



House of Commons
Health Committee

Suicide prevention: interim report

Fourth Report of Session 2016–17

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

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Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department for Health.

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Committee reports are published on the Committee's website at www.parliament.uk/healthcom and in print by Order of the House.

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

Committee staff

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).

Contacts

All correspondence should be addressed to the Clerk of the Health Committee, House of Commons, London SW1A 0AA. The telephone number for general enquiries is 020 7219 6182; the Committee's email address is healthcom@parliament.uk.

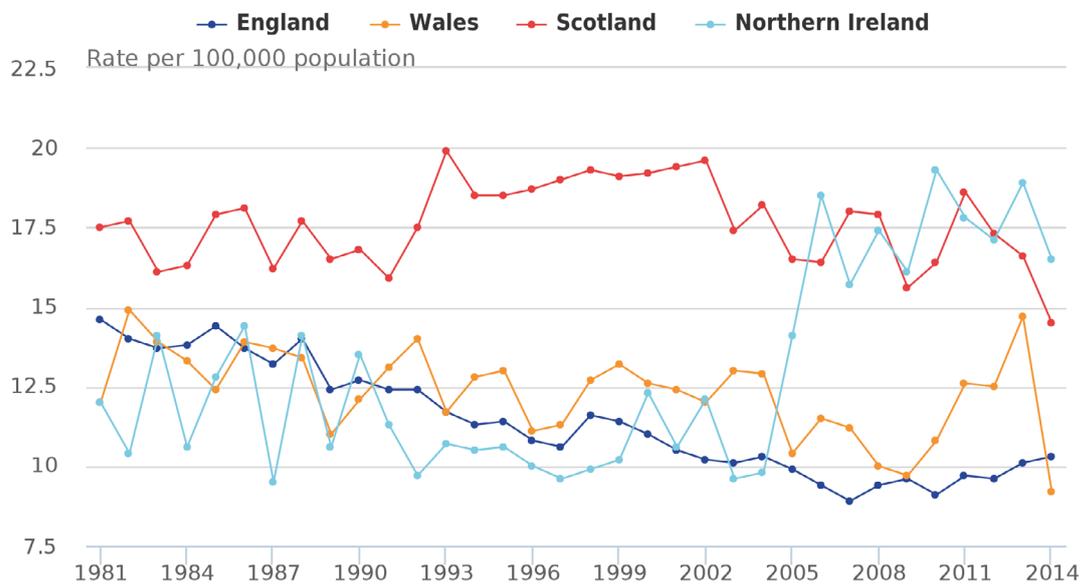
Contents

1	Introduction and summary	3
2	Implementation	6
3	Services to support people who are vulnerable to suicide	8
4	Consensus statement on sharing information with families	11
5	Data	12
6	Media	14
7	Conclusion	15
	Conclusions and recommendations	16
	Formal Minutes	18
	Witnesses	19
	Published written evidence	20
	List of Reports from the Committee during the current Parliament	24

1 Introduction and summary

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 under 49³ 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 this month, 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

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

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

7 Samaritans ([SPR0072](#))

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 Yet the clear message we have heard throughout our inquiry is that suicide is preventable.

4. Our inquiry into suicide prevention received over 150 submissions.⁹ We heard oral evidence from a range of organisations and individuals¹⁰ including those bereaved by suicide or with lived experience of suicidal ideation, from whom we heard powerful evidence both about their experiences and about the work they are now doing to help prevent suicide.¹¹ We also visited Liverpool to hear from representatives from the Cheshire and Merseyside Suicide Prevention Network and organisations seeking to improve mental health and wellbeing through sport and by reaching out to those in distress who would not otherwise contact services to seek help.¹²

5. The Government has indicated that a refresh of the suicide prevention strategy will be published in January 2017. We have heard striking and informative evidence which we hope the Government will take into account before drawing its final conclusions. As it is not possible for us to publish a full report in time for it to influence the Government's refreshed strategy, we have decided to publish this interim report in order to set out the key messages we have heard from witnesses throughout our inquiry.

6. We will be producing a full report in due course following a session with witnesses to hear their views on the Government's updated suicide prevention strategy, once it has been published.

7. In this report we outline five key areas for consideration by the Government before the refreshed strategy is finalised:

- (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.

8 Public Health England ([SPR0120](#))

9 Health Committee, Suicide prevention, [written evidence](#)

10 Health Committee, Suicide prevention, [oral evidence](#)

11 Health Committee, Suicide prevention, oral evidence, [Tuesday 8th November 2016](#)

12 "Suicide prevention: Committee visits Liverpool and Salford", [Health Committee news release](#), 24 November 2016

- (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.

2 Implementation

8. The clear message given to us by stakeholder groups is a simple one—implementation of the Government’s 2012 suicide prevention strategy has been characterized by inadequate leadership, poor accountability, and insufficient action.¹³ Over the past four years, there has been a failure to translate the suicide prevention strategy into actual improvements. Implementation, which is largely the responsibility of local authorities and local health services, has been highly variable and subject to insufficient oversight. Hamish Elvidge, a father who lost his son to suicide and Chair of the Matthew Elvidge Trust and the Support After Suicide Partnership, told us very compellingly:

To me, it is extraordinary and very distressing that four years after the strategy was published we do not know how many local authorities have implemented anything [...] we cannot allow more lives to be lost because we do not have effective governance and implementation. It is such a waste of time and a waste of money.¹⁴

9. Public Health England has just published guidance for local authorities on suicide prevention¹⁵—a hugely useful resource—but it has taken four years for this to happen, suggesting that suicide prevention has not been given sufficient priority. Witnesses from local authorities welcomed the guidance but told us that it will not achieve anything unless its implementation is robustly monitored and enforced.¹⁶

10. To date, there has been no published monitoring by the Government or its agencies of the implementation of the strategy. We are reliant on research published by the All Party Parliamentary Group on Suicide and Self Harm Prevention in 2015 which showed that 30% of local authorities did not have any form of suicide prevention strategy in place. This rose to 64% in London.¹⁷ We understand that Public Health England has now updated this assessment, and believe that more local authorities now have suicide prevention plans.¹⁸ But in the view of our witnesses, it is not enough for PHE simply to count the number of local authorities which report that they have a plan in place. The quality of the plans, whether they follow the PHE best practice guidance, and whether they are actually being implemented are all far more useful measures.¹⁹

11. The refreshed suicide prevention strategy must be underpinned by a clear implementation strategy, with strong national leadership, clear accountability, and regular and transparent external scrutiny. In the words of a bereaved parent, “we cannot allow more lives to be lost because we do not have effective governance and implementation”.²⁰

13 Q7 [Ruth Sutherland, Chief Executive, Samaritans]; Q67 [Dr Peter Aitken, Chair of Faculty of Liaison Psychiatry, Royal College of Psychiatrists]; Q270 [Professor Louis Appleby, Chair, National Suicide Prevention Strategy Advisory Group].

14 Q237 [Hamish Elvidge, Chair, Matthew Elvidge Trust, and Chair, Support After Suicide Partnership]

15 Public Health England, [Local suicide prevention planning - a practice resource](#), October 2016

16 Q18 [Dr Ann John, UK Faculty of Public Health]

17 All-Party Parliamentary Group on Suicide and Self Harm Prevention, [Inquiry into Local Suicide Prevention Plans in England](#)

18 Q312 [Professor Kevin Fenton, Director of Health and Wellbeing, Public Health England]

19 Q270 [Professor Louis Appleby]; Samaritans ([SPR156](#))

20 Q237 [Hamish Elvidge]

12. We recommend that the Government's updated strategy should include a clear implementation programme, with strong external scrutiny of local authority plans and progress. Local areas also need a clear message from the top that suicide prevention plans are mandatory.

3 Services to support people who are vulnerable to suicide

13. **Approximately one third of people who end their lives by suicide have not been in contact with health services in the year before their death.**²¹ However, this is not because they are in some way ‘unreachable’—on the contrary, we should regard all suicides as preventable. In Liverpool we met a bereaved mother who said simply “my son wasn’t hard to reach—it was the services that were hard to reach”. If such a high proportion of people in need of help are not accessing current services, then we must adapt the services we offer.

14. We should embrace innovative approaches that reach out to those in distress in order to offer an alternative before an avoidable loss of life to suicide. Supporting this group of people who are vulnerable to suicide involves tackling the stigma that persists—particularly for men—in talking about emotional health, and also in offering non-traditional routes to help for people who are unlikely to approach mainstream services—for example online services, or help in non-clinical settings for young men who seldom contact their GP.²² It is also crucial to enhance practical support to help people deal with the challenges that can push them towards a crisis, including bereavement, relationship breakdown, gambling, poor housing, alcohol and drug use, and financial problems. Unfortunately we have heard that owing to local authority funding reductions, many of these services are being cut.²³ The strategy needs to consider how the voluntary sector and commissioned services will be enabled to provide vital support services to those in acute distress and at risk of suicide. We also heard support for the wider use of training in mental health first aid in a number of workplace and public facing roles, including those working in agencies assessing those on benefits, to help identify and provide signposting or support for those in distress.

15. Suicide is complex and rarely if ever attributable to a single cause. Blaming approaches are unhelpful and we should instead focus on all the factors that allow a successful strategy to identify those at risk and intervene early. This should include Government re-examining its own policy in areas such as alcohol, gambling and drugs, where there have been missed opportunities to reduce the risk of suicide.

16. For every life lost to suicide, the estimated total cost to the economy is around £1.67 million.²⁴ The Association of Directors of Public Health told us in written evidence that for every person who ends their life by suicide, a “minimum of six people will suffer a severe impact”.²⁵ Those bereaved by suicide are themselves at greater risk of suicide. During the Committee’s evidence session with bereaved families, we heard how, as well as coping with a devastating loss, they also face onerous practical problems including dealing with coroners’ inquests and incident reviews. They are not entitled to any form of support, nor are they entitled to a family liaison officer which would be standard practice in many other situations. Steve Mallen, a bereaved parent and founder of the MindEd Trust, described being given a leaflet and then left to cope alone: “That is it. That is the sum total of interaction that one gets, and you are facing an abyss that is beyond imagination.

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

22 NCISH ([SPR0087](#)) para 12

23 Q91 [Dr Peter Aitken]

24 Department of Health ([SPR0110](#))

25 Association of Directors of Public Health ([SPR0049](#))

That is very difficult”.²⁶ We heard examples of excellent support services for people bereaved by suicide in Liverpool, including SOBS (Survivors of Bereavement by Suicide) and AMPARO, as well as CHUMS in Bedfordshire and If U Care Share in the North East—but these services are few and far between and funding for them is precarious.

17. We need to build greater resilience and wellbeing in young people in order to tackle rising levels of distress and self harm. We also need to take the opportunity to provide support for young people in distress and at times of particular vulnerability, including in higher education settings. We will be looking in further detail at mental health and education in a joint inquiry with the Education Select Committee in 2017.²⁷

18. **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.**²⁸ Some may have an identified mental health problem, but others may have no obvious mental health difficulties, and identifying these people so they can be supported can be difficult. Tools already exist to support GPs in doing this—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; but without strong, well co-ordinated national leadership to drive forward awareness and implementation, it is too easy for these resources which could save lives to be ignored amidst a huge range of other competing priorities. Whilst we heard concerns in some written submissions about the role of drug treatments and suicide, the evidence we heard from Professor Louis Appleby, Chair of the Government’s suicide prevention advisory group, and Professor Carmine Pariante of the Institute of Psychiatry was that there is greater risk from not using medication where appropriate, provided that this is following evidence-based guidelines.

19. There are serious concerns about the ongoing long waits after referral from primary care to specialist services and we urge the Government to address in its suicide prevention strategy how this situation will be improved.

20. **Approximately one third of people who end their lives by suicide are under the care of specialist mental health services.**²⁹ Professor Louis Appleby told us that

You have to do crisis teams properly; they have to be 24-hour services; they have to be services that provide the right level of skill in their frontline staff and the right level of contact. They cannot just be an occasional drop-in to check that someone is taking their medication; they have to be a proper substitute, an alternative, as they were originally designed, to in-patient care. What appears to have happened in some parts of the country is that crisis teams are not now providing an adequate alternative to in-patient care: they do not have the seniority of staff; they are taking on a lot of patients who are at a very high degree of risk who probably need something more protective.³⁰

26 Q229 [Steve Mallen, MindEd Trust]

27 Children and young people’s mental health—the role of education, <http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/news-parliament-20151/children-young-people-mental-health-education-launch-16-17/>

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

29 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, [Making Mental Health Care Safer](#), October 2016

30 Q253 [Professor Louis Appleby]

He also told us that the single riskiest time is the three days following discharge from inpatient services.³¹ We support the calls for all patients discharged from inpatient care to be followed up within three days, rather than the seven days that is the current standard, and recommend that this standard be implemented urgently.³²

21. There is a high risk of completed suicide in those who have self harmed. We heard about the importance of liaison psychiatry services in accident and emergency departments as this is the setting in which so many people in acute distress are in contact with services. We welcome the Government's commitment that every hospital should have this service by 2020, but Professor Appleby told us that there was no reason why this could not be introduced next year, in every part of the country.³³ In Liverpool, however, we heard that liaison psychiatry services have just been closed. The suicide prevention strategy should focus on the need for liaison psychiatry to be adequately staffed and resourced. We were also concerned to hear examples of poor and delayed communication between A&E and primary care. Good communication is particularly important when people present with suicidal ideation.

22. **Our evidence suggests that there are three distinct groups of people at risk from suicide, and different approaches are needed for each:**

- **For people not in contact with any service, we support greater emphasis on public mental health and wellbeing as well as ongoing efforts to reduce stigma. We recommend that the suicide prevention strategy should include measures to improve the identification of those at risk of suicide within local communities and the provision of accessible support, including within non-traditional settings and recognising the important role of the voluntary sector. Renewed focus should be given to providing mental health training for staff in public facing roles, especially in higher risk situations, and to providing practical support for those experiencing adversity which may lead to a crisis, including bereavement and financial distress.**
- **To help people who are in contact with primary care services, GPs need better training in suicide risk. NICE guidelines should be promoted and implemented across primary care.**
- **We recommend that all patients being discharged from inpatient care should receive follow up support within three days of discharge, rather than the current standard of seven days. The deadline for establishing liaison psychiatry services in every hospital should be brought forward from 2020 to 2017.**

23. **We recommend that all suicide prevention plans should include mandatory provision of support services for families who have been bereaved by suicide.**

31 Q255 [Professor Louis Appleby]

32 Q264 [Professor Louis Appleby]

33 Q260 [Professor Louis Appleby]

4 Consensus statement on sharing information with families

24. We heard very powerful evidence from those bereaved by suicide that professionals should be sharing information with the families of those who are suicidal. 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.³⁴ Hamish Elvidge explained it very helpfully:

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?”³⁵

25. Such was the strength of feeling on this issue, Hamish Elvidge, together with other bereaved families now working in this field, worked in conjunction with the Royal Colleges to develop a consensus statement on information sharing.³⁶ However, little has been done to promote awareness of and implement the Consensus Statement, or to support the culture change that is needed in this area.³⁷ As PAPHYRUS, a national charity dedicated to the prevention of young suicide, argued in their written evidence, “the Consensus Statement of the Royal Colleges and the Department of Health must be properly promoted, disseminated and used at local practice level among all health professionals.”³⁸

26. Although a patient’s right to confidentiality is paramount, there are instances where professionals sharing information—with consent—with a person’s trusted family or friends could save their life. Stronger action needs to be taken to raise awareness of the Consensus Statement, to train staff in this area (including training on how to seek consent), 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.

34 Q197 [Shirley Smith, If U Care Share Foundation]; Q208 [Clare Milford Haven, Founder, James Wentworth-Stanley Memorial Fund]; Q211 [Steve Mallen, Chairman, MindEd Trust]

35 Q206 [Hamish Elvidge]

36 [Consensus Statement on information sharing and suicide prevention](#)

37 Q206 [Hamish Elvidge]

38 PAPHYRUS ([SPR0027](#)) para 7

5 Data

27. Accurate and timely statistics are essential both for the development and evaluation of suicide prevention policy. Reliable data and early identification of suicide are also crucial to allow rapid responses to emerging patterns that could indicate clusters and trends which could help prevent further deaths by suicide. This rapid response might include reducing access to certain places or to certain (perhaps novel or emerging) methods of suicide or signposting to and providing appropriate help for those in acute distress who are contemplating suicide. Difficulties in collecting accurate and timely statistics are undermining the ability to prevent suicide. The lack of high quality data is causing us to fail future families and individuals.

28. Professor Louis Appleby (amongst others) underlined the importance of consistency across the coronial system, noting that coroners do excellent and vital work but that the system is heavily dependent on individual coroner judgment, and therefore can vary widely between areas.³⁹ Concerns were also raised by witnesses about narrative conclusions. The use of narrative conclusions can provide coroners with a way to “alleviate the impact of the conclusion of suicide”⁴⁰ but witnesses were concerned that a greater use of narrative conclusions has increased data inaccuracy, and can result in an underestimation of the number of suicides.⁴¹ The timeliness of the provision of data is another key problem, with coroners’ conclusions sometimes reached more than a year after a person has taken their life. This information is therefore available too late to identify suicide clusters or potential ‘cluster triggers’ which could inform important short-term public health interventions.⁴²

29. The Chief Coroner noted that “coroners are independent judges” and that providing early information to public health officials and suicide conclusions themselves is a matter for individual coroners to decide upon.⁴³ We recognise this but consider that further guidance could be developed for coroners in order to ensure increased consistency nationwide both between coroners’ conclusions themselves and between assistance provided for public health officials following potential clusters of suicides.

30. Currently 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. We heard from witnesses that the standard of proof for conclusions of death by suicide should be changed to meet the civil standard, that is, on the balance of probabilities.⁴⁴ As Professor Appleby told us, “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.”⁴⁵ As the Chief Coroner told us in written evidence, “what standard of proof applies in relation to conclusions in the coroner’s courts is a matter ultimately for Parliament”.⁴⁶

39 Q279, Q280, Q281 [Professor Louis Appleby]; Q59 [Ruth Sutherland]

40 [Chief Coroner Guidance No. 17, Conclusions: Short-form and narrative](#), para 63

41 Q51 [Dr Ann John]

42 Haringey Suicide Prevention Group ([SPR0065](#)) para 11

43 Chief Coroner ([SPR0162](#))

44 Q296 [Professor Louis Appleby]; POPYRUS ([SPR0027](#)) para 4; CALM ([SPR0088](#)) para 8.4; National Police Chiefs’ Council ([SPR0073](#)) para 4.8

45 Q296 [Professor Louis Appleby]

46 Chief Coroner ([SPR0162](#))

31. Our evidence suggests the need for a more rapid provisional notification of suicide at the time when a suspected death by suicide occurs. We recommend that the Government take action to improve consistency between coroners and to make routine the use of provisional notifications of suicide. Furthermore, 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.

6 Media

32. Irresponsible media reporting and portrayals of suicide can lead to copycat behaviour, especially among young people and those already at risk.⁴⁷ Descriptions of novel or emerging suicide methods can lead to more people choosing to take their lives using one of these methods.

33. There are already clear guidelines for the media, in particular Samaritans' *Media Guidelines for Reporting Suicide*.⁴⁸ Public Health England's guide for local areas on how to respond rapidly to clusters of suicide also includes management of the media.⁴⁹ The main issue relating to the media is the failure to universally implement the guidance. Except for the responsible reporting of suicide clause in the Editors' Code of Practice (which Samaritans argue needs strengthening), all other guidelines are voluntary and there appear to be no consequences for blatant breaches of the guidelines, whether wilful or ignorant.

34. 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. We 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. 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.⁵⁰

35. We also note the role of the internet and social media in promoting suicidal behaviour. The internet provides the means for individuals to easily access information about suicide methods. Participants in a recent study by the University of Bristol exploring the impact of the Internet on suicidal behaviour "discussed how exposure to suicide content, including reading about others' suicide or suicide attempts, had served to validate or justify this as an acceptable option/legitimate course of action."⁵¹ However while the internet is a source of potential harm, it can also be a source of benefit. As Dr Ann John told us, "online communities can be quite supportive. It is not all bad, particularly for vulnerable groups like young people from LGBT communities, to be able to express these thoughts but then be encouraged to seek help. It can be a positive thing."⁵²

36. We recommend that the suicide prevention strategy should review the accountability and responsibility for the adherence to media guidelines. The guidelines must have teeth and the refreshed suicide prevention strategy must make clear who is responsible for dealing with breaches by the media, at national and local level. We recommend that the refreshed suicide prevention strategy should include a commitment by the Government to work with internet providers and social media platforms to consider what changes should be made to restrict access to sites which encourage self harm or give detailed advice on suicide methods.

47 UK Faculty of Public Health ([SPR0107](#)); YoungMinds ([SPR0071](#)) para 5.1; Association of Directors of Public Health ([SPR0049](#))

48 Samaritans, [Media Guidelines for Reporting Suicide](#), 5th edition (September 2013)

49 Public Health England, [Preventing suicides in public places](#)

50 Q390 and Q391 [Professor Kevin Fenton]

51 Dr Lucy Biddle ([SPR0093](#))

52 Q48 [Dr Ann John]

7 Conclusion

37. Our evidence has made clear that suicide is preventable and that much more can and should be done to support vulnerable individuals. We look forward to the publication of the Government's refreshed suicide prevention strategy and we hope to see the crucial points we have addressed in this short report taken into account. We will scrutinise the updated strategy and will hold a follow-up hearing with key stakeholders to hear their views before publishing a full report.

Conclusions and recommendations

Implementation

1. The refreshed suicide prevention strategy must be underpinned by a clear implementation strategy, with strong national leadership, clear accountability, and regular and transparent external scrutiny. In the words of a bereaved parent, “we cannot allow more lives to be lost because we do not have effective governance and implementation”. (Paragraph 11)
2. We recommend that the Government’s updated strategy should include a clear implementation programme, with strong external scrutiny of local authority plans and progress. Local areas also need a clear message from the top that suicide prevention plans are mandatory. (Paragraph 12)

Services to support people who are vulnerable to suicide

3. Our evidence suggests that there are three distinct groups of people at risk from suicide, and different approaches are needed for each:
 - For people not in contact with any service, we support greater emphasis on public mental health and wellbeing as well as ongoing efforts to reduce stigma. We recommend that the suicide prevention strategy should include measures to improve the identification of those at risk of suicide within local communities and the provision of accessible support, including within non-traditional settings and recognising the important role of the voluntary sector. Renewed focus should be given to providing mental health training for staff in public facing roles, especially in higher risk situations, and to providing practical support for those experiencing adversity which may lead to a crisis, including bereavement and financial distress.
 - To help people who are in contact with primary care services, GPs need better training in suicide risk. NICE guidelines should be promoted and implemented across primary care.
 - We recommend that all patients being discharged from inpatient care should receive follow up support within three days of discharge, rather than the current standard of seven days. The deadline for establishing liaison psychiatry services in every hospital should be brought forward from 2020 to 2017. (Paragraph 22)
4. We recommend that all suicide prevention plans should include mandatory provision of support services for families who have been bereaved by suicide. (Paragraph 23)

Consensus statement on sharing information with families

5. Although a patient’s right to confidentiality is paramount, there are instances where professionals sharing information—with consent—with a person’s trusted family or friends could save their life. Stronger action needs to be taken to raise awareness of the Consensus Statement, to train staff in this area (including training on how to

seek consent), 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. (Paragraph 26)

Data

6. Our evidence suggests the need for a more rapid provisional notification of suicide at the time when a suspected death by suicide occurs. We recommend that the Government take action to improve consistency between coroners and to make routine the use of provisional notifications of suicide. Furthermore, 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 31)

Media

7. We recommend that the suicide prevention strategy should review the accountability and responsibility for the adherence to media guidelines. The guidelines must have teeth and the refreshed suicide prevention strategy must make clear who is responsible for dealing with breaches by the media, at national and local level. We recommend that the refreshed suicide prevention strategy should include a commitment by the Government to work with internet providers and social media platforms to consider what changes should be made to restrict access to sites which encourage self harm or give detailed advice on suicide methods. (Paragraph 36)

Formal Minutes

Tuesday 13 December 2016

Members present:

Dr Sarah Wollaston, in the Chair

Heidi Alexander	Dr James Davies
Luciana Berger	Andrea Jenkyns
Rosie Cooper	Andrew Selous

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

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

Paragraphs 1 to 37 read and agreed to.

Resolved, That the Report be the Fourth 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 10 January at 9.45am.]

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 Institutions [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](#)

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 Cruse 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](#))
- 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 Steve Mallen ([SPR0119](#))
- 62 Mrs Elizabeth Koole ([SPR0079](#))
- 63 Mrs Linden Lynn ([SPR0127](#))
- 64 Mrs Samantha Carr ([SPR0129](#))
- 65 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) ([SPR0087](#))
- 66 National Institute for Health and Care Excellence ([SPR0085](#))
- 67 National Police Chiefs' Council ([SPR0073](#))
- 68 National Suicide Prevention Alliance ([SPR0124](#))
- 69 National Union of Journalists ([SPR0052](#))
- 70 Network Rail ([SPR0153](#))

- 71 Network Rail ([SPR0143](#))
- 72 NHS Clinical Commissioners ([SPR0061](#))
- 73 NHS Providers ([SPR0131](#))
- 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 PAPHOS Prevention of Young Suicide ([SPR0027](#))
- 79 Prison Reform Trust ([SPR0031](#))
- 80 Prisons and Probation Ombudsman ([SPR0062](#))
- 81 Professor David Gunnell ([SPR0032](#))
- 82 Professor Keith Hawton ([SPR0030](#))
- 83 Public Health England ([SPR0120](#))
- 84 Recovery Focus ([SPR0029](#))
- 85 Royal College of General Practitioners ([SPR0132](#))
- 86 Royal College of Midwives ([SPR0116](#))
- 87 Royal College of Nursing ([SPR0057](#))
- 88 Royal College of Paediatrics and Child Health ([SPR0112](#))
- 89 Royal College of Psychiatrists ([SPR0130](#))
- 90 Royal National Lifeboat Institution (RNLI) ([SPR0138](#))
- 91 Samaritans ([SPR0072](#))
- 92 Samaritans ([SPR0156](#))
- 93 SANE ([SPR0133](#))
- 94 Sarah Waters ([SPR0047](#))
- 95 Stewart Cambridge ([SPR0042](#))
- 96 Suicide Crisis ([SPR0012](#))
- 97 Suicide Crisis ([SPR0150](#))
- 98 Support after Suicide Partnership ([SPR0059](#))
- 99 Sussex Community Development Organisation ([SPR0056](#))
- 100 SW Zero Suicides Collaborative ([SPR0122](#))
- 101 TFL ([SPR0159](#))
- 102 The James Wentworth-Stanley Memorial Fund ([SPR0157](#))
- 103 The Matthew Elvidge Trust ([SPR0114](#))
- 104 The Mental Health Foundation ([SPR0161](#))
- 105 The Royal British Legion ([SPR0151](#))
- 106 The Royal College of Obstetricians and Gynaecologists (RCOG) ([SPR0050](#))
- 107 The UK Faculty of Public Health ([SPR0107](#))

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

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