prevention, a suicide prevention

365 ONS, Drug-related deaths and suicide in prison custody in England and Wales: 2008 to 2016, 25 July 2019. The number of suicides recorded in prisons during this time might not be the same as the number recorded in the Safety in Custody statistics due to different practices.

366 Prisoner Deaths (sps.gov.uk)

367 Deaths in custody: disclosures | Department of Justice (justice-ni.gov.uk)

368 HM Prisons and Probation Service, Managing prisoner safety in custody: PSI 64/2011, updated 13 July 2021

learning tool developed in partnership with the Samaritans, and guidance distributed nationally on supporting someone who is self-harming. Noting that risk of suicide can be high for prisoners in the early days of custody, including for those on remand, the response said a "staff toolkit helps staff to assess risk effectively and promote supportive conversations in the early days of custody".[369]

The National Institute for Health and Care Excellence (NICE) has published a guideline – Preventing suicide in community and custodial settings – aimed at, amongst others, those working in prisons.[370]

The Scottish Prison Service published the Talk to Me: Prevention of Suicide in Prisons Strategy in 2019.[371] The strategy is currently subject to a review.[372] The Northern Ireland Prison Service updated its Suicide and self-harm prevention policy in 2013.[373]

Comment

HM Inspectorate of Prisons

In his Annual Report 2021-22 the Chief Inspector of Prisons for England and Wales, Charlie Taylor, noted that since the inspectorate had resumed full inspection after the pandemic, it had raised key concerns about weak suicide and self-harm prevention measures at more than half of the adult men's establishments inspected. He said these concerns typically related to a failure to identify risk when prisoners arrived or a broader lack of strategic planning to reduce levels of self-harm.[374]

In January 2019, Peter Clarke, then Chief Inspector of Prisons, called for an independent external inquiry on self-inflicted deaths in prisons:

> … 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.[375]

Independent Monitoring Boards

Dame Anne Owers, Chair of the Independent Monitoring Boards, when giving oral evidence to the Justice Committee in July 2019, expressed surprise that

369 PQ HL5680 [on Prisons: Suicide], 6 March 2023

370 NICE, Preventing suicide in community and custodial settings, NG105, 10 September 2018

371 Scottish Prison Service and NHS Health Scotland, Talk to Me: Prevention of Suicide in Prison Strategy 2016-2021, 2015

372 SP WA 30 January 2023, S6W-14048

373 Northern Ireland Prison Service, Suicide and Self harm prevention policy (PDF), 2011, updated 2013

374 HM Chief Inspector of Prisons for England and Wales, Annual Report 2021-2022, HC 411, 13 July 2022, p40

375 'Prison suicide rate is a scandal, says HM chief inspector', The Guardian, 9 July 2019

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.[376]

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 2019/20 (PDF) said it was troubling that many of its investigations into self-inflicted deaths during the year found that the same failings kept occurring and it was repeating recommendations made before.[377]

The PPO's 2020/21 Annual Report (PDF) noted the concerns the PPO identified in its investigations that year had remained the same as in previous years, although a particular theme during the pandemic had been a lack of staff contact with prisoners.[378]

The PPO's 2021/22 Annual Report (PDF) said its recommendations relating to suicide and self-harm prevention that year had again included assessing prisoners based on their risk factors, accurate record keeping and care plans, carrying out meaningful welfare checks – including after court appearances and family/friend deaths, and following ACCT procedures.[379]

376 Justice Committee, Oral evidence: Prison governance (PDF), HC 2128, 16 July 2019, Q366
377 Prison and Probation Ombudsman, Annual Report 2019/20 (PDF), CP 301, November 2020, p42
378 Prison and Probation Ombudsman, Annual Report 2020/21 (PDF), CP 519, September 2021, p59
379 Prison and Probation Ombudsman, Annual Report 2021/22 (PDF), CP 738, October 2022, p62

10 Media reporting on suicide

Suicidal behaviour can be prompted by the way suicide is reported in the media.[380] 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.[381]

The Government's 2012 National suicide prevention strategy noted "two key aspects to supporting the media in delivering sensitive approaches to suicide and suicidal behaviour":

1. promoting the responsible reporting and portrayal of suicide and suicidal behaviour in the media

2. continuing to support the internet industry to remove content that encourages suicide and provide ready access to suicide prevention services.[382]

The Samaritans have published media guidelines for reporting suicide.[383]

The National Union of Journalists has published guidelines for reporting mental health and death by suicide.[384]

The following sections summarise how the press, broadcasters, and social media platforms must deal with content on 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 states:

380 See, for example, Sisask M & Värnik A, 'Media roles in suicide prevention: a systematic review', International Journal of Environmental Research and Public Health, Vol. 9, 4 January 2012

381 Reporting on Suicide, Recommendations for reporting on suicide (accessed 31 May 2023)

382 DHSC, Preventing suicide in England: a cross-government outcomes strategy to save lives, September 2012, p43

383 Samaritans, Media Guidelines for Reporting Suicide, April 2020

384 National Union of Journalists, Guidelines for reporting mental health and death by suicide, November 2014

> 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.[385]

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 publications and complainants on the reporting of suicide.[386]

A smaller number of publications have joined IMPRESS. The IMPRESS Standards Code states:

> When reporting on suicide or self-harm, publishers must not provide excessive details of the method used or speculate on the motives.[387]

Other publications, for example the Guardian, have not joined either regulator but have appointed their own internal readers' ombudsmen.

10.2 Broadcasting

Ofcom, the UK's communications regulator, has published a Broadcasting Code that sets the rules for programmes broadcast on television, radio and BBC on-demand services in the UK. Section 2 of the Broadcasting Code covers "harm and offence" that includes the following 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.
>
> [...]
>
> 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.[388]

Compliance with the code is the responsibility of individual broadcasters. Complaints about BBC programmes should initially be made to the BBC.[389]

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385 IPSO, Editors' Code of Practice, January 2021, clause 5 (accessed 31 May 2023)

386 Duffy N, How the UK press takes reporting of suicide seriously, IPSO Blog, 27 April 2017 (accessed 31 May 2023)

387 IMPRESS, Standards Code, clause 9.1 (accessed 31 May 2023)

388 Ofcom, The Ofcom Broadcasting Code, March 2021, ss2.4-5

389 BBC website, Complaints (accessed 31 May 2023)

Complaints about the content of other broadcasters should be put to Ofcom.[390]

10.3 Social media

The Government's fifth progress report on its suicide prevention strategy noted an increase in suicide rates among people aged under 25.[391] According to the report, increasing social media use had been identified as one possible factor in the rise in the UK and other countries.[392]

The Samaritans has warned that while the internet can be an "invaluable resource" for people experiencing self-harm and suicidal feelings, it can also provide access to content that can be distressing and triggering.[393]

The Samaritans website has a range of material on the internet and suicide. This includes industry guidelines for managing self-harm and suicide content online. The guidelines have been developed with government, tech companies, academics and third sector organisations, and are designed to evolve in response to emerging issues, the evidence base and the Government's plans to regulate online content.[394]

Social media companies

Currently, content on user-to-user online services (for example, Twitter and Facebook) is governed primarily by the individual platform's terms of service. For instance, Twitter's suicide and self-harm policy or Meta's suicide and self-injury community standards. Stakeholders, for instance the children's charity NSPCC, have suggested that these systems do not do enough to protect users from harmful online content.[395] In response, some services have introduced changes to their policies.

In 2019, Meta (the parent company of Facebook and Instagram), announced updates to its policies around suicide and self-harm-related content on its platforms.[396] These policies were amended to prohibit graphic self-harm images. For Instagram, non-graphic self-harm-related content was removed from "search, hashtags and the explore tab".[397] In November 2020, Instagram

390 Ofcom website, Complain about TV, radio or on demand services (accessed 31 May 2023)
391 DHSC, Preventing suicide in England: Fifth progress report of the cross-government outcomes strategy to save lives, March 2021, para 2.6
392 As above, para 2.8
393 Samaritans website, The internet and suicide (accessed 31 May 2023)
394 Samaritans website, Guidelines for sites and platforms hosting user-generated content (accessed 31 May 2023)
395 BBC News, Facebook's Instagram 'failed self-harm responsibilities', 20 November 2020
396 Meta press release, Tightening Our Policies and Expanding Resources to Prevent Suicide and Self-Harm, 10 September 2019
397 Instagram blog post, Changes We're Making to Do More to Support and Protect the Most Vulnerable People who Use Instagram, 7 February 2019 (accessed 31 May 2023)

announced it would use technology to assist with the identification of this content. As of 14 April 2022, content in the UK flagged by the identification technology is then sent on to a review team. These moderators can then "remove it, direct the person posting to local support organizations or, if necessary, contact the emergency services".[398] There have been further calls for change amongst some UK stakeholders; organisations suggest that online spaces are still not safe enough, particularly for young people.[399]

The Online Safety Bill

The Government's plans to tackle harmful content online, including content related to suicide and self-harm, are set out in its Online Safety Bill.

The Bill was first introduced in the House of Commons on 17 March 2022. It had its second reading on 19 April 2022. A carry-over motion was approved on the same date.

The Online Safety Bill (PDF) [Bill 4 2022-23] was re-introduced in the Commons on 10 May 2022 and completed its Commons stages on 17 January 2023. For details of how the Bill was amended, see the Library briefing on the Online Safety Bill: Commons stages.

The Bill was introduced in the House of Lords on 17 January 2023.[400] Lords second reading took place on 1 February 2023. The Bill began its committee stage in the Lords on 19 April 2023.

Key aims of the Bill are to increase user safety online and to improve users' ability to keep themselves safe online. All regulated services would have to protect users from illegal content. There would be additional duties for services likely to be accessed by children. In addition to these more general duties, the Government has said it will introduce an amendment to the Bill that would create the new offence of "sending a communication that encourages serious self-harm".[401]

Children

The Bill would make "social media companies legally responsible for keeping children and young people safe online".[402] To this end, the Government has said that it plans to designate "content promoting suicide, self-harm or eating disorders as categories of primary priority content".[403] This means that

398 Instagram blog post, An important step towards better protecting our community in Europe, 10 November 2020 (accessed 31 May 2023)

399 NSPCC, We're calling for the Online Safety Bill to create a children's watchdog that stands up for them against Big Tech, 23 May 2023

400 HL Bill 87 (PDF)

401 WS HCWS397 [on Online Safety Bill- Update] 29 November 2022

402 Department for Science, Innovation and Technology and Department for Digital, Culture, Media and Sport, A guide to the Online Safety Bill, 16 December 2022

403 HL Deb 16 May 2023 c188

regulated service providers would have to put systems and processes in place to "prevent children of any age from encountering" this content.[404]

The largest providers would also have to publish "summaries of their risk assessments for illegal content and material that is harmful to children".[405] This would allow users and parents to "understand the risks presented by these services" and the approaches each platform was taking to children's safety.[406]

Adults

Protections for adults take the form of the so-called 'triple shield':

1. Illegal: "The Bill includes a number of priority offences, and companies must proactively prevent users from encountering this content."[407] This would include illegal suicide or self-harm related content.

2. Terms and conditions: "Remove content that is prohibited by their own terms and conditions".[408] That is, regulated providers would have to ensure they adhered to their own terms and conditions.

3. User empowerment: this would enable users to "reduce the likelihood that they will see certain categories of content if they so choose".[409] This would include legal content related to suicide, and content that promotes self-harm. Companies would have to offer tools, such as "human moderation, blocking content flagged by other users or sensitivity and warning screens" to enable adults to avoid such content.[410]

Ofcom would have enforcement powers including issuing fines of up to £18 million or 10% of a company's worldwide revenue (whichever was higher), as well as business disruption measures. The Bill would also empower Ofcom to require the largest service providers to publish annual transparency reports. Ofcom would be able to specify the information service providers included in these.

Stakeholder responses

Broadly, while welcoming the overall direction of the Bill, many organisations have called for its suicide and self-harm provisions to be strengthened.[411]

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404 Online Safety Bill [HL Bill 87] (PDF), c11(3)(a)

405 WS HCWS397 [on Online Safety Bill- Update] 29 November 2022

406 As above

407 As above

408 As above

409 As above

410 As above

411 See for instance: Molly Rose Foundation, Online Safety Bill is to be watered down by the removal of measures that would have forced social media sites to take down material designated 'harmful but legal', November 2022; NSPCC, We're calling for effective action in the Online Safety Bill as child abuse image crimes reach record levels, 22 February 2023

The CEO of Samaritans, for instance, said that the Bill's "important protections" are limited to children. They suggest that self-harm and suicide content should be regulated "for people of all ages".[412]

The Library's briefing The Online Safety Bill: A reading list, published 2 May 2023, provides a selection of further reading on the Online Safety Bill.

10.4 Comment

In its March 2017 report on suicide prevention, the Health Select Committee said it was concerned about the level of non-adherence to the guidelines on media reporting of suicide (PDF). The committee recognised the "excellent work" of Samaritans but said it was "concerned that there appears to be no accountability or responsibility for monitoring adherence to the guidelines."[413]

The committee said 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."[414]

The committee recommended that the IPSO Editors' Code of Practice should be amended so "excessive detail" became "unnecessary detail". It also that Ofcom's Broadcasting Code needed strengthening to "ensure that detailed description or portrayal of suicide methods, including particular locations where suicide could be easily imitated, are not permissible."[415]

Government response

The Government's response (July 20217) began by stating that the Government was "committed to a free and open press and does not interfere with what the press does and does not publish".[416] According to the response, the Government had supported the Samaritans over many years, built strong relationships with the broadcast, print and online media, and developed guidelines for the responsible reporting of suicide.[417] The committee's recommendations on the Editors' Code and the Broadcasting Code were matters for IPSO and Ofcom respectively.[418]

412 Government is failing the public with online safety bill, says Samaritans, Samaritans new [online], 16 January 2023 (accessed 31 May 2023)
413 Health Committee, Suicide prevention (PDF), HC 1087, 16 March 2017, para 120
414 As above, para 124
415 As above, paras 128-33
416 Department of Health, Government response to the Health Select Committee's inquiry into suicide prevention (PDF), Cm 9466, July 2017, p27
417 As above, p27
418 As above, p30

10.5 Scotland, Wales and Northern Ireland

Scotland

One of the priorities of the Scottish Government's Suicide Prevention Strategy 2022-32 is to build a whole of Government and society approach to address "the social determinants which have the greatest link to suicide risk".[419] To achieve this, the Scottish Government will: "Undertake work to ensure sensitive media reporting (both traditional and social media)."[420]

Wales

The Welsh Government's Suicide and self harm prevention strategy 2015 to 2022 includes an objective to support the media "in responsible reporting and portrayal of suicide and suicidal behaviour".[421] This refers to the need to adhere to IPSO's Code of Conduct as well as an "awareness of tackling stigma in relation to suicide and self-harm, encouraging help seeking behaviour and educating the public" to understand the complexity of reasons why someone might take their own life and how to respond to person in crisis.[422]

Northern Ireland

The Northern Ireland Department of Health's Protect Life 2 2019-24 strategy includes an objective to "enhance responsible media reporting on suicide".[423] The strategy notes that the internet can promote awareness-raising and signpost sources of help. However, it also warns that social networking sites can facilitate cyber bullying, and the promotion of self-harm and suicide.[424]

419 Scottish Government, Creating Hope Together: suicide prevention strategy 2022 to 2032 (PDF), September 2022, p13

420 As above

421 Welsh Government, Talk to me: Suicide and Self Harm Prevention Strategy for Wales (PDF), 2015, p16

422 As above, p16

423 Northern Ireland Department of Health, Protect Life 2: A Strategy for Preventing Suicide and Self Harm in Northern Ireland 2019-2024 (PDF), September 2019, p16

424 As above, p38

11 Suicide prevention in the Armed Forces

The Armed Forces published a Suicide prevention strategy and action plan in April 2023.

The plan was prompted in part by an upward trend in death by suicide in the armed forces (see box 1 below).[425]

The strategy says while the latest figures (published in March 2023) show, for the latest 20-year period, men serving in the regular armed forces remained at a "significantly lower risk of suicide" than the UK general population, since 2017 the number of male suicides in the army has increased.[426]

The Ministry of Defence (MOD) also said internal evidence highlighted areas where suicide prevention, intervention and postvention activity "could be improved."[427]

Since 2022 the MOD has made suicide prevention one of its health priority themes for armed forces personnel, along with mental wellbeing and resilience.[428] The Defence people health and wellbeing strategy 2022 to 2027 says the goal is "a reduction in incident and impact of suicide".[429]

The suicide prevention strategy identifies eight focus areas with accompanying actions. Actions include gathering data and evaluation existing methods to identify and manage those at risk, raise awareness of suicide prevention and programmes of postvention support.[430]

The suicide prevention health priority group will review progress in March 2024.

425 MOD, Armed Forces suicide prevention strategy and action plan, 23 April 2023

426 As above

427 As above

428 The other two health priority themes for people are musculoskeletal health and addressing health inequalities such as gender and ethnicity. MOD, The Defence People health and wellbeing strategy 2022 to 2027, 22 June 2022

429 MOD, The Defence People health and wellbeing strategy 2022 to 2027, 22 June 2022

430 As above

Box 1 Suicides in the UK regular armed forces

The Ministry of Defence (MOD) publishes annual statistics on suicide and open verdict deaths among the UK regular armed forces. The latest set of statistics was published on 30 March 2022, for the period 1984 to 2022. Key points:

- The UK regular armed forces have seen a declining trend in male suicide rates since the 1990s and were consistently lower than the UK general population over the last 35 years.
- However, since 2017 the number of male suicides in the army has increased, and the risk of suicide among men in the army was the same as the UK general population for the first time since the mid-1990's.
- Suicide rates in the army among men aged 20 to 24 years were significantly higher than the UK general population. This is different to trends seen in the UK general population where men aged 45 to 54 years had the highest rates of suicide.[431]

The published report contains coroner confirmed suicides only. The armed forces suicide prevention plan notes that, because of increased delays in coroner inquests, around half of all suspected suicides from 2021 and 2022 (25 of 48 deaths) are awaiting a coroner verdict.[432]

The Samaritans have developed a guide specifically for armed forces personnel to help peers.

11.1 Coroners' verdicts

The military's approach to preventing suicide has been criticised by coroners.

Olivia Perks, an officer cadet, was found deceased in her room at Sandhurst military academy in February 2019. In May 2023 coroner Alison McCormick, recording a conclusion of suicide, said chain of command missed an opportunity to request a medical assessment and "the risks to Olivia were not managed in accordance with the Army policy for the risk management of vulnerable people."[433]

In November 2021 a senior coroner for Berkshire issued a 'prevention of future deaths' report into the suicide of LCpl Joel Robinson in March 2019.[434] The coroner found the approach by the Army appears "to be a passive one", in

431 MOD, UK armed forces suicides: 1984 to 2022, 30 March 2023

432 MOD, The Defence People health and wellbeing strategy 2017 to 2022, 22 June 2022

433 BBC News, Olivia Perks: Army missed chance to stop cadet's suicide, coroner says, 26 May 2023; Forces Net, Opportunities missed to prevent suicide of Olivia Perks at Sandhurst, inquest says, 26 May 2023

434 Courts and Tribunals Judiciary, Joel Robinson: Prevention of future deaths report, 29 November 2021

which a soldier would have to seek help, rather than there being a process which "actively looks at risk factors to identify soldiers who may be vulnerable." The coroner suggested the army consider how to identify key risk factors and to regularly review mental health of individual soldiers.

11.2 Veterans

The provision of veterans' healthcare is primarily the responsibility of the NHS. In March 2021 the Government launched the Operation Courage service, creating a single point to access mental health services for veterans.

The MOD says the Office for Veterans' Affairs has been working with the Office for National Statistics to "develop a ten-year retrospective study looking at suicides in the veteran community".[435]

The MOD collates statistics on causes of deaths among the UK armed forces veterans of the 1982 Falklands campaign and the 1990 to 1991 Gulf conflict.

The Defence Committee examined the scale of mental health issues in the armed forces and veterans community in 2019 and on the provision of care in 2019. In January 2021, the Defence Committee held two follow up oral evidence sessions on Armed Forces and Veterans' Mental Health.

Further information on mental health support for veterans can be found in section 5 of Commons Library briefing Support for UK Veterans.

[435] MOD, Armed Forces Covenant and Veterans annual report 2022, 19 December 2022

12 Coroners' conclusions on suicide

In England and Wales, deaths which appear to have been 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 they are made aware that the body is within that coroner's area and they have reason to suspect:

- 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.[436]

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.[437] 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.

436 Coroners and Justice Act 2009, s1
437 Coroners and Justice Act 2009, s10

The Commons Library briefing Coroners' investigations and inquests, provides information about the work of coroners.[438]

12.2 Conclusions

Terminology

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 a narrative, or both, as when the coroner adds a brief narrative to a short-form conclusion in order to explain the reasons for the determination. It is for the coroner to decide what is appropriate to the case in question.

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.[439] The notes to Form 2 list the short-form conclusions, one of which is suicide.

The level of certainty (standard of proof) for a conclusion of suicide

The level of certainty for a conclusion of suicide is the same as the civil standard of proof, that is, the balance of probabilities. This is a lower threshold than the standard of proof applied in the criminal courts – which is being sure, or "beyond all reasonable doubt".

Until the 2018 case of *R (Maughan) v HM Senior Coroner for Oxfordshire and others*,[440] both case law and the leading practitioners' texts considered the higher standard of proof was necessary for a coroner's conclusion of suicide in England and Wales. This meant, in order to return a conclusion of suicide, the coroner (or jury) had to be sure the deceased intentionally took their own life. That position was reflected in Note (iii) to Form 2. This note is now omitted from Form 2.[441]

In *Maughan*, the High Court held that previously decided cases did not correctly state the law, and that the lower civil standard of proof applies to a

438 Commons Library briefing, CBP-3981, Coroners' investigations and inquests

439 SI 2013/1616, as amended

440 [2018] EWHC 1955 (Admin) (PDF)

441 The Coroners (Inquests) (Amendment) Rules 2021 (SI 2021/1379), which came into force on 12 January 2022, amended the Schedule to The Coroners (Inquests) Rules 2013 (SI 2013/1616) by omitting from Form 2 (Record of an inquest) note (iii) that begins with the words "The standard of proof". The version of the Rules on legislation.gov.uk as at 17 May 2023 is the original (as made) and does not show this amendment.

conclusion of suicide. In November 2020, the Supreme Court confirmed the civil standard applies to all inquest conclusions."[442]

Chief Coroner guidance

The Chief Coroner has published updated guidance, Conclusions: short-form and narrative.[443] This advises, 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.[444]

The guidance deals specifically with the suicide conclusion.[445] It makes two points:

> First, the conclusion of suicide should not be avoided by coroners simply out of sympathy for the bereaved family, or for any other reason. It is the coroner's judicial duty, when suicide is proved on the evidence, to record the conclusion of suicide according to the law and the findings which justify it. It would be wrong, for example, to record an 'open' conclusion when the evidence is clear.[446]
>
> Secondly, coroners should make express reference in each case of possible suicide to the two elements which need to be proved: (i) [the deceased] took his/her own life; and (ii) [the deceased] intended to do so (or, put together, 'he/she intentionally took his/her own life'). Both elements must be proved on the balance of probabilities. Suicide must never be presumed.[447]

Coroners (Determination of Suicide) Bill [HL]

On 7 June 2022, The Lord Bishop of St Albans introduced into the House of Lords the Coroners (Determination of Suicide) Bill, a Private Member's Bill that would require a coroner to record an opinion as to the relevant causative factors in a suicide, after the conclusion of an inquest.[448]

Previous bills: Requirement to record gambling addiction as a causative factor in cases of suicide

The Bishop of St Albans had introduced two previous versions of the Bill: one on 16 January 2020, which made no further progress, and a second on 9 June 2021. The latter Bill completed its stages in the House of Lords but failed to

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442 *R (Maughan) v HM Senior Coroner Oxfordshire and others* [2020] UKSC 46 (PDF)

443 Chief Coroner, Conclusions: Short-Form and Narrative, Guidance No 17 (PDF), revised 7 September 2021

444 As above, para 15

445 As above, paras 41 to 43

446 Footnote to quoted 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)"

447 Footnote to quoted text: "*R v City of London Coroner, ex parte Barber* [1975] 1 WLR 1310"

448 Coroners (Determination of Suicide) [HL] Bill, Bill 20 of 2022-23 [as introduced] (PDF)

receive a date for second reading in the House of Commons due to prorogation.

These bills would have required a coroner to record an opinion as to the role of gambling addiction and any other factors relevant to the causation of suicide.

2022 Bill: Recording a wider range of causative factors in cases of suicide

Provisions in the third, most recent Bill would refer only to 'suicide' in relation to causation. It received second reading on 28 October 2022.

The Bishop of St Albans said the impetus for the Bill was the frustration caused by attempts to reform "the Wild West of online gambling",[449] but that revisions would now allow for the recording of a wide range of causative factors in cases of suicide, including an option of "no discernible factor".[450]

The Bill would require the Office for National Statistics to publish coronial opinions on causative factors of suicide on an annual basis. The Bishop of St Albans said the collection of such data would be crucial to informing the Government's work on suicide prevention.[451]

Reaction to the 2022 Bill

Responding for the Government, Parliamentary Under Secretary of State at the Ministry of Justice, Lord Bellamy, said the Government was not yet able to support the Bill.[452]

Lord Bellamy asserted the Bill would lead to an inappropriate extension to the coroner's jurisdiction,[453] while any data collected would likely be insufficiently complete to be useful for policy-setting purposes.[454] He also said a coroner could already use the existing system of prevention of future deaths reports to highlight relevant circumstances relating to a death. In consequence, Lord Bellamy said it would be "disproportionate and potentially counterproductive to take the Bill further."[455]

449 HL Deb 28 October 2022, c1661
450 As above, c1662
451 As above, c1663
452 As above, c1671
453 As above
454 As above, c1672
455 As above

12.3 Northern Ireland and Scotland

Northern Ireland

Northern Ireland has its own coroner service and legislation.[456] Following the Supreme Court judgment in *Maughan*, the civil standard applies to inquest conclusions there too.[457]

Scotland

Fatal Accident Inquiries

Unlike in England, Wales and Northern Ireland, Scotland does not have a system of coroners' inquests.

The Lord Advocate has responsibility in Scotland to investigate any death which requires further explanation.[458] Procurators fiscal are qualified lawyers, employed by the Crown Office and Procurator Fiscal Service (COPFS), who act on the instructions of the Lord Advocate. Within COPFS, the Scottish Fatalities Investigation Unit (SFIU) is a specialist unit responsible for investigating all sudden, suspicious, accidental and unexplained deaths.[459] The SFIU may sometimes investigate the death of a Scottish resident outside the UK.[460]

Once a person's death is reported to the Procurator Fiscal, it is for the Procurator Fiscal to decide whether any further investigation needs to take place.[461]

In the majority of cases no further enquiries are required beyond a post-mortem examination.[462] However, in some cases there will be a Fatal Accident Inquiry (FAI) which is a type of court hearing which considers the circumstances of a death. An FAI is presided over by a sheriff and is normally held in the Sheriff Court.[463]

The purpose of an FAI is to establish:

- Where and when the death occurred;
- The cause of the death;
- Any precautions by which the death might have been avoided;

456 Department of Justice, Coroners Service for Northern Ireland [accessed 17 May 2023]
457 *In the matter of Steponaviciene's Application* [2020] NICA 61 (PDF)
458 gov.scot, Lord Advocate: role and functions, 16 August 2021
459 Crown Office and Procurator Fiscal Service, Our role in investigating deaths [accessed 17 May 2023]
460 mygov.scot, Apply to bury or cremate in Scotland. Suspicious deaths abroad [accessed 17 May 2023]
461 COPFS, Our role in investigating deaths. When we investigate deaths [accessed 17 May 2023]
462 COPFS, The Family Liaison Charter (PDF), September 2016, para 4.1
463 As above, section 6

- Any defect in systems that caused or contributed to the death; and
- Any other facts which are relevant to the circumstances of the death.

An FAI cannot make any findings of fault or blame against individuals.[464]

Information about FAIs is available at:

- COPFS, Our role in investigating deaths
- COPFS, The Family Liaison Charter (PDF), September 2016, section 6
- Scottish Government, Fatal Accident Inquiries: follow up review, 7 August 2019.

The evidential standard for facts to be proven for FAIs is the civil standard of proof: the balance of probabilities.[465]

Suicide cases

Guidance for medical practitioners on which deaths need to be reported to COPFS states that "Deaths where the circumstances indicate the possibility of suicide" must be reported to the Procurator Fiscal.[466]

There will not always be an 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:

> Once the Fiscal has received all the information needed, they'll assess the circumstances of a death by suicide. In most cases there will be no further proceedings by the Fiscal following a death report being received from the police. However, in a very small number of suicide cases, the circumstances of the death may require the Fiscal to report the death to the Crown Office (the headquarters of the Procurator Fiscal Service), for a decision to be made as to whether a Fatal Accident Inquiry should be held. All suicides which occur while a person was in legal custody require a Fatal Accident Inquiry to be held.[467]

[464] COPFS, The Family Liaison Charter (PDF), September 2016, para 6.2

[465] Explanatory Notes to the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016, para 61

[466] COPFS, Reporting deaths to the Procurator Fiscal. Information and Guidance for Medical Practitioners, last updated 1 May 2019, section 3

[467] SAMH, After a suicide (PDF), p9

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