



House of Commons
Health Committee

Suicide prevention

Sixth Report of Session 2016–17

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Sixth Report of Session 2016–17

*Report, together with formal minutes
relating to the report*

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Health Committee

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Evidence relating to this report is published on the [inquiry publications page](#) of the Committee's website.

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The current staff of the Committee are Huw Yardley (Clerk), Katya Cassidy (Second Clerk), Laura Daniels (Senior Committee Specialist), Stephen Aldhouse (Committee Specialist), Dr Charlotte Refsum (Clinical Fellow), Cecilia Santi O Desanti, (Senior Committee Assistant), Lucy Hale (Committee Assistant), and Alex Paterson (Media Officer).

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Summary

In December 2016, we published an interim report on suicide prevention in order to help inform the Government's updated suicide prevention strategy. We welcome the Government's recent focus on suicide prevention and mental health, and the publication of its update to the strategy in the form of a progress report, the third of its kind. We subsequently heard further evidence on the progress report from stakeholders and this report builds on our initial findings and takes account of their views.

The clear message we have heard throughout our inquiry is that suicide is preventable. The current rate of suicide is unacceptable and is likely to under-represent the true scale of this avoidable loss of life.

We agree with witnesses to our inquiry that the underlying strategy is essentially sound but that the key problem lies with inadequate implementation. Whilst we welcome the fact that 95% of local authorities now have a suicide prevention plan in place or in development, we are concerned that there is currently little or no information about the quality of those plans. It is not enough simply to count the number of plans in existence—there must be a clear, effective quality assurance process and implementation at local and national level.

We welcome the provision of funding for suicide prevention but we are concerned that it will be too little and too late to implement the strategy as effectively as required. We call on the Government to set out how it will make sure that funding is available for the actions outlined in the strategy.

Recognising the need to reach people who are at risk of suicide but not in contact with any health services, we welcome the role of the voluntary sector and the importance of those working in non-clinical settings. A joined-up approach is essential and local authorities' suicide prevention plans should include a strategy for reaching those who are unlikely to access traditional services, particularly men. We recognise the importance of ongoing work to tackle stigma and build public confidence to discuss mental health. We are pleased that Health Education England and Public Health England are reviewing the training materials for staff working in front-line settings to help them to recognise and provide initial help and signposting for individuals who are in distress.

We heard evidence that clinicians sometimes fail to recognise patients who are suicidal. We call on the General Medical Council, Royal College of General Practitioners and Health Education England to improve training for students and clinicians in the assessment of suicide risk.

We are disappointed that the Government has not adopted our recommendation that all patients who are discharged from inpatient care should receive follow up within three days. We remain concerned that the ongoing workforce shortfall is the key barrier to this goal. We call on the Government to resource crisis resolution home treatment teams, to establish and sustain liaison psychiatry services in all acute hospitals and to implement the Mental Health Taskforce recommendations.

Self-harm is the single biggest indicator of suicide risk. We agree with the Government that it is unacceptable that only 60% of people who present at emergency departments for self-harm receive a psychosocial assessment. As well as a guaranteed psychosocial assessment, all patients presenting with self-harm should have a safety plan.

We are disappointed with the lack of progress on the promotion of the Consensus Statement on information sharing as this could save lives, and by the lack of proposals for action in the progress report.

Throughout our inquiry we heard from bereaved families about the devastating and lasting impact of suicide. Those bereaved in this way are themselves at far greater risk and high quality support for individuals bereaved by suicide must be included in suicide prevention plans.

Irresponsible media reporting can have a damaging effect on vulnerable people. We recognise and commend the important work done by Samaritans in this area and urge the Department of Health and Public Health England to be vocal and proactive in supporting their work. The IPSO Editors' Code of Practice and the Ofcom Broadcasting Code should be strengthened to ensure that detailed descriptions of suicide methods, particularly those that are new or emerging, and locations which could be a precedent for other vulnerable individuals are not presented or portrayed.

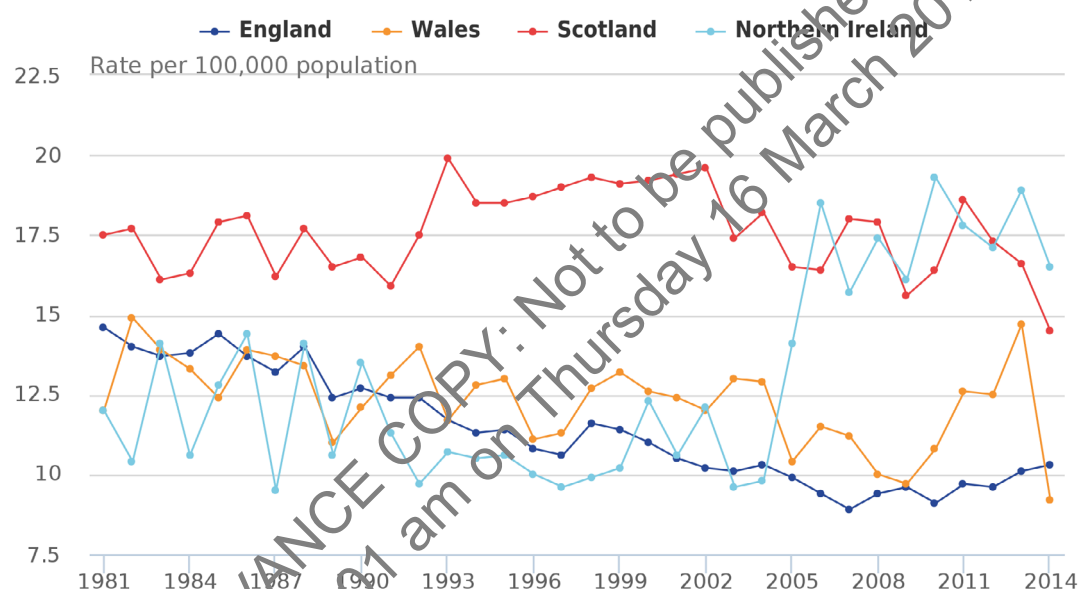
Unreliable and inaccurate data hampers suicide prevention. It is difficult to reliably assess which public health initiatives are the most effective without consistency in the recording of suicide. We are disappointed that the Government has not committed to look at this in more detail or to review the standard of proof for conclusions of death by suicide. We consider it essential that there is better guidance for coroners to reduce the number of hard-to-code narrative conclusions and that there is rapid communication between all agencies so that local public health teams are aware of possible clusters or new methods so that early preventative action can be taken.

If the Government wishes to be truly ambitious in reducing the toll of suicide, there are many further steps which it could take, as set out in this report. The Government must prioritise effective implementation because without it, any strategy is of very limited value.

1 Introduction

1. The scale of the avoidable loss of life from suicide is unacceptable. 4820 people are recorded as having died by suicide in England in 2015 but the true figure is likely to be higher.¹ The 2014 suicide rate in England (10.3 deaths per 100,000) was the highest seen since 2004, and the 2015 rate was only marginally lower at 10.1.² Suicide disproportionately affects men, accounting for around three quarters of all suicides, but rates are rising in women. It remains the biggest killer of men aged 49 and under³ and the leading cause of death in people aged 15–24.⁴

Figure 1: Suicide rates in the UK 1981–2014



Source: Office for National Statistics, 2016.

2. Suicide is now the leading cause of death directly related to pregnancy in the year after mothers give birth—the latest Confidential Enquiry into Maternal Deaths, published in December 2016, reveals that between 2009 and 2014 111 women in the UK died by suicide during or up to a year after pregnancy.⁵ There are also rising levels of suicides in prisons and particular concerns about the risks following release from prison.⁶

1 Office for National Statistics, Suicide in England and Wales, 2015 registrations

2 Ibid

3 Office for National Statistics, <http://visual.ons.gov.uk/what-are-the-top-causes-of-death-by-age-and-gender/>

4 Office for National Statistics, Death registrations summary tables, 2015

5 Maternal, Newborn and Infant Clinical Outcome Review Programme, [Saving Lives, Improving Mothers' Care: surveillance of maternal deaths in the UK 2012–14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–14](#)

6 Howard League for Penal Reform and Centre for Mental Health, Preventing prison suicide, 2016

3. Suicide is also a health inequality issue: there is a well-established link between suicide and poor economic circumstances.⁷ People in the lowest socio-economic groups living in the most deprived areas are ten times more at risk of suicide than those in the most affluent group in the least deprived areas.⁸

4. We launched our inquiry in July 2016, and heard oral evidence in November 2016 from a wide range of organisations, professionals and other individuals, including those bereaved by suicide or with lived experience of suicidal thoughts. We received over 170 written submissions to the inquiry⁸ and also received 1600 responses to a survey run by Mind. We are grateful for these hugely useful contributions to our inquiry.

5. We also visited the north-west, meeting representatives from the Cheshire and Merseyside Suicide Prevention Network and organisations seeking to improve mental health and wellbeing through sport in Liverpool, and a liaison psychiatry service in Salford.

6. The strong message that we have heard throughout our inquiry is that suicide is preventable.

7. The Government indicated that an update to the suicide prevention strategy⁹ would be published in January 2017. In order to seek to influence the updated strategy, we published an interim report in December 2016,¹⁰ in which we outlined five key areas for consideration by the Government before the finalisation of the refreshed strategy. Those areas were:

- (1) **Implementation**—a clear implementation programme underpinned by external scrutiny is required.
- (2) **Services to support people who are vulnerable to suicide**—this includes wider support for public mental health and wellbeing alongside the identification of and targeted support for at risk groups; early intervention services, access to help in non-clinical settings, and improvements in both primary and secondary care; and services for those bereaved by suicide.
- (3) **Consensus statement on sharing information with families**—professionals need better training to ensure that opportunities to involve families or friends in a patient's recovery are maximised, where appropriate.
- (4) **Data**—timely and consistent data is needed to enable swift responses to suspected suicides and to identify possible clusters, in order to prevent further suicides.
- (5) **Media**—media guidelines relating to the reporting of suicide are being widely ignored and greater attention must be paid to dealing with breaches by the media, at national and local level. Consideration should also be given to what changes should be made to restrict access to potentially harmful internet sites and content.¹¹

7 Samaritans (SPR0072)

8 Health Committee, Suicide prevention, written evidence

9 [Preventing Suicide in England: a cross-government outcomes strategy to save lives](#)

10 Fourth Report of Session 2016–17, [Suicide prevention: interim report](#), HC 300

11 Fourth Report of Session 2016–17, [Suicide prevention: interim report](#), HC 300, paragraph 7

8. The updated strategy (which took the form of an annual progress report on the strategy, the third of its kind¹²) was published on 9 January 2017 alongside the Government's response to the Mental Health Task Force¹³ and the Prime Minister's announcements on mental health.¹⁴

9. Following the publication of the progress report, we held an oral evidence session with stakeholders on 31 January 2017 to hear their views.

10. The Government's recent focus on suicide prevention and mental health is welcome and necessary. Whilst the Government recognised our work in their progress report, we were disappointed that our concerns were not fully addressed nor were all of our recommendations taken on board.

11. We consider that there are further steps which could be taken to reduce suicide. Those steps are set out in this report. We would like to see greater ambition from the Government in putting in place practical measures that we, and witnesses to our inquiry, believe will make a significant contribution to suicide prevention.

12. Although the strategy could be improved in some areas, we agree with witnesses that the key issue is not with the strategy itself, but with ensuring effective and consistent implementation across the country. As set out in one of the written submissions to our inquiry, "like all strategies what really matters is how [it is] implemented".¹⁵ It matters little how good the suicide prevention strategy is on paper if it is not effectively implemented.

13. We are grateful to all those who have contributed to our inquiry and we recognise that for many people, telling us their personal experience of bereavement or suicidal crisis will have taken great courage. We have sought to make their voices heard.

14. We wish to acknowledge the work of the National Suicide Prevention Strategy Advisory Group—we have heard from many of its members throughout our inquiry. Their work is vital and we commend their diligence and insight as they advise the Government on its suicide prevention strategy.

12 [Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives](#)

13 [The government's response to the Five Year Forward View for Mental Health](#)

14 ['Prime Minister unveils plans to transform mental health support'](#), Government press release, 9 January 2017

15 [Royal College of Psychiatrists \(SPR0174\)](#)

2 Implementation

15. We made clear in our interim report that the fundamental issue with the Government's updated 2012 suicide prevention strategy is its implementation. As we observed in that report, "over the past four years, there has been a failure to translate the suicide prevention strategy into actual improvements" and "implementation, which is largely the responsibility of local authorities and local health services, has been highly variable and subject to insufficient oversight".¹⁶

16. We asked witnesses in our evidence session after the publication of the Government's progress report whether that report met their expectations. Ruth Sutherland, Chief Executive of Samaritans, responded:

No. I think it is the same as when we opened last time on implementation, resource, accountability and leadership at national and local levels. While the refreshed strategy contains a lot of good things, it is still light on the how. It is not telling us how the 10% target [*the Five Year Forward View for Mental Health set the target that by 2020–21 the number of people taking their own lives will be reduced by 10%*] is to be achieved, how the implementation is to be resourced, where the leadership lies and how we will know whether we are getting there and what the progress is.¹⁷

Hamish Elvidge, a bereaved father and Chair of the Matthew Elvidge Trust (a trust aiming to tackle the issue of depression in young people) and the Support after Suicide Partnership, concurred:

There is a lot of good intent in the Government's work, but not a lot of clarity around how it is to be delivered.¹⁸

17. We agree. We welcome the Government's progress report and the measures contained in it but it is extremely concerning that there is still no clear implementation strategy. **We welcome the Secretary of State's promise that the Government "will put in place a more robust implementation programme to deliver the aims of the National Strategy as recommended by the HSC [Health Select Committee]"¹⁹ and we urge him to publish details of the implementation programme as soon as possible.**

18. The lack of detail about implementation in the report does not leave us confident that the steps set out in the report will be realised. Without effective implementation, these measures cannot contribute to a reduction in deaths by suicide.

Quality of local authorities' plans

19. The Secretary of State, in his ministerial foreword to the progress report, states that he is "delighted that 95 per cent of local authorities now have plans in place or in

16 Fourth Report of Session 2016–17, [Suicide prevention: interim report](#), HC 300, paragraph 8

17 Q396 [Ruth Sutherland, Chief Executive, Samaritans]

18 Q400 [Hamish Elvidge, Chair, The Matthew Elvidge Trust, and Chair, Support after Suicide Partnership]

19 [Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives, Ministerial foreword](#)

development”.²⁰ We are also pleased to hear of this improvement since the All Party Parliamentary Group on Suicide and Self-Harm Prevention’s 2014 survey, which found that 30% of local authorities in England did not have a plan.²¹

20. However, while it is commendable that “95 per cent of local authorities now have [suicide prevention] plans in place or in development”,²² we do not know anything either about the quality of the plans themselves or about how well the plans are being implemented. As PAPYRUS (a charity dedicated to the prevention of suicide in young people, whose Chief Executive we met on our visit to Merseyside) notes in written evidence, “the presence of a document in a local authority is no proof of activity” and “there needs to be proper and effective accountability in delivering on local suicide prevention plans”.²³

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

22. **It is essential that there is a strong and clear quality assurance process to ensure that local authorities’ plans meet quality standards. This will also enable more support to be provided to local authorities where it is needed. In its response to this report, the Government should set out how the quality assurance process will work; who will be responsible for it; how it will report; how often it will be carried out; and when it will start.**

23. **We recommend that Public Health England’s suicide prevention planning guidance for local authorities should be developed into quality standards against which local authorities’ suicide prevention plans should be assessed.**

Ensuring effective implementation

24. It is important that suicide prevention plans meet the quality standards: this is a far better measure than simply whether there is a plan in existence. However, even the best suicide prevention plan will fail if it is not properly implemented. As Samaritans told us, “it is critical to look at what action is actually being taken and whether the plan is being implemented”.²⁴

25. There must be overall national leadership to ensure that local suicide prevention plans are being implemented. We recognise concerns from witnesses that this might reduce or remove local accountability²⁵—this is not our intention. However we consider that national oversight as to whether the strategies are working is essential to ensure that the target for reducing suicide by 10 per cent can be met.

20 [Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives](#), Ministerial foreword

21 All-Party Parliamentary Group on Suicide and Self Harm Prevention, Inquiry into Local Suicide Prevention Plans in England

22 [Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives](#), Ministerial foreword

23 PAPYRUS (SPR0167)

24 Samaritans (SPR0173), paragraph 4

25 Q401 [Councillor Richard Kemp]

26. There is a role for local scrutiny of implementation of suicide prevention plans in the first instance. We suggest this could be a role for health overview and scrutiny committees within local authorities. However this does not diminish the need for national oversight, which will be better placed to take a broad perspective of where plans are working (and therefore what best practice can be shared), which plans are not being implemented effectively, and which local authorities may need more support.

27. **We consider that oversight of nationwide implementation could usefully be carried out by an implementation board, as recommended by Samaritans and Hamish Elvidge (Chair of the Matthew Elvidge Trust (a trust aiming to tackle the issue of depression in young people) and the Support after Suicide Partnership). As well as ensuring implementation of local authorities' plans, the implementation board should have responsibility for overseeing the implementation of the other aspects of the Government's suicide prevention strategy.**

28. **We recommend that health overview and scrutiny committees should also be involved in ensuring effective implementation of local authorities' plans. This should be established as a key role of these committees. Effective local scrutiny of a local authority's suicide prevention plan should reduce or eliminate the need for intervention by the national implementation board.**

29. We heard different views on whether the responsibility for the quality assurance process should rest with the implementation board or with a separate body.²⁶ There appear to be advantages and disadvantages of both options, but we have not heard sufficient evidence on this particular point to make a specific recommendation about whether the implementation board should be responsible for the quality assurance process.

30. **The Government should consult the National Suicide Prevention Strategy Advisory Group on whether the implementation board should also be responsible for the quality assurance process of local authorities' plans, or whether that responsibility should rest with another body.**

Zero suicide approach

31. We welcome the "zero suicide" approach pilots being carried out in three NHS trusts. This approach is underpinned by the belief that suicide is preventable and that it is not inevitable for people in crisis and we commend that attitude. We observe that many of the methods that were suggested when these pilots were announced (including joining up of services, good follow up care post discharge from inpatient care and training for front line staff²⁷) are ones that we have recommended during the course of our inquiry, both in our interim report and in this report.

32. We recognise that the early outcomes of these pilots have not yet been fully evaluated. We also note that the zero suicide approach appears not to be fully integrated with the wider suicide prevention strategy in all areas: there is no mention of it in the Government's 2012 strategy nor in the third progress report. Rather than making recommendations

26 Q408 [Hamish Elvidge]; Q409 [Ruth Sutherland]

27 ["Nick Clegg calls for new ambition for zero suicides across the NHS"](#), Government press release, 9 January 2015

on further implementation at this point, we await the evaluation of the pilots. We also reiterate that we commend and encourage any approach which acknowledges that suicide is not inevitable and seeks to prevent all suicide.

Funding

33. We remain concerned that the funding for suicide prevention will not be sufficient to ensure the implementation of the interventions required. As Samaritans note:

The provision of funding by NHS England for suicide prevention from 2018/19–2020/21 is of course a welcome development although we question whether this will be anywhere near enough to cover the wide range of interventions required across the whole country. The £5m allocated for 2018/19 represents an average of just under £33,000 for each of the 152 upper-tier local authority areas and the £10m allocated for each of the following two years represents an average of just under £66,000. We should also bear in mind that this coincides with a period where the overall ring-fenced public health grants to local authorities have been cut quite significantly with a £200m in-year cut in 2015/16 followed by an average real terms cut of 3.9% in each year to 2020/21.²⁸

34. Witnesses have told us that there are “major steps which [...] can still be taken if the Government is to be truly ambitious”²⁹ particularly in the areas such as liaison psychiatry and self-harm. However while many of these steps are referred to in the strategy”, RCPsych state that “it is unclear how possible implementation of the strategy will be without significant additional resources and policy changes”.³⁰ Dr Peter Aitken told us in oral evidence that

The general sense is that the level of uplift required in mental health spend to meet the ambition and the strategy is not available.³¹

He went on to give specific examples:

While it is welcome that liaison psychiatry services are being rolled out across the five year forward view and there is investment in improving access to psychological therapies for children, and in maternal health and so on, if you look at the detail of the 10 recommendations of the national confidential inquiry as to what ought to happen, it is hard to see where the help is to get crisis and home treatment teams 24 hours a day; it is difficult to see how we protect and build on community treatment for people who do not want to come for care. There are some real concerns around the core elements of mental health delivery that are not met in the five year forward view piece.³²

28 Samaritans (SPR0173), paragraph 11

29 Royal College of Psychiatrists (SPR0174)

30 Royal College of Psychiatrists (SPR0174)

31 Q397 [Dr Peter Aitken]

32 Q397 [Dr Peter Aitken]

35. Samaritans also outlined the importance of ensuring that the funding is allocated in the right place. They explained that while the current understanding is that the additional funding will be allocated to CCGs, the funding is required for public health interventions (for which the local authority is responsible) as well as for clinical services:

It is important to note that many of the interventions required from a local suicide prevention plan are not NHS-based and so it is essential that this money is used appropriately to cover activities involving public health and other services in addition to NHS-based initiatives.³³

36. Ruth Sutherland expanded on this in oral evidence, explaining that it is unclear where the money is and how it is to be distributed:

If it is to be through the health route and go to CCGs, it is only £33,000 per CCG; it is a tiny amount of money within their much larger budget, with all the other pressures and things they have. If it went to the local authority and it were ring-fenced, it would be likely to have more impact. It is still too small but, if you have a small amount of money, put it in the right place and use it to the greatest effect. [...] If it went to the local authority and was ring-fenced for the purpose, it could be tied. There are good examples of local authorities joining together and pooling their resources and making the most of them. It could be incentivised in that way, so that you get more money if you can work collaboratively with others. There is a very complicated picture locally in terms of STP plans and health and wellbeing boards. We want some clarity about where the responsibility lies and who is going to oversee it. Health and wellbeing boards [...] would be a place for it. The directors of public health are there; they have the lead in suicide prevention, and if the money were ring-fenced within those budgets perhaps it would make more impact.³⁴

37. Sustainability and transformation plans are likely to be the appropriate means by which collaborative suicide prevention planning between public health teams and CCGs takes place. Dr Aitken told us that his priority for progress with implementation is

To see sustainability and transformation plans explaining transparently how they are going to deliver the mental healthcare necessary in the suicide prevention strategy and being very clear about how that is going to be managed and monitored.³⁵

38. We welcome the provision of funding for suicide prevention guaranteed for 2018/19–2020/21. However, unless it is supported by other funding already committed by the Government to mental health, and unless that funding actually reaches the front line, we are concerned that it will not be sufficient to fund the suicide prevention activity required both to meet the Government’s target of a 10 per cent reduction in suicides and to implement the strategy.

33 Samaritans (SPR0173)

34 Q398–399 [Ruth Sutherland]

35 Q415 [Dr Peter Aitken]

39. We note that there are currently important steps which could be taken to reduce suicide but which cannot be acted upon due to the lack of significant additional resource. The Government should make a clear commitment to assuring the funding for every action outlined in the suicide prevention strategy. In order to demonstrate this commitment, the Government should make an estimate of the cost of each activity referred to in the strategy, and indicate what funding is currently allocated to each. This will allow the funding gaps to be identified and addressed.

40. The Government must make clear who has overall responsibility in each area (whether that is the CCG, the director of public health, or another body) to ensure that the money is allocated in the right places within the area to fund both NHS initiatives and public health activity. The Government should set out how the additional funding will be distributed and accounted for so that local authorities and CCGs can plan their suicide prevention work effectively. If there is insufficient funding, the Government should be realistic about what is achievable on existing resources and set out the evidence on prioritising resources.

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3 Services to support people vulnerable to suicide

41. In our interim report, we described the three groups for whom tailored support should be targeted. We were told that approximately one third of people who end their lives by suicide are in each category:³⁶ those who have not been in contact with health services in the year before their death; those who were in contact with their GP preceding their death but were not receiving specialist mental health services; and those who are under the care of specialist mental health services.

People not in contact with any health services

42. Witnesses to our inquiry told us of the importance of whole community public involvement in suicide reduction and noted that the Government's progress report on the strategy does not include recommendations about mobilising the public.³⁷ They told us of the importance of "information, education, awareness and public understanding of suicidal behaviour". Ruth Sutherland commented on the belief that one in six of the population experience suicidal thoughts and explained that

If upstream we are all more aware that life is difficult and sometimes you need someone to interrupt your dark thoughts, and if people are better able and equipped to do that, we are likely to have more success.³⁸

43. For many people who experience suicidal thoughts, certain challenges may push them towards a crisis. These challenges might include bereavement, poverty, unemployment, relationship breakdown, gambling, housing issues, alcohol and drug misuse, financial problems or any one of a number of other issues. In many of these situations, the development of suicidal thoughts could have been avoided if appropriate support had been provided for an individual's particular situation. Dr Peter Aitken explained it like this:

Citizens advice bureaux and the nextday housing accommodation officer used to be two of the mainstays of practice in the mid-1990s. You would have somewhere to send people who were in debt and somewhere to send people who needed re-homing urgently. That is not available any longer. That is putting a terrific pressure on health services to try to find ways to support basic life before you can do any medicine.³⁹

44. In many areas, there are voluntary organisations providing practical support in some of these spheres. But many local authority funded support services are being cut due to local authority funding reductions. Dr Liz England of the Royal College of General Practitioners told us about her local authority:

Unfortunately, our local authority has now cut 50% of everything, so we do not have the capacity. We cannot refer into it now because it is not there.

36 The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH), Suicide in Primary Care in England: 2002–2011, 2014

37 Q418 [Ruth Sutherland], Royal College of Psychiatrists (SPR0174)

38 Q420 [Ruth Sutherland]

39 Q91 [Dr Peter Aitken]

That is happening in many areas. We had an organisation supporting people and 50% of their resources were cut.⁴⁰

45. This is concerning, and reinforces the need for funding to be allocated in a way which ensures that it will be used to maintain support services and public health activities in local authorities, to help prevent people reaching the point of suicide.

46. However another key barrier to these services providing an alternative option for support for people who could be vulnerable to a suicidal crisis is the lack of coordination. GPs cannot refer an individual to a support service or organisation if they do not know what is available of an appropriate standard.

47. We recommend that local authorities keep and maintain a record of services of a suitable standard (both in the voluntary sector and commissioned services) to which individuals can be signposted for both practical and emotional support. Part of the work of health overview and scrutiny committees in scrutinising local authorities' suicide prevention plans should be ensuring that these records are created and maintained. There should also be an annual review of the impact of any loss of these services.

48. There is also a key role for organisations and services at high risk locations, including the police and the rail industry. These organisations are in a crucial position to be able to put in place measures to prevent suicide. We heard from Network Rail about their action on suicide prevention, including 'hard' prevention methods such as fencing on disused platforms and 'soft' measures including signage and training of staff. In particular high-risk locations, they also "train the local community to look out for those who are vulnerable to suicide".⁴¹

49. The College of Policing outlined the importance of its role in identifying and responding to those who are vulnerable to suicidal thoughts and might decide to take their own life:

As the police service is often the first to respond to calls from the public and people contemplating suicide, the College has an important role in providing officers and staff with the best possible knowledge and advice on how to respond.⁴²

50. We were pleased to hear from the Royal National Lifeboat Institution the steps it is taking to work out what role it can play in suicide prevention. While suicide prevention is currently not a key objective of the RNLI (unlike Network Rail, for example) the RNLI recognised that approximately 11% of their activity, and 44% of their activity on the Thames, is in relation to suicide, and is therefore seeking to explore how their role as first responders to incidents on the water fits into a wider multi-agency collaborative approach to suicide prevention.⁴³

51. Local authorities should promote a joined-up, multi-agency collaborative approach to suicide prevention to improve data sharing and knowledge between different sectors which will ultimately lead to more efficient and effective action on preventing suicide.

40 Q90 [Dr Liz England, Royal College of General Practitioners]

41 Q139 [Ian Stevens, Suicide Prevention Programme Manager, Network Rail]

42 College of Policing (SPR0069)

43 Q137 [Melanie Hide, Head of Corporate Affairs, Royal National Lifeboat Institution]

52. **We recommend that organisations and services at high risk locations, including the police and Network Rail (as well as other organisations such as the RNLI where appropriate), should be involved in the development and implementation of local authorities' suicide prevention plans.**

53. In our interim report, we emphasised the need to “embrace innovative approaches that reach out to those in distress in order to offer an alternative before an avoidable loss of life to suicide”.⁴⁴ We noted the importance of tackling the stigma that persists in talking about emotional health (particularly for men) and of offering non-traditional routes to help for people who are unlikely to access mainstream services.

54. We are pleased that the Government strategy, and the progress report on the strategy, recognise that men are a high risk group. We have seen and heard of examples of good work being done in this area, including by Everton in the Community and State of Mind (organisations that we visited),⁴⁵ CALM (Campaign Against Living Miserably) and Men's Sheds.

55. It is encouraging that the Government's third progress report acknowledges that

We must look at more innovative ways of targeting men, especially middle-aged men, to address the barriers that prevent them from seeking help. We also need to consider what interventions and services would be most effective to meet their needs.⁴⁶

56. However the report does not include any detail on how progress will be made. **We recommend that local authorities should include in suicide prevention plans a strategy for how those who are at risk of suicide but are unlikely to access traditional services will be reached. This should include up-to-date knowledge about what services are available in the voluntary sector.**

57. We repeat our concern about funding of these initiatives. A successful strategy in this area will allow public health teams within local authorities to identify those at risk and intervene early. If vulnerable people who need help are not accessing the services currently on offer, then the services must be adapted. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) recommends that online services and help in non-clinical settings should be widely available, but that aim cannot be achieved unless local authorities have access to funding to enable it.⁴⁷

58. We recognise the importance of promoting emotional wellbeing in order to tackle mental health problems in young people. We also note the importance of taking the opportunity to provide support for young people in distress, and at times of particular vulnerability, including in further and higher education settings. We are looking in further detail at children and young people's mental health and education in our current joint inquiry with the Education Committee.

44 Fourth Report of Session 2016–17, [Suicide prevention: interim report](#), HC 300, paragraph 14

45 Annex, Visit to Liverpool and Salford

46 [Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives](#), paragraph 17

47 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (SPR0087)

People in contact with primary care services

59. As we explained in our interim report, approximately one third of people who end their lives by suicide are in contact with their GP preceding their death, but are not receiving specialist mental health services. We concluded that GPs need better training in suicide risk.⁴⁸

60. Dr Liz England (Royal College of GPs) raised concerns about the lack of training in mental health in medical schools. She said that “we have to start right at the beginning of medical school to introduce mental health alongside the physical health aspects”.⁴⁹ She also noted the importance of psychiatry placements for GPs in training and the fact that there is no mandatory psychiatry or mental health within GP rotations.

61. **We recommend that the GMC should ensure that all undergraduate medical students receive training in the assessment of suicide risk as well as depression. We also recommend that the Royal College of General Practitioners and Health Education England should include the assessment of depression and suicide risk in the training and examinations for GPs. The Government should monitor progress on the addition of these competencies to medical school and Royal College exams.**

62. We noted in our interim report that tools already exist to support GPs in identifying mental health problems, including NICE guidelines on identifying and treating depression, and training programmes to assist professionals in detecting and supporting people who may be at risk of suicide.⁵⁰ However, as we observed in that report, it is far too easy for these resources to go unused amidst GPs’ workloads and competing priorities.

63. It is promising that the Government has acknowledged the need for training for GPs and GP surgery staff:

Training for GPs and GP surgery staff in awareness of suicidality and safety planning can play a crucial role in suicide prevention, and Health Education England has been working with Public Health England to review materials such as e-learning tools and is considering how best to support this nationally.

Awareness training should encourage the implementation of NICE guidelines to improve the identification, treatment and management of depression in primary care.⁵¹

48 Fourth Report of Session 2016–17, [Suicide prevention: interim report](#), HC 300, paragraphs 18 and 22

49 Q81 [Dr Liz England]

50 Fourth Report of Session 2016–17, [Suicide prevention: interim report](#), HC 300, paragraph 18

51 [Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives](#), paragraphs 27–28

64. We are pleased that training on awareness of depression and suicide risk already exists and that Health Education England and PHE are reviewing e-learning and other materials. It would be valuable for PHE to use its oversight of how many clinicians have taken these training courses to ensure that there is appropriate follow-up in areas where this training is not prioritised.

65. Strong and coordinated national leadership is required to ensure that GPs and primary care nurses receive adequate ongoing training in detecting suicide risk. We recommend that NICE guidelines and other training resources should be promoted and made readily available for practitioners by Public Health England and Health Education England. There should be national oversight by Public Health England to ensure that all practitioners involved in the assessment of those who could be at risk of suicide are accessing this training.

Drug treatments and suicide

66. We concluded in our interim report that, whilst we heard concerns in some written submissions about the role of drug treatments and suicide, expert witnesses to our inquiry told us that there is greater risk from not using medication where appropriate, provided that it is following evidence-based guidelines.⁵² The Government did not address this issue at all in its progress report. **We urge the Government to ensure that NICE guidelines on the appropriate use of drug treatments for depression are promoted and implemented by clinicians.**

People under the care of specialist mental health services

67. Approximately one third of people who end their lives by suicide are under the care of specialist mental health services.⁵³ The Government's progress report acknowledges that "the number of people who die by suicide whilst in contact with crisis resolution home treatment teams remains worryingly high". However, it does not address the recommendation we made in our interim report that all patients being discharged from inpatient care should receive high quality follow up support within three days of discharge, rather than the current standard of seven days. This is disappointing; that recommendation was aimed precisely at reducing suicide risk in people being treated by crisis resolution home treatment teams.

68. The Royal College of Psychiatrists agreed with our recommendation and told us in written evidence that they were "disappointed that the Government did not include this in their report".⁵⁴ They told us that ideally this should be in addition to some other follow-up in the first week:

We believe that the safest way to prevent suicides would be for two contacts to be made by the crisis team within seven days, with the first happening within the first three days. This would allow someone to provide support, when most suicides happen, and then slightly later to see if any other issues

52 Fourth Report of Session 2016–17, [Suicide prevention: interim report](#), HC 300, paragraph 18

53 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, *Making Mental Health Care Safer*, October 2016

54 Royal College of Psychiatrists (SPR0174)

emerge. It is also important that the guidance is clear that this follow up needs to be done for all people with concerns leaving all acute care not just those leaving A&E.⁵⁵

69. Dr Peter Aitken told us that the key issue in being able to implement this follow-up is a lack of workforce resource:

Many hard-pressed crisis response teams at the moment are barely able to make a telephone call check in that first week, so you can see the implication for resource immediately. If we are already dealing with a limited resource pool, it proves quite challenging to think a bit about how that commitment can be kept.⁵⁶

70. We recognise Dr Aitken's concern about the lack of workforce resource for this follow up. We are concerned that there are some crisis resolution home treatment teams who are so under-resourced that they are barely able to make a telephone call check in with vulnerable people who have only recently been discharged from inpatient care. We do not consider a text message alone to be an adequate follow up in those circumstances.

71. We repeat our recommendation that all patients being discharged from inpatient care should receive high quality follow up support within three days of discharge. We recommend that this should be in addition to a further instance of follow up support within the first week post-discharge. The Government must ensure sufficient funding for crisis resolution home treatment teams to ensure that they have enough resource to provide adequate support.

72. The Government set out its target for liaison psychiatry services in the progress report:

By 2020/21 all acute hospitals will have all-age liaison mental health services in place with at least 50 per cent meeting the 'Core 24' standard for adults and older adults.⁵⁷

73. The Royal College of Psychiatrists was cautious about the feasibility of our recommendation to bring forward the deadline for establishing liaison psychiatry services in every acute hospital to 2017:

The College welcomes plans in the Five Year Forward View to extend liaison mental health services and was also pleased to see the Committee encourage the Government to go further and bring forward the deadline for establishing liaison psychiatry services in every hospital from 2020 to 2017. The two main barriers to achieving this appear to be both finances and recruitment. While it may be possible for the Government to commit additional funds it would be difficult to recruit enough psychiatrists and other staff to be able to provide a liaison psychiatry service in every hospital this year.⁵⁸

55 Royal College of Psychiatrists (SPR0174)

56 Q426 [Dr Peter Aitken]

57 [Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives](#), paragraph 32

58 Royal College of Psychiatrists (SPR0174)

74. We reluctantly acknowledge the fact that recruitment is a barrier to meeting a 2017 deadline. We are concerned that RCPsych considers that “even in the longer term recruitment will continue to be a significant challenge”⁵⁹ and that the College suggests that workforce issues may be a barrier to implementing the Mental Health Taskforce. We note with concern that Core Psychiatry training currently has the lowest fill rate of any higher specialty training.⁶⁰

75. We urge the Government to ensure that there are enough trained staff to establish and sustain liaison psychiatry services in every acute hospital.

76. More broadly, the Health Education England Mental Health workforce strategy must set out what the Government is going to do to ensure that there are enough trained staff to implement the Mental Health Taskforce recommendations.

77. We welcome the expansion of the Improving Access to Psychological Therapies (IAPT) programme, as set out in the progress report, which will considerably increase the availability of support for people with common mental health problems, including depression and anxiety. However, as Dr Peter Aitken explained, IAPT is not sufficiently integrated into mental health teams and is therefore ill suited to suicide risk assessment:

The IAPT investment, while it can help to manage and treat depression and anxiety, does not in itself help the general practitioner re-equip with suicide risk assessment skills or management. If an IAPT service finds somebody to be suicidal in the context of their work treating them for depression and anxiety, they will in most instances refer them back to the GP or make an onward referral to specialist mental health services.⁶¹

This causes avoidable delays.

78. Dr Aitken explained that IAPT services are an “extremely robust evidence-based approach”⁶² to ensuring that an individual has the right care for diagnosed depression or anxiety. The therapy is delivered by a well-trained worker with specific skills, from “basic advice, help and treatment through to complex psychotherapy”.⁶³ However, as he went on to explain,

The IAPT service does not have the front-end multidisciplinary biopsychosocial risk assessment machinery that community mental health teams or even general practice primary care teams do. They are very much a delivery mechanism for highly effective care interventions for somebody who has already been assessed as having depression or anxiety. Unfortunately, for people with depression, [...] the reality is that very many have intrusive thoughts of suicide; they have suicidal ideation. Sometimes that suicidal ideation will become intent, but at the point it becomes intent the IAPT service is not equipped to manage the risk, so the intentful person, or the

59 Royal College of Psychiatrists (SPR0174)

60 [Letter from Professor Ian Cumming, Chief Executive, Health Education England, to the Chair of the Health Committee](#), 19 January 2017, Table 1, 2016 Specialty fill rates

61 Q421 [Dr Peter Aitken]

62 Q422 [Dr Peter Aitken]

63 Q422 [Dr Peter Aitken]

person who is speaking about ideation, may very often find themselves being pushed back to the general practitioner or the community mental health service.⁶⁴

79. We welcome the Government's expansion of the Improving Access to Psychological Therapies (IAPT) programme. However we urge the Government to ensure that it is properly integrated into mental health teams supporting people with complex mental health conditions, to ensure that patients being supported by the IAPT programme who experience suicidal ideation can be supported effectively and quickly.

Other at risk groups

80. We also note with concern the levels of perinatal suicide and the rising levels of suicides in prisons. The latest Confidential Enquiry into Maternal Deaths, published in December 2016, reveals that between 2009 and 2014 111 women in the UK died by suicide during or up to a year after pregnancy.⁶⁵ This is a matter of great concern and we will be following up on this issue as part of our regular reviews of the progress following the publication of the National Maternity Review report 'Better Births' in February 2016.

81. In January 2017, the Ministry of Justice published statistics on deaths in prison custody for 2016. These statistics demonstrated that there was a record high of 119 self-inflicted deaths in custody in England and Wales. As the bulletin reported,

The rate of self-inflicted deaths has doubled since 2012. The likelihood of death in custody is 1.7 times higher than in the general population, while self-inflicted death is 8.6 times more likely.⁶⁶

82. The Royal College of Psychiatrists set out their views on how this issue was addressed in the Government's strategy:

The report is right to flag concerns that there have been sharp increases over recent years in reported deaths by suicide following police custody and increases in the number of self-inflicted deaths in prisons.

The report however then goes on to suggest that these rates are rising because of a number of external reasons including that "Prisons contain a high proportion of vulnerable individuals, many of whom have experienced negative life events that increase the likelihood of self-harm or suicide". It does not however explain why these rates are rising, as it has always been true that people in prisons are especially vulnerable, nor identify/recommend action for supporting this group.

64 Q422 [Dr Peter Aitken]

65 Maternal, Newborn and Infant Clinical Outcome Review Programme, [Saving Lives, Improving Mothers' Care: surveillance of maternal deaths in the UK 2012–14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–14](#)

66 Ministry of Justice, [Safety in Custody Statistics Bulletin, England and Wales, Deaths in prison custody to December 2016, Assaults and Self-Harm to September 2016](#)

Instead it would have been better if the strategy had acknowledged the impact of The National Offender Management Service having to make cuts of almost 25% in real terms in 2014–15 and the number of prison officers falling by around 2,500 since 2013.⁶⁷

We note that a significantly greater number of prison officers have been lost since 2010.⁶⁸

83. We agree that this is a hugely concerning issue and we are pleased that the Justice Committee and the Joint Committee on Human Rights have been scrutinising, and continue to scrutinise, the Government's policy and action on this matter.⁶⁹

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67 Royal College of Psychiatrists (SPR0174)

68 Sixth Report of the Justice Committee, Session 2015–16, [Prison safety](#), HC 625, paragraph 35

69 Sixth Report of the Justice Committee, Session 2015–16, [Prison safety](#), HC 625; Joint Committee on Human Rights, [Mental health and deaths in prisons](#)

4 Self-harm

84. Self-harm is the single biggest indicator of suicide risk. Approximately 50% of people who have died by suicide have a history of self-harm.⁷⁰ We agree with the Government therefore that “it is timely that we increase our efforts to address this issue”. We are pleased that the third progress report expands the 2012 strategy to include self-harm prevention in its own right.

85. As the Government sets out in its report, the NICE guidelines for the treatment of self-harm “set out effective pathways for self-harm and in particular highlighted the importance of undertaking psychosocial assessments for people who have presented at emergency departments for self-harm”.⁷¹ The report continues

The evidence suggests this can be effective in achieving better outcomes for people who self-harm as well as being a low cost intervention that all hospitals could implement. Yet, only around 60 per cent of people receive such an assessment. This is unacceptable: it is essential that everyone who attends A&E for self-harm receives an assessment that meets NICE guidelines.⁷²

86. We agree that it is unacceptable that only 60% of people who present at emergency departments for self-harm receive a psychosocial assessment. It is promising that the Government is working with a variety of partners to “explore how to improve the measurement of self-harm in emergency departments and incorporate measurements of whether those presenting receive a psychosocial assessment into the new Emergency Care Data Set, which is in development”.⁷³

87. We note the variation in secondary care services: in some hospitals, as few as 1 in 5 people receive the appropriate assessment.⁷⁴ Professor Nav Kapur, Head of Research at the Centre for Suicide Prevention in the University of Manchester, told us in written evidence that

This is not simply a resource issue but a consequence of how services are organized and prioritized. It also perhaps an indication of how people who harm themselves are sometimes viewed within health services.⁷⁵

88. We heard that from the point of view of one of the witnesses to our inquiry:

I know from my personal experience of going through A&E, having either self-harmed or attempted suicide, of one occasion being left in the corridor and hearing, “Oh, we all know Mrs Ash; she is always in here.” You feel you are worthless anyway; you do not need somebody you have come to ask for help to make you feel even more worthless.⁷⁶

70 [Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives](#), paragraph 56

71 Ibid, paragraph 58

72 Ibid

73 Ibid, paragraph 61

74 Professor Nav Kapur (SPR0178)

75 Professor Nav Kapur (SPR0178)

76 Q184 [Marie Ash]

This perception by health professionals of individuals who present at emergency departments after self-harm or attempted suicide is extremely concerning, and cannot be resolved without culture change within secondary care services.

89. Professor Keith Hawton, Director of the Centre for Suicide Research at the University of Oxford, outlined the importance of psychosocial assessments being of an appropriate quality:

It is also important that the quality of psychosocial assessment is ensured. This should not just be an assessment of possible presence of mental illness and risk, but a much fuller assessment, including of the individual's problems and needs. Establishing a quality criterion for such assessment could be useful.⁷⁷

90. The Royal College of Psychiatrists told us that after receiving a psychosocial assessment, every patient should have a 'safety plan':

This plan should be co-produced with the patient, who will identify most of the elements; if the patient is unable to articulate their wishes or when the risk is high, however, the clinician may have to take a more directive role. Rather than targeting only 'high' risk patients (a subjective and hence meaningless phrase) a more universal low level approach may be more effective - ie ensuring all patients have a safety plan.⁷⁸

91. Dr Aitken told us that "the rate limiter in delivering those services is simply workforce".⁷⁹ We state again our concerns that the workforce is not sufficient to provide an effective mental health service which takes opportunities to detect suicide risk and ensure appropriate support to reduce that risk.

92. All patients who present with self-harm must receive a psychosocial assessment in accordance with NICE guidelines. Patients who present at A&E with self-harm should have a safety plan, co-produced by the patient and clinician, and properly communicated and followed up. We urge the Government to set out its plans for ensuring that the workforce is sufficient to meet these objectives.

77 Professor Keith Hawton (SPR0030), paragraph 5

78 Royal College of Psychiatrists (SPR0174)

79 Q421 [Dr Peter Aitken]

5 Confidentiality and consent

93. As we stated in our interim report, we heard evidence from those bereaved by suicide that there is an issue with confidentiality and sharing information with families. We explained this issue:

Patients have a legal right to confidentiality, but encouraging the option to involve trusted family or friends can improve support and aid recovery. However, we heard that too often, misunderstanding about confidentiality, lack of confidence, or even simply time constraints can lead professionals to adopt a 'tick box' approach to seeking consent. Professionals may err on the side of not involving families, rather than taking the time to explore fully with the patient whether there would be benefit in contacting a trusted family member or friend.⁸⁰

94. Hamish Elvidge helped us to understand the difference between the 'tick box' approach to seeking consent, and the difference that explaining the benefits of sharing information when seeking consent can make:

One way is to say "Do we have your consent to share information with a family member, friend or colleague?" The chances are that the answer will be, "No." Or you could say, "In our experience, it is always much better to involve a family member, friend or colleague whom you trust in your treatment and recovery, and we know the triangle of care is likely to result in a greater chance of successful recovery. This will result in you recovering much quicker. Would you like us to make contact with someone and would you like us to do this with you now?"⁸¹

95. We recommended that stronger action needed to be taken to increase awareness of the Consensus Statement on information sharing and suicide prevention, to train staff, and to "engender a culture shift away from the current presumption that suicidal patients will not want their family or friends to be involved in their recovery".⁸² We were disappointed that the Government, in the third progress report on the strategy, took upon itself no responsibility for this action. Instead, the report notes that

The National Suicide Prevention Strategy Advisory Group (NSPSAG) is working with the Royal Colleges to explore ways in which we can improve the awareness of the Consensus Statement with their members.⁸³

96. We commend the work of the NSPSAG in this area, and we do not wish to suggest that they should be in any way less involved in this work. However, it is disappointing that, despite the Government acknowledging in its report that it had heard from stakeholders and from us that it "should do more to promote the Consensus Statement",⁸⁴ there are no

80 Fourth Report of Session 2016–17, [Suicide prevention: interim report](#), HC 300, paragraph 24

81 Q206 [Hamish Elvidge]

82 Fourth Report of Session 2016–17, [Suicide prevention: interim report](#), HC 300, paragraph 26

83 [Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives](#), paragraph 38

84 [Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives](#), paragraph 37

proposals for action to be taken. Furthermore, our recommendations went further than just raising awareness, and there is no recognition in the Government's progress report on the strategy that any action on training staff is required.

97. Hamish Elvidge, who was involved in the development of the Consensus Statement and is also involved in the NSPSAG's work in raising awareness of it, told us in November that

In September 2016, the advisory group invited the royal colleges to update them on the progress they had made. The truth is that they had not made any progress. I think one royal college had issued it with an email or a newsletter. No change had occurred.⁸⁵

98. In our follow-up evidence session on 31 January, he gave us his views on the continued lack of progress:

I was very encouraged by what the Select Committee said about professionals needing better training on how to involve families in care and assessment. You recognised the fact that, if that is done, it is likely to result in support and better recovery, but it is disappointing that so little has been done about it. The sum total of the Government's response was simply that we should do more to promote the consensus statement. That consensus statement has now had its third anniversary. No details were provided on how it is going to be achieved and when the statement might be embedded in best practice for GPs, nursing, A&E, psychiatry or whatever.⁸⁶

99. We were pleased to hear that there have been positive discussions between members of the NSPSAG and at least one Royal College (the Royal College of Psychiatrists),⁸⁷ which we understand was a step forward in generating agreement that the Consensus Statement should be embedded into the culture of those who will be involved with individuals who have suicidal thoughts.

100. We are disappointed that the Government has not included any proposals for action on the Consensus Statement in its report on the strategy. We recommend that there should be a named responsible individual within Government to support the NSPSAG in discussions with the Royal Colleges and to ensure progress in raising awareness of the Consensus Statement and training of staff in this area (including training on how to seek consent).

101. Writing a blog on 'Confidentiality in the context of suicide prevention',⁸⁸ Professor Sir Simon Wessely, the President of the Royal College of Psychiatrists (RCPsych), has recognised the importance of improving practice in the area of information sharing. It is encouraging that he states that RCPsych will emphasise the approaches encouraged in the Consensus Statement as the College revises its guidance on suicide and self-harm. He states that "this will be an important contribution to changing culture and practice in this area".⁸⁹

85 Q206 [Hamish Elvidge]

86 Q433 [Hamish Elvidge]

87 Q433 [Hamish Elvidge]

88 The Huffington Post, [Confidentiality in the Context of Suicide Prevention](#), 6 December 2016

89 The Huffington Post, [Confidentiality in the Context of Suicide Prevention](#), 6 December 2016

102. Dr Peter Aitken recognised the concerns from a health professional's point of view:

We at college council have had a good conversation about what we might need to do to set the direction of the College of Psychiatrists to make sure that happens. I wonder, however, when I meet colleagues in my practice how nervous they are of legal consequences that possibly are not there. Doctors are occasionally rather in awe of their legal colleagues. Some of us worry that something bad will happen if we are not very careful about confidentiality.⁹⁰

103. This concern is understandable. However, Professor Sir Simon Wessely, after explaining in his blog that when a practitioner is satisfied that a suicidal patient lacks capacity to make decisions about information sharing, the practitioner should use their professional judgement to determine what is in the person's best interest, counters some of these concerns:

I know what any professional reading this piece is thinking: what if I get this wrong, or, more accurately, what if someone thinks I have got it wrong? The spectre of the GMC, other regulatory bodies or the Courts looms large in their thinking, and I am not surprised. 'Safety first' becomes the agenda. Better not take any risks. But I think these concerns, although understandable, are overstated. In my experience, if doctors make well-justified, well-recorded decisions to share information in the best interest of a patient who is in suicidal crisis, consistent with their professional codes of practice, this will be understood, respected and upheld in courts of law. Courts are exceptionally reluctant to rule against doctors who have clearly acted in good faith in the interests of their patients.⁹¹

104. We commend this approach. We nevertheless also agree with Dr Aitken that it would be wise to include trust legal departments, legal authorities and defence unions in the discussions between the NSPSAG and the royal colleges. As Dr Aitken explained, it is crucial that

When doctors ask for advice from their trust's legal departments or from their defence union they are offered support that is sympathetic to the consensus statement, because if as a doctor you have to make a decision on your own late at night and you phone the defence union which comes straight back with, "Be very careful about that," you tend to be very careful about it.⁹²

105. We recommend that further discussions between the NSPSAG and the Royal Colleges on the Consensus Statement should involve representatives from trust legal departments, legal authorities and defence unions, in order to ensure consistent guidance.

106. We were extremely concerned to hear that, in some situations, individuals who were suicidal did consent to information being shared with a trusted friend or family member but this was not acted upon. We heard this particularly powerfully from Steve Mallen,

90 Q434 [Dr Peter Aitken]

91 The Huffington Post, [Confidentiality in the Context of Suicide Prevention](#), 6 December 2016

92 Q434 [Dr Peter Aitken]

a bereaved father whose son Edward died by suicide in 2015: despite Edward giving consent for medical professionals to share information with his parents, they did not do so. Situations like these are clearly unacceptable.

107. Training for medical staff on the Consensus Statement and on how to seek consent should include educating medical professionals on the importance of action when a patient has given consent for information to be shared with a friend or family member.

108. We also note the importance of general practitioners being kept informed about their patients who are at risk of suicide.

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6 Support for those bereaved by suicide

109. For every person who ends their life by suicide, a “minimum of six people will suffer a severe impact”;⁹³ people bereaved by suicide are 65% more likely to go on to take their own life.⁹⁴ The estimated total cost to the economy of each suicide is £1.67 million, and “60% of the cost of each suicide is attributed to the impact on the lives of those bereaved by suicide”.⁹⁵ It is therefore appropriate that ‘providing better information and support to those bereaved or affected by suicide’ was a key area for action within the Government’s 2012 suicide prevention strategy.

110. However, as the Government admits in the third progress report on the strategy,

Delivery in this area has not progressed enough to ensure that there are good quality and consistent suicide bereavement services in every area across the country. Unfortunately, those bereaved by suicide tell us they do not always receive the support and help they need and this must be addressed.

111. We agree. We also note the importance of the timeliness of support for the bereaved by suicide. The Government reports that it continues to “provide funding to support the dissemination of the Help is at Hand guide, which was commissioned by Public Health England and refreshed in 2015 and provides valuable and compassionate guidance and advice to people bereaved by suicide.”⁹⁶ We are pleased that the Government has committed to continuing to fund Help is at Hand, but, as we were told in written evidence, “we are a long way from having effective dissemination, which would ensure that everyone affected receives a copy, as part of a support service across all parts of the country”.⁹⁷

112. A dissemination plan is being developed by the Support after Suicide Partnership which aims to include coroners, funeral directors, the police, and health professionals. However, as we were told in written evidence,

The only way that dissemination will be effective is when all parts of the country have a support service, which requires the police/coroners/others to provide this resource to every family within a maximum of 48 hours, as part of a fully integrated, local support service.⁹⁸

113. As we recognised in our interim report, there are examples of excellent support services for people bereaved by suicide, including If U Care Share in the North East, CHUMS in Bedfordshire, AMPARO in Liverpool and SOBS (Survivors of Bereavement by Suicide). However there is little funding for these services: most are charitable organisations funded by donation.

114. We recommend that ensuring high quality support for all those bereaved by suicide should be included in all local authorities’ suicide prevention plans. Bereavement support should be a key criterion on which local authorities’ plans are quality assured.

93 Association of Directors of Public Health (SPR0049)

94 Q430 [Hamish Elvidge]

95 [Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives](#), paragraph 115

96 [Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives](#), paragraph 113

97 The Matthew Elvidge Trust (SPR0172), paragraph 2.2

98 The Matthew Elvidge Trust (SPR0172), paragraph 2.2

115. We recommend that those bereaved by suicide should receive a copy of 'Help is at Hand' within a maximum of 48 hours, but where possible when contact is first made with the family/friends of the deceased individual. Further support, including information about counselling but also support for the practical problems that bereaved individuals will face (including coroners' inquests and incident reviews), should be offered as soon as is practicable. The next of kin should have access to a victim liaison officer to support them through the inquest.

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7 Media

116. The Government's 2012 suicide prevention strategy outlined support for the media in delivering sensitive approaches to suicide and suicidal behaviour as a key area for action. The strategy set out two key aspects to that support:

- a) Promoting the responsible reporting and portrayal of suicide and suicidal behaviour in the media; and
- b) Continuing to support the internet industry to remove content that encourages suicide and provide ready access to suicide prevention services.⁹⁹

117. Samaritans explained the danger of irresponsible media reporting:

Significant worldwide research shows links between certain types of media reporting of suicide and increases in suicide rates. Reports which include detailed descriptions of a suicide method can lead to more deaths using the same method, and dramatic or romanticised coverage of a death by suicide can lead to vulnerable people over-identifying with particular characteristics of the person who has died and this may influence their decision to take their own life.¹⁰⁰

Guidelines for responsible reporting of suicide

118. In our interim report, we made clear that there are already clear and coherent guidelines for the media, most notably Samaritans' *Media Guidelines for Reporting Suicide*.¹⁰¹ However, as we noted in our interim report,

During the course of our inquiry, we have identified several instances of inappropriate reporting and portrayal of suicide, all by leading broadcasters and mainstream newspapers.¹⁰²

119. We again note with concern the widespread continued use of the term "commit suicide", which reinforces stigmatising attitudes from a time when suicide was a criminal offence. This is of significant concern because stigma around suicide leads to vulnerable individuals not seeking the help they need.

120. We remain concerned about the level of non-adherence to the guidelines on media reporting of suicide. While recognising the excellent work that Samaritans do in this area, we are concerned that there appears to be no accountability or responsibility for monitoring adherence to the guidelines. As we noted in our interim report,

When we questioned Public Health England, they did not believe that they were responsible for taking action to counter irresponsible reporting, nor could they identify whose responsibility it was to do so.¹⁰³

99 [Preventing Suicide in England: a cross-government outcomes strategy to save lives](#), paragraph 5.1

100 Samaritans (SPR0072), paragraph 36

101 Samaritans, *Media Guidelines for Reporting Suicide*, 5th edition (September 2013)

102 Fourth Report of Session 2016–17, [Suicide prevention: interim report](#), HC 300, paragraph 34

103 Fourth Report of Session 2016–17, [Suicide prevention: interim report](#), HC 300, paragraph 34

121. We found it unacceptable that it has been unclear who is responsible and accountable for media reporting of suicide. We are concerned that Public Health England told the Committee that the accountability and follow-up was not part of Public Health England's role but was left wholly for Samaritans to deal with. Moreover the progress report on the strategy, rather than outlining in detail any specific action that the Government is taking in this area, just sets out the excellent work done by Samaritans. To be clear, we are not undermining the work of Samaritans in this area, nor are we suggesting that their work is inadequate. But it should not be the role of a charity, whose work is funded by donation, to be ultimately accountable and responsible for promoting and monitoring adherence to the guidelines.

122. We are pleased that, as Professor Fenton told us in written evidence,

PHE and Samaritans remain in regular contact on media reporting of suicides. If there is a concern from the Samaritans on media reporting of suicides, Samaritans has the ability and option to escalate these concerns to PHE and also to the National Suicide Prevention Strategy Advisory Group and its Chair Professor Appleby.¹⁰⁴

123. We are also pleased that, prompted by our discussions with PHE on this point, these current arrangements will become formalised through a partnership agreement by the end of March 2017.¹⁰⁵ **We note the lack of detail on the action that may be taken if concerns are escalated to PHE and we recommend that PHE should include options for action in its partnership agreement with Samaritans.**

124. **We urge the Department of Health and Public Health England to be vocal and proactive in their support for the work ensuring responsible reporting of suicide. We recommend that there should be a nominated person within the Government/Public Health England who is 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 in their work with the media.**

125. **A clear message must be sent to the media that the Government supports Samaritans' media guidelines and the work that Samaritans do in helping journalists report suicide responsibly.**

Local media

126. Work with local media on responsible reporting of suicide is likely to be highly variable, and irresponsible reporting at local level results in a risk of regional clusters of suicide. We recognise that work with local media is likely to be most effective when done at a local level, and note that this is being done already in some local authorities, including in Kent, Devon and Bristol.¹⁰⁶

104 Public Health England (SPR0166)

105 Public Health England (SPR0166)

106 Kent County Council (SPR0095); Devon Suicide Prevention Alliance (SPR0094); Southwest Zero Suicides Collaborative (SPR0122); Public Health England (SPR0166)

127. **We recommend that when producing and updating suicide prevention plans, local authorities should include work with local media to ensure good practice in local media sources and to ensure timely follow-up discussions when a guideline has not been followed.**

Regulation

128. In 2006 a new sub-clause on the reporting of suicide was added into the Editors' Code of Practice. The current version states that:

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.¹⁰⁷

129. Samaritans, whose work precipitated the addition of the sub-clause, contend that the current clause in the Editors' Code of Practice does not go far enough:

The IPSO Editors' Code of Practice clause on suicide does not sufficiently protect against the introduction of new methods in England, due to the inclusion of the term "excessive detail". Any mention of the method carries the risk of increasing public awareness.¹⁰⁸

130. Samaritans argue that the word "excessive" should be replaced with "unnecessary", noting the particular importance of not including detail where a new and emerging method of suicide is concerned. We agree. Witnesses throughout our inquiry have told us of the dangers of making readily available information new and emerging methods of suicide.¹⁰⁹

131. **We recommend a change to the IPSO Editors' Code of Practice to replace the term "excessive detail" with "unnecessary detail".**

132. We are also concerned about Ofcom's regulation of broadcast media. We have been made aware of inappropriate and graphic detail of suicide on television programmes. We recognise the need for programme makers to portray dramatic situations but we contend that this can be done without unnecessary and exact detail about a suicide method which could influence imitative behaviour. This is of particular concern where the method depicted is relatively uncommon and where scenes show suicide as being quick, easy and painless.

133. **We recommend that the Ofcom Broadcasting Code should be strengthened to ensure that detailed description or portrayal of suicide methods, including particular locations where suicide could be easily imitated, are not permissible.**

Social media and the internet

134. We note the important work done by Samaritans and others relating to the online environment. The internet can provide the means for vulnerable individuals easily to

107 IPSO Editor's Code of Practice

108 Samaritans (SPR0072), paragraph 39

109 See, for example, National Suicide Prevention Alliance (SPR0124); Professor David Gunnell (SPR0032); Samaritans (SPR0072).

access information about suicide methods; online content about suicide methods “can make suicide more accessible and more lethal by allowing rapid, uncensored dissemination of information about methods”.¹¹⁰

135. However, the internet can also be beneficial for vulnerable people, both because they come across help sites and support from online communities and because exposure to suicide content has been shown to discourage individuals from attempting certain methods, where information online portrayed them as unpleasant or unfeasible.¹¹¹

136. The third progress report on the strategy sets out that

The Government expects social media companies, and others, to have robust processes in place and to act promptly when abuse is reported, including acting quickly to assess the report, removing content which does not comply with the acceptable use policies or terms and conditions in place and, where appropriate, suspending or terminating the accounts of those breaching the rules in place.¹¹²

137. This is promising. However it is unclear whether this expectation has been sufficiently communicated to social media companies and other relevant stakeholders. If the Government expects companies to have robust processes in place, then there must be monitoring of these processes to ensure adherence.

138. We recommend that the Government should clearly set out its expectations of social media companies and relevant stakeholders relating to processes for dealing with harmful content on social media. There should be responsibility within Government for ensuring that these organisations have robust processes in place and for monitoring adherence to the processes.

139. Given that the internet can be a beneficial and timely source of help for vulnerable individuals, action to reduce the danger of the internet for vulnerable and potentially suicidal individuals should not completely repress the opportunities for support, but should increase the chances of vulnerable individuals being confronted with support and help online. Dr Lucy Biddle, who recently led a study exploring the impact of the internet on suicidal behaviour, explained in written evidence that:

Age-appropriate help material should be made available for young adults who commonly access the Internet for advice about emotional distress, self-harm and suicide.

Individuals appear most likely to seek and browse online help when experiencing lower levels of suicidal intent, while those in suicidal crisis tend to actively avoid help sites, links and ‘pop ups’. It is critical to develop novel online help approaches that can reach and engage those in active suicidal crisis.¹¹³

110 Dr Lucy Biddle, (SPR0093), paragraph 3.2

111 Dr Lucy Biddle, (SPR0093), paragraph 3.5

112 [Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives](#), paragraph 124

113 Dr Lucy Biddle (SPR0093), paragraphs 4.3–4.4

140. We are pleased that there is research being done in this area. The progress report sets out that

Samaritans is involved in two research projects relating to the online environment, with Bristol and Edinburgh Universities, which seek to increase the understanding of why people look online for help and support, how trust and empathy can be developed in online settings, how people who are suicidal use the internet and the impact this has on their suicidal thoughts and behaviours.¹¹⁴

141. **We note the research projects relating to the online environment, in which Samaritans are involved. We urge the Government to closely examine the findings of that research and to report back to us on the action that it proposes to take as a result.**

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114 [Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives, paragraph 125](#)

8 Data

142. In our interim report, we outlined the importance of good quality, accurate data.¹¹⁵ Poor quality data are undermining the ability to prevent suicide. Access to timely data allows rapid responses (for example, reducing access to places or methods of suicide) to patterns that could indicate suicide clusters, which could help prevent further deaths by suicide. Reliable data will help those evaluating preventative action to know which public health and clinical initiatives are effective in preventing suicide, therefore allowing effective action to be replicated and encouraged.

143. We recognise that ensuring good quality data will not, by itself, save lives. Nevertheless, data is a hugely important issue when seeking to prevent suicide. Bad data is undoubtedly a problem—there is no point looking at and seeking to learn from data if it is not trustworthy. It is difficult to know which public health initiatives are working without reliable data and relying on incorrect data could lead to certain initiatives being advocated when they are actually ineffective.¹¹⁶

144. We are disappointed that in the third progress report on the suicide prevention strategy there was no reference made to changing the standard of proof, and the only reference made to coroners was to say that “ONS is also engaging further with coroners to improve the quality of reporting of suicides”. We made clear recommendations in our interim report which would have improved the quality of data including its usefulness for preventing suicide, and it is disappointing that the Government has not included any of them in its latest update report on the strategy.

Standard of proof

145. As we explained in our interim report, a conclusion of suicide must meet the ‘criminal’ standard of proof, that is, that the coroner or jury must be certain, beyond reasonable doubt, that the person took their own life *and* intended to do so. Suicide and unlawful killing are the only two conclusions which must meet this higher standard.

146. The higher standard of proof for suicide is harmful for two reasons. The first is that it increases the stigma around suicide. Ged Flynn, Chief Executive of PAPYRUS, explained why stigma around suicide is dangerous:

The consequences of not being open and acknowledging that the person was instrumental in bringing about their own death is to increase the stigma around suicide. This increases the reluctance of those who are considering ending their lives to acknowledge and speak about their suicidal thoughts. It impedes help-seeking.¹¹⁷

147. Professor Louis Appleby, arguing for a change to the standard of proof, told us that

Its equivalence with criminal proof reflects the history of suicide. [...] There is a principle here, which is that that standard of proof is a reflection of a system that is full of prejudice and stigma, which we ought to dismantle.¹¹⁸

¹¹⁵ Fourth Report of Session 2016–17, [Suicide prevention: interim report](#), HC 300, paragraph 27

¹¹⁶ See paragraph 159

¹¹⁷ PAPYRUS (SPR0027), paragraph 11

¹¹⁸ Q296 [Professor Louis Appleby]

148. The current standard of proof also causes misclassification of deaths by suicide, leading to an underestimation of the numbers of individuals who have taken their lives by suicide. We explain this in detail below.

149. We recognise that different bereaved families and individuals will view the issue of the standard of proof differently. It has been suggested that some families would prefer for the death of a loved one not to be recorded as a suicide, due to the stigma attached to suicide. However we are guided by the evidence of the bereaved families and individuals from whom we heard in the course of this inquiry. PAPYRUS, a majority of whose trustees have lost a child or young sibling to suicide, was clear that you do not deal with stigma by colluding with it:

We understand the reluctance of many parents/partners or family members to hear a suicide conclusion returned following the death of a family member, but the consequences of not being open and acknowledging that the person was instrumental in bringing about their own death is to increase the stigma around suicide.¹¹⁹

150. Many of the bereaved families from whom we heard in our inquiry are now actively working to prevent suicide. Our evidence suggests that bereaved families recognise that accurately recording a death by suicide as suicide, though difficult to accept in some circumstances, will achieve a different and far better outcome for future families.

151. We recommend that the standard of proof for conclusions of death by suicide should be changed to the balance of probabilities rather than beyond reasonable doubt.

Coroners' conclusions

152. If a coroner does not feel that the standard of proof has been met for a death of an individual, he or she has three options. The coroner can declare a conclusion of accidental death; the coroner can declare an open conclusion; or the coroner can choose to solely use a narrative conclusion.

153. Open conclusions are included in the Office for National Statistics' suicide registrations. However, coroners are discouraged from recording open conclusions. The Chief Coroner's *Guidance No. 17, Conclusions: Short-form and narrative* makes clear that

Open conclusions are to be discouraged, save where strictly necessary. An open conclusion should 'only be used as a last resort, notably when the coroner [or the jury] is simply unable to reach any conclusion on the balance of probabilities as between two competing verdicts'. [...] In some cases a narrative conclusion will be preferable to an open conclusion. A narrative will give the coroner (or jury) the opportunity to state what findings are made and what are not.¹²⁰

119 PAPYRUS (SPR0027), paragraph 11

120 [Chief Coroner, Guidance No. 17: Conclusions: Short-form and narrative](#), paragraphs 68, 69 and 73

154. Professor Keith Hawton, Director of the Centre for Suicide Research at the University of Oxford, noted that he and other experts in this field have “considerable concerns about the accuracy of data based on coroners’ verdicts, even when open verdicts are included as possible suicides.”¹²¹

155. A coroner, when faced with a suspected suicide which does not meet the standard of proof, who is discouraged from using an open conclusion has two options left. The coroner can record the death as accidental (which would not appear in the suicide registrations and would therefore skew the data) or can choose to use a narrative conclusion.

Narrative conclusions

156. Narrative conclusions are not in and of themselves a problem. However, if a coroner has used a narrative conclusion with no short-form conclusion, ONS must code the death. In some circumstances, a coroner will include enough detail about the deceased’s actions and intent for the ONS to code the death as a suicide. However in other circumstances, the coroner will not have included sufficient detail for the ONS to code the death as a suicide. These “hard-to-code” conclusions result in deaths which are likely to be suicides not being coded as such. David Gunnell (a public health physician and researcher and member of the National Suicide Prevention Strategy Advisory Group) notes that in England and Wales, hard to code narrative conclusions are increasing (from 6% in 2011 to 8% in 2014), “compromising suicide prevention activity and leading to significant under-estimation of suicide rates and trends”.¹²²

157. Professor Gunnell highlights the variability between coroners and regions:

As the use of narrative verdicts varies tremendously from coroner to coroner over time this may have distorted the assessment of suicide prevention activities in some areas.¹²³

158. Research undertaken by Professor Gunnell and other colleagues showed that areas which reported the largest declines in suicide between 2001/2 and 2009 were the areas which experienced the greatest increase in use of narrative verdicts. Some of Professor Gunnell’s research shows huge variation between the decisions of coroners across the country in studies of “clinically defined suicides”. This can lead to ineffective action, as he explains:

I’ve seen claims made for the success of local prevention programmes, where apparent suicide reductions have more likely reflected changes in local Coroner practice (increased use of narrative verdicts).¹²⁴

159. We are concerned that unreliable data could hinder the efforts of public health teams to reduce suicide. We note that if the standard of proof for conclusion of suicide was the civil, rather than the criminal, standard, coroners would be able to record likely suicides as suicide, rather than facing a choice between a conclusion of accidental death, an open conclusion or a narrative conclusion.

121 Professor Keith Hawton (SPR0030), paragraph 17

122 Professor David Gunnell (SPR0032), paragraph 7.1

123 Professor David Gunnell (SPR0032), paragraph 7.2

124 Professor David Gunnell (SPR0179)

160. Apart from a change to the standard of proof, we also consider that improvements to the way in which narrative conclusions are recorded are essential for improving data accuracy. We are encouraged that in a discussion between our Chair and the Chief Coroner on this subject, the Chief Coroner recognised the importance of ensuring consistency between coroners, but he is limited in his powers to change practice due to the independence of coroners and in the resources available to him to help to bring about greater consistency.

161. We recommend that the Chief Coroner should be given adequate resourcing to allow clear oversight of the variation in the recording of suicide. We also recommend mandatory training for all coroners, both those already in post and newly appointed, on the use of short form and narrative conclusions, to ensure consistency across England and Wales.

162. Witnesses have also told us of the importance of inclusion of detail about the intent of the deceased and the method of suicide in narrative conclusions.¹²⁵ Detail on intent and method will reduce the number of hard-to-code narrative conclusions, therefore ensuring greater accuracy in ONS data. Systematic and consistent details of method of suicide will also enable quick intervention by public health teams who can act to ensure that the likelihood of further deaths by certain methods is reduced, including restricting access to high-lethality methods of suicide.

163. We recognise the concerns that including detail about lethal (and particularly new or emerging) methods of suicide in coroners' rulings could be counter-productive, as it could lead to vulnerable individuals using information found in coroners' conclusions to take their own lives. **We suggest that the Government should explore whether information about lethal methods of suicide could be made available to statistical agencies and public health teams, but withheld from public view.**

164. We recommend that training for coroners on suicide should include the importance of including sufficient detail in a narrative conclusion about the deceased individual's intent and method used in order to minimise the number of hard-to-code narrative conclusions. Accurate data is crucial to the understanding of what approaches work best in reducing suicide. We suggest that this training could be given by experts in the field of data and suicide prevention.

165. While acknowledging that coroners are independent judges and that the Chief Coroner cannot direct them to take specific action, we consider that training for coroners could include information about how vital sharing information with public health and mental health teams where appropriate at an early stage can be for reducing the likelihood of a cluster of suicides.

166. We recommend that training and guidance for coroners should include material about the importance of timely information sharing with public health and mental health teams where appropriate in order to identify possible clusters and the proliferation of emerging new methods of suicide.

9 Conclusion

167. We are hugely concerned about the current rate of suicide but we are encouraged that evidence to our inquiry has suggested that suicide is preventable. In order to achieve a reduction in the number of deaths by suicide, the Government must take tangible action and ensure effective implementation of the strategy.

168. We are grateful that the Ministerial Foreword to the third progress report on the strategy recognised our inquiry and our initial recommendations. However, despite the progress report asserting that it “addresses many of those recommendations”,¹²⁶ it is disappointing that so few of our recommendations have been adopted, and in particular that certain specific proposals to tackle issues that the strategy itself acknowledges were not accepted.

169. We look forward to receiving the Government response to this report. In particular, we await the details of the Government’s implementation plan for the strategy. We will continue to examine the progress made on the Government’s suicide prevention strategy. **We intend to hold a follow-up hearing after there has been opportunity for the Government and other relevant stakeholders to implement the measures set out in the latest progress report. We urge the Government to take forward the recommendations we make in this report.**

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126 [Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives, Ministerial foreword](#)

Conclusions and recommendations

Implementation

1. We welcome the Secretary of State's promise that the Government "will put in place a more robust implementation programme to deliver the aims of the National Strategy as recommended by the HSC [Health Select Committee]" and we urge him to publish details of the implementation programme as soon as possible (Paragraph 17)

Quality of local authorities' plans

2. We welcome the fact that 95 per cent of local authorities have a suicide prevention plan in place or in development. However we are concerned that there is currently no detail about the quality of those plans. It is not enough simply to count the number of local authorities which report that they have a plan in place. (Paragraph 21)
3. It is essential that there is a strong and clear quality assurance process to ensure that local authorities' plans meet quality standards. This will also enable more support to be provided to local authorities where it is needed. In its response to this report, the Government should set out how the quality assurance process will work; who will be responsible for it; how it will report; how often it will be carried out; and when it will start. (Paragraph 22)
4. We recommend that Public Health England's suicide prevention planning guidance for local authorities should be developed into quality standards against which local authorities' suicide prevention plans should be assessed. (Paragraph 23)

Ensuring effective implementation

5. We consider that oversight of nationwide implementation [of local authorities' plans] could usefully be carried out by an implementation board, as recommended by Samaritans and Hamish Elvidge (Chair of the Matthew Elvidge Trust (a trust aiming to tackle the issue of depression in young people) and the Support after Suicide Partnership). As well as ensuring implementation of local authorities' plans, the implementation board should have responsibility for overseeing the implementation of the other aspects of the Government's suicide prevention strategy. (Paragraph 27)
6. We recommend that health overview and scrutiny committees should also be involved in ensuring effective implementation of local authorities' plans. This should be established as a key role of these committees. Effective local scrutiny of a local authority's suicide prevention plan should reduce or eliminate the need for intervention by the national implementation board. (Paragraph 28)
7. The Government should consult the National Suicide Prevention Strategy Advisory Group on whether the implementation board should also be responsible for the quality assurance process of local authorities' plans, or whether that responsibility should rest with another body. (Paragraph 30)

Funding

8. We welcome the provision of funding for suicide prevention guaranteed for 2018/19–2020/21. However, unless it is supported by other funding already committed by the Government to mental health, and unless that funding actually reaches the front line, we are concerned that it will not be sufficient to fund the suicide prevention activity required both to meet the Government's target of a 10 per cent reduction in suicides and to implement the strategy. (Paragraph 38)
9. We note that there are currently important steps which could be taken to reduce suicide but which cannot be acted upon due to the lack of significant additional resource. The Government should make a clear commitment to assuring the funding for every action outlined in the suicide prevention strategy. In order to demonstrate this commitment, the Government should make an estimate of the cost of each activity referred to in the strategy, and indicate what funding is currently allocated to each. This will allow the funding gaps to be identified and addressed. (Paragraph 39)
10. The Government must make clear who has overall responsibility in each area (whether that is the CCG, the director of public health, or another body) to ensure that the money is allocated in the right places within the area to fund both NHS initiatives and public health activity. The Government should set out how the additional funding will be distributed and accounted for so that local authorities and CCGs can plan their suicide prevention work effectively. If there is insufficient funding, the Government should be realistic about what is achievable on existing resources and set out the evidence on prioritising resources. (Paragraph 40)

Services to support people vulnerable to suicide

People not in contact with any health services

11. We recommend that local authorities keep and maintain a record of services of a suitable standard (both in the voluntary sector and commissioned services) to which individuals can be signposted for both practical and emotional support. Part of the work of health overview and scrutiny committees in scrutinising local authorities' suicide prevention plans should be ensuring that these records are created and maintained. There should also be an annual review of the impact of any loss of these services. (Paragraph 47)
12. Local authorities should promote a joined-up, multi-agency collaborative approach to suicide prevention to improve data sharing and knowledge between different sectors which will ultimately lead to more efficient and effective action on preventing suicide. (Paragraph 51)
13. We recommend that organisations and services at high risk locations, including the police and Network Rail (as well as other organisations such as the RNLI where appropriate), should be involved in the development and implementation of local authorities' suicide prevention plans. (Paragraph 52)

14. We recommend that local authorities should include in suicide prevention plans a strategy for how those who are at risk of suicide but are unlikely to access traditional services will be reached. This should include up-to-date knowledge about what services are available in the voluntary sector. (Paragraph 56)

People in contact with primary care services

15. We recommend that the GMC should ensure that all undergraduate medical students receive training in the assessment of suicide risk as well as depression. We also recommend that the Royal College of General Practitioners and Health Education England should include the assessment of depression and suicide risk in the training and examinations for GPs. The Government should monitor progress on the addition of these competencies to medical school and Royal College exams. (Paragraph 61)
16. Strong and coordinated national leadership is required to ensure that GPs and primary care nurses receive adequate ongoing training in detecting suicide risk. We recommend that NICE guidelines and other training resources should be promoted and made readily available for practitioners by Public Health England and Health Education England. There should be national oversight by Public Health England to ensure that all practitioners involved in the assessment of those who could be at risk of suicide are accessing this training. (Paragraph 65)

Drug treatments and suicide

17. We urge the Government to ensure that NICE guidelines on the appropriate use of drug treatments for depression are promoted and implemented by clinicians. (Paragraph 66)

People under the care of specialist mental health services

18. We repeat our recommendation that all patients being discharged from inpatient care should receive high quality follow up support within three days of discharge. We recommend that this should be in addition to a further instance of follow up support within the first week post-discharge. The Government must ensure sufficient funding for crisis resolution home treatment teams to ensure that they have enough resource to provide adequate support. (Paragraph 71)
19. We urge the Government to ensure that there are enough trained staff to establish and sustain liaison psychiatry services in every acute hospital. (Paragraph 75)
20. More broadly, the Health Education England Mental Health workforce strategy must set out what the Government is going to do to ensure that there are enough trained staff to implement the Mental Health Taskforce recommendations. (Paragraph 76)
21. We welcome the Government's expansion of the Improving Access to Psychological Therapies (IAPT) programme. However we urge the Government to ensure that it is properly integrated into mental health teams supporting people with complex

mental health conditions, to ensure that patients being supported by the IAPT programme who experience suicidal ideation can be supported effectively and quickly. (Paragraph 79)

Self-harm

22. All patients who present with self-harm must receive a psychosocial assessment in accordance with NICE guidelines. Patients who present at A&E with self-harm should have a safety plan, co-produced by the patient and clinician, and properly communicated and followed up. We urge the Government to set out its plans for ensuring that the workforce is sufficient to meet these objectives. (Paragraph 92)

Confidentiality and consent

23. We are disappointed that the Government has not included any proposals for action on the Consensus Statement in its report on the strategy. We recommend that there should be a named responsible individual within Government to support the NSPSAG in discussions with the Royal Colleges and to ensure progress in raising awareness of the Consensus Statement and training of staff in this area (including training on how to seek consent). (Paragraph 100)
24. We recommend that further discussions between the NSPSAG and the Royal Colleges on the Consensus Statement should involve representatives from trust legal departments, legal authorities and defence unions, in order to ensure consistent guidance. (Paragraph 105)
25. Training for medical staff on the Consensus Statement and on how to seek consent should include educating medical professionals on the importance of action when a patient has given consent for information to be shared with a friend or family member. (Paragraph 107)

Support for those bereaved by suicide

26. We recommend that ensuring high quality support for all those bereaved by suicide should be included in all local authorities' suicide prevention plans. Bereavement support should be a key criterion on which local authorities' plans are quality assured. (Paragraph 114)
27. We recommend that those bereaved by suicide should receive a copy of 'Help is at Hand' within a maximum of 48 hours, but where possible when contact is first made with the family/friends of the deceased individual. Further support, including information about counselling but also support for the practical problems that bereaved individuals will face (including coroners' inquests and incident reviews), should be offered as soon as is practicable. The next of kin should have access to a victim liaison officer to support them through the inquest. (Paragraph 115)

Media

Guidelines for responsible reporting of suicide

28. We note the lack of detail [in the third progress report] on the action that may be taken if concerns [about irresponsible media reporting of suicide] are escalated to PHE and we recommend that PHE should include options for action in its partnership agreement with Samaritans. (Paragraph 123)
29. We urge the Department of Health and Public Health England to be vocal and proactive in their support for the work ensuring responsible reporting of suicide. We recommend that there should be a nominated person within the Government/Public Health England who is 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 in their work with the media. (Paragraph 124)
30. A clear message must be sent to the media that the Government supports Samaritans' media guidelines and the work that Samaritans do in helping journalists report suicide responsibly. (Paragraph 125)

Local media

31. We recommend that when producing and updating suicide prevention plans, local authorities should include work with local media to ensure good practice in local media sources and to ensure timely follow-up discussions when a guideline has not been followed. (Paragraph 127)

Regulation

32. We recommend a change to the IPSO Editors' Code of Practice to replace the term "excessive detail" with "unnecessary detail". (Paragraph 131)
33. We recommend that the Ofcom Broadcasting Code should be strengthened to ensure that detailed description or portrayal of suicide methods, including particular locations where suicide could be easily imitated, are not permissible. (Paragraph 133)

Social media and the internet

34. We recommend that the Government should clearly set out its expectations of social media companies and relevant stakeholders relating to processes for dealing with harmful content on social media. There should be responsibility within Government for ensuring that these organisations have robust processes in place and for monitoring adherence to the processes. (Paragraph 138)
35. We note the research projects relating to the online environment, in which Samaritans are involved. We urge the Government to closely examine the findings of that research and to report back to us on the action that it proposes to take as a result. (Paragraph 141)

Data

Standard of proof

36. We recommend that the standard of proof for conclusions of death by suicide should be changed to the balance of probabilities rather than beyond reasonable doubt. (Paragraph 151)

Coroners' conclusions

37. We recommend that the Chief Coroner should be given adequate resourcing to allow clear oversight of the variation in the recording of suicide. We also recommend mandatory training for all coroners, both those already in post and newly appointed, on the use of short form and narrative conclusions, to ensure consistency across England and Wales. (Paragraph 161)
38. We suggest that the Government should explore whether information about lethal methods of suicide could be made available to statistical agencies and public health teams, but withheld from public view. (Paragraph 163)
39. We recommend that training for coroners on suicide should include the importance of including sufficient detail in a narrative conclusion about the deceased individual's intent and method used in order to minimise the number of hard-to-code narrative conclusions. Accurate data is crucial to the understanding of what approaches work best in reducing suicide. We suggest that this training could be given by experts in the field of data and suicide prevention. (Paragraph 164)
40. We recommend that training and guidance for coroners should include material about the importance of timely information sharing with public health and mental health teams where appropriate in order to identify possible clusters and the proliferation of emerging new methods of suicide. (Paragraph 166)

Conclusion

41. We intend to hold a follow-up hearing after there has been opportunity for the Government and other relevant stakeholders to implement the measures set out in the latest progress report. We urge the Government to take forward the recommendations we make in this report. (Paragraph 169)

Annex: Visit to Liverpool and Salford

Background

The Committee visited Merseyside and Salford on Monday 14 November 2016 to hear from organisations engaged in suicide prevention. The visit included sessions at Goodison Park, where they met representatives from Everton in the Community and State of Mind; Listening Ear, to hear from the Cheshire and Merseyside Suicide Prevention Network and AMPARO, and Salford Royal NHS Foundation Trust, to meet members of the Salford Mental Health Liaison Team.

Committee members present: Dr Sarah Wollaston (Chair); Heidi Alexander; Luciana Berger; Ben Bradshaw; Dr James Davies; and Helen Whately.

Everton in the Community

The Committee heard presentations from Michael Salla, Director of Health and Sport, Everton in the Community, the official charity of Everton Football Club, and Professor Andy Smith, Professor of Sport and Physical Activity, Edge Hill University, (Edge Hill University is Everton in the Community's academic partner.)

Everton in the Community's vision is "to be the most effective charity that uses sport as a tool to identify and support vulnerable people". The Committee heard about the various projects run by Everton in the Community, including "Tackling the Blues", a sports based programme targeting children and young people who are experiencing, or are at risk of developing, mental illness and "Active Blues", which is funded by Sport England to help inactive men aged 35–50 to become active and improve their mental wellbeing. Both of those programmes are delivered in partnership with Edge Hill University. Drawing upon research conducted as part of "Tackling the Blues" at Edge Hill University, Professor Andy Smith told the Committee about the benefits of focusing on a whole school approach to mental health and wellbeing and developing a culture where mental health is a priority.

The Committee also heard from Dave, a military veteran who developed post-traumatic stress disorder after serving in Afghanistan. He told the Committee about his issues with gambling, which led to poor mental health. After participating in Everton in the Community's ex-military project, his experience then led him to volunteer with Everton in the Community supporting veterans before becoming the Project Coordinator of the ex-military project.

State of Mind

State of Mind describes itself as a charity that harnesses the power of sport to promote positive mental health among sportsmen and women, fans and wider communities to prevent suicide. The Committee heard from Malcolm Rae OBE, Chair of the Board of Trustees, State of Mind Sport, and Dr Phil Cooper, a Nurse Consultant and co-founder of State of Mind.

State of Mind told the Committee about its role in seeking to tackle stigma around suicide and encouraging people who are experiencing mental health problems to seek timely help,

particularly those individuals who might be inhibited from engaging with mainstream NHS services. The Committee heard about how rugby players get involved with State of Mind, encouraging individuals to talk about mental health. Danny Sculthorpe, a retired rugby league player, told the Committee about the work he does with State of Mind delivering training programmes, drawing on his own experience of mental health problems following an injury. He contemplated suicide but recovered after talking to his family. He told the Committee that “the biggest thing that saved my life was talking”.

Cheshire and Merseyside Suicide Prevention Network and AMPARO

The Committee heard presentations from and held a discussion with various representatives of the Cheshire and Merseyside Suicide Prevention Network: Sue Forster, Chair of the Cheshire and Merseyside Suicide Prevention Network Board and Interim Director of Public Health for St Helens, Jane Boland, Suicide Prevention Clinical Lead, Mersey Care NHS Trust, Audrey Jones, Head of Clinical Governance, Cheshire and Wirral Partnership NHS Foundation Trust, Angela Samata, Project Lead for James Place, Dawn Leicester, Director, Champs Public Health Collaborative, Pat Nicholls, Mental Wellbeing Lead, Champs Public Health Collaborative, Ged Flynn, Chief Executive, PAPYRUS, Richard Brown, CEO, Listening Ear, Charley Alvis, AMPARO Case Worker, Listening Ear, Heidi Moulton, AMPARO beneficiary, Katie Donnelly, Health Improvement Specialist, Warrington Borough Council, Steve Gavin, Public Health Project Development Manager, Wirral Borough Council, Christine Hurst, Senior Coroner's Officer, Cheshire Police, Julie Chadwick, Assistant Director, Integrated Governance, 5 Boroughs Partnership, Cheryl Yeadsley, Project Officer, Champs Support Team, and Suzanne McGuckin, Communications Officer, Champs Support Team.

The Committee heard comprehensive presentations from representatives of the network followed by a wide-ranging discussion. The vision of the network is that “Cheshire and Merseyside is a region where suicides are eliminated, where people do not consider suicide as a solution to the difficulties they face; a region that supports people at a time of personal crisis and builds individual and community resilience for improved lives”. Representatives from the network told the Committee about the structure of the network and its strategic approaches: preventing suicide; transforming services; and post suicide support. The Committee heard about the training that had been made mandatory across all Mersey care staff and the importance of more in depth training for clinicians, including training on confidentiality.

The Committee also heard from AMPARO, which provides support for family members in Merseyside and Cheshire following suicide. AMPARO has been delivered by Listening Ear since April 2015. Support is provided 1:1 and staff can assist with a range of practical matters such as dealing with the police and coroners, helping with any media enquiries, help with overcoming isolation experienced and contacting and signposting to other local support services.

Heidi, a bereaved mother, spoke powerfully about her experience following the death of her son by suicide. She told the Committee that “he wasn't hard to reach, the services are hard to reach”. Heidi told the Committee about the support provided to her by AMPARO, including crucial practical support with her statement for the coroner.

The Committee heard concerns about funding for services, including precarious funding for AMPARO and SOBS (Survivors of Bereavement by Suicide).

Salford Mental Health Liaison Service

Salford Mental Health Liaison Team offers comprehensive mental health support, available 24 hours a day, 7 days a week to people aged 16 years and over who are inpatients in Salford Royal, Intermediate Care, or have presented in the Emergency Department and are experiencing problems with their mental health. This award winning service has demonstrated improvements in the health and wellbeing outcomes of its service users as well as delivering financial gains for the Trust. The Committee met Dr Ross Overshott, consultant in Liaison Psychiatry, and his team.

The Committee heard about the RAID model of Liaison Mental Health provision. The team described integration of Mental Health Team and Emergency Department working. Mental Health Liaison Service Practitioners take referrals of patients with suspected mental health problems from triage without the requirement for medical clearance by the Emergency Department Team and manage patients jointly with the medical team. Patient notes are shared between the emergency department and the mental health liaison team. It also described regular joint learning between Mental Health Liaison and Emergency Department teams. This would cover analysis of serious incidents, complex case discussion and patient pathway development. The team also described integration with local emergency service providers in the police and fire service. These services form part of their Emergency Village Forum.

The Committee heard about the achievements of the team. Admission rates for patients with mental health problems had halved at Salford Royal from 15.8% to 8.8%. 95.4% of patients were seen and discharged within 4 hours.

Committee members asked about the role of liaison mental health teams in preventing suicide. The Salford Mental Health Liaison Team said suicide was relatively rare so preventing individuals at imminent risk was a small part of their job. A larger part of it they said, is identifying longer-term risk factors for suicide, such as debt and depression, and managing them.

Another question was raised about the impact that the service had had on suicide rates in the area. The Salford Mental Health Team again said that it would be difficult to ascribe any changes in the suicide rate to any one service as this is a multi-pronged approach with community services. Despite this, there was noted to be a small increase in the suicide rate in Greater Manchester area recently, though on root cause analysis, this was thought likely to be a natural variation.

Formal Minutes

Tuesday 7 March 2017

Members present:

Dr Sarah Wollaston, in the Chair

Heidi Alexander	Dr James Davies
Luciana Berger	Andrew Selous
Mr Ben Bradshaw	Helen Whately
Rosie Cooper	Dr Philippa Whitford

Draft Report (*Suicide prevention*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 169 read and agreed to.

Summary agreed to.

Annex agreed to.

Resolved, That the Report be the Sixth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Tuesday 14 March at 2.00pm.]

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Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee's website.

Tuesday 1 November 2016

Question number

Ruth Sutherland, Chief Executive, Samaritans, **Sophie Corlett**, Director of External Relations, Mind, and **Dr Ann John**, Associate Professor, Swansea University Medical School

[Q1–63](#)

Saffron Cordery, Director of Policy and Strategy, NHS Providers, **Dr Liz England**, Royal College of General Practitioners, and **Dr Peter Aitken**, Chair of the Faculty of Liaison Psychiatry, Royal College of Psychiatrists

[Q64–134](#)

Tuesday 8 November 2016

Ian Stevens, Suicide Prevention Programme Manager, Network Rail, and **Melanie Hide**, Head of Corporate Affairs, Royal National Lifeboat Institution

[Q135–164](#)

Marie Ash, Devon Suicide Prevention Alliance, **Shirley Smith**, If U Care Share Foundation, **Clare Milford Haven**, The James Wentworth-Stanley Memorial Fund, **Hamish Elvidge**, The Matthew Elvidge Trust, **Steve Mallen**, The MindEd Trust, **Dr Marc Bush**, Chief Policy Adviser, YoungMinds, and **Joy Hibbins**, Suicide Crisis

[Q165–244](#)

Tuesday 29 November 2016

Professor Louis Appleby, National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, and **Professor Carmine Pariante**, Institute of Psychiatry

[Q245–310](#)

Rt Hon Jeremy Hunt MP, Secretary of State for Health, **Jonathan Marron**, Director of Community, Mental Health and 7 Day Services, Department of Health, **Professor Kevin Fenton**, Director of Health and Wellbeing, Public Health England, and **Phoebe Robinson**, Head of Mental Health—Secure Care Policy, NHS England

[Q311–394](#)

Tuesday 31 January 2017

Ruth Sutherland, Chief Executive, Samaritans, **Dr Peter Aitken**, Chair of the Faculty of Liaison Psychiatry, Royal College of Psychiatrists, **Hamish Elvidge**, the Matthew Elvidge Trust, and **Councillor Richard Kemp**, Deputy Chair, Community Wellbeing Board, Local Government Association

[Q395–447](#)

Published written evidence

The following written evidence was received and can be viewed on the [inquiry publications page](#) of the Committee's website.

SPR numbers are generated by the evidence processing system and so may not be complete.

- 1 Adrian Stott ([SPR0002](#))
- 2 Agenda ([SPR0066](#))
- 3 Alcohol Concern ([SPR0026](#))
- 4 Anessa Rebar ([SPR0155](#))
- 5 Anonymous A ([SPR0007](#))
- 6 AntiDepAware ([SPR0023](#))
- 7 APRIL (Adverse Psychiatric Reactions Information Link) ([SPR0121](#))
- 8 Association of Directors of Public Health UK ([SPR0049](#))
- 9 Autistica ([SPR0013](#))
- 10 Bristol Health Partners ([SPR0128](#))
- 11 British Association for Psychopharmacology ([SPR0158](#))
- 12 British Transport Police ([SPR0090](#))
- 13 CALM, the Campaign Against Living Miserably ([SPR0088](#))
- 14 Care Not Killing Alliance ([SPR0101](#))
- 15 Cassel Hospital - West London Mental Health Trust ([SPR0051](#))
- 16 Centre for Mental Health ([SPR0136](#))
- 17 Chief Coroner ([SPR0162](#))
- 18 Childhood Bereavement Network ([SPR0126](#))
- 19 Citizens Commission on Human Rights (United Kingdom) ([SPR0067](#))
- 20 College of Policing ([SPR0069](#))
- 21 Connecting with People ([SPR0118](#))
- 22 Cruise Bereavement Care ([SPR0077](#))
- 23 David Healy ([SPR0045](#))
- 24 Department for Work and Pensions ([SPR0035](#))
- 25 Department of Health ([SPR0110](#))
- 26 Devon and Somerset Fire and Rescue Service ([SPR0003](#))
- 27 Devon Suicide Prevention Alliance ([SPR0094](#)), ([SPR0169](#))
- 28 Dignity in Dying ([SPR0092](#))
- 29 Dr Lucy Biddle ([SPR0093](#))
- 30 Dr Minh Alexander ([SPR0082](#))
- 31 Dr Sharon McDonnell ([SPR0010](#))
- 32 General Medical Council ([SPR0134](#))
- 33 Gerry Cadogan ([SPR0017](#))

- 34 Health Education England ([SPR0135](#))
- 35 If U Care Share Foundation ([SPR0106](#))
- 36 Independent Mental Health Services Alliance ([SPR0060](#))
- 37 International Coalition for Drug Awareness ([SPR0137](#))
- 38 Ivan Pierson ([SPR0041](#))
- 39 Justice for Men & Boys (and the women who love them) ([SPR0053](#))
- 40 Kent County Council ([SPR0095](#))
- 41 Kernow CCG ([SPR0125](#))
- 42 King's College London ([SPR0068](#))
- 43 Lancaster University ([SPR0034](#))
- 44 Leonie Fennell ([SPR0044](#))
- 45 Liberty ([SPR0070](#))
- 46 Living and Dying Well ([SPR0015](#))
- 47 Loose Women ([SPR0148](#))
- 48 Luciana Berger MP ([SPR0154](#))
- 49 Male Psychology Network ([SPR0104](#))
- 50 Medical Research Council ([SPR0140](#))
- 51 Mersey Care NHS Foundation Trust ([SPR0089](#))
- 52 Mind ([SPR0146](#))
- 53 Mind in Haringey/Haringey Suicide prevention group ([SPR0065](#))
- 54 MindFreedom Ireland ([SPR0098](#))
- 55 Money and Mental Health ([SPR0111](#))
- 56 MQ: Transforming Mental Health ([SPR0103](#))
- 57 Mr Ashley Wright ([SPR0064](#))
- 58 Mr Bob Fiddaman ([SPR0043](#))
- 59 Mr David Roberts ([SPR0096](#))
- 60 Mr Greg White ([SPR0063](#))
- 61 Mr Raymond Paul Gregory ([SPR0164](#))
- 62 Mr Steve Mallen ([SPR0119](#))
- 63 Mrs Elizabeth Koole ([SPR0079](#))
- 64 Mrs Linden Lynn ([SPR0127](#))
- 65 Mrs Samantha Carr ([SPR0129](#))
- 66 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) ([SPR0087](#))
- 67 National Institute for Health and Care Excellence ([SPR0085](#))
- 68 National Police Chiefs' Council ([SPR0073](#))
- 69 National Suicide Prevention Alliance ([SPR0124](#))
- 70 National Union of Journalists ([SPR0052](#))

- 71 Network Rail ([SPR0153](#)), ([SPR0143](#))
- 72 NHS Clinical Commissioners ([SPR0061](#))
- 73 NHS Providers ([SPR0131](#)), ([SPR0170](#))
- 74 Norfolk Children's Services ([SPR0147](#))
- 75 Note by the Parliamentary Office of Science and Technology on the experiences and perspectives of individuals personally affected by suicide ([SPR0149](#))
- 76 NSPCC ([SPR0040](#))
- 77 Older adult faculty of the Royal College of Psychiatrists ([SPR0117](#))
- 78 PAPYRUS ([SPR0167](#)), ([SPR0027](#))
- 79 Prison Reform Trust ([SPR0031](#))
- 80 Prisons and Probation Ombudsman ([SPR0062](#))
- 81 Professor David Gunnell ([SPR0032](#)), ([SPR0179](#))
- 82 Professor Keith Hawton ([SPR0030](#))
- 83 Professor Navneet Kapur ([SPR0178](#))
- 84 Public Health England ([SPR0120](#)), ([SPR0166](#))
- 85 Recovery Focus ([SPR0029](#))
- 86 Royal College of Anaesthetists ([SPR0163](#))
- 87 Royal College of General Practitioners ([SPR0132](#))
- 88 Royal College of Midwives ([SPR0116](#))
- 89 Royal College of Nursing ([SPR0057](#))
- 90 Royal College of Paediatrics and Child Health ([SPR0112](#))
- 91 Royal College of Psychiatrists ([SPR0130](#)), ([SPR0174](#))
- 92 Royal National Lifeboat Institution (RNLI) ([SPR0138](#))
- 93 Samaritans ([SPR0072](#)), ([SPR0156](#)), ([SPR0173](#)), ([SPR0176](#))
- 94 SANE ([SPR0133](#))
- 95 Sarah Waters ([SPR0047](#))
- 96 Steve Mullen ([SPR0171](#))
- 97 Stewart Cambridge ([SPR0042](#))
- 98 Suicide Crisis ([SPR0012](#)), ([SPR0150](#)), ([SPR0168](#))
- 99 Support after Suicide Partnership ([SPR0059](#))
- 100 Sussex Community Development Organisation ([SPR0056](#))
- 101 SW Zero Suicides Collaborative ([SPR0122](#))
- 102 TFL ([SPR0159](#))
- 103 The James Wentworth-Stanley Memorial Fund ([SPR0157](#))
- 104 The Matthew Elvidge Trust ([SPR0114](#)), ([SPR0172](#)), ([SPR0177](#))
- 105 The Mental Health Foundation ([SPR0161](#))
- 106 The Royal British Legion ([SPR0151](#))
- 107 The Royal College of Obstetricians and Gynaecologists (RCOG) ([SPR0050](#))

- 108 The UK Faculty of Public Health ([SPR0107](#))
- 109 Transport for London ([SPR0144](#))
- 110 UMHAN (University Mental Health Advisers Network) ([SPR0036](#))
- 111 University of Exeter ([SPR0038](#))
- 112 YMCA England ([SPR0152](#))
- 113 YoungMinds ([SPR0071](#)), ([SPR0175](#))
- 114 youplus ([SPR0019](#))

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List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the [publications page](#) of the Committee's website.

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2015–16

First Report	Child obesity—brave and bold action	HC 465 (Cm 9330)
Second Report	Appointment of the Chair of the Care Quality Commission	HC 195
Third Report	Appointment of the Chair of the Food Standards Agency	HC 663
Fourth Report	Primary care	HC 408 (Cm 9331)

Session 2016–17

First Report	Impact of the Spending Review on health and social care	HC 139 (Cm 9385)
Second Report	Public health post-2013	HC 140 (Cm 9378)
Third Report	Winter pressure in accident and emergency departments	HC 277
Fourth Report	Suicide prevention: interim report	HC 300
Fifth Report/ First Joint Report	Appointment of the Parliamentary and Health Service Ombudsman	HC 810

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