Suicide Prevention: Policy and Strategy

Contents:
Summary
1. Suicide rates in the UK
2. Suicide prevention policies
3. Health services
4. Education
5. Employment
6. Social security
7. Transport
8. Prisons
9. Media
10. Armed forces
11. Coroners’ conclusions
Contents

Summary 5

1. Suicide rates in the UK 8
   1.1 Suicide rates by age, gender, and country 8
   1.2 Suicidal thoughts and self-harm in England 10

2. Suicide prevention policies 13
   2.1 The National Suicide Prevention Strategy in England 13
   2.2 Devolved administration strategies 14
       Scotland 14
       Wales 15
       Northern Ireland 16

3. Health services 17
   3.1 National policy 17
   3.2 Local suicide prevention plans 19
   3.3 Support for mental health patients and other high-risk groups 20
       Primary and community care 21
       Specialist services and support 21
       Information sharing 21
       Perinatal suicide prevention 22
   3.4 Patient safety policies 22
   3.5 Devolved nations 23
       Scotland 23
       Wales 23
       Northern Ireland 24

4. Education 25
   4.1 Schools 25
       Suicide Prevention in England 25
       Fourth Progress Report of the Suicide Prevention Strategy 26
       Safeguarding in schools 26
       Identifying mental health issues 27
       Initiatives to improve mental health in schools 28
       Support for pupils’ mental health during the coronavirus pandemic 29
       Mental health education on the curriculum 29
       Concerns over mental health provision in schools 29
       Bullying and mental health 30
   4.2 Further and Higher Education 31
       Government policy on preventing student suicide 32
       Guidance for universities on preventing student suicide 33
       Step Change Framework 34
       University Mental Health Charter 34
       Reports 35
   4.3 Devolved nations 35
       Scotland 35
       Wales 36
       Northern Ireland 37

5. Employment 39
   5.1 Suicide rates by occupation 39
   5.2 Employment policy and mental illness 39
6. **Social security**
   6.1 Benefit claimants and mental health 44
   6.2 Training and guidance for DWP staff 46
   6.3 ESA and PIP assessments 48
      The Work Capability Assessment and “substantial risk” 49
      Assessment procedures 49
      Work and Pensions Committee inquiry 50
      Reassessing ESA and PIP claimants 53
   6.4 Conditionality and sanctions 56
   6.5 Scotland 58

7. **Transport**
   7.1 Railways 61
      British Transport Police 61
      Partnership working 63
      Department for Transport 64
   7.2 Roads 64

8. **Prisons**
   8.1 Statistics 67
   8.3 Recent comment 69
      HM Inspectorate of Prisons 69
      Independent Monitoring Boards 70
      The Prisons and Probation Ombudsman 70
   8.4 Government position 71

9. **Media**
   9.1 Press 72
   9.2 Broadcasting 73
   9.3 Social media and the internet 74
      The impact of social media 74
      Online Harms White Paper 75
   9.4 Health Committee report (March 2017) 76
      Government response 76
   9.5 Devolved nations 77

10. **Armed forces**
    10.1 A new strategy 79
    10.2 The numbers 80
    10.3 Suicide among Veterans 80
      Post-operational suicide rates 81
    10.4 Defence Committee reports 81

11. **Coroners’ conclusions**
    11.1 Statutory requirements 83
    11.2 Conclusions 83
    11.3 Chief Coroner guidance 84
    11.4 Suicide conclusions: coroner statistics 84
    11.5 The standard of proof for a conclusion of suicide 85
    11.6 The position in Northern Ireland 85
    11.7 The position in Scotland 85
Contributing authors

Carl Baker (SGS), Section 1;
Lizzie Parkin (SPS), Sections 2 and 3;
Nerys Roberts (SPS), Section 4;
Daniel Ferguson (BTS), Section 5;
Steven Kennedy (SPS), Sections 6;
Roderick McInnes (SGS), Section 6 (statistics);
Andrew Haylen (BTS), Section 7;
Jaqueline Beard (HAS), Section 8;
John Woodhouse (HAS), Section 9;
Louisa Brooke-Holland (IADS), Section 10; and
Terry McGuinness (HAS), Section 11.

Cover page image copyright Holding hands by annstheclaff. Licensed under CC BY 2.0 / image cropped.
Summary

This paper set out suicide prevention policies in England.

The national suicide prevention strategy, Preventing Suicide in England: A cross-government outcomes strategy to save lives, was first published in 2012. Its key aims are to reduce the suicide rate in the general population in England and better support those bereaved or affected by suicide. It was updated in 2017 to including tackling self-harm as an issue in its own right. To support the strategy, the NHS asked that all CCGs should deliver local multi-agency suicide prevention plans.

The strategy included a commitment to reduce the rate of suicides in England by 10% by 2020/21 (compared to 2015 levels). The most recent progress report, published January 2019, showed that there was a 9.2% reduction in suicides. The Government will measure success against this target based on the suicide registrations for 2020, expected to be published by the ONS in 2021.¹

The NHS Long-term Plan (January 2019) reaffirmed the NHS's commitment to make suicide prevention a priority over the next decade. It committed to rolling out funding to further Sustainability and Transformation Partnership (STP) areas, implementing a new Mental Health Safety Improvement Programme, and rolling out suicide bereavement services across the country.

The Cross-Government suicide prevention workplan (January 2019) also commits every area of Government to taking action on suicide and sets out clear deliverables and timescales to monitor progress against the key commitments set out in the Suicide Prevention Strategy.

The Government has allocated funding of £57 million for suicide prevention work up to 2023/24.²

A fifth progress report was published in March 2021. This sets out additional Government support and funding for suicide prevention to address additional pressures caused by the COVID-19 pandemic. This includes £5 million to support suicide prevention voluntary and community sector organisations in 2021 to 2022. The report also notes that, although full data is not yet available, early indications do not suggest a rise in the number of suicides when comparing pre- and post-lockdown figures, for January to August 2020.

Suicide rates

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

¹ HM Government, Preventing suicide in England: fourth progress report of the cross-government outcomes strategy to save lives, January 2019, page 9
² PQ 54973 [on suicide: males], 4 June 2020
Suicide prevention in different policy areas
This paper covers the following policy areas:

- **Health services** – with details of suicide prevention measures and mental health support in the NHS Long Term Plan (January 2019) and other NHS England reports. It also covers local suicide prevention plans, and NHS support for high risk groups;

- **Education** – setting out suicide prevention measures taken by educational institutions, including schools and the mental health services they provide, as well as further and higher education institutions which have a legal duty under the *Equality Act 2010* to support their students, including those with mental illness conditions;

- **Employment** – outlining policies designed to keep people who suffer from mental health problems in work, including implementation of a Government strategy for support for people with health conditions in the workplace called ‘Improving Lives’, as well as a recent consultation on proposals to reduce ill health-related job loss;

- **Social security** – outlining support for benefit claimants with mental health problems, training and guidance for DWP staff, the risks in ESA and PIP assessments, and concerns about the impact of conditionality and sanctions on people with mental health conditions;

- **Transport** – detailing suicide prevention measures for railways and roads undertaken by the British Transport Police (BTP) and the Department of Transport, as well as suicide prevention strategies developed by Samaritans, BTP, Network Rail, Highways England, and other parts of the transport sector;

- **Prisons** – outlining current prison service policy and health services for prisoners, Government policy to prevent suicide in prisons, as well as concerns about the levels of self-harm and suicides in prisons;

- **Media** – outlining issues connected to the reporting of suicide, as well as the role of the internet and social media;

- **Armed forces** – providing information on suicide in the UK regular armed forces, the Ministry of Defence Mental Health and Wellbeing Strategy (July 2017), concerns around suicide among veterans; and

- **Coroners’ conclusions** – explaining how the civil standard of proof – i.e. “on the balance of probabilities” – applies for suicide conclusions, rather than the higher threshold applied by the criminal courts – i.e. proof “beyond all reasonable doubt”.

Suicide prevention in the devolved nations
The latest suicide prevention plans for the devolved administrations, covered briefly in this paper, are:
• **Scottish Government** – *Suicide Prevention Action Plan: Every Life Matters*, August 2018;

• **Welsh Government** – *Talk to me 2: Suicide and Self Harm Prevention Strategy for Wales 2015-2022*, June 2015; and

1. Suicide rates in the UK

1.1 Suicide rates by age, gender, and country

In 2019 in England and Wales there were 5,691 deaths where the cause was identified as suicide. This amounts to 11.0 deaths per 100,000 population. This is a significant increase on previous years, and is the highest rate recorded since 2002. Nevertheless, it is lower than rates recorded in the 1980s and 1990s – in 1981, the rate was 14.5 per 100,000 population.

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

Men are three times more likely than women to take their own lives, and this gender gap has grown in the past 35 years. The suicide rate among women in the UK has halved since 1981. The rate among men was 12% lower in 2019 than in 1981. However, the 2018 and 2019 rise in suicide rates affected both genders to a similar degree, with both male and female rates rising by around one sixth.

Information on suicides among transgender or gender dysphoric people is not generally available.4

---

3 The summary statistics here are given for England and Wales only, because 2019 data was not available for Scotland and Northern Ireland at the time of the ONS data publication.

4 According to the ONS – in reply to a Freedom of Information request for the suicide rate for transgender/gender dysphoric persons – the information they hold on deaths, including on gender, is limited to what is recorded on the death certificate by a doctor, or to information about the cause and circumstances of the death.
The suicide rate is higher in Northern Ireland than other UK countries. The chart below shows the three-year moving average suicide rate up to 2019 for England and Wales and 2018 for Scotland and Northern Ireland.

**Suicide rate in the four UK nations**

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

- England
- Wales
- Scotland
- Northern Ireland

Note: The sharp increase between 2004 and 2006 in Northern Ireland coincides with a change to the Coroner’s Service. See this Northern Ireland Assembly research paper for more information. Recorded rates for Northern Ireland may be revised downwards in future following a review.


In England and Wales in 2019 the suicide rate was highest for age groups between 40 and 54. The rate among 45 to 49-year olds in particular was almost 50% higher than the overall average.

**The suicide rate is highest among ages 40-54**

England and Wales rate per 100,000 population, by 5-year age group, 2019

Source: ONS, *Suicides in England and Wales: 2019 registrations*

provided by a coroner. For more information on this, see ONS, *Suicide rates and transgender persons*, 21 June 2018.
The charts below show how the suicide rate has changed over the past 30 years for men and women of different ages in England and Wales. In both genders there were substantial falls between 1989 and 2009 among those aged 65 and above. Among women there was also a fall among those aged 45-64 between 1989 and 1999.

Among both genders there was a rise in the suicide rate among ages 10-24 between 2009 and 2019 – but among men, the rate in this age group remains below the 1989 rate.

1.2 Suicidal thoughts and self-harm in England

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

- 5.4% of people surveyed reported having suicidal thoughts in the past year. This is an increase from 3.8% in 2000.
- 6.4% reported having ever self-harmed, up from 2.4% in 2000.
- 0.7% reported having attempted suicide in the past year. This rate has increased slightly since 2000.
Some groups saw larger increases in suicidal thoughts and suicide attempts over the period – e.g. people aged 55-64.

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

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

Source: NHS Digital Adult Psychiatric Morbidity Survey 2017
2. Suicide prevention policies

2.1 The National Suicide Prevention Strategy in England

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

It specified six areas for action. A seventh area was added in the 2017 progress report, to include addressing self-harm as an issue in its own right:

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. Reducing rates of self-harm as a key indicator of suicide risk

The Department of Health and Social Care publish annual progress reports on the national strategy. Each report sets out current trends and outlines where progress has been made and what still needs to happen.

Further detail on each of the policy areas covered by the strategy is provided later in the briefing.

In January 2019, the fourth national suicide prevention strategy progress report was published alongside the first Cross-Government suicide prevention workplan. The workplan commits every area of Government to acting on suicide and sets out clear deliverables and timescales to monitor progress against the key commitments set out in the Suicide Prevention Strategy.

The workplan was produced in response to a recommendation from the Health Committee’s inquiry into suicide prevention, which called for a clear implementation strategy, with strong national leadership, clear accountability, and regular and transparent external scrutiny.

The subsequent workplan sets out key actions to address suicide, which include:

---

7. Department of Health and Social Care, Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives, January 2017
8. Department of Health, Government Response to the Health Select Committee’s Inquiry into Suicide Prevention, Cm9446, July 2017, p2-3
14 Suicide Prevention: Policy and Strategy

• Ensuring the effectiveness of every local authority suicide prevention plan;

• Ensuring every mental health trust has a zero-suicide ambition plan for mental health inpatients by the end of 2019;

• Implementing the Prison Safety Programme across the prison estate;

• Improving data collection at local and national level, and harnessing technology to identify those most at risk of suicide and self-harm.

The Government also established a National Suicide Prevention Strategy Delivery Group to track, monitor and report on the implementation of the Workplan.

2.2 Devolved administration strategies

Scotland

The Scottish Government previously published the following strategies:


• Suicide Prevention Strategy 2013-16 (December 2013)

The Scottish Government’s current suicide prevention action plan, Every Life Matters (August 2018) was designed to continue the work from the previous strategy as well as “the strong downward trend in suicide rates in Scotland”. The foreword to the action plan noted that suicide rates in Scotland had fallen by 20% between 2002-2006 and 2013-17, i.e. the two periods covered by the Scottish Government’s previous strategies.9

The resulting publication committed to a new target to reduce further “the suicide rate by 20% by 2022”10 and set 10 priority actions:

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

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

---

9 Scottish Government, Suicide Prevention Action Plan: Every Life Matters, August 2018, p2

10 Ibid., pp2-3
Action 3. The Scottish Government will work with the NSPLG and partners to encourage a coordinated approach to public awareness campaigns, which maximises impact.

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

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

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

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

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

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

Action 10. The Scottish Government will work with the NSPLG and partners to develop appropriate reviews into all deaths by suicide, and ensure that the lessons from reviews are shared with NSPLG and partners and acted on.11

Wales

The Welsh Government has previously published:

- *Together for Mental Health* (2012) which included a number of suicide prevention measures

The most recent strategy, *Talk to me 2: Suicide and Self Harm Prevention Strategy for Wales 2015-2022*, outlined six key objectives:

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

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

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

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

Objective 5: Reduce access to the means of suicide

Objective 6: Continue to promote and support learning, information and monitoring systems and research to improve our

11 Ibid., p4
understanding of suicide and self harm in Wales and guide action\textsuperscript{12}

**Northern Ireland**

In September 2019, the Department of Health published *Protect Life 2: A Strategy for Preventing Suicide and Self Harm in Northern Ireland 2019-2024*. The stated aim of this strategy is to reduce the suicide rate in Northern Ireland by 10% by 2024, as well as to ensure suicide prevention services and support are delivered appropriately in deprived areas where suicide and self-harm rates are highest.

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.\textsuperscript{13}

\textsuperscript{12} Ibid, pp15-17

\textsuperscript{13} Ibid, p16. The full rationale for these objectives are outlined in Appendix 1.
3. Health services

This section sets out the work of health services to prevent suicide. For information on mental health policy in England more generally, see the Commons Library briefing paper Mental health policy in England, published in January 2021.

3.1 National policy

The Five Year Forward View for Mental Health was published in February 2016 by the independent Mental Health Taskforce. The report made recommendations on suicide prevention and reduction, also including an objective to reduce suicides by 10% in England by 2020/21.14

NHS England accepted the recommendations of the report and agreed with the Government that to support the transformation of mental health services there would be an additional investment, including £25 million specifically on suicide prevention.15

The NHS Long-term Plan (January 2019) reaffirmed the NHS's commitment to make suicide prevention a priority over the next decade, with an expansion of mental health crisis care and specialist services, including a new mental health safety improvement programme for mental health inpatients. The Plan noted that “...we are on track to deliver a 10% reduction in suicide rates by 2020/21” 16. The Plan also stated that reducing suicides will remain an NHS priority over the next decade, and set out measures to achieve this:

With the support of partners in addressing this complex, system-wide challenge, we will provide full coverage across the country of the existing suicide reduction programme. Through an enhanced mental health crisis model, anyone experiencing a crisis will be able to call NHS 111 and have 24/7 access to mental health support as well as the services described earlier in this chapter. We will expand specialist perinatal mental health services so that more women who need it have access to the care they need from preconception to two years after the birth of their baby. We are investing in specialist community teams to help support children and young people with autism and their families, and integrated models of primary and community mental health care which will support adults with severe mental illnesses, and support for individuals who self-harm.17

The NHS Long-term Plan committed the NHS to implementing the Mental Health Safety Improvement Programme (MHSIP). The programme focuses 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 around challenges that are common across many or all local systems. The MHSIP works

14 NHS England, Five Year Forward View for Mental Health, February 2016, p13
15 NHS England, Implementing the Five Year Forward View For Mental Health, July 2016, pp35-36
16 NHS England, NHS Long Term Plan, 7 January 2019
17 Ibid, para 3.105
with each of the 54 NHS Trusts providing mental health services to understand their safety concerns and devise an improvement programme accordingly. The Programme launched in May 2018 and was a two-year programme funded until March 2020. Further detail of funding beyond this point is not yet available. Further detail on the Programme is provided in the NHS Patient Safety Strategy (June 2019).

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

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

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

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

Alongside this appointment, £1.8 million of funding was pledged to the Samaritans’ suicide helpline. A further £2 million investment (for between 2018 to 2020) was announced for the Zero Suicide Alliance to help achieve the zero inpatient suicide ambition. This funding was in addition to the £25 million in suicide prevention funding first announced in 2016.

The Government has recently announced that it will invest £57 million in suicide prevention, as set out in the NHS Mental health Implementation Plan (July 2019), which covers the period 2019/20 – 2023/24. This will see investment in all areas of the country by 2023/24 to support local suicide prevention plans and establish suicide bereavement support services. The Implementation Plan provides a breakdown in funding per year for suicide prevention activity, alongside other areas of specific investment for mental health.

---

18 PQ 197068 [on mental health services], 30 November 2018
19 Public Health England, Department of Health and Social Care [DHSC], New Funding for Health and Social Care in England, 16 May 2018
20 ‘Zero suicide is our simple but powerful NHS mission’, The Telegraph, 31 January 2018 (an opinion piece written by Jeremy Hunt MP)
21 PM pledges action on suicide to mark World Mental Health Day, 9 October 2018
22 £2 million investment to help NHS achieve zero inpatient suicide ambition
23 PQ 107145 [on Suicide], 21 October 2020
The NHS Mental Health Implementation Plan also sets out how funding allocations for suicide reduction programmes will be targeted, based on rates of suicide in each sustainability and transformation partnership area, with funding amounts being based on the number of suicides in an area and as a proportion of suicides in England.24

The National Confidential Inquiry into Suicide and Safety in Mental Health publishes annual reports on suicide in England, Northern Ireland, Scotland and Wales, and provides recommendations to improve patient safety in mental health settings and reduce suicide rates.

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

The Public Health Outcomes Framework (PHOF) and NHS Outcomes Frameworks also include specific indicators for suicide as well as a range of other indicators that are likely to have an impact on suicide. These may be used to influence action to be taken by local government and health services who have a mandatory duty to report against these indicators.

3.2 Local suicide prevention plans

The Five Year Forward View for Mental Health (2016) and the Government’s suicide prevention strategy recommended that all local authorities should have multi-agency suicide prevention plans. The plans should target high-risk locations and support high-risk groups, including men and people in contact with mental health services:

The Department of Health, PHE and NHS England should support all local areas to have multi-agency suicide prevention plans in place by 2017, contributing to a 10 per cent reduction in suicide nationally. These plans should set out targeted actions in line with the National Suicide Prevention Strategy and new evidence around suicide, and include a strong focus on primary care, alcohol and drug misuse. Each plan should demonstrate how areas will implement evidence-based preventative interventions that target high-risk locations and support high-risk groups (including young people who self-harm) within their population, drawing on localised real-time data. Updates should be provided in the Department of Health’s annual report on suicide.25

All Local Authorities now have suicide prevention action plans and multi-agency partnerships in place.26

In May 2018, the Department of Health and Social Care, Public Health England and NHS England announced the first local areas that will receive funding from a £25 million investment over three years for suicide prevention. The funding was initially allocated to areas that are

---

24 PQ 1433 [on Suicide], 8 January 2020
25 NHS England, Five Year Forward View for Mental Health, p77 (Recommendations for Government)
26 Public Health England, Local suicide prevention planning, September 2020
worst affected by suicide.\textsuperscript{27} It includes targeted prevention campaigns for men; psychological support for people with financial difficulties; better care after discharge; and improved self-harm services for all ages.\textsuperscript{28}

Local Government Association and Association of Directors of Public Health have led work with local authorities to self-assess their plans. Guidance is published by Public Health England for local areas on suicide prevention planning which set out the key priority areas for planning:

- 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\textsuperscript{29}

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


The Strategy identified these as young and middle-aged men, people in the care of mental health services, people in contact with the criminal justice system, specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers, and people with a history of self-harm.\textsuperscript{30}

The Fourth Progress Report also set out areas of work to reduce suicide among people in contact with mental health services, for whom it says suicides are some of the most preventable. The strategy highlights that around one third of people who die by suicide have been under specialist mental health services in the preceding year, and two thirds have seen their GP. Additionally, just over half of people sought help following an attempted suicide from either their GP or hospital services.\textsuperscript{31}

\textsuperscript{27} For the full list of areas, see NHS England, \textit{Suicide prevention and reduction}, 16 May 2018
\textsuperscript{28} Public Health England and DHSC, \textit{New Funding for Health and Social Care in England}, 16 May 2018
\textsuperscript{29} Public Health England, \textit{Local suicide prevention planning}, September 2020, page 15
\textsuperscript{31} HMG, \textit{Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives}, January 2017, para. 21
Primary and community care
For primary care, the Government has highlighted improved training for GPs and their staff in suicide awareness and safety planning. The General Medical Council and the Royal College of GPs provide training for GPs in suicide and self-harm.  

The Third Progress Report also highlighted new models of enhanced primary care, including the Urgent and Emergency Care Vanguards, to test new ways for people with mental health problems to access urgent care in the community. The Department of Health asked NICE to develop a new guideline – Preventing suicides in community and custodial settings (NG105) which was published in September 2018.  

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

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

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

---

32 See DH, Government response to the Health Select Committee’s Inquiry into Suicide Prevention, Cm 9466, July 2017, p15
33 HMG, Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives, January 2017, pp12-13
34 Ibid., para 32, p14
35 NHS England, Five Year Forward View for Mental Health Dashboard, January to March 2017
36 DH, Government response to the Health Select Committee’s Inquiry into Suicide Prevention, Cm 9466, July 2017, p18
37 Health Committee, Suicide Prevention, Sixth report of Session 2016-17, 7 March 2017, HC 1087, paras 21 and 95
working with relevant Royal Colleges to promote the tool among its members.\textsuperscript{38}

**Perinatal suicide prevention**

The latest report of the confidential enquiry on maternal deaths, \textit{Saving Lives, Improving Mothers’ Care} (November 2019), shows that suicide continues to be the leading cause of maternal death in the first year after giving birth, and highlights the important role of specialist perinatal mental health services, particularly in forward planning for the care of women with known pre-existing mental health problems.

NHS England’s \textit{Five Year Forward View for Mental Health} set out a target for at least 30,000 additional women each year to access evidence-based specialist perinatal mental health treatment by 2020/21. A PQ response in July 2019 noted that at least 9,000 additional women received specialist perinatal mental health treatment in 2018/19.\textsuperscript{39}

The NHS Long Term Plan includes a commitment for a further 24,000 women to be able to access specialist perinatal mental health care by 2023/24. The Plan also noted that specialist care will also be available from preconception to 24 months after birth, which will provide an extra year of support.\textsuperscript{40}

### 3.4 Patient safety policies

The \textit{NHS Patient Safety Strategy} was published in July 2019 and includes national and regional actions to continue to improve patient safety.

The Strategy details the Mental Health Safety Improvement Programme (MHSIP), which focuses on suicide prevention and reduction for mental health inpatients. This Programme provides bespoke support to mental health trusts on their individual safety priorities as well as support around challenges that are common across many or all local systems. The MHSIP works with each of the 54 NHS Trusts providing mental health services to understand their safety concerns and devise an improvement programme accordingly. The Programme launched in May 2018 and was a two-year programme funded until March 2020.\textsuperscript{41}

Further detail of funding beyond this point is not yet available.

As also outlined in the Strategy, the NHS in England is developing a new Patient Safety Incident Response Framework (PSIRF) to replace the current \textit{Serious Incident Framework}. The expectation is that all parts of the NHS in England will be using the new framework by Autumn 2021.

High-profile reviews and inquiries such as those at \textit{Mid Staffordshire}, \textit{Gosport} and \textit{Morecambe Bay} have found serious failings in hospital care, and highlighted that patients, families, carers and staff can experience closed and defensive cultures when things go wrong in the NHS. Long-standing failings identified in care provided to people with

\textsuperscript{38} DH, \textit{Government response to the Health Select Committee’s Inquiry into Suicide Prevention}, July 2017, pp21-22

\textsuperscript{39} \textit{PQ 276533 [Pregnancy: Mental Health Services]}, 17 July 2019

\textsuperscript{40} NHS England, \textit{NHS Long Term Plan}, 7 January 2019

\textsuperscript{41} \textit{PQ 197068 [on mental health services]}, 30 November 2018
mental illness and learning disability have also led to a particular focus on these areas.\textsuperscript{42}

Further information on patient safety is available in the Library briefing on The structure of the NHS in England – section 7 (June 2020)

### 3.5 Devolved nations

#### Scotland

The Scottish Government’s Suicide Prevention Action Plan: Every life matters, published in August 2018, commits the Scottish Government to fund the creation and implementation of refreshed mental health and suicide prevention training and develop a Scottish Crisis Care Agreement. A package of new resources to support workforce development in mental health improvement and suicide prevention launched in May 2019, as the first phase of work on developing training in this area.\textsuperscript{43}

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

To help fulfil these commitments and support implementation of the strategy more generally, NHS Health Scotland hosts the Choose Life programme which provides leadership and guidance to local suicide prevention coordinators around the Scotland, as well as training courses on suicide prevention action. It coordinates with other agencies closely involved in suicide prevention action in Scotland, including local authorities, NHS Boards, the Police and the voluntary sector.\textsuperscript{44}

In March 2017 the Scottish Government published a 10-year Mental Health Strategy which is designed to complement current suicide prevention measures.\textsuperscript{45}

#### Wales

The second objective in the latest Welsh Government’s suicide prevention strategy – Talk to me 2 – is “to deliver appropriate responses to personal crises, early intervention and management of suicide and self-harm”. In particular, this commits the Welsh Government to the mantra that “those who are the first point of contact need to have the necessary knowledge, skills and attitudes to ensure that compassionate and supportive evidence-based care is delivered.” It recommends that GPs have appropriate suicide prevention education and states that

\textsuperscript{42} Further information can be found in the Library briefings on Learning Disability and Mental health policy.

\textsuperscript{43} 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

\textsuperscript{44} ‘National and local implementation’, Choose Life website [accessed 28 November 2017]

\textsuperscript{45} Scottish Government, Mental Health Strategy: 2017-2027, March 2017, p28
emergency staff “must have the necessary knowledge, skills and attitudes to recognise, assess, signpost, manage and initiate appropriate follow up for those within whom they come into contact and who are in distress”.  

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

All these actions were, at the time of publication, designed to be considered alongside the Welsh Government’s suicide prevention measures in its mental health strategy, Together for Mental Health, which was first launched in 2012, and its delivery plan. The Welsh Government has recently finished consulting on the latest iteration of its mental health delivery plan for 2019 to 2022.

**Northern Ireland**

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

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

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

---

46 Welsh Government, Talk to me 2: Suicide and Self Harm Prevention Strategy for Wales 2015-2020, June 2015, paras 40 & 76-78, pp15-16 and 22-23
47 Ibid., p13
49 Ibid., p42
4. Education

4.1 Schools

Suicide Prevention in England

The 2012 *Suicide Prevention Strategy for England* identifies children and young people as a group for whom “a tailored approach to their mental health is necessary if their suicide risk is to be reduced.”\(^{50}\) The Strategy states that an effective school-based suicide prevention strategy would include:

- a co-ordinated school response to people at risk and staff training;
- awareness among staff to help identify high risk signs or behaviours (depression, drugs, self-harm) and protocols on how to respond;
- signposting parents to sources of information on signs of emotional problems and risk;
- clear referral routes to specialist mental health services.\(^{51}\)

The strategy adds that “appropriate training on suicide and self-harm should be available for staff working in schools and colleges.”\(^{52}\)

**Box 1: England - mental health in the school curriculum**

Personal, Social Health and Economic (PSHE) education is highlighted by the Suicide Prevention Strategy as providing an opportunity for schools to teach about issues – such as sex and relationships, substance misuse, and emotional and mental health – that may help children “to recognise, understand, discuss and seek help earlier for any emerging and emotional problems.”\(^{53}\)

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

Since September 2020 health education - including coverage of mental health - has been a statutory part of the curriculum for primary and secondary schools in England. Schools were given some flexibility around the requirements, owing to the coronavirus pandemic. The DfE publishes a range of guidance on the requirements.

Further information is available in two other Library briefings:

- [Personal, social, health and economic education in schools (England)](#)
- [Relationships and sex education in schools (England)](#)

The Strategy notes that interventions at a community level after a suicide can help prevent copycat and suicide clusters and ensure support

---


\(^{51}\) *Ibid.*, p22

\(^{52}\) *Ibid.*, p17

Suicide Prevention: Policy and Strategy

is available, and states that this approach may be used in schools, colleges and universities. It highlights the Samaritans’ Step-by-Step post-suicide intervention service for schools across the UK, whereby Samaritans branches provide guidance and information on the impact of suicide on school communities, and ways to promote recovery and prevent suicide clusters.\textsuperscript{54}

**Fourth Progress Report of the Suicide Prevention Strategy**

The Fourth Progress Report of the Suicide Prevention Strategy for England was published in January 2019. The report noted the “key role” that schools and colleges have to play in “promoting good mental health for children and young people and in early intervention when problems arise.”\textsuperscript{55} It also highlighted Government proposals and actions in this area, including:

- Expanding pilots to establish single points of contact for mental health to more schools,\textsuperscript{56}
- Incentivising schools and colleges to train Designated Senior Leads for Mental Health.
- Creating new Mental Health Support Teams to work in or close to schools.
- Publishing guidance for schools on preventing bullying and providing funding to tackle homophobic, biphobic and transphobic bullying in schools.

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

**Safeguarding in schools**

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

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

Where schools have immediate concerns about the risk of suicide, their safeguarding role is set out in our statutory guidance, Keeping Children Safe in Education. This emphasises that schools should have a designated senior lead, with responsibility for the handling of safeguarding concerns, in place. Where schools have immediate concerns about the risk of suicide, an immediate referral should be made to children’s social care.\textsuperscript{57}

\textsuperscript{54} Ibid, p41
\textsuperscript{56} Ibid, p31. See Department for Education [DfE], Mental health services and schools link pilot: evaluation, 9 February 2017 for further information.
\textsuperscript{57} PQ 228146 [on Children: Suicide], 23 March 2015
The safeguarding guidance also applies to sixth form colleges and general further education colleges and relates to their responsibilities towards children under the age of 18.58

**Identifying mental health issues**

As well as outlining what schools should do in response to an immediate suicide concern, the PQ response cited above also noted the key role that schools have in identifying and supporting pupils with mental health conditions more generally. At the same time, however, the Government has acknowledged that teachers are not mental health professionals and, where more serious problems occur, it expects that pupils should receive additional support from CAMHS services, voluntary organisations and GP practices.59

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

- How and when to refer to CAMHS;
- Practical advice to support children with emotional and behavioural difficulties;
- Strengthening pupil resilience tools to identify pupils who are likely to need extra support; and
- Where and when to access community support.60

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

In March 2015, the DfE published guidance on counselling in schools, which provides schools with practical advice on setting up and improving counselling services for pupils.61 The DfE has stated that it “recognises that school-based counselling by qualified practitioners can play an effective role in supporting mental health and wellbeing”. It has also emphasised, however, that it is “up to schools to decide what support to provide for pupils based on their individual circumstances.”62 Schools are not required to report centrally on the counselling services they provide, but a survey published by the Government in 2017 indicated that 61% of schools offered counselling services, and 84% of secondary schools provided their pupils with access to counselling support.63

---

58 DfE, Keeping children safe in education: Statutory guidance for schools and colleges, 18 January 2021, p3
59 PQ 111153 [on Schools: Counselling], 7 November 2017
60 DfE, Mental health and behaviour in schools, 2018
61 DfE, Counselling in schools, February 2016
62 PQ 279120 [on Pupils: Counselling], 24 July 2019
63 DfE, Supporting Mental Health in Schools and Colleges, August 2017, p29
Initiatives to improve mental health in schools

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

- Incentivising schools to identify and train a Designated Senior Lead for Mental Health, with new training to help leads and staff deliver whole school approaches to promoting better mental health.
- Creating new Mental Health Support Teams to work with groups of schools and colleges, and work with Designated Senior Leads in addressing the problems of children with mild to moderate mental health problems, and provide a link to services for children with severe problems.
- Building on existing mental health awareness training so that a member of staff in every primary and secondary school in England receives mental health training.64

The Government’s response to the consultation, published in July 2018, committed to taking forward all proposals in the Green Paper. It stated that the Government aimed to offer training to designated mental health leads to one fifth of schools from September 2019.65 In July 2019, the DfE announced that it had begun recruiting a specialist provider to deliver the training.66

The response added that the Government was “committed to providing mental health awareness training to every secondary school by 2019 and every primary school by 2022”. In the first year, the response said, training had been provided to a member of staff in a third of secondary schools (1,000 schools), and by June 2019 it aimed to have reached a further 1,000 schools.67 In July 2019, the DfE announced that the training would be rolled out nationally to schools and colleges in phases over four years from September 2019.68

In December 2018, the Government announced 25 trailblazer areas where the first Mental Health Support Teams would be established. It was expected that each team would support up to 8,000 children in around 20 schools in their area. The teams began training in January 2019.69 A further 57 sites were announced in July 2019.70

Further information on mental health in schools, including the Green Paper proposals, is provided in Section 6 of the Library Briefing, Children.

---

64 PQ 901024 [on Mental Health Services: Children], 10 October 2017
66 National mental health programme between schools and NHS, DfE press release, 12 July 2019
67 ibid, p34
68 DfE and DHSC, NHS and schools in England will provide expert mental health support, 20 December 2018.
69 ibid PQ 268557 [on Mental Health Services: Young People], 2 July 2019
70 NHS website article, ‘Transforming children and young people’s Mental Health Support Teams and pilots’, undated.
and young people’s mental health – policy, CAMHS services, funding and education (December 2020).

Support for pupils’ mental health during the coronavirus pandemic
The Government is funding an £8 million programme – Wellbeing for Education Return – delivering training and support to school and college staff. The programme, beginning in September 2020, is intended to help schools cope with the additional pressures and mental health issues faced by some pupils and staff during the pandemic.71

Other Government-funded coronavirus support for children, young people, families and schools is outlined in the DHSC policy paper, Staying mentally well this winter, and includes:

- A pilot scheme offering online and telephone advice to school leaders, run by Education Support.
- Grants to children’s charities including Barnardo’s, Fosterline, and others.
- A catch-up premium of £650 million to schools; academic catch-up is identified as “vital protective factor” for some young people’s wellbeing.72

Mental health education on the curriculum
The Relationships Education, Relationships and Sex Education and Health Education (England) Regulations 2019 provide for Health Education to be compulsory in state-funded schools from September 2020. Independent schools must also offer health education as part of PSHE.

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

Concerns over mental health provision in schools
Concerns have been raised that the provision of mental health support in schools is patchy. This was, for example, noted by the Care Quality Commission (CQC) in a review of CAMHS services in 2017. The CQC noted that when pupils can access high-quality counselling through their schools, it can be an effective form of early intervention. The CQC also said, however, that it is not always available, and that in some cases there are concerns about the quality of support on offer.73

It has been suggested that the funding pressures on schools may have led many to reduce mental health services, such as in-school counsellors. In their 2017 joint report on children and young people’s mental health, the Commons Education and Health Committees cited survey evidence that 78% of primary schools reported financial

72 Department of Health and Social Care, Staying mentally well this winter, 23 November 2020.
73 Care Quality Commission, Review of children and young people’s mental health services; Phase one report, October 2017, pp23-24
constraints as a barrier to providing mental health services for pupils. The report argued that it was a “false economy to cut services for children and young people” given that over half of mental ill health starts before the age of 15, and recommended that the Government should review the effect of budget reductions on in-school mental health services.\(^\text{74}\)

In its response to the joint report, the Government provided the results of a survey of mental health provision in schools showing, amongst other things, that 56% of primary maintained schools and 84% of maintained secondary schools offered counselling services. These figures have also been cited by the Government in more recent responses to parliamentary questions.\(^\text{75}\) The response also stated that the announced additional £1.3 billion for core school budgets, along with the introduction of the national funding formula, would “help schools provide more support for those with mental illness.”\(^\text{76}\)

The Government’s position on increasing counselling services in schools was also set out in response to a parliamentary question in January 2021.

**Bullying and mental health**

Bullying has been identified as a common theme in suicide by young people and children. The DfE has published advice for schools, last updated in July 2017, on preventing and tackling bullying. This sets out the Government’s approach to bullying, and the legal powers schools have to address it. The advice also outlines principles that underpin the most-effective anti-bullying strategies in schools.\(^\text{77}\)

In September 2016 the Government Equalities Office announced a £3 million programme from 2016 to 2019 to prevent and address homophobic, biphobic and transphobic bullying in schools. The programme is focused on primary and secondary schools in England that had no, or ineffective, measures in place.\(^\text{78}\) In November 2018 the programme was extended to 2020, with the allocation of an extra £1 million of funding.\(^\text{79}\)

The Government Equalities Office has also published cyberbullying guidance and an online safety toolkit for schools. The Fourth Progress Report on the Suicide Prevention Strategy states that these resources “will help provide advice to schools on understanding, preventing and responding to cyberbullying.”\(^\text{80}\)

---

\(^{74}\) Education and Health Committees, *Children and young people’s mental health — the role of education*, HC 849, May 2017, p12

\(^{75}\) PQ 269133, 3 July 2019


\(^{77}\) DfE, *Preventing and tackling bullying*, July 2017

\(^{78}\) ‘Schools around the country to stamp out LGBT bullying’, Government Equalities Office, September 2017; PQ 6636 [on Pupils: Bullying], 9 September 2017

\(^{79}\) £2.6 million to improve lives of LGBT people, Government Equalities Office, 4 November 2018

\(^{80}\) HMG, *Preventing suicide in England: Fourth progress report of the cross-government outcomes strategy to save lives*, January 2019, p32
4.2 Further and Higher Education

This section provides a brief overview of this area. More detailed information on student mental health is available in Library Briefing 8593, *Support for students with mental health conditions in higher education in England*, 17 December 2020 pages 14-16.

There is a strong connection between mental ill health and suicide or self-harm. The ability to identify students who are at risk of suicide is difficult. The *Stepchange* website states that only 12% of students who died by suicide were reported to be seeing student counselling services.

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

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

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

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

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

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

- **Nightline**: a service run for students, by students. Trained student volunteers answer calls, emails and messages in person to fellow students;

---

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

82 PQ 14451 [on Students: Suicide], 10 November 2015
• **Student Minds**: a charity which carries out research and campaigns on mental health issues. It trains volunteers and supports student-led societies across campuses; and

• **Students Against Depression**: a website offering advice, information, guidance and resources to those suffering from depression and suicidal thinking.

Following a pilot, Samaritans is also exploring expansion of Step by Step, its suicide prevention service for schools, for the higher education sector.83

**Government policy on preventing student suicide**

The *Fourth Progress Report* of the Suicide Prevention Strategy (2019) noted the pressures faced by modern-day students – including workload, financial difficulties and the transition of moving away from home – and stated that “it is important that students receive the support they need to cope with these issues.”84 It then highlighted actions taken by the Government in this area, including:

• Analysing data on student suicides in England (see box 4).

• Supporting the launch of the Step Change framework for improving student mental health and wellbeing.

• Supporting the development of guidance for universities on preventing suicides.

• Plans for a mental health charter.

At a *mental health summit* in 2018, Sam Gyimah the Minister for universities announced other mental health initiatives:

• A Department for Education-led working group would be set up into the transition students face when going to university. In March 2019, the DfE announced that a new taskforce – the Education Transitions Network – had been set up to look at how students moving to university can be better supporting in their first year.85

• The Government would explore whether an opt-in requirement for universities could be considered, so they could have permission to share information on student mental health with parents or a trusted person.86 A UUK task group is exploring how students’ families can be better involved in mental health support while ensuring that the confidentiality rights of students are respected.87

In June 2019, the Higher Education Policy Institute published their annual *Student Academic Experience Survey 2019*. The report questioned students about their wellbeing and asked if they would be happy for their institution to contact their parents if

---


84 *Ibid.*, p32

85 *Government creates new student mental health taskforce*, DfE press release, 7 March 2019

86 *New package of measures announced on student mental health*, DfE press release, 28 June 2018

87 *Government creates new student mental health taskforce*, DfE press release, 7 March 2019
there were a concern about their mental health. 66% of students were happy for their parents to be contacted in the event of extreme circumstances; 18% were not happy for their parents to be contacted at all.\(^88\)

More information on these actions is provided in the sections below. An outline of Government policy on student mental health more broadly was provided in response to a parliamentary question in May 2019.\(^89\)

**Guidance for universities on preventing student suicide**

In September 2018, Universities UK (UUK) and PAPYRUS, a national charity dedicated to the prevention of young suicide, published *Suicide Safer Universities*, guidance for universities in preventing student suicides. The guidance states that suicide prevention, intervention and “postvention” should be connected as a specific strategy as a component of a university’s overarching mental health strategy. The strategy, the guidance adds, should be created in partnership with staff, students, and external stakeholders, and should be developed into a multi-agency action plan detailing how, by who and when it will be implemented.\(^90\)

The guidance also sets out best practice for universities in preventing student suicides, intervening when students get into difficulties, and responding to student suicides.\(^91\) It ends with a checklist, setting out that universities should, among other things:

- Make suicide safety an institutional priority;
- Develop a suicide-safer strategy and action-plan as a distinct component of their overarching mental health strategy;
- Train suicide intervention and postvention teams, and train all student-facing staff in suicide awareness;
- Create strong links with local and national partners from the health sector, voluntary sector, and local authorities; and
- Work together with schools, colleges and other universities in the area to ensure smooth transitions between educational settings.\(^92\)

---

**Box 2: ONS estimates of suicide among higher education students**

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

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

Male students had a significantly higher rate of suicide than female students.

The number of suicides in the analysis was lower than in previous ONS estimates. This is likely because it focused on higher education students only, while previous estimates also covered further education students.93

Step Change Framework

Universities UK’s, Stepchange Framework was introduced in 2017 and its states that universities should adopt mental health as a strategic priority and that institutions should implement a whole university approach with students and staff involved at all stages. The Framework gives guidance on leadership, data, staff, prevention, early intervention, support, transition and partnerships. The Stepchange framework was updated in May 2020, this refreshed approach is discussed in an article on the Wonkhe website, The new Stepchange is an opportunity to renew our efforts on mental health, 21 May 2020.

In a May 2018 report, Minding Our Future, Universities UK argued that student mental health needed to become a shared priority, with services redesigned to integrate university support with NHS care more effectively. The report stated that in some areas universities, NHS organisations and local authorities were starting to form local partnerships to develop mental health strategies to improve services for students. Universities UK would, the report said, work with health and education bodies to identify how they could best be supported by national policy.94

University Mental Health Charter

In December 2019 the University Mental Health Charter was published. The charter was developed by Student Minds in partnership with the UPP Foundation, the Office for Students (OfS), National Union of Students (NUS) and Universities UK.95 The Charter Award Scheme is a voluntary programme which will recognise and reward universities that promote good mental health, demonstrate good practice, make student and staff mental health a university-wide priority and deliver improved mental health and wellbeing outcomes. The Charter covers suicide risk and prevention.

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

93 ONS, Estimating suicide among higher education students, England and Wales: Experimental Statistics, 25 June 2018
94 Universities UK, Minding Our Future: Starting a conversation about the support of student mental health, May 2018
95 Student Minds launch University Mental Health Charter, Student Minds press release, 4 July 2018
Reports
Student mental health has been the focus of a number of reports in recent years, including:

- Higher Education Policy Institute, *Measuring well-being in higher education*, May 2019
- Insight Network, *University Student Mental Health Survey 2018*, March 2019
- Education Policy Institute, *Prevalence of mental health issues within the student-aged population*, 10 September 2018
- Universities UK, *Minding our future. Starting a conversation about the support of student mental health*, 11 May 2018
- IPPR, *Not by degrees: Improving student mental health in the UK’s universities*, September 2017

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

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

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

---

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

- Reviewing Personal and Social Education (PSE), the role of pastoral guidance in local authority schools, and services for counselling for children and young people; and
- Rolling out improved mental health training for those who support young people in educational settings.\(^98\)

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.\(^99\)

**Wales**

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

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

- School-based suicide prevention programmes are designed to either reduce risk, and/or increase protective factors by: increasing knowledge and understanding of suicide; changing attitudes towards suicide; and increasing awareness of risk factors and encouraging help seeking behaviour;
- School based prevention programmes are not in routine use in Wales. There is some evidence that they have a short term impact but it is not known if these changes persist in the longer term; and that
- There is evidence that training for individuals who frequently come in to contact with people at risk of suicide, including teachers, increases confidence in recognising those who may be at risk of suicide and referring them appropriately for help. Whether or not such training has an impact on suicidal behaviour has however not yet been established.\(^100\)

The strategy then outlines the provision of counselling in Welsh schools and highlights that the school nursing service is also “frequently seen as a source of advice and support for pupils and teachers.” It states that

---

\(^{98}\) Ibid., p4  
\(^{99}\) Ibid., p18  
this counselling provision might “contribute to suicide and self-harm prevention efforts, being suitably placed and accessible to children and young people in crisis.” The strategy adds that the importance of emotional support is also acknowledged by colleges of further and higher education.\(^{101}\)

**Northern Ireland**

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

- Suicide prevention training for teachers;
- Guidance on responding to critical incidents in schools, which provides a process for schools to follow when a suicide that is in any way linked to the school community has occurred; and
- 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 focused 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.\(^{102}\)

Regarding future developments, the strategy states that the Department of Education, the Department of Health, the Public Health Agency and the Education Authority have started work on developing “a joined-up framework across government for supporting the emotional health and wellbeing of children and young people.” It adds that this will include further consideration of child-focused interventions, building on what is already in place through the “iMatter” programme.\(^{103}\)

On further and higher education, the strategy cites evidence that students are “experiencing increasing levels of stress, anxiety, mental illness, and suicidal behaviour” and states that the need for more preventative action has been recognised. It adds that “there is a growing appreciation of the need for a whole university / college approach to mental health and wellbeing” and cites the development of the UK-wide University Mental Health Charter (see Section 1.2 above).\(^{104}\)

\(^{101}\) Ibid., p25


\(^{103}\) Ibid, p37

\(^{104}\) Ibid., p47
The strategy outlines the key objectives and associated actions underpinning the strategy. A number of actions explicitly refer to schools, and further and higher education institutions:

1.4 Develop a joined up framework across government to support the wellbeing of children and young people in educational settings and beyond. This will include the development and implementation of policies and guidance which promote emotional resilience in educational settings.

[...]

4.5 Encourage universities, colleges, schools and training organisations to promote a culture of help-seeking behaviour and suicide prevention awareness among their students and trainees.

[...]

9.9 Support for school staff to help them provide effective support to children & young people affected by suicide or suicidal behaviours at home.\(^{105}\)

A more detailed, timetabled implementation plan will be developed by the Public Health Agency working with a newly formed Protect Life 2 Strategy Steering Group.\(^{106}\)

\(^{105}\) Ibid., pp57-8 & 60-1

\(^{106}\) Ibid., p55
5. Employment

5.1 Suicide rates by occupation

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

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

5.2 Employment policy and mental illness

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

Thriving at work (the Stevenson/Farmer Review)

On 9 January 2017, the then Prime Minister, Theresa May, asked Lord Dennis Stevenson and Paul Farmer to “lead a review on how best to ensure employees with mental health problems are enabled to thrive in the workplace and perform at their best‖. The review report - *Thriving at Work: the Stevenson / Farmer review of mental health and employers* - was published on 26 October 2017. It contained a large number of recommendations for employers, the public sector and government centred on the idea of implementing “mental health core standards”, explained as follows:

The mental health core standards should provide a framework for workplace mental health and we have designed them in a way

---

109 Ibid., para. 1.41.
110 ‘Prime Minister unveils plans to transform mental health support’, Gov.uk, 6 January 2017
that they can be tailored to suit a variety of workplaces and be implemented by even the smallest employers. We believe all employers can and should:

- Produce, implement and communicate a mental health at work plan
- Develop mental health awareness among employees
- Encourage open conversations about mental health and the support available when employees are struggling
- Provide your employees with good working conditions
- Promote effective people management
- Routinely monitor employee mental health and wellbeing.\(^{111}\)

**Improving Lives: The Future of Work, Health and Disability**

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

> In the workplace setting we want employers who have the support and confidence to recruit and retain disabled people and people with long-term health conditions, and to create healthy workplaces where people can thrive and progress.\(^{112}\)

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

- Improving advice and support for employers of all sizes;
- Increasing transparency;
- Reforming Statutory Sick Pay; and
- Ensuring the right incentives and expectations are in place for employers.\(^{113}\)

The WHU is overseeing the implementation of the recommendations.

**Implementation of Improving Lives**

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


\(^{113}\) *Ibid.*, para. 28. See also Chapter 2 (pp. 24-34).
partnered with Business in the Community, a charity, to create a toolkit for employers on reducing the risk of suicide.114

In November 2018, the WHU published a voluntary framework for employers to report on steps they are taking to support disabled employees and ensure wellbeing in the workplace.115 This is part of the strategy for improving transparency. The stated rationale is that “transparency and reporting are effective levers in driving the culture change required to build a more inclusive society.”116 The reporting framework is designed for employers with over 250 workers, although it can be applied by employers of any size. No statistics are held on the number of employers that are carrying out transparency reporting although the Government has said that it will be publishing a report on the implementation of the framework in October 2019.117

In January 2019, Paul Farmer, CEO of Mind and co-author of Thriving at work, published a blog post on the Mental Health at Work website assessing the progress that has been made in implementing the recommendations in his report. The blog states that “things are moving in the right direction”. He also noted that progress was still needed on certain issues, including the reform of Statutory Sick Pay and the Government’s proposal to expand the scope of the Equality Act 2010 to cover more people with mental health problems.118

Health is everyone’s business

On 18 July 2019, the Government published Health is everyone’s business, a consultation on proposals to reduce ill health-related job loss.119 The proposals in the consultation form part of the implementation of Improving Lives in the workplace setting. The key proposals include:

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

115 DWP and DHSC, Voluntary Reporting on Disability, Mental Health and Wellbeing, November 2018.
116 Ibid., p. 3.
118 Paul Farmer, What progress has been made when it comes to Thriving at Work?, Mental Health at Work, 17 January 2019.
119 HMG, Health is everyone’s business: Proposals to reduce ill health-related job loss, CP 134, July 2019.
understand and are able to act on their responsibilities to their employees. 120

**Right to request workplace modifications**

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

Currently, under the *Equality Act 2010*, employers have a duty to make reasonable adjustments for employees who have a disability. 121 This duty only applies where the employee has a disability as defined by section 6 of the Act:

(1) A person (P) has a disability if—

(a) P has a physical or mental impairment, and

(b) the impairment has a substantial and long-term adverse effect on P’s ability to carry out normal day-to-day activities.

The consultation recognises that there are workers with health conditions who may not fall within this definition. The Government is seeking views on whether to introduce a right to request workplace modifications that would apply to a broader range of workers. 122 The paper sets out a number of potential eligibility tests, ranging from workers who have taken long-term sickness absences (four weeks or more) to a worker returning from a sickness absence of any length. It also suggests that unlike the existing duty to make reasonable adjustments, employers could refuse to make modifications in certain cases. The new right could be modelled on the right to request flexible working where employers can refuse requests on certain grounds listed in statute. 123

**Reform of statutory sick pay**

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

Currently, eligibility for SSP is limited to employees who earn above the Lower Earnings Limit (£120 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 £96.35 per week. Payment of SSP ends when an employee returns to work. 124

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

120 Ibid., para. 12.
122 HMG, *Health is everyone’s business: Proposals to reduce ill health-related job loss*, CP 134, July 2019, paras 48-64.
123 See *Employment Rights Act 1996*, section 80G.
• Allowing SSP to continue during phased returns to work (i.e. wages and SSP paid pro rata);
• Extending SSP to employees who earn under the Lower Earnings Limit;
• Removing the concept of qualifying days;
• Charging a new single labour market enforcement body with the enforcement of SSP;
• Increasing the penalty (currently £3,000) for the non-payment of SSP following a HMRC or Employment Tribunal decision on liability; and
• Adopting a targeted rebate of SSP for SMEs.\textsuperscript{125}

The consultation closed on 7 October 2019.

\textsuperscript{125} HMG, \textit{Health is everyone’s business: Proposals to reduce ill health-related job loss}, CP 134, July 2019, paras 78-123.
6. Social security

6.1 Benefit claimants and mental health

At August 2020, of the 1.89 million claimants of Employment and Support Allowance (an income replacement benefit for people with health conditions and disabilities), 940,000 (50%) were recorded as having a mental or behavioural disorder as their main disabling condition. As of January 2021, of the 2.64 million claimants of Personal Independence Payment (which helps claimants with the extra costs of disability and is replacing Disability Living Allowance for people of working age), around 969,000 (37%) had a mental or behavioural disorder as their main disabling condition.126

In both benefits, the proportion of claimants whose main disabling condition is a mental and behavioural disorder is highest among the youngest age groups. 67% of ESA claimants and 70% of PIP claimants in the under-35 age category have a mental or behavioural disorder as their main condition.127

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

Since 2012, the DWP has been undertaking internal reviews in cases where it is alleged the Department’s actions are linked to the death of a benefit recipient. The Government’s Suicide Prevention Strategy states that these “Internal Process Reviews” (IPRs; formerly known as “Peer Reviews”) are “a tool for staff to look at the handling of a specific case”:

The purpose is to scrutinise Department for Work and Pensions handling of particular cases to identify whether processes have been properly followed and if appropriate, identify recommendations for changes to the process. It is a mechanism aimed at ensuring we learn lessons and take appropriate action, rather than about apportioning blame.128

Following a ruling of the Information Tribunal in May 2016,129 the DWP published redacted copies of 49 IPRs.130 A further Freedom of Information (FoI) response in September 2018 – following a request submitted by Disability News Service (DNS) – gives information on reviews conducted since April 2016 and recommendations made.131

Further information on Internal Process Reviews is given in a National Audit Office (NAO) report on Information held by the Department for Work and Pensions.132

---

126 Source: DWP Stat-Xplore
127 Ibid.
128 HMG, Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives, January 2017, para. 94
130 See DWP, Peer reviews of handling of benefit claims, 12 May 2016
131 DWP FoI response VTR 2897, 17 September 2018
Work & Pensions on deaths by suicide of benefit claimants, published in February 2020. Following correspondence in late 2019 with the then Work and Pensions Committee Chair, Frank Field, the NAO was prompted to engage with the Department to establish what information it held on benefit claimants who ended their lives by suicide, how that information was produced, and how it was stored, accessed and used.

The NAO found, amongst other things, that:

- The DWP had investigated 69 deaths in the previous six years, although it was “highly unlikely” that this represented the number of cases it could have investigated.
- 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 “systematic issues which might have been brought to light through these reviews could be missed”.

The NAO report also touches on measures the DWP is taking to improve its processes. This includes the establishment of a new unit within the Department responsible for a number of activities including:

- Improving the ‘coroner’s focal point’ – making sure all coroners are aware of the Department’s coroner focal point and in which circumstances they should report a death to the Department, and revamping internal guidance so that DWP staff are 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 will focus on identifying cases, maximising learning, and prevention.

Further details of these and other initiatives are given in a letter of 20 March 2020 from the Secretary of State to Stephen Timms, the Chair of the Work and Pensions Committee. This includes information on the new DWP ‘Service Excellence Directorate’ and £36 million additional funding secured for 2020-21 for the Department’s ‘Excellence Plan’ to
“increase investment in safeguarding, decision making and how we learn from the most complex cases”.

Information on the DWP Serious Case Panel, including its terms of reference and the minutes of its first four meetings, is available on GOV.UK.

At an evidence session on 22 July 2020, the Work and Pensions Committee took evidence from the Secretary of State and from the DWP Permanent Secretary, Peter Schofield, on safeguarding vulnerable people and how the DWP learns lessons from serious cases. A letter from the Secretary of State dated 29 September 2020 responding to various follow-up questions from Stephen Timms gives more detailed information on developments regarding safeguarding, including extracts from updated guidance for DWP staff.

6.2 Training and guidance for DWP staff

In recent years there have been calls on the DWP to do more to ensure that it has in place necessary policies and protocols to identify vulnerable claimants, to strengthen safeguards and to apply them consistently.\(^{133}\) In response to a case in 2017\(^{134}\) where the DWP was found not to have followed its own procedures when it stopped a woman’s benefits after she missed a Work Capability Assessment, and she took her own life 15 days later, a petition was presented to Parliament calling for, amongst 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.”\(^{135}\) The petition, which closed on 15 September 2019, received 55,784 signatures. In its response, the Government said that it “apologised unreservedly” for the failings in this particular case, but had no plans to hold an inquiry into deaths relating to actions taken by the DWP.

In her 2018-19 annual report on DWP complaints, the Independent Case Examiner, Joanna Wallace, voiced concern about the number of instances where the DWP had not followed safeguarding procedures aimed at protecting vulnerable claimants. While acknowledging that many of the Department’s policies and procedures recognised the need for safeguarding, Ms Wallace added:

> ...too often this year I have seen cases where those steps have not been followed. I don’t wait until my annual report to raise concerns and have been doing so during the year, particularly with regard to DWP’s services to working age people. Very recent discussions reassure me that real action is being taken to make sure these vulnerability safeguards do work effectively – and also that my concerns about meeting vulnerable customers’ needs are

\(^{133}\) See Owen Stevens, UC and complex needs, CPAG Welfare Rights Bulletin 271, August 2019

\(^{134}\) See Benefits officials’ apology after mum’s suicide, BBC News, 10 June 2019

\(^{135}\) See Justice for Jodey Whiting: Independent inquiry into deaths linked to the DWP
shared at the highest levels in DWP. It is an important matter and I will continue to pay close attention to it in the coming year.136

Details of the steps taken by the Department for Work and Pensions to “improve how we respond to those with complex lives” can be found in the letter of 20 March from the Secretary of State to the Chair of the Work and Pensions Committee, from the Committee’s evidence session of 22 July 2020, and the follow-up letter to the Committee in September 2020, referred to above. Actions include:

- 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 September 2020, around 30,000 Work Coaches had received this training, and before rollout was paused due to the Covid-19 pandemic, 18,000 DWP staff in other customer facing roles had also completed mental health training.

- Recruiting 37 ‘Safeguarding Leaders’ across the country to “work across all services and with key partners, to support and deliver a constituent service to vulnerable customers” – see Annex C to the Secretary of State’s letter of 29 September 2020 to the Committee for a full job description. By September 2020, 25 Safeguarding Leaders had been appointed.

- 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 a ‘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, and forms part of the wider ‘Keeping Safe’ training that 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 the Universal Credit guidance chapter Suicide and self-harm.137

The DWP also has ‘safeguarding’ procedures to be followed in situations where a claimant deemed to be vulnerable fails to comply with a requirement and, as a result, their benefit payments are at risk. This could include, for example, where a claimant fails to attend a mandatory interview, fails to return a questionnaire or attend an

---

136 DWP complaints: Annual report by the Independent Case Examiner 2018 to 2019, 12 September 2019, p4
137 Version 3.0, current October 2020
assessment, or fails to undertake a mandatory activity. Home visits are a key element of the safeguards (the DWP refers to these as ‘Core Visits’) – where staff make attempts to contact the person before a decision is made to impose a sanction or terminate a claim. The DWP’s revised guidance on Core Visits is in Annex A to the Secretary of State’s letter of 29 September 2020. In her letter, the 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.

In addition to the Core Visits guidance, the Universal Credit guidance includes a chapter on Safeguarding.138

Currently, DWP staff use ‘pinned notes’ – in essence, electronic ‘post-it’ notes – to record claimants’ vulnerabilities or support needs on the UC system. Concerns have been voiced about the pinned notes system, including by the NAO, which in July 2020 said that the DWP needed to improve its understanding of vulnerable claimants and how best to support them to ensure that no one slips through the net.139

Giving evidence to a joint session of the Commons Work and Pensions Committee and Lords Economic Affairs Committee on 9 March 2021, the Minister for Welfare Delivery, Will Quince, conceded that the lack of a ‘marker’ to track vulnerable claimants through the UC system was “a deficit”. However, the Minister said that work was progressing “at pace” in the DWP to develop a ‘claimant profiles’ system to track vulnerable and disadvantaged people through the UC system, which he hoped would go live in the first half of 2021.140

6.3 ESA and PIP assessments

The DWP uses third-party contractors to provide health and disability assessments to inform decisions about benefits. The Centre for Health and Disability Assessments (CDHA), a wholly-owned subsidiary of Maximus, has since 1 March 2015 held the main medical services contract under which assessments are carried out for various benefits including Employment and Support Allowance (ESA) and Universal Credit. Personal Independence Payment assessments are carried out under separate contracts. Atos Healthcare (operating as Independent Assessment Services) holds the contracts for undertaking PIP assessments in Northern England and Scotland, and London and Southern England. Capita Business Services Ltd holds the contracts covering Wales and Central England, and Northern Ireland.

138 Version 2.0, current October 2020
139 NAO, Universal Credit: getting to first payment, HC 376 2019-21, 10 July 2020
140 HL Economic Affairs Committee and HC Work and Pensions Committee evidence session, Q21
In March 2019, the then Secretary of State for Work and Pensions, Amber Rudd, announced that her Department had launched a ‘Health Transformation Programme’ to develop a new, integrated service, supported by a single digital system, for both PIP and Work Capability Assessments, from 2021. The Government hopes this will provide a more “joined up” experience for claimants.

The coronavirus pandemic has interrupted the DWP’s plans to create a single assessment service, but has also imposed “forced changes” to assessment processes from which the Department is planning to learn. Proposals for reforming assessments are expected to be set out in the forthcoming Green Paper on Health and Disability Support.

Issues relating to the existing assessment arrangements are covered below, followed by an outline of more recent developments.

The Work Capability Assessment and “substantial risk”

There are provisions in legislation under which people not scoring sufficient points in the Work Capability Assessment (WCA) – who would otherwise be found “fit for work” – can nevertheless be treated as having a limited capability for work, or for work-related activity, as appropriate, if “exceptional circumstances” apply. This includes where the person suffers from some specific bodily or mental disablement which means there would be a substantial risk to their health, or the health of another person, if they were found not to have limited capability for work or limited capability for work-related activity.

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

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

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

Assessment procedures

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

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

---

141 Centre for Health and Disability Assessments, WCA Handbook, updated 8 October 2020

142 Ibid. para. 3.8.2.1
carefully. Assessors approach this issue with sensitivity and ask questions in a structured way that is appropriate to the individual, based on their knowledge of the claimant’s clinical history and their judgement on the claimant’s current mental state.

If the assessor has concerns that a claimant is at substantial and imminent risk with regard to self-harm or suicide, they have a professional responsibility to act quickly in order to safeguard the claimant’s welfare; this might include speaking to the claimant’s GP, and/or calling an ambulance.

Companions are encouraged to accompany the claimant to a face to face consultation and can play an active role. This is helpful for claimants with mental, cognitive or intellectual impairments, who cannot provide an accurate account of their condition due to a lack of understanding, or unrealistic expectations of their ability. 143

Evidence presented to the Work and Pensions Committee in 2017, however, suggested that assessments had not been working well for some people with mental health conditions.

Work and Pensions Committee inquiry

In September 2017 the Work and Pensions Committee launched an inquiry examining the effectiveness of assessment processes used to determine eligibility for PIP and ESA. 144 In November 2017 The Guardian reported that the Committee had been “deluged by people sharing stories about being denied disability benefits or battles to keep their entitlements.” 145 An online forum launched to allow people to share their experiences received nearly 4,000 individual submissions, the most ever received by a select committee inquiry. Common themes emerging from the complaints from claimants included:

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

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

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

143 PQ 193 [on Social Security Benefits: Mental Illness], 27 June 2017  
144 See PIP and ESA Assessments inquiry, Work and Pensions Committee website  
• Claimants regularly report that their concerns are not taken seriously by assessors and that their statements are routinely ignored.

• Assessors often do not have the necessary knowledge or expertise to assess the impact of mental health problems.

• The nature of face-to-face assessments leading claimants to break down due to the distress it causes them, only for the written report to state that the claimant coped well.

• People finding the whole claims, assessment and appeals process confusing and threatening, with detrimental effects in their mental health.

• Instances where the assessment process has led to people being hospitalised, have their medication increased, or attempt to take their own lives.

• Dissatisfaction with the “Mandatory Reconsideration” process for challenging decisions, which many claimants viewed as a tool to dissuade people going to appeal.

• Claimants or those supporting them not taking their claim to appeal because of the distress the process had caused them up to that point, and/or being overwhelmed at the thought of going through the appeals process.

• Although some people expressed dissatisfaction with the appeals process, the most common view was that the appeals stage was the first time when the full range of information presented as part of the assessment process had been properly considered.

• Appeals Tribunals expressing surprise at the high levels of disabilities among people with mental health conditions who had been initially assessed as not eligible for PIP.146

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

In December 2017, Rethink Mental Illness published a report, ‘It’s broken her’: Assessments for disability benefits and mental health. Drawing on findings from a series of interviews and a focus group-style discussion with people with personal experience of the Work Capability Assessment and of mental illness which took place in January 2017, and an online survey conducted in April 2017 which had over 650 respondents, the report found that assessments can be “traumatising and anxiety-inducing” for the following reasons:147

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

147 Rethink Mental Illness, ‘It’s broken her’: Assessments for disability benefits and mental health, December 2017, p7
“Numerous issues” with the paper forms that claimants must submit, including their complexity, length and the inflexible nature of the questions they ask.

The requirement for claimants to collect their own medical evidence is “extremely burdensome, often expensive, and time-consuming”.

Staff who perform face-to-face assessments frequently have a poor understanding of mental illnesses.

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

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

- Major reform of the PIP and ESA assessments to reduce the distress caused to people affected by mental illness and better reflect the realities of living with mental health conditions.
- Exempt claimants from face-to-face assessments where clear medical evidence exists that they have severe forms of mental illness, and where assessments are necessary claimants should be encouraged to seek support from carers, friends or family members.
- All assessors and DWP decision-makers should be appropriately trained in mental health.148

The Work and Pensions Committee’s report – together with a separate report detailing claimant experiences of PIP and ESA assessments – was published in February 2018.149 The Committee found that failings in the end-to-end processes had contributed to a lack of trust in both benefits and undermined confidence among claimants. It made a series of recommendations covering, amongst other things, the recording of assessments, the supply and use of evidence, the clarity of communications, and guidance in relation to home assessments and the role of companions at assessments. The Committee did not make any specific recommendations regarding the assessment of people with mental health conditions, but in light of evidence received from claimants and from organisations it said that the DWP should demonstrate that it was “alert to the risk to mental health posed by parts of the application processes and seek to offset this.” Accordingly, it recommended that:

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

148 Ibid. p18  
application forms, identifying how they can be made more claimant-friendly and less distressing for claimants to fill in.\textsuperscript{150}

In its \textit{response published on 18 April 2018}, the Government said that it would commission research from external contractors to cover whether any aspects of ESA and PIP claim forms had the potential to cause distress, to identify what changes should be made, and to test the revised forms with applicants. This work would commence in summer 2018 and a report would be published in 2019.\textsuperscript{151}

All assessors carrying out Work Capability Assessments were given face-to-face training on “exploring self-harm and suicidal ideation” in May 2018. The training, which was quality assured by the Royal College of Psychiatrists, was designed to enhance assessors’ skills in sensitively exploring these subjects when undertaking assessments.\textsuperscript{152}

\textbf{Reassessing ESA and PIP claimants}

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

In September 2017 the DWP announced criteria for “switching off” reassessments for ESA claimants in the Support Group\textsuperscript{153} 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.\textsuperscript{154}

In June 2018 the Government announced that people awarded the highest level of support under PIP whose “needs are expected to stay the same or increase” would be given “ongoing” PIP awards and would only have to face a “light touch” review every 10 years.\textsuperscript{155} DWP said it would work with stakeholders to design the light touch review process. Further information is given in Commons Library briefing CBP-7820, \textit{ESA and PIP reassessments}, 10 May 2019.

\begin{footnotesize}
\begin{enumerate}
\item \textsuperscript{150} Word and Pensions Committee, \textit{PIP and ESA assessments}, HC 829 2017-19, 14 February 2018, para 21
\item \textsuperscript{151} DWP, \textit{PIP and ESA assessments: Government Response to the Committee’s Seventh Report of 2017–19}, HC 986 2017-18
\item \textsuperscript{152} HMG, \textit{Preventing suicide in England: fourth progress report of the cross-government outcomes strategy to save lives}, January 2019, paras 2.49
\item \textsuperscript{153} ESA claimants are placed in the Support Group if, following a Work Capability Assessment, they are found to have a limited capability for work and for work-related activity
\item \textsuperscript{154} Centre for Health and Disability Assessments, \textit{WCA Handbook}, updated 8 October 2020, Appendix 8
\item \textsuperscript{155} Government to end unnecessary PIP reviews for people with most severe health conditions’, DWP press release, 18 June 2018
\end{enumerate}
\end{footnotesize}
In a report published in October 2020,\textsuperscript{156} Mind said that people in very vulnerable circumstances are forced to recount traumatic experiences at every stage of the assessment process, and that frequent use of face-to-face assessments can make people more unwell. While noting that some people could now have reassessments switched off, it argued that 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.

Reforming assessments

The DWP’s ‘Health Transformation Programme’ is aiming to develop a new, integrated service, supported by a single digital system, for Personal Independence Payment and Work Capability Assessments.\textsuperscript{157} On 2 March 2020 the Minister for Disabled People, Justin Tomlinson, provided an update on progress in creating a single assessment service. The Department would initially develop the new service on a small scale “in a defined part of the country, a Transformation Area”:

For claimants in this Transformation Area, assessments will be conducted by the DWP, rather than outsourced to providers. This will give us the flexibility to explore new ideas including:

- trialling better ways of carrying out face-to-face assessments;
- how to triage more effectively so that only those people who need a face-to-face assessment will have to undergo one;
- how to make it easier for claimants to understand the evidence they need to provide and why;
- how to remove the need for claimants to give the same information twice;
- how to ensure that claimants are aware of the whole range of support available to them both from DWP and more widely.

Our ambition in developing the new service is that it captures the experience and insights of those who use the service or who represent users of the service. We have already acted on this and will continue to drive forward engagement on the future of the health and disability agenda through our upcoming Green Paper.\textsuperscript{158}

The DWP began testing a ‘single digital platform’ in a small number of assessment centres, but work was paused following the coronavirus outbreak. On 24 February 2021, however, Mr Tomlinson announced that IT development would resume as part of the work of the new ‘Departmental Transformation Area (DTA)’:

The DTA will provide a safe environment to test, adapt and learn from new ideas and processes before rolling out at a greater

\textsuperscript{156}  Mind, \textit{People, Not Tick Boxes: Our call to reform the disability benefits system}, 7 October 2020
\textsuperscript{157}  HCWS1376
\textsuperscript{158}  HCWS138
scale, and ultimately nationally. The first site in the DTA will be in London and is scheduled to start from April 2021. This approach recognises that our claimants include some of the most vulnerable in society and it is critical that we carefully develop the new integrated health assessment service.\footnote{PQ 155229, 24 February 2021}

Coronavirus

The pandemic has prompted significant changes to assessments for health and disability benefits.\footnote{For more detailed information on the changes see section 2.2 of Commons Library briefing CBP-8973, Coronavirus: Withdrawing crisis social security measures, 17 March 2021} Face-to-face assessments were suspended from March 2020. Paper-based assessments have been conducted instead, where possible. The DWP also introduced telephone assessments, and has on as smaller scale been trialling video assessments.

On 23 March 2020 the DWP also announced the suspension of reviews and reassessments for health and disability benefits. Where benefit awards were due to expire, the DWP would extend end dates so that people continued to receive their existing level of financial support.\footnote{Coronavirus update - benefit reviews and reassessments suspended, DWP press release, 23 March 2020} From July 2020, some review and reassessment activity gradually resumed for Personal Independence Payment and Disability Living Allowance, but face-to-face assessments continued to be suspended.\footnote{Face-to-face assessment suspension continues for health and disability benefits, DWP press release, 6 July 2020}

The Department has now announced that face-to-face assessments for PIP and Work Capability Assessments for Universal Credit and ESA will resume from May 2021, although initially this will only be for those it is “unable to fully assess by other channels”. Face-to-face assessments will take place alongside existing paper-based and telephone assessments, “which will continue to take place where suitable”.\footnote{Face-to-face assessments to resume for health and disability benefits, DWP press release, 29 March 2021} Regulations in force from 25 March 2021 make it clear that telephone and video channels can be used as additional methods for conducting assessments to establish entitlement to PIP, ESA, Universal Credit and Industrial Injuries Disablement Benefit.\footnote{The Social Security (Claims and Payments, Employment and Support Allowance, Personal Independence Payment and Universal Credit) (Telephone and Video Assessment) (Amendment) Regulations 2021; SI 2021/230}

The DWP is looking to learn lessons from “forced changes” to assessment processes, and it is expected that the forthcoming Health and Disability Support Green Paper will seek views on, amongst other things, whether telephone and video assessments should continue after the pandemic, and if so, in what form and to what level.\footnote{Scottish Affairs Committee evidence session on welfare policy in Scotland, HC 889 2019-21, 18 March 2021, Q178}

In November 2020, the Social Security Advisory Committee (SSAC) recommended that, in order to get a better understanding of the

159  PQ 155229, 24 February 2021
160  For more detailed information on the changes see section 2.2 of Commons Library briefing CBP-8973, Coronavirus: Withdrawing crisis social security measures, 17 March 2021
161  Coronavirus update - benefit reviews and reassessments suspended, DWP press release, 23 March 2020
162  Face-to-face assessment suspension continues for health and disability benefits, DWP press release, 6 July 2020
163  Face-to-face assessments to resume for health and disability benefits, DWP press release, 29 March 2021
164  The Social Security (Claims and Payments, Employment and Support Allowance, Personal Independence Payment and Universal Credit) (Telephone and Video Assessment) (Amendment) Regulations 2021; SI 2021/230
165  Scottish Affairs Committee evidence session on welfare policy in Scotland, HC 889 2019-21, 18 March 2021, Q178
impact of suspending face-to-face assessments, the DWP and the Department for Communities in Northern Ireland should produce, and publish, “an evaluation of decision making in ESA, UC and PIP to include a comparative analysis of case outcomes for telephone, paper-based and face to face assessments.”166 In a letter to the SSAC Chair on 3 March, the Minister for Disabled People, Justin Tomlinson, promised that officials would share with the Committee the DWP’s plans to evaluate a “multi-channel” approach to assessments, and consult the Committee on draft guidance “once the policy and delivery of a multi-channel assessment strategy has been agreed”.

In a report published in October 2020 drawing on findings from in-depth interviews with people with mental health problems who had experienced remote benefits assessments during the coronavirus pandemic, the mental health charity Mind said that while some people reported that not having to attend face-to-face assessments had significantly reduced the pressure they faced, others had struggled to take part over the phone and risked being “locked out” of their benefits as a result. Mind recommends that people should be given more choices over the method of assessment so that everyone applying for benefits has “the opportunity to put their case across and get a fair hearing”.167

6.4 Conditionality and sanctions

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

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

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

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

When considering whether a sanction is appropriate, a Decision Maker will take all the claimant’s individual circumstances, including any health conditions or disabilities and any evidence of good reason, into account before deciding whether a sanction is warranted.168

---

166 SSAC, A review of the COVID-19 temporary measures, 18 November 2020
167 Mind, People, Not Tick Boxes: Our call to reform the disability benefits system, 7 October 2020
168 PQ 166197 [on Social Security Benefits: Disqualification], 24 July 2018
A major five-year research programme concluded, however, that welfare conditionality was “largely ineffective in facilitating people’s entry into or progression within the paid labour market over time.” Instead, it found that for a significant number of respondents, conditionality “triggered a sustained range of negative behaviour changes and outcomes” which included, amongst other things, disengagement, increased poverty or destitution, and exacerbated mental health conditions.\(^{169}\)

In a report published in October 2020, Mind said that established evidence showed that the threat of sanctions “does not help disabled people move closer to work”. People with mental health problems had told it that the pressure of attending Jobcentre appointments could become “unmanageable, damaging their health and moving them further away from work”. Mind also argues that 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 that the Government should end the use of sanctions for disabled people and for anyone waiting to go through benefit assessments.\(^{170}\)

**Work and Pensions Committee inquiry**

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

In its subsequent report published on 6 November 2018, the Committee noted that witnesses had stressed the “disproportionate impact of both the threat, and application of sanctions on disabled claimants’ well-being.”\(^{171}\)

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 amount of anxiety” experienced by people with mental health problems “as they attempt to navigate the system in good faith”.\(^{172}\)

The Committee concluded that the Government had presented no evidence that conditionality and sanctions were improving employment outcomes for disabled people and those with health conditions. It

\(^{170}\) Mind, *People, Not Tick Boxes: Our call to reform the disability benefits system*, 7 October 2020
\(^{172}\) Ibid.
recommended that the Government immediately stop imposing conditionality and sanctions on anyone found to have limited capability for work, or who presents a valid doctor’s note stating they cannot work. Instead, it should work with experts to develop a programme of voluntary employment support for those who can get into work.  

In its response published in February 2019, the DWP said that it would explore the possibility of a general policy not to apply conditionality to people waiting for a Work Capability Assessment, although the decision would be left to individual Work Coaches. It did not accept the recommendation to exempt claimants found fit for work who continue to present a fit note, however, as this would “undermine the WCA process and create a loophole whereby claimants could avoid conditionality indefinitely despite being ‘fit for work’.” 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.

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

As part of its response to the coronavirus outbreak, the DWP suspended work-related conditionality for benefit claimants, but from August 2020 began to reintroduce ‘claimant commitments’ on a phased basis. The Department has emphasised that claimant commitments are tailored to reflect claimants’ individual circumstances and that Work Coaches will ensure that any requirements imposed are ‘reasonable’. Ministers and officials also highlight that sanction rates have been low since the reintroduction of conditionality. For further details see section 2.1 of Library briefing CBP-8973, Coronavirus: Withdrawing crisis social security measures.

6.5 Scotland

Until relatively recently, social security was almost entirely a reserved matter in Great Britain, but the Scotland Act 2016 devolved significant welfare powers to the Scottish Parliament. Amongst other things, the Act transferred responsibility for disability benefits, including Disability Living Allowance and Personal Independence Payment. In addition, the

---

173 Ibid. para. 63
175 Ibid. paras 38, 40
176 Labour Market Policy Update: Written statement HCWS1545, 9 May 2019
Scottish Parliament now has the power to top-up reserved benefits, create new benefits in areas not otherwise connected with reserved matters, vary the payment arrangements for Universal Credit, and establish its own employment programmes. The Scottish Government has set up its own social security agency – Social Security Scotland – to deliver devolved benefits, based on the “core values of dignity, fairness and respect.”

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

- A redesigned application process involving significantly fewer face to face assessments, which will be carried out by qualified assessors employed by Social Security Scotland rather than private sector contractors, and audio-recorded as standard.

- Moving the burden of collecting information from the client to Social Security Scotland. Case Managers will assume responsibility for gathering information from various sources suggested by the individual - such as family members, nurse specialists, charity support worker.

- Only in circumstances in which there is no other practicable way to make a decision about entitlement to assistance will an individual be required to attend an assessment.

- 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.  

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

The Scottish Government’s suicide prevention action plan, Every life matters, published in August 2018, recognises that for many people, their interaction with the social security system may come at a time of great difficulty, such as losing their job or becoming disabled, and that such life events can be triggers for suicidal thoughts. Accordingly, it committed to providing training for social security staff to enable them “to recognise signs of distress, and to signpost people to appropriate support.” It adds:

Within our social security agency we will equip our people to confidently handle and talk about mental health generally, including suicide awareness and prevention. Working with

---

177 See Commons Library briefing CBP-9048, Social security powers in the UK, 9 November 2020

178 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
partners, we will develop and utilise a range of learning opportunities that fully equip social security agency staff to have a wider awareness of the challenges and circumstances the person may be facing; to possess a knowledge of the systems and support functions that are available; and importantly, to be skilled in having sensitive conversations including suicide awareness.\textsuperscript{179}

\textsuperscript{179} Scottish Government, \textit{Suicide Prevention Action Plan: Every Life Matters}, August 2018, p4
7. Transport

7.1 Railways

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

Public fatalities on the railways

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

British Transport Police

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

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

---

181 Ibid
182 BTP, From Criss to Care – A strategy for supporting people in mental health crisis and preventing suicide on the railway, 2016-2019, August 2016
detained under Section 136 of the *Mental Health Act 1983* or *Section 297 of the Mental Health (Care and Treatment) (Scotland) Act 2003*.\(^{183}\)

One of the notable ways the BTP works in this area is by employing Suicide Prevention and Mental Health teams that bring together police officers and staff and psychiatric medical professionals. They signpost people to support and put in place suicide prevention plans for those who are vulnerable. They also provide support to families of those who have tried to harm themselves. For example, as explained by the BTP:\(^{184}\)

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

Each year these teams will case manage over 2000 people who have presented on the railway in suicidal circumstances. This process has proved very successful with a very low return fatality rate of only 0.6%\(^{185}\).

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

1. prevent suicide occurring on Great Britain’s railways;
2. support vulnerable people and those in mental health crisis on the railway; and
3. effectively manage the impacts of suicide on the railway.

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

- capture relevant data and analyse it to understand the vulnerability of people, places and times;
- work with local authorities to contribute to and support local Suicide Prevention Plans.
- provide post-event site visits to advise on preventative location-based options;
- work with the rail industry to identify national priority locations for suicide prevention engineering and community outreach activity;
- provide effective intervention and case management through use of statutory powers, the Suicide Prevention Plan process and joint BTP and Health Suicide Prevention and Mental Health teams;

---

\(^{183}\) BTP, *From Criss to Care – A strategy for supporting people in mental health crisis and preventing suicide on the railway, 2016-2019*, August 2016

\(^{184}\) BTP, *Preventing suicide on the railway* [accessed 9 September 2019]

\(^{185}\) National Suicide Prevention Alliance, *British Transport Police* [accessed 9 September 2019]
provide a professional response to suicidal incidents, which aims to protect life and minimise disruption; and

provide effective training for BTP officers and staff through a suite of internal and external products.  

**Partnership working**

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

According to the BTP:

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

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

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

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

BTP launched the **Small Talk Saves Lives** campaign in November 2017 with Samaritans and Network Rail and train operating companies. The first campaign of its type on the railway, aims to give commuters the confidence to trust their own instincts and intervene if they see someone vulnerable who may be at risk of suicide on or around the rail

---


188 Ibid., p25

189 Samaritans, *Supporting local railway stations* [accessed 9 September 2019]
network, and to talk to them to interrupt their suicidal thoughts. The second phase of the campaign launched in April 2018, with phase three launching in November 2018.

Department for Transport

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

It further noted the DfT’s work on suicide prevention on the railways, including its collaborations with the National Suicide Prevention Alliance (NSPA) and the Department of Health:

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

The Fourth Progress Report of the Strategy, published in 2019 noted that the DfT had established a suicide prevention awareness group in 2018, which:

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

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

7.2 Roads

Samaritans has extended its involvement with the transport sector by working with the Parliamentary Advisory Council for Transport Safety (PACTS) to produce a report into road suicide, which was launched in a special PACTS conference in October 2017. This report shows that

---

190  Network Rail, Suicide prevention campaigns [accesses 9 September 2019]
192  Ibid., pp27-8
193  Ibid., pp27-8
194  Ibid.
roads, vehicles and road infrastructure are being used by individuals seeking to end their lives. The report revealed that there are likely to be around 50 deaths each year by suicide on UK roads. It provides evidence that this is likely an underestimate of the true number:

Highways England has estimated that there were between 15 and 41 suicides per year on England’s road network in the period 2001 to 2014. It is not possible to give a precise figure but, based on various sources, PACTS estimates that an average of over 50 deaths by suicide per year occur on the roads in the UK. The number of suicide attempts is also not known with any precision. However, depending on definition, it is vastly in excess of the number of deaths.195

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

- clarification of ministerial responsibilities and identification of road-related suicide in official guidance;
- changes to the standard of proof required for a suicide conclusion by coroners (as previously recommended by the House of Commons Health Select Committee), and improved reporting by coroners;
- standardised incident recording by the police and others in cases where suicide or attempted suicide is suspected;
- closer working on this issue by public health, highways, emergency services and voluntary sectors; and
- a review of how suicides are recorded and retained in road casualty reports (STATS19).196

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

- embedding the Suicide Prevention Strategy within Highways England, its supply chain and service providers;
- ensure effective internal working within Highways England through the development of an enhanced capability and the establishment of a Suicide Prevention Working Group;
- improve the collation, analysis and sharing of data to ensure they deliver more effective and inclusive suicide prevention plans;

195  PACTS, Suicides on UK Roads – Lifting the Lid, October 2017
196  ‘PACTS launches new report: ‘Suicide on UK roads – Lifting the Lid’’, PACTS press notice, 18 October 2017
• 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.  

8. Prisons

8.1 Statistics

Suicides

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

In 2019:

- There were 85 apparent suicides in prisons in England and Wales.
- This was roughly equivalent to 1 suicide per 1,000 prisoners.\(^{198}\)
- This number was slightly above the average of 81 per year since 2010.

As shown in the chart, the number of suicides generally declined between 2000 and 2010 before rising to a peak of 124 in 2016 and then falling again.

In the 12 months to September 2020, there were 70 apparent suicides, although this is unlikely to be the final figure since some deaths were still awaiting classification at the time of writing.

The Office for National Statistics (ONS) undertook detailed more research into suicide in prison custody in England and Wales: 2008 to 2016 in 2019 which found that:

Male prisoners were at an increased risk of dying by suicide compared with the general male population; the risk of male prisoners dying by suicide was 3.7 times higher than the general male population during the nine-year period.\(^{199}\)

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

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

\(^{198}\) Based on an annual daily prison population of 82,935. Please note that this does not represent the total number of individuals who spend time in custody throughout the year.

Self-harm

Self-harm in custody statistics are only available for England and Wales. The latest at the time of writing show that in the year ending June 2020:

- There were 61,153 incidents of self-harm in prisons in England and Wales, which was equivalent to around 741 per 1,000 prisoners. This was the highest number of self-harm incidents on record.
- These incidents related to 12,736 individuals, each with an average of 4.8 self-harm incidents throughout the year. Both the number of individuals committing acts of self-harm and the number of incidents per person have increased in recent years.

Self-harm is much more prevalent among female prisoners. There were 3,273 incidents of self-harm per 1,000 female prisoners compared with 624 per 1,000 male prisoners.

As the chart shows, the rate among female prisoners has been rising to a historic high since 2012, although it was high for a sustained period prior to 2011.

The impact of Covid-19 restrictions

Given that some deaths in prison during 2020 are still awaiting classification, it is not possible to say how many suicides there were during the period in which prisons were implementing restrictions to limit the spread of Covid-19. The number of suicides confirmed so far between April and September 2020 is below the average for that time of year (based on the past 20 years) although we cannot read anything into this for the reason just given.

Self-harm data is currently only available up to the end of June 2020. In Q2 2020, there were 132 self-harm incidents per 1,000 male prisoners, which was the lowest rate recorded in a quarter since Q1 2018. However, the rate had already fallen on the previous quarter in Q1 2020 and the numbers alone cannot tell us anything about the impact of the Covid-19 restrictions.

By comparison, the rate among female prisoners rose in Q2 2020, to 856 incidents per 1,000 prisoners and the second highest rate recorded in a quarter, after Q4 2019. The rate has been rising in general since 2012.
8.2 Prison service 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.\(^{200}\) It states that staff must identify prisoners at risk of self-harm and/or suicide. Prisoners at risk of harm to self must be managed using the Assessment, Care in Custody and Teamwork (ACCT) procedures set out in the PSI.

NICE has published a guideline – *Preventing suicide in community and custodial settings* – aimed at, amongst others, those working in prisons.\(^{201}\)

8.3 Recent comment

**HM Inspectorate of Prisons**

In his *Annual Report 2019-20* then Chief Inspector of Prisons, Peter Clarke, noted that suicide and self-harm in prisons continued to rise. The inspectorate made recommendations about suicide and self-harm prevention measures at just over half the prisons it reported on in the year. In over two-thirds of prisons the inspectorate found managers had not done enough to understand the causes of self-harm, so had not developed an adequate strategy to reduce the number of incidents. The inspectorate concluded that care for prisoners in crisis, delivered through ACCT case management, was not good enough at just over half the prisons. The inspectorate had concerns about the delivery of constant supervision to prisoners in acute crisis at nearly a third of prisons.\(^{202}\)

In an Annex to the Annual Report 2019-20 focused on the impact of COVID-19 and covering the period to the end of June 2020, the inspectorate commented on support for those at risk of self-harm and suicide in adult men’s prisons:

> Recorded levels of self-harm in many men’s prisons we visited had remained the same or slightly reduced under the new restrictions. Prisoners who were vulnerable because of their mental health continued to be well supported at many prisons. The number of self-inflicted deaths remained similar to previous years.\(^{203}\)

In prisons holding women the inspectorate found the incidence of self-harm remained consistently high:

> Despite enhanced welfare checks and access to Listeners and peer support, the sudden withdrawal of significant structured support had had an impact on the most vulnerable prisoners.\(^{204}\)

---


\(^{201}\) NICE, *Preventing suicide in community and custodial settings*, NG105, 10 September 2018


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

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

**Independent Monitoring Boards**

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

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

**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 2018/19 stated that in its investigations it repeatedly identified failings in the way ACCT, the process of supporting and managing prisoners at risk of suicide and self-harm, is managed in prisons.

The PPO’s Annual Report 2019/20 acknowledged that HMPPS had revised parts of the ACCT process and associated guidance. The PPO expressed hope that this would “deliver the necessary improvements to the way prisoners are supported”. However, the PPO was disappointed that the roll out of the new ACCT has taken so long and had been paused, along with the rest of the safety programme, due to the COVID-19 pandemic.

The PPO said it was troubling that many of its investigations into self-inflicted deaths during the year found that the same failings keep occurring and it was repeating recommendations that it had made before.
8.4 Government position

The Ministry of Justice in answer to a PQ in September 2020 set out steps it was taking to address self-harm and suicide in prisons:

- We have given over 25,000 prison staff better training to spot and prevent self-harm;
- We have refreshed our partnership with the Samaritans which supports the Listeners scheme, whereby selected prisoners are trained to provide emotional support to their fellow prisoners;
- We have also piloted improvements to Assessment, Care in Custody and Teamwork (ACCT), the multidisciplinary case management approach to supporting prisoners thought to be at risk of self-harm or suicide. We are currently planning the resumption of roll-out of the revised ACCT across the prison estate.210

8.5 Devolved nations

Scotland

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

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

Northern Ireland

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

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

---

210 PQ 906360 [on Prisons: Self-harm], 20 September 2020
9. Media

Suicidal behaviour can be prompted by the way suicide is reported in the media.211 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.212

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

- promoting the responsible reporting and portrayal of suicide and suicidal behaviour in the media; and
- continuing to support the internet industry to remove content that encourages suicide and provide ready access to suicide prevention services.213

The Samaritans have published Media Guidelines for Reporting Suicide.

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

9.1 Press

There are two press regulators. Many titles have signed up to the Independent Press Standards Organisation (IPSO). The IPSO Editors’ Code of Practice includes this on reporting suicide:

When reporting suicide, to prevent simulative acts care should be taken to avoid excessive detail of the method used, while taking into account the media's right to report legal proceedings.214

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

According to an April 2017 IPSO blog, since September 2014, IPSO has upheld one complaint and resolved three between publication and complainant on the reporting of suicide.215

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

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

---

212 Recommendations for reporting on suicide, Reporting on Suicide website [accessed 2 December 2020]
213 HMG, Preventing suicide in England: a cross-government outcomes strategy to save lives, September 2012, p43
214 IPSO, Editors’ Code of Practice, July 2019, clause 5
215 Niall Duffy, How the UK press takes reporting of suicide seriously, IPSO Blog, 27 April 2017
9.2 Broadcasting

Ofcom’s Broadcasting Code (January 2019) sets the rules for programmes broadcast on television and radio in the UK. Section 2 of the Code covers “harm and offence”. It includes this on violence, dangerous behaviour and suicide:

2.4 Programmes must not include material (whether in individual programmes or in programmes taken together) which, taking into account the context, condones or glamorises violent, dangerous or seriously antisocial behaviour and is likely to encourage others to copy such behaviour.

(See Rules 1.11 to 1.13 in Section One: Protecting the Under-Eighteens.)

2.5 Methods of suicide and self-harm must not be included in programmes except where they are editorially justified and are also justified by the context.

(See Rule 1.13 in Section One: Protecting the Under-Eighteens.)

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

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

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

• must not be featured in programmes made primarily for children unless there is strong editorial justification;

• must not be broadcast before the watershed (in the case of television), when children are particularly likely to be listening (in the case of radio), or when content is likely to be accessed by children (in the case of BBC ODPS), unless there is editorial justification.

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

• must not be featured in programmes made primarily for children unless there is strong editorial justification;

• must not be broadcast before the watershed (in the case of television), when children are particularly likely to be listening (in the case of radio), or when content is likely to be accessed by children (in the case of BBC ODPS), unless there is editorial justification.

Ofcom publishes guidance notes on its Code. These include:

• Guidance notes: Section two - Harm and offence, July 2017

• Guidance notes: Section one - Protecting the under-eighteens, March 2015
General guidance (April 2017) on the Code states that compliance is the responsibility of individual broadcasters.

9.3 Social media and the internet

In a 2008 report, Tanya Byron recommended that the application of the law to the encouragement of suicide should be clarified.\(^{216}\)

The Coroners and Justice Act 2009 amended the Suicide Act 1961 to consolidate and simplify previous legislation and to make clear that the law applies to online actions in the same way as it does offline.\(^{217}\) Under section 2(1) of the 1961 Act (as amended), it is an offence to conduct an act capable of encouraging or assisting the suicide or attempted suicide of another person with the intention to so encourage or assist. The offence does not require the person to know the other person or identify them. Crown Prosecution Guidance states that:

> In the context of websites which promote suicide, the suspect may commit the offence of encouraging or assisting suicide if he or she intends that one or more of his or her readers will commit or attempt to commit suicide.\(^{218}\)

The impact of social media

The Government’s Second Progress Report on its Suicide Prevention Strategy noted the “limited systematic evidence” on the influence of social media on self-harm and suicidal behaviour.\(^{219}\) The report set out these “emerging findings” on the role of social media in the aftermath of youth suicides:

- Suicidal tweeters show a high degree of reciprocal connectivity (i.e. they follow each other), when compared with other studies of the connectivity of Twitter users, suggesting a community of interest.
- A retweet graph shows that users who post suicidal statements are connected to users who are not, suggesting a potential for information cascade and possibly contagion of suicidal statements.
- The reaction on Twitter to the Hayley Cropper Coronation Street suicide storyline was mostly information/support and debate about the morality of assisted dying, rather than statements of suicidal feelings.
- Tweets about actual youth suicide cases are far more numerous than newspaper reports and far more numerous than tweets about young people dying in road traffic accidents, which suggests that suicide is especially newsworthy in social media. In newspapers there is no significant difference between the two types of death, in terms of number of reports per case...\(^{220}\)

---


\(^{218}\) Crown Prosecution Service, *Policy for prosecutors in respect of cases of encouraging or assisting suicide*, February 2010 (updated October 2014), para 20

\(^{219}\) HMG, *Preventing suicide in England: Two years on Second annual report on the cross-government outcomes strategy to save lives*, February 2015, p10

\(^{220}\) Ibid, p10
Online Harms White Paper

The then Government’s Online Harms White Paper, published in April 2019, set out how it intended to tackle a range of harmful content online, including “encouraging or assisting suicide.”

The plans include a new statutory duty of care to make social media companies take more responsibility for the safety of their users and for tackling the harm caused by content on their services. An independent regulator would oversee and enforce compliance with the duty.

Chapter 7 of the White Paper set out what companies would need to do to fulfil the duty of care. On self-harm and suicide, it stated:

7.34 Companies will be required to take robust action to address harmful suicidal and self-harm content that provides graphic details of suicide methods and self-harming, including encouragement of self-harm and suicide. Services must also respond quickly to identify and remove content which is illegal or violates terms of use, and act swiftly and proportionately when this content is reported to them by users.

The regulator would expect the following areas to be covered in a code of practice:

• Steps to ensure that vulnerable users and users who actively search for or have been exposed to this content, including content that encourages eating disorders, are directed to, and able to access, adequate support.

• Ensuring that companies work with experts in suicide prevention to ensure that their policies and practices are designed to protect the most vulnerable (and to ensure that moderators receive appropriate training).

• Steps companies should take to ensure that their services are safe by design, including tools to help users avoid material or behaviour which encourages suicide or self-harm, and measures to block content and block, mute and stay hidden from other users.

• Guidance about how to ensure it is easy for users to understand these tools, and the company’s terms of use in relation to these harms, when they sign up to use the service.

• Processes to stop algorithms promoting self-harm or suicide content to users.

• Measures to ensure that reporting processes and processes for moderating content and activity are transparent and effective at tackling the encouragement of self-harm and suicide and measures to ensure that users are kept up to date with the progress of their report.

• Steps services should take to ensure they engage sufficiently with civil society groups and law enforcement, so that moderators are educated about what constitutes self-harm or suicide encouragement and how it can be prevented and tackled.

• Steps companies should take to ensure harm is tackled rapidly, such as removing content which is illegal or violates acceptable use, and blocking users responsible for activity which violates

---

221 HMG, Online harms white paper, April 2019, p31
222 For background see the Library Paper: Social media regulation (26 February 2020)
terms and conditions, as well as steps that services can take to ensure that these measures are conducted sensitively.

- Processes companies should have in place to ensure that users can appeal the removal of content or other responses, in order to protect users’ rights online.

- Steps to prevent banned users creating new accounts to continue to encourage suicide or self-harm.223

A consultation on the proposals closed on 1 July 2019. The Government published its initial response in February 2020. This stated that the Government was minded to make Ofcom the regulator for online harms. The Government has said that a full response will be published this year with legislation to follow “early next year”.224

9.4 Health Committee report (March 2017)

In its March 2017 report on suicide prevention, the Health Select Committee said that it was concerned about the level of non-adherence to the guidelines on media reporting of suicide. The Committee recognised the “excellent work” of Samaritans but said that it was “concerned that there appears to be no accountability or responsibility for monitoring adherence to the guidelines.”225

The Committee recommended, among other things, that there needed to be a nominated person within Government or Public Health England who was “ultimately responsible for ensuring that the Government has a firm grasp of the current media situation and for supporting Samaritans and other organisations and individuals.”226

The Committee recommended that the IPSO Editors’ Code of Practice should be amended so that “excessive detail” became “unnecessary detail”. It also recommended strengthening Ofcom’s Broadcasting Code to “ensure that detailed description or portrayal of suicide methods, including particular locations where suicide could be easily imitated, are not permissible.”227

Government response

The Government’s response to the Committee’s report was published in July 2017. Pages 27-32 deal with the Committee’s recommendations on the role of the media. The Government began by stating that it was “committed to a free and open press and does not interfere with what the press does and does not publish”.228 It then noted, amongst other things, the role of the Samaritans:

(...) The Cross-Government Suicide Prevention Strategy sets out the importance of responsible media reporting of suicide. We have supported the Samaritans over many years, which has built strong relationships with the broadcast, print and online media and has developed guidelines for the

223 Ibid, pp72-3
224 HC Deb 19 November 2020 cc449-50
225 Health Committee, Suicide prevention, 16 March 2017, HC 1087 2016-17, para 120
226 Ibid, para 124
227 Ibid, paras 128-33
228 DH, Government response to the Health Select Committee’s inquiry into suicide prevention, Cm 9466, July 2017, p27
responsible reporting of suicide. The National Lead at Public Health England works closely with the Samaritans to share information and to highlight needs for proactive engagement, for example emerging clusters and high profile inquests. Whilst there has been great progress in how the media reports suicide, sadly we still see examples of poor reporting. Our stakeholders continue to look at ways in which they can work proactively with the media to improve this.\textsuperscript{229}

The Government said that the Committee’s recommendations on the Editors’ Code and the Broadcasting Code were matters for IPSO and Ofcom.\textsuperscript{230}

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

To respond to the HSC’s [Health Select Committee] recommendations, Public Health England, DHSC, Samaritans and the Chair of NSPSAG have worked together to agree a protocol for action if there are national public health concerns around an emerging cluster, high profile online challenge or high profile or novel method. This ensures that Directors of Public Health, PHE Centre leads and key stakeholders are reached with briefing and advice.

Samaritans continues to work with online providers to look at how to maximise positive opportunities online and minimise harmful content. The University of Bristol has worked in partnership with Samaritans to complete ground-breaking research into suicide and the online environment. Funded by the Department of Health and Social Care, it provides unique insights into why people use the internet when they are feeling suicidal, its impact and what we can do to make the online environment ‘safer’…\textsuperscript{231}

9.5 Devolved nations

Scotland

The Scottish Government’s Suicide Prevention Action Plan (August 2018) said:

...We need to maximise the positive influence of social media and its potential for key messaging, working with NHS24, NHS Health Scotland and other interested partners to develop a strong online suicide prevention presence across Scotland that caters for all ages.\textsuperscript{232}

Wales

\textsuperscript{229} Ibid, p27
\textsuperscript{230} Ibid, p30
\textsuperscript{231} HMG, \textit{Preventing suicide in England: Fourth progress report of the cross-government outcomes strategy to save lives}, January 2019, pp46-7
\textsuperscript{232} Scottish Government, \textit{Suicide Prevention Action Plan: Every Life Matters}, August 2018, p14
The Welsh Government’s Suicide Prevention Plan for 2015-20 includes an objective to “Support the media in responsible reporting and portrayal of suicide and suicidal behaviour.”\textsuperscript{233}

**Northern Ireland**

The Northern Ireland Department of Health’s Protect Life 2 (September 2019) includes an objective to “Enhance responsible media reporting on suicide.”\textsuperscript{234}

\textsuperscript{233} Welsh Government, *Talk to me 2: suicide and self harm prevention strategy for Wales 2015-2020*, June 2015, p16

10. Armed forces

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

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

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

The MOD says: “historically, the only age group with a statistically significant increased risk of suicide compared to the UK general population were Army males aged under 20 years of age. However, the number of suicides in this age group has fallen since the 1990s and for the latest twenty-year period (1998-2019), the rate of suicide in young Army males was the same as the rate in males of the same age in the UK general population.”

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

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

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

10.1 A new strategy

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

235 Ministry of Defence, Suicide and open verdict deaths in the UK armed forces: annual summary and trends over time 1 January 1984 to 31 December 2018, 28 March 2019
236 Ministry of Defence, Defence people mental health and wellbeing strategy 2017 to 2022, 20 July 2017, p3 (foreword by the Secretary of State for Defence)
237 The other three are: stigma reduction; occupational stress; culture and behaviours.
238 Further information on mental health support given to Veterans can be found in Library briefing paper CBP07693, Support for UK Veterans, June 2018, Section 4
Further information on mental health in the armed forces can be found in a briefing note by the Parliamentary Office of Science and Technology: *Psychological health of military personnel*, published on 3 February 2016.

### 10.2 The numbers

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

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

### 10.3 Suicide among Veterans

The MOD does not routinely collect information on suicide rates among Veterans and The Samaritans have bemoaned the lack of routinely collected data on suicide deaths among Veterans (the Samaritans received a £3.5 million grant from the Government in 2016 specifically to support Service personnel, veterans and their families). The head of research at the Samaritans wrote a blog on “suicide in the UK armed forces” on the back of the grant award. The MOD says it is compiling a Veterans register and has established a Veterans’ Board to address the specific needs of veterans.

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

MPs discussed Veteran Suicide in a [debate](https://www.parliament.uk) on 3 April 2019. Tobias Ellwood, the Parliamentary Under-Secretary of State for Defence, referred to the national suicide prevention strategy and having a Minister responsible for suicide prevention. He also identified the ‘Falklands war’ cohort as those he is most concerned about because

---

239 ‘Suicide and open verdict deaths in the UK armed forces: annual summary and trends over time 1 January 1984 to 31 December 2016’, Ministry of Defence, 30 March 2016, para 15-17

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

241 HC Deb 10 July 2017 c6


“they are stoic and still have that stigma – not wanting to put their hand up.”

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

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

When asked specifically about the rate of suicide among personnel who have seen active service in Afghanistan and Iraq, the Ministry of Defence said the suicide rate among those deployed was lower than those who had not deployed:

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

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

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

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

244 HC Deb 3 April 2019 c455WH
245 PQ347 [on Veterans: Suicide], 30 June 2017
246 HL3467 [on Armed Forces: Suicide], 30 November 2016
247 “New study into Iraq and Afghanistan veterans launched”, Ministry of Defence, 22 October 2018
health care, in February 2019. The Committee recommended the MOD considers options for regular statistical releases on veteran suicides.\textsuperscript{249}
11. Coroners’ conclusions

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

11.1 Statutory requirements

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

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

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

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. A determination may not be worded in such a way as to appear to determine any question of criminal liability of any named person or to determine any question of civil liability.

Another Commons Library briefing paper, Coroners’ investigations and inquests, provides information about coroners and their work.

11.2 Conclusions

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

Conclusions can be short-form or a narrative, or both, as when the coroner adds a brief narrative to a short-form conclusion in order to

---

250 Coroners and Justice Act 2009, section 1
251 Ibid, section 10
252 Commons Library briefing SN03981, Coroners’ investigations and inquests, 11 February 2020
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. The notes to Form 2 list the short form conclusions, one of which is suicide.

11.3 Chief Coroner guidance

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

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

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

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

11.4 Suicide conclusions: coroner statistics

The Ministry of Justice publishes annual coroner statistics. The most recent annual bulletin, published in May 2020, presents statistics of deaths reported to coroners in England and Wales in 2019. This notes that the proportion of conclusions recorded as suicide has remained broadly constant for a number of years, though with a recent rise, and that there are some regional variations:

The proportion of conclusions recorded as suicide has remained broadly constant over the past ten years, generally at around 11-12%. However, in 2018, it accounted for 14% of all inquest conclusions and 15% in 2019. This proportion varies from 3% in Gateshead and South Tyneside to 33% in East Sussex.
11.5 The standard of proof for a conclusion of suicide

The standard of proof for a conclusion of suicide is the civil standard of proof – i.e. the balance of probabilities.

This is a lower threshold than the standard of proof applied in the criminal courts – i.e. being sure, or “beyond all reasonable doubt”. Until the 2018 case of R (Maughan) v HM Senior Coroner for Oxfordshire and others, both case law and the leading practitioners’ texts considered that the higher standard of proof was necessary for a coroner’s conclusion of suicide in England and Wales. This meant that, in order to return a conclusion of suicide, the coroner (or jury) had to be sure that the deceased intentionally took their own life.

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

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

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 conclusion of suicide. In November 2020 the Supreme Court confirmed that the civil standard applies to all inquest conclusions.

11.6 The position in Northern Ireland

Northern Ireland has its own coroner service and legislation. Following the Supreme Court judgment in Maughan, the civil standard applies to inquest conclusions there too.

11.7 The position in Scotland

Fatal Accident Inquiries

Unlike in England, Wales and Northern Ireland, Scotland does not have a system of coroners’ inquests. The responsibility for the investigation of any death in Scotland (and sometimes of a Scottish resident outside the UK) that requires further explanation rests with the Crown Office and Procurator Fiscal Service (COPFS).

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

Information about FAIs is available at:

- COPFS, Our role in investigating deaths;

---

258 [2018] EWHC 1955 (Admin)
259 See Section 12.2 of this briefing paper
260 R (Maughan) v HM Senior Coroner Oxfordshire and others [2020] UKSC 46
261 Personal communication from SPICe, 23 September 2019
A FAI must take place when someone dies in legal custody or a death is caused by an accident at work. FAIs can be held in other circumstances if it is thought to be in the public interest. The aim is to prevent future deaths or injuries. Sheriffs may make recommendations covering precautions which could have resulted in the death being avoided.\textsuperscript{262}

The evidential standard for facts to be proven for FAIs is the civil standard of proof – the balance of probabilities.\textsuperscript{263}

### Suicide cases

All deaths where the circumstances are thought to have been as a result of intentional self-harm must be reported to the Procurator Fiscal. The COPFS states that one of the principal reasons for this is to exclude the possibility that the death is suspicious in nature. In most such deaths, the Procurator Fiscal will instruct a post-mortem examination.\textsuperscript{264}

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

> The Procurator Fiscal (referred to here as the Fiscal) is a lawyer who works for Scotland’s prosecution service. The Fiscal is responsible for investigating all sudden, suspicious, accidental and unexplained deaths and any death occurring in circumstances which give rise to serious public concern. The Fiscal must enquire into any death where the circumstances point to suicide. The Fiscal has legal responsibility for the deceased person until the death certificate is issued and the deceased person is released to the person arranging the funeral.

(…)

> The Fiscal will investigate the cause and circumstances and will then decide whether any further investigation is needed. This may involve instructing a post mortem, to be carried out by a forensic pathologist. The Fiscal is responsible for directing the level and type of post mortem examination, subject to advice from investigating police officers, medical experts and other expert advisers.

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

\textsuperscript{262} Personal communication from SPICe, 23 September 2019

\textsuperscript{263} Explanatory Notes, \textit{Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016}, 14 January 2016, para. 61

\textsuperscript{264} COPFS, \textit{Information for bereaved relatives The role of the Procurator Fiscal in the investigation of deaths}, p6
About the Library
The House of Commons Library research service provides MPs and their staff with the impartial briefing and evidence base they need to do their work in scrutinising Government, proposing legislation, and supporting constituents.

As well as providing MPs with a confidential service we publish open briefing papers, which are available on the Parliament website.

Every effort is made to ensure that the information contained in these publicly available research briefings is correct at the time of publication. Readers should be aware however that briefings are not necessarily updated or otherwise amended to reflect subsequent changes.

If you have any comments on our briefings please email papers@parliament.uk. Authors are available to discuss the content of this briefing only with Members and their staff.

If you have any general questions about the work of the House of Commons you can email hcenquiries@parliament.uk.

Disclaimer
This information is provided to Members of Parliament in support of their parliamentary duties. It is a general briefing only and should not be relied on as a substitute for specific advice. The House of Commons or the author(s) shall not be liable for any errors or omissions, or for any loss or damage of any kind arising from its use, and may remove, vary or amend any information at any time without prior notice.

The House of Commons accepts no responsibility for any references or links to, or the content of, information maintained by third parties. This information is provided subject to the conditions of the Open Parliament Licence.