



Department
of Health

Government Response to the Health Select Committee's Inquiry into Suicide Prevention

July 2017



Government Response to the Health Select Committee's Inquiry into Suicide Prevention

Presented to Parliament
by the Secretary of State for Health
by Command of Her Majesty

July 2017

Cm 9466



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Any enquiries regarding this publication should be sent to us at Department of Health, 79 Whitehall, London SW1A 2NS

Print ISBN 9781474148559

Web ISBN 9781474148566

ID P002891482

07/17

Printed on paper containing 75% recycled fibre content minimum

Printed in the UK by the Williams Lea Group on behalf of the Controller of Her Majesty's Stationery Office

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1. Introduction

Suicide has a devastating impact on family, friends and communities and highlights a serious and tragic social injustice. Someone dies by suicide every 90 minutes in the UK and in England 13 people die by suicide each day. Every death by suicide is one too many, and although attempting suicide, or feeling suicidal, can affect anyone, it typically affects the most vulnerable people and those from the poorest backgrounds living in the most disadvantaged communities. For example, men living in the most deprived areas have an up to 10 times higher risk of suicide than men living in more affluent areas. We must address this kind of inequality. The Cross-Government Suicide Prevention Strategy sets out the Government's priorities for addressing suicide and self-harm and we are fully committed to implementing its aims. We know the factors that may lead someone to suicide can be complex and that is why we continually monitor suicide data and trends and strive towards preventing suicide wherever possible.

Following its inquiry into suicide prevention, the House of Commons Health Select Committee published, *Suicide prevention: interim report (HC300)* on 19 December 2016 and *Suicide Prevention (HC1087)* on 17 March 2017.

The Government is grateful for the Health Select Committee's interest in suicide prevention and welcomes these thoughtful and insightful reports. The Committee has accurately identified the key challenges for improving suicide prevention and the Government has carefully considered the Committee's reports and the issues that they raise. This paper sets out the Government's response to the recommendations of both reports.

The Government published an updated Cross-Government Suicide Prevention Strategy in January which set out how we are strengthening delivery of its key areas for action to drive implementation nationally and locally to achieve the ambition of reducing the national suicide rate by 10 percent by 2020/21. By the end of the year, every local area will have a multi-agency suicide prevention plan in place to drive local implementation.

We acknowledge that there is a long way to go to achieve this ambition and suicide rates in England remain too high. However, we are encouraged that after years of increasing suicides since 2008, we began to see the suicide rate decrease between 2014 and 2015. England continues to have the lowest suicide rates in the UK and low when compared to other European countries.

International best practice recognises the importance of targeting groups at high risk of suicide as well as addressing the wider health and social determinants of suicide. The Government published its response for delivering the vision of the Five Year Forward View for Mental Health and our significant extra investment in mental health services will enable us to address these inequalities. We will set out a Mental Health Workforce Strategy soon to support delivery of this vision. This Government has also set out measures to improve mental health awareness in the general population and will publish a green paper later this year to improve children and young people's mental health. We will continue to implement further access standards to ensure people receive the mental health treatment they need and implement evidence-based pathways of care for mental health services to ensure a further 1 million people can access treatment by 2020/21.

These ambitious mental health reforms will ensure we have the capacity and framework to challenge the inequality of suicide.

2. The Government's response to the Committee's conclusions and recommendations

Implementation

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”. (Interim Report Paragraph 11)

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. (Interim Report Paragraph 12).

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. (Final Report Paragraph 17).

We are clear that in order to deliver the aims of the Cross-Government Suicide Prevention Strategy we need a strong and consistent drive from Government on progress, appropriate external scrutiny, high-level oversight and more effective local implementation.

In January, the Prime Minister set out a wide range of measures to improve mental health services and published the cross-Government response to the Five Year Forward View for Mental Health and the updated Cross-Government Suicide Prevention Strategy. The updated strategy set out how we are strengthening implementation of its key areas for action as well as adding a new key area for action to address self-harm. These include:

- Reducing the risk of suicide in high risk groups;
- Tailoring approaches to improve mental health in specific groups;
- Reducing access to means of suicide;
- Providing better information and support to those bereaved or affected by suicide;
- Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour;
- Supporting research, data collection and monitoring; and
- Reducing rates of self-harm as a key indicator of suicide risk.

The Secretary of State for Health wrote to all local authority chief executives in October 2016 to encourage them to develop local suicide prevention plans. To date, over 95 percent of local authorities have suicide prevention plans in place or in development and Public Health England is working with the remaining local authorities which do not, as yet, have plans. As we did with local mental health crisis care concordat action plans, we are engaging local authorities to support them to implement and quality assure suicide prevention plans. Following publication of its guidance to local authorities, Public Health England held a series of regional suicide prevention seminars for local authorities, which were attended by over 500 people. We will use the quality assurance process for local suicide prevention plans to share further best practice from those local authorities which are already implementing innovative and robust local plans.

Quality of local authorities' plans

We welcome the fact that 95 per cent of local authorities have a suicide prevention plan

in place or in development. However we are concerned that there is currently no detail about the quality of those plans. It is not enough simply to count the number of local authorities which report that they have a plan in place. (Final Report Paragraph 21)

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. (Final Report Paragraph 22)

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. (Final Report Paragraph 23)

We are working with the National Suicide Prevention Strategy Advisory Group (NSPSAG), Department for Communities and Local Government and Public Health England to develop an assurance process that supports local authorities to develop robust multi-agency suicide prevention plans and ensures their regular review and development.

We have liaised with the NSPSAG to agree the assurance process and criteria and we will test this with a sample of local authorities to start the process in the summer. The Five Year Forward View for Mental Health recommended that the Department of Health, Public Health England and NHS England should support all local areas to have a suicide prevention plan in place by the end of the year and we will ensure local plans are also quality assured over the same period. We are establishing an assessment group comprising members of the NSPSAG, National Suicide Prevention Alliance, our delivery partners and expert stakeholders to ensure we have the right balance of leading suicide prevention experts and academics, delivery agencies (including voluntary and charitable sector partners), and experts by experience.

We will learn from the successful mental health crisis care concordat action plan assurance process which involved self-assessment and was based on best practice criteria. However, we want to make improvements where we can. Therefore, we will ensure that there is more proactive support for local authorities to complete the self-assessment and we will share best practice that is already evident in local authorities that have well-established plans. Where self-assessments show areas for further development and improvement we will support local authorities to do this. We also want to learn from the mental health crisis care concordat network which is managed by the Department of Health and the Home Office to establish a similar network for local authorities to develop their suicide prevention plans. Where possible we will look to maximise on these established links.

Quality will be assessed against best practice guidance issued to local authorities by Public Health England to develop their suicide prevention plans and to develop and deliver suicide bereavement services. This will ensure plans are assessed against consistent standards. We will continue to liaise with Public Health England to develop their guidance to local authorities.

Ensuring effective implementation

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. (Final Report Paragraph 27)

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. (Final Report Paragraph 28)

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. (Final Report Paragraph 30)

The Department of Health is working with the Department for Communities and Local Government and our stakeholders to support local authorities in assuring the quality of their multi-agency suicide prevention plans this year.

There are no plans to establish a National Implementation Board. We are working with the National Suicide Prevention Strategy Advisory Group (NSPSAG) and key stakeholders to develop the assurance process and criteria for assessment which we will test with a sample of local authorities. The quality assurance will be undertaken by a group comprising members of the NSPSAG, National Suicide Prevention Alliance, our delivery partners and expert stakeholders. The NSPSAG will have oversight of the results of the quality assurance process which will also be reported to Ministers before being published on Public Health England's Atlas of Variation: <http://healthierlives.Public Health England.org.uk/topic/suicide-prevention>

We will engage with local authorities about appropriate involvement of other bodies such as Health Overview and Scrutiny Committee's. Public Health England's suicide prevention planning guidance already recommends the involvement of Health and Wellbeing Boards. However, it is for local authorities, working with the NHS and other local agencies to determine which organisations and professionals should be involved in implementing local plans.

Funding

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. (Final Report Paragraph 38)

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. (Final Report Paragraph 39)

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. (Final Report Paragraph 40)

The Government is investing record levels to improve mental health services. The Five Year Forward View for Mental Health is supported by £1 billion of additional investment by 2020. We have also invested £1.4 billion to improve children and young people's mental health by 2020, including £150 million specifically to address eating disorders.

Spending on mental health is higher than ever before with £11.4 billion in 2016/17¹, and in order to meet the Mental Health Investment Standard set out in NHS Shared Planning Guidance 2017/18-2018/19, CCGs must increase their spend each year in line with their overall growth in allocations.

Funding of £25 million is being provided to NHS England between 2018-2020, specifically for suicide prevention, as part of the Five Year Forward View for Mental Health. The Department of Health is liaising with NHS England and Public Health England this year to determine the priorities for the additional funding, which is likely to support local plans as well as a small group of priorities that have the greatest impact on suicide numbers. We will publish details of these priorities and the allocation of funding in the annual updates to the National Suicide Prevention Strategy.

In addition to the £25 million, it is expected that a significant majority of the total funding detailed in Implementing the Five-Year Forward View for Mental Health will contribute towards the objective of reducing suicides. For example, investment in community-based mental health crisis services and implementing liaison mental health services in general hospital emergency departments. Furthermore, we made available £15 million to implement additional health-based places of safety for people experiencing a mental health crisis and the Prime Minister announced an additional £15 million this year to build on this work to ensure that people are supported in the right place to suit their needs.

To ensure that funding for mental health is reaching the right places, NHS England wrote to all CCGs and mental health providers in February to seek assurance that plans for 2017/18-2018/19 would meet the Mental Health Investment Standard and the commitment to deliver in full the Five Year Forward View for Mental Health. In addition, guidance for CCGs in developing Sustainability and Transformation Plans includes a clear requirement they must work towards the national ambition to reduce suicides by 10 percent by 2020.

Transparency on spending and delivery is a major lever to ensure that the Five Year Forward View for Mental Health is delivered. As an example, the NHS England financial reporting system requires CCG-level information on total mental health spend and spend against additional allocations, including for children and young people's mental health.

The information in the financial returns is validated as part of NHS England's formal financial reporting process and since October 2016, NHS England has published CCG-level data on spend in the Five Year Forward View for Mental Health Dashboard which is published quarterly. The Dashboard includes indicators on suicide and self-harm prevention as well as crisis care and liaison mental health.

Mental health is one of five clinical areas that form part of the overall CCG Improvement and Assessment Framework (CCGIAF); this provides an assessment of CCG performance in mental health and is published on MyNHS.

In addition, commissioners are required to report their planned spend on mental health as part of the NHS England planning round and to report on actual mental health spend on a quarterly basis through formal in-year reporting.

¹ £11.4bn figure correct as at 21 June 2017

The Cross-Government National Suicide Prevention Strategy is an extensive and long-term strategy for reducing suicides. It recognises that this will be delivered across a range of Government departments, agencies and sectors and those organisations are responsible for funding these activities. A significant amount of this work will be delivered at a local level through multi-agency suicide prevention plans and funding for these plans is the responsibility of local economies.

The Government is committed to achieving the ambition in the Five Year Forward View for Mental Health to reduce the national suicide rate by 10 percent by 2020. We are working with the National Suicide Prevention Strategy Advisory Group (NSPSAG) to set out the work programme for suicide prevention up to 2020 and setting out annual priorities, milestones and deliverables. We will liaise with other Government departments and delivery partners to secure their commitment to delivery and agree these priorities with Ministers.

Due to the wide range of activities set out in the National Suicide Prevention Strategy, and that they will be delivered across a range of sectors, it is not possible to accurately determine the cost of delivering each activity.

Services to support people who are vulnerable to suicide

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 suicide prevention plans should include mandatory provision of support services for families who have been bereaved by suicide. (Interim Report Paragraph 23)

Two thirds of people who die by suicide are not in contact with mental health services and around half of people who have attempted suicide do not seek specialist help. When people do seek help after an attempted suicide, this is more likely to be from family and friends. Suicide prevention is therefore a significant public health issue.

We are committed to ensuring that every local area implements a multi-agency suicide prevention plan by the end of the year and we will work with local authorities to quality assure their plans. Local authorities should work with the NHS and the full range of other local services and professionals who have a role to play in suicide prevention to implement local action targeted at those most at risk.

In the updated National Suicide Prevention Strategy, we set out how we are strengthening the strategy in key areas, including better targeting of high risk groups such as men and people in contact with mental health services and criminal justice services. We welcome the forthcoming report from the National Audit Office on mental health in prisons and we will consider its recommendations carefully. There are groups that require tailored approaches to meet their specific needs. For example, the Department of Health will work the Government Equalities Office to develop a plan to meet the mental health needs of lesbian, gay, bi-sexual and transgender (LGBT) people.

For people who are not in contact with services, targeting should be through informed local suicide prevention plans which are based on the demographics and associated risks of local communities. Health and social care services, schools, colleges, universities, employers, civic organisations and community leaders should all be working together to achieve an ambition to reduce suicide in their local community. Voluntary and charitable sector organisations play a valuable role in bringing local communities together and reaching out to people to reduce suicide and in many circumstances can provide services in non-health settings which feel more accessible to some groups.

It is important that professionals who work in public facing roles in high risk areas and professionals who may come into contact with people at risk of suicide should have awareness training in suicide prevention. We are supportive of the successful work of Network Rail in training over 15,000 personnel working on the rail network. In the updated National Suicide Prevention Strategy we set out how we will explore ways of sharing Network Rail's best practice approach and expanding suicide awareness into other sectors such as the construction industry and other areas of the transport network. In addition to this, the Prime Minister announced we would roll-out Mental Health First Aid training to every secondary school by 2019, with 1,000 schools being reached this year. The Government is looking at ways of extending this commitment to provide Mental Health First Aid training to every school.

We continue to support the Time to Change national anti-stigma campaign which aims to break down the stigma associated with mental health and has been successful in changing the attitudes towards mental illness of over four million people. Last year we invested a further £12.5 million to support delivery of the next phase of the programme which includes the successful 'In Your Corner' social marketing campaign aimed at raising mental health awareness in men.

Suicide is a leading cause of death in our young people and self-harm is an increasingly concerning issue. Each year in England and Wales there are around 200,000 presentations (all ages) at emergency departments for self-harm and many more people self-harm in the community; many of these people may not come into contact with any services. We will publish a Children and Young People's Mental Health Green Paper this year which will look at options around improving mental health awareness and resilience in young people. We are also committed to undertaking the national Children and Young People's Psychiatric Morbidity Survey to support data improvement and to highlight mental health issues in young people since it was last undertaken in 2004. In addition to this, the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) report into suicide prevention in children and young people, published this month, highlights key themes around suicide prevention in young people.

Health Professionals

Public Health England developed the Public Mental Health Leadership and Workforce Development Framework in 2015 to improve the capability of the public health workforce in mental health. The framework includes reducing suicide as one of its aims and recommends mental health awareness training for public mental health professionals. It advises training a wide range of non-mental health professionals such as GPs, nurses, teachers, housing officers, to deliver simple, non-specialist, effective and brief interventions as well as referring people to other services when needed. Public Health England and Health Education England have also published a collation of emerging practice examples of mental health promotion and prevention training programmes available in England for the workforce to support those who wish to commission or deliver such training as part of building a public health system capable of meeting the growing mental health challenge:

<http://www.yhscn.nhs.uk/media/PDFs/children/Docs%20and%20Links/Mental-health-promotion-and-prevention-training-programmes.pdf>

Public Health England is also working closely with Health Education England, which has commissioned the National Collaborating Centre for Mental Health to develop a self-harm/suicide prevention competency framework. The framework, underpinned by a systematic review and collaboration with service, academic and experiential experts and the Royal Colleges, will establish competencies required for effective interventions by individuals working across generalist to specialist settings for all ages. This programme of work will also support the development of online resources for children and young people and their families through MindEd.

The Committee recommends improving suicide awareness in GPs and wider primary care. Health Education England, in collaboration with Skills for Health and Skills for Care, has developed the Mental Health Core Skills and Education Framework which provides guidance for the development and delivery of appropriate and consistent cross-sector education and training for those with occasional contact, or those working with individuals with mental health problems. The framework covers a number of topics including mental health awareness and promotion and self-harm and suicide prevention which would directly address the training needs of practitioners working with individuals presenting with self-harm and suicide risk.

Local delivery

Local authorities are well placed to reach people not in contact with any service within local communities, because their work on public health addresses many of the risk factors, such as alcohol and drug misuse, and spans efforts to address wider determinants of health such as employment and housing.

Public Health England has produced a range of evidence, data, guidance and seminars to support local authorities to reach vulnerable people who are not in contact with traditional services. We will continue to provide further active support both nationally and through Public Health England regional centre leads across England.

Involving the full range of partners to develop a suicide prevention plan will help local areas to be aware of what services are available in their local area, help to identify any gaps and ensure that high risk groups can be identified and supported within existing services. This includes specifically targeting men, the highest risk group, and collaborating with the voluntary and charitable sector to make the maximum use of all local resources.

We do know that some local areas already keep a record of support services for suicide prevention and may be part of their 'social prescribing' policies. However, it is for local areas to determine with their multi-agency group how best to implement, monitor and evaluate their suicide prevention strategies, which would include how people access and are signposted to support and advice.

Public Health England is working with the National Suicide Prevention Alliance (NSPA) to update and expand their directory of support currently available as an interactive map on their website. This includes launching a library of resources on its website such as guidance and support for local suicide prevention planning and information on how to talk to someone you are concerned about.

Local authorities can contact the NSPA if they would like support services or resources for their area to be included on the NSPA website.

There is also some innovative work happening locally. For example, Common Unity and Forward for Life have collaborated on the design and development of a mobile friendly directory of services. Called 'The Waiting Room', it allows users to quickly launch a local directory of services from a Quick Response (QR) code which they can scan via an app on their smartphone. In the four months since its launch, the Birmingham Waiting Room homepage has had over 5,000 hits. The project has seen investment from both the private and public sector.

Public Health England's Mental Health Prevention Concordat resources to local authorities will recommend that local areas undertake a needs and assets assessment, linked to local Joint Strategic Needs Assessments, to promote and use community and personal assets to support people. Guidance and a toolkit on undertaking a JSNA for mental health will also be available soon.

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. (Final Report Paragraph 51)

Public Health England's suicide prevention planning guidance provides advice on developing multi-agency groups and partnerships, including a range of different agencies outside traditional health care settings, such as the voluntary sector, police, criminal justice, education and drug and alcohol services. It also sets out how these groups can collect and share valuable sources of data through data sharing agreements and how to collect and monitor local suicide data to inform the priorities and objectives of their strategies.

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. (Final Report Paragraph 56)

Public Health England's suicide prevention planning guidance sets out in detail how local areas can develop suicide prevention strategies and what these should include. Local suicide prevention strategies should be guided by addressing the key areas for action in the National Suicide Prevention Strategy, which includes targeting high risk groups and tailoring mental health approaches for groups with specific needs, which may include those who traditionally do not access mainstream services.

The suicide prevention planning guidance recommends that local strategies should look at seven priority areas:

- Tackling suicide in men and considering providing services in settings that men can access, including online;
- Preventing and responding to self-harm through a range of services in secondary, primary and community settings and making use of the voluntary and charitable sector;
- Addressing the mental health of children and young people;
- Treatment of depression in primary care;
- Providing support in acute mental health services;
- Tackling high frequency locations;
- Reducing isolation; and
- Providing bereavement support services, especially for those bereaved by suicide.

As above, Public Health England is also working with the National Suicide Prevention Alliance (NSPA) to update and expand their directory of support currently available as an interactive map on their website. We are also working with them to launch a library of resources on their website including guidance and support for local suicide prevention planning and information on how to talk to someone you are concerned about.

Local authorities can contact the NSPA if they would like support services or resources for their area to be included on the NSPA website.

People in contact with primary care services

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. (Final Report Paragraph 61)

The Five Year Forward View for Mental Health recommended that the Department of Health and NHS England should work with the Royal College of GPs and Health Education England to ensure that by 2020 all GPs, including the 5,000 joining the workforce by 2020/21, receive core mental health training, and to develop a new role of GPs with an Extended Scope of Practice (GPwER) in Mental Health, with at least 700 in practice within five years.

Health Education England is also committed to publishing a Mental Health Workforce Plan in the summer, which will set out the future shape and skill-mix of the workforce over the next ten years to deliver the recommendations of the Five Year Forward View for Mental Health and Future in Mind. The Workforce Plan will address core training in basic mental health awareness and knowledge, understanding of mental health law, public mental health, compassion, and communication skills.

For professions involved in the care and support of people with mental health problems, it will include tailored curricula with competencies in dealing with the common physical health problems people may present with, shared decision-making, mental health prevention (including suicide prevention), empowering people to understand their own strengths and self-manage, carer involvement and information sharing.

The Five Year Forward View for Mental Health also committed Health Education England and Public Health England to develop an action plan so that by 2020/21 validated courses are available in mental health promotion and prevention for the public health workforce (including primary care).

The General Medical Council and the Royal College of GPs are working to ensure that medical students, GP trainees and GPs receive training in assessing and managing depression and suicide risk. Outcomes for graduates; Tomorrow's doctors published by the General Medical Council (undergraduate medical training) sets out competencies for medical students to be able to identify risk to self (suicide, self-harm and/or neglect, engaging in high risk behaviour) and risk to and from others. This includes developing skills to assess a patient's potential risk to themselves and others, at any stage of their illness, and in particular be able to assess a patient following an episode of deliberate self-harm. Outcomes to be achieved include identifying appropriate strategies for managing patients with dependence issues and other demonstrations of self-harm.

The Royal College of GP's curriculum for trainee GPs describes competencies for the care of people with mental health problems and managing complex and long-term conditions. This includes being able to manage risk associated with suicidal ideation and understanding the importance of recognising and treating depression and anxiety in people with long-term physical illnesses and common mental health problems in older people and the importance of considering complex multi-morbidities in such patients.

The Royal College of GPs provides online toolkits to support GPs and this includes a Mental Health Toolkit which provides tools for suicide prevention and risk assessment.

Training courses are available for GPs, GP trainees, GP trainer or educator, medical students and nurses on suicide prevention which explore issues around suicide such as the interplay of numerous factors, culminating in suicidal behaviour. Training also describes the practical aspects of suicide prevention in primary care and strategies and resources for the mitigation of suicide.

NICE Guidelines

The Government promotes the implementation of NICE guidelines in various ways. The Five Year Forward View for Mental Health recommends that people have access to services that meet NICE best practice standards. NICE standards are promoted through the Cross-Government Suicide Prevention Strategy and through various guidance including the suicide prevention planning guidance issued by Public Health England to local authorities. NICE is currently developing a new guideline, Preventing suicides in community and custodial settings, to be published in 2018 and we will work with NICE and delivery partners to ensure that this guideline is widely promoted and implemented.

Drug treatments and suicide

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

Identifying and treating depression is important in suicide prevention and Public Health England's suicide planning guidance to local authorities sets out key areas for action within local suicide prevention plans which includes addressing depression in primary care.

NICE has published a number of clinical guidelines for mental health conditions that recommend psychological therapies. This includes recommendations on the use of specific drugs (including anti-depressants in children and adults), interventional procedures and computerised Cognitive Behavioural Therapy: <https://www.nice.org.uk/guidance/conditions-and-diseases/mental-health-and-behavioural-conditions/depression>

We also welcome NICE guidelines on the treatment and management of depression in adults and the recent pathway guidance on anti-depressant treatment in adults. This guidance sets out preventative action for people at risk of suicide and we encourage the NHS to implement these guidelines. Clinical guidelines represent best practice and should be taken fully into account by clinicians.

People under the care of specialist mental health services

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. (Interim Report Paragraph 22)

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. (Final Report Paragraph 71)

Currently NHS funded providers must ensure there is a follow-up for patients recently discharged from hospital within seven days. NHS England is developing an evidence-based treatment pathway for acute mental health care, guided by a multi-stakeholder expert reference group. This will include consideration of follow-up within three days of hospital discharge. NHS England will publish the guidance and recommendations in due course.

However, this should not reduce the need for effective care planning at the beginning and throughout a person's stay in hospital and for effective and robust discharge planning to ensure that patients have the right support at the right time post-discharge from hospital to meet their needs in the community.

We support the recommendation of the Committee that there should be sufficient investment in crisis resolution home treatment teams. Although the NHS suicide rate has decreased, the number of suicides by people under the care of crisis resolution home treatment teams remains too high. We are investing £400 million to develop improved mental health crisis care services in the community through investment in Crisis Resolution Home Treatment Teams (CRHTTs) as a genuine alternative to an acute inpatient admission. This will support NHSE's commitment to eliminate inappropriate out of area placements (OAPs) for non-specialist inpatient acute care, which we know is a result of system pressures. Not sending those who are acutely unwell out of area is one of the key elements of safer care in mental health services identified in the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH).

In addition, as per the Five Year Forward View for Mental Health, NHS Improvement and the Care Quality Commission, with support from NHS England and Public Health England, are working to support services to ensure that all deaths by suicide across NHS-funded mental health settings, including out-of-area placements, are learned from and fed into CQC inspections, to prevent repeat events. This work is delivered through NHS Improvement's patient safety team, and is informed by the National Quality Board's guidance on learning from deaths (first edition published March 2017).

The Committee recommends the deadline for implementing liaison mental health services in emergency departments is brought forward from 2020 to 2017. To implement the ambition to roll-out liaison mental health services will require the workforce capacity to increase. NHS England has worked closely with Health Education England and the Royal College of Psychiatrists to consider workforce issues including capacity. This also included careful consideration of the need to ensure staff in emergency departments are trained and the impact of expanding the liaison mental health workforce on community based crisis services. NHS England has set out a clear trajectory for achieving this ambition by 2020/21.

We urge the Government to ensure that there are enough trained staff to establish and sustain liaison mental health services in every acute hospital. (Final Report Paragraph 75)

The latest survey of liaison mental health shows that there are already liaison mental health services in almost every acute hospital with a 24/7 A&E department. However, the ambition set out in the Five Year Forward View for Mental Health, and investment of at least £249m goes further than this. It is to ensure that not only do all-age liaison mental health services exist in every hospital, but that at least 50 percent of hospitals are operating at the Core 24 standard for adults and older adults by 2020/21. This means a fully staffed team integrated into the acute hospitals, operating 24/7 and offering 1 hour response to emergency referrals in A&E.

The ambition of 50 percent coverage by 2020/21 was developed closely with the liaison faculty at the Royal College of Psychiatry, and was deemed to be a stretching but achievable ambition to expand the workforce.

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. (Final Report Paragraph 76)

Health Education England is developing a Mental Health Workforce Plan, to support the Five Year Forward View for Mental Health, to set out the future shape and skill-mix of the mental health workforce. An objective of the Workforce Plan is to recommend steps to ensure that a sufficient workforce with the right skills is available to deliver the recommendations of the Five Year Forward View for Mental Health and Future in Mind. Health Education England expects to publish the Workforce Plan in the summer.

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. (Final Report Paragraph 79)

The Five Year Forward View for Mental Health includes a commitment to expand psychological therapies for people with depression and anxiety disorders (Improving Access to Psychological Therapy (IAPT) services). By the end of 2020/21, 1.5 million people will access IAPT services each year.

Most of the expansion will be in 'integrated IAPT' services, co-located in and integrated with physical health services, and focused on people with anxiety/depression in the context of long-term physical health problems and/or people with distressing and persistent medically unexplained symptoms (MUS). We are investing in an extra 3,000 mental health therapists to be working in primary care by 2020 to support the expansion of IAPT services in localities.

IAPT services focus on early intervention, and the delivery of outcomes-focussed talking therapies for mild to moderate common mental health problems. These services do not focus on managing high levels of risk in the same way as secondary mental health care. It is therefore vital that IAPT services maintain good links and relationships with secondary mental health services to ensure appropriate management of risk and support suicide prevention across settings.

IAPT services should work collaboratively with secondary mental health to ensure that people are appropriately assessed and treated in the correct service for them. They should also ensure that if the risk of suicide for an individual becomes at any time higher than that appropriate for an IAPT service then smooth and speedy transitions between services take place.

NHS England will publish implementation guidance for integrated IAPT later this year, which will cover the importance of good links with secondary mental health services.

NHS England is working with experts through the National Collaborating Centre for Mental Health to review and improve pathways within community mental health services across primary and secondary care. This will highlight the importance of good links with IAPT, to ensure prompt referral where needed.

The focus on integration was also included in guidance to Sustainability and Transformation Plan (STP) leaders, which stated that their plans should include work on 'supporting physical and mental health needs in every interaction' across the whole system, including through new models of care.

Self-harm

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. (Final Report Paragraph 92)

We set out in the updated National Suicide Prevention Strategy how we are strengthening its delivery in key areas which includes expanding the scope of the strategy to address self-harm as an issue in its own right. The updated strategy fully supports ensuring that every person who presents at an emergency department for self-harm receives a psychosocial assessment and is directed to appropriate support. NICE produced *Self-harm in over 8s: short-term management and prevention of recurrence* and *Self-harm in over 8s: long-term management*, which recommend a comprehensive needs assessments for people who self-harm and advice on coping strategies and harm minimisation for people who repeatedly self-harm. In the longer-term the guidelines recommend co-produced care plans including risk assessments with the patient and multi-disciplinary teams, which can be shared with families and carers. Mental health professionals should determine with the patient what form that advice takes and whether that includes a safety plan.

Public Health England's suicide prevention planning guidance to local authorities advises that local suicide prevention plans should prioritise a number of areas including how local areas are addressing self-harm through a range of services including the voluntary and charitable sector.

Geographically, the provision of good quality self-harm prevention services is patchy. However, work is underway to address this situation both in community services and in urgent and emergency care.

The Five Year Forward View for Mental Health set a commitment for NHS England to work with delivery partners to develop a clear and comprehensive set of care pathways. For adult community mental health services, work will include a specific focus on self-harming behaviours by patients in the community. Material will support local health economies to deliver services in line with existing NICE guidance for the short- and long-term management of self-harm. For Children and Young People (CYP), a guide that supports local areas to deliver a multi-agency response, including for CYP in crisis, will be produced. This guide will include embedding appropriate and effective management for self-harm in, for example, community services, acute care and children and young people's mental health services.

Advice within the local authority guidance is as follows:

- Ensure all first responders have supplies of, and distribute the Help is at Hand z-card in the immediate aftermath of a suspected suicide;
- Disseminate the Help is at Hand booklet to affected individuals via Coroner's office, local funeral directors and voluntary sector organisations
- Provide Help is at Hand materials in community settings such as libraries, primary care and community centres and through bereavement support organisations;
- Map current provision of bereavement support services to identify gaps to address through commissioning;
- Support community response in settings such as schools, colleges and workplaces; and
- Ensure individual approaches for anyone identified as being at risk of contagion, including rapid referral for community mental health support where needed.

Help is at Hand is a practical and compassionate guide for those bereaved by suicide, as well as a guide for first responders such as ambulance staff, police and healthcare workers to use in the immediate aftermath including a new wallet sized z-card signposting to the full booklet. It provides a range of advice including what people can expect when dealing with coroners and going through the inquest process.

The Public Health England's suicide prevention planning guidance describes different 'suicide surveillance' models for ensuring that public health teams have early notification of bereavement by suicide so that they can put plans in place to support those affected and rapidly respond to any emerging clusters. This is complemented by Support after a suicide: A guide to providing local services, a practical guide for commissioners to understand why and how they can deliver support after suicide in their local areas. To accompany this there are two resources to support local areas to deliver these services on the ground and to support evaluation Support after a suicide: Developing and delivering local bereavement support services and Support after a suicide: Evaluating local bereavement support services. This guidance sets out different models for local areas to consider to ensure timely access to Help is at Hand and support for those affected, including at the inquest. It includes case studies for local areas to consider for example:

- Amparo, commissioned by CHAMPS public health partnership, who has established a suicide liaison service to ensure that first contact is established within 24 hours; and
- Durham County Council who have a suicide alert system that links into a range of support services, including a bereavement support service, relationship and financial support, as well as community interventions

Public Health England has also produced a guide for local areas on how to rapidly respond to clusters of suicide including managing the media. Crisis management in the event of a suicide: a postvention toolkit for employers offers practical and sensitive guidance for employers to follow in the aftermath of an employee suicide.

Victim Liaison Officers

Victim liaison officers work with people who have been the victim of crimes. This would not be appropriate in the case of suicide. However, Public Health England's suicide prevention planning guidance includes examples of various local models where they have implemented Family Liaison Services for people bereaved by suicide to support them through the various practicalities, including the inquest process. This provides good examples of services other local areas can commission; however this is a matter for local determination.

Data

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. (Interim Report Paragraph 31)

The Government supports the aim of speeding up the process of notification of suicide to ensure that data is as timely as possible. We have been working over a number of years with partners such as the Office for National Statistics and with coroners and the Chief Coroner to look at ways of doing this. However, it is important that we do this carefully to ensure that we maintain the accuracy and quality of data.

We understand the Committee's desire to improve consistency between coroners but we must accept that coroners are independent and should be able to reach their own conclusions based on the evidence. The Office for National Statistics continues to work with coroners and has issued advice previously to improve consistency in the explanation of the meaning of coroner conclusions on cases of suicide. However, we acknowledge that there is more we can do to improve the quality of data and consistency of coroners' conclusions on suicide and our engagement with coroners will continue.

Public Health England's suicide prevention planning guidance highlights potential models for real-time suicide prevention surveillance in local area which includes working with coroners. A coroner may agree to provide provisional notification of a suicide to local public health teams, where a death suggests suicide ahead of the coroner's conclusion. This can help to identify trends and potential suicide clusters. However, developing these models is a matter for local determination with the agreement of local coroners.

Standard of proof

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. (Final Report Paragraph 151)

The Government is currently considering whether the suicide standard of proof should be lowered from 'beyond reasonable doubt' to 'on the balance of probabilities'.

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. (Final Report Paragraph 163)

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. (Final Report Paragraph 164)

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. (Final Report Paragraph 166)

The Office for National Statistics continually works to improve the quality of data around suicide and has good working relationships with coroners and the Chief Coroner. The Office for National Statistics already has access to information from death certificates which enables it to gather data on methods of suicide which it reports to the National Suicide Prevention Strategy Advisory Group. It also includes statistics on suicide methods within its data publications on suicide registrations.

However, there is more that we can do and the Office for National Statistics has been in discussions with the Chief Coroner about data quality which has included the importance of accurate information about suicide methods and drugs and how accurate reporting by coroners can both directly and indirectly prevent such future deaths. The Office for National Statistics has also undertaken work to look into drug-related deaths which involved visits to coroners and this helped highlight just how much valuable information coroners have and the importance of coroners providing sufficient details in their reports which can in turn improve the quality of suicide data.

We understand that the Chief Coroner set out in correspondence to the Health Select Committee the complexities around sharing with others information obtained as part of the coroner investigation. He emphasised the role of coroners as independent death investigation judges. What additional ability coroners have to share information obtained as part of the death investigation with other local bodies will depend on a number of factors and these will differ locally, and in the final analysis, will be a judicial decision based on the facts of the individual case.

Public Health England's Local Suicide Prevention Planning guidance encourages public health teams to work locally with coroners to gain intelligence on suicide, including emerging methods, which is not currently available nationally. This and the guide to providing support after suicide covers 'real time suicide surveillance', where coroners can agree to provide information in advance of the formal coroner's conclusion to ensure timely information sharing to respond quickly to emerging patterns that could indicate clusters, increasing trends or new methods of death.

Media

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. (Interim Report Paragraph 36)

The Government is committed to a free and open press and does not interfere with what the press does and does not publish. The Cross-Government Suicide Prevention Strategy sets out the importance of responsible media reporting of suicide. We have supported the Samaritans over many years, which has built strong relationships with the broadcast, print and online media and has developed guidelines for the responsible reporting of suicide. The National Lead at Public Health England works closely with the Samaritans to share information and to highlight needs for proactive engagement, for example emerging clusters and high profile inquests. Whilst there has been great progress in how the media reports suicide, sadly we still see examples of poor reporting. Our stakeholders continue to look at ways in which they can work proactively with the media to improve this.

Online content

The Samaritans has been working closely with a number of online providers to highlight the negative and serious impact of suicidal, self-harm and other harmful content online. As a result progress has been made, including: a fixed “OneBox” above search results on Google UK which provides Samaritans’ helpline numbers for users who have searched for suicide and self-harm related words and phrases; working with YouTube to empower users to keep the community safe; and working with the Twitter Trust & Safety Council to make the network a safer and more secure environment for its users.

However, it should be noted that this is an incredibly complex and challenging ambition and will not happen overnight. The internet has provided young people with some amazing opportunities, but a top Government priority is to protect them from risks they might face online. The UK is a world leader in internet safety, and both the work of the UK Council on Child Internet Safety and measures in the recently enacted Digital Economy Act will be instrumental in better protecting against harmful content.

Government takes the issue of child safety online very seriously and engages intensively with industry through the UK Council on Child Internet Safety. We expect social media companies to respond quickly to incidents of abusive behaviour on their networks. This includes having easy to use reporting tools, robust processes in place to respond promptly when abuse is reported, and suspending or terminating the accounts of those who do not comply with acceptable use policies.

The Digital Economy Act will go further to help to ensure that online abuse is more effectively tackled by requiring a code of practice to be established. The code will set out guidance about what social media providers should do in relation to conduct on their platforms that is directed at an individual and involves bullying or insulting the individual or other behaviour likely to intimidate or humiliate the individual. The code of practice will include guidance on arrangements for notification by users; the process for dealing with notifications; terms and conditions in relation to these arrangements and processes; and, the giving of information to the public about the action providers take against harmful behaviour. We will consult with social media and other interested parties on what the code will look like.

But there is still more to do, and we all have a part to play in making the online world a safer place for everyone to discover, explore and enjoy.

Behaviour that would never be tolerated in the real world has become increasingly common - and even encouraged - online with a potentially devastating impact on young minds. We all have a responsibility to do more to help children to stay safe. The Department for Culture, Media and Sport is leading the cross-Government drive to make the internet safer, working collaboratively with the Home Office, Department for Education, Department of Health and Ministry of Justice, alongside external stakeholders, to achieve this. We will be working with experts, social media companies, tech firms, charities and young people themselves in order to learn about the issues in this area. We want to know more about the scope of the problem, where the gaps are, and start to think about solutions. The work is expected to include the following four priorities:

- how to help young people help themselves;
- helping parents face up to the dangers and discuss them with children;
- industry's responsibilities to society; and
- how technology can help provide solutions.

Guidelines for responsible reporting of suicide

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 Public Health England and we recommend that Public Health England should include options for action in its partnership agreement with Samaritans. (Final Report Paragraph 123)

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. (Final Report Paragraph 124)

Since the Committee published its interim report in December 2016, the Chair of the National Suicide Prevention Advisory Group, Department of Health, Public Health England and Samaritans have been exploring arrangements for the responsible reporting of suicide. We will report on this work as it develops.

We have agreed that Samaritans will provide an annual report and update to the National Suicide Prevention Strategy Advisory Group (NSPSAG) on progress with supporting and monitoring the media. This report will be presented to the NSPSAG and we will include details in future annual update reports on the Cross-Government Strategy.

Local media work to ensure responsible reporting will also be part of the quality assurance of suicide prevention plans. It is recognised that Samaritans already work independently of government to engage with media, and support and encourage responsible coverage of suicide. This includes a full advice service for local and national media (pre-publication and pre-broadcast), training for media outlets, monitoring and assessing news reporting of suicide and following up with editors where there are concerns over content and publishing confidential media briefings, for example ahead of inquests, or concerning celebrity stories. If in this role they become aware of coverage of an emerging new method or potential suicide cluster or other area or issue of concern they make contact with the National Lead for Suicide Prevention at Public Health England. They will also share information in the event of any particularly unusual, high profile and concerning coverage.

The job description for the National Public Health England Suicide Prevention Lead will be updated to include a role of working with Samaritans to enhance information sharing across agencies and to support Samaritans in managing responsible reporting of suicide, where necessary. They will also keep the Department of Health and Public Health England's centre leads across England updated as necessary. Conversely, if the Department of Health or the centre leads see reporting of concern they will alert the Public Health England Suicide Prevention lead who will involve Samaritans.

In the event of a high profile death, for example a celebrity, and in particular if it involves an emerging method, Public Health England will co-ordinate communications across government, working closely with the Samaritans. In particular, Public Health England will ensure that the Department of Health is regularly updated and briefed.

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. (Final Report Paragraph 125)

The Government is committed to a free and open press and does not interfere with what the press does and does not publish. The Government has always been supportive of the work of Samaritans on independently producing and promoting media guidelines for the responsible reporting of suicide. We have promoted this work through the Cross-Government Suicide Prevention Strategy and in progress reports to the strategy. The work that Public Health England is doing with Samaritans to establish an outline agreement, as above, is a clear signal of how important we see this work.

Local media

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. (Final Report Paragraph 127)

Public Health England's suicide prevention planning guidance to local authorities is clear that local suicide prevention strategies should support delivery of national priorities, including working with media to promote responsible reporting of suicide.

The quality assurance process of local suicide prevention plans will assess the quality of local priorities to promote the responsible reporting of suicide in the media. We will publish the results of the quality assurance process by the end of the year alongside details of local suicide prevention plans on Public Health England's Atlas of Variation.

Regulation

We recommend a change to the IPSO Editors' Code of Practice to replace the term "excessive detail" with "unnecessary detail". (Final Report Paragraph 131)

This is a matter for IPSO. The Editors' Code of Practice is governed by the Editors' Code Committee who write, review and revise the Code. The Committee recently consulted on the Code and they are currently considering the responses to the consultation. More information is available at: <http://www.editorscode.org.uk/index.php>

Public Health England has submitted a response to the IPSO consultation on changes to the Code of Practice. Public Health England recommended that as the national agency to protect and improve the public's health it is recognised as a legitimate 'representative agency' that can raise a complaint should it feel that there is evidence that the public's health is being put at risk.

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. (Final Report Paragraph 133)

The Office of Communications (Ofcom) is the independent regulator of the communications industry and accountable to Parliament. It is a matter for Ofcom, and not the Government, to determine what should be included in the Broadcasting Code.

We know that the Broadcasting Code already makes clear that programmes must not include suicidal behaviour that is likely to be copied:

“Violence, dangerous behaviour and suicide:

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

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

The guidance which accompanies the Code states:

“This rule reflects a continued concern about the impact of real or portrayed suicide, and self-harm, on those whose minds may be disturbed. Whilst it is always difficult to prove causality, various studies have shown that there may be a short-lived increase in particular methods of suicide portrayed on television. Broadcasters should consider whether detailed demonstrations of means or methods of suicide or self-harm are justified.”

The National Suicide Prevention Strategy Advisory Groups (NSPSAG) will look at ways in which it can work proactively with Ofcom to look at where there may be ways of strengthening the Broadcasting Code.

Social media and the internet

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. (Final Report Paragraph 138)

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.

The Prime Minister set out a range of measures to improve mental health services in January. This included publishing a children and young people’s mental health green paper later this year. The forthcoming Children and Young People’s Green Paper will consider action to minimise the risks social media poses, whilst maximising its benefits.

The Department for Digital, Culture, Media and Sport leads on internet safety, and will be taking forward the Government’s aim of making the UK the safest place in the world for young people to go online. The recently enacted Digital Economy Act includes stipulation for the publication of a code of practice for social media companies which will be an important part of our strategy, but we will also be seeking to raise awareness of online harms and working with social media and technology companies to look at what more can be done to make the internet a safer place.

We will report on progress with this work in due course.

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. (Final Report Paragraph 141)

The Samaritans has commissioned a wide range of useful research on suicide prevention and we consider the findings of these and other research in developing national policy. We have noted the work on Digital Futures programme which reported a range of themes of how people use the online environment and on the future digitisation of services. The Department of Health also funded research undertaken jointly by Samaritans and the University of Bristol about online suicidal content and the experiences of people who had searched the internet for suicide-related content or support. We have shared this research with colleagues within the Department and other Government departments and will consider their findings in the national policy context.

The Samaritans also published the Dying from Inequality report which raised important issues around the increased risk of suicide for people from low socio-economic groups and disadvantaged areas. This raises important considerations for addressing the wider social determinants of suicide and how local suicide prevention and mental health prevention strategies should look at these inequalities.

The refreshed Cross-Government Suicide Prevention Strategy published in 2012 announced a call to action on suicide prevention research and provided investment of £1.5 million. Many of these research projects have concluded and we will consider their findings carefully in progressing national suicide prevention policies. In addition, the Department of Health continues to fund suicide prevention research in a range of settings and we will continue to evaluate their findings to inform national policy.

3. Conclusion

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. (Final Report Paragraph 169)

The Government welcomes the interim and final reports of the Committee and has carefully considered its recommendations across Government in providing this response.

Much of the work outlined in this response is in progress to reach long-term aims but the Government remains fully committed to driving the implementation of the Cross-Government Suicide Prevention Strategy to achieve the ambition of reducing suicides by 10 percent by 2020 and addressing the inequality and tragedy of suicide.

We welcome the Committee's commitment to hold a follow-up hearing to look at the implementation of the updated National Suicide Prevention Strategy and we will participate fully in this process.

ISBN 978-1-4741-4855-9



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