**Suicide Prevention: follow-up Inquiry**

**Summary of key points**

* Good progress has been made since 2017: we have a national cross-government delivery group, the first tranche of the £25 million allocated by NHS England for suicide prevention is now starting to reach some of the highest risk areas for suicide, and practically every local area has a suicide prevention plan.
* However, there is still a long way to go, particularly in reducing suicide in the most at risk and hardest to reach groups.
* Despite national prioritisation, we remain concerned that progress is being held back by delays across government, with no clear vision for how suicide rates are going to be reduced by 10% by 2020/21.
* A comprehensive, ambitious and cross-government workplan is still needed.Currently the work plan is a collation of a small number of government department activities and there is no vision of how to reach the two-thirds of people who die by suicide that are not in touch with mental health services.
* We want to see improved, timely data collection, and more support and resource for local areas to share best practice, to reduce duplication and enhance the effectiveness of plans. As well as robust evaluation of local plans that is rooted in public health and focussed on impact and delivery.
* Samaritans continues to work closely with the media to advise on safe reporting and portrayal of suicide, as well as with online platforms around harmful online content. However more still needs to be done to strengthen the Independent Press Standards Organisation (IPSO) Editors’ Code of Practice and the Ofcom broadcasting code, as well as the Government’s draft Code of Practice for social media platforms.
* There are clear opportunities to set out ambitious new targets on suicide prevention and a more sustainable approach to public health funding, with the upcoming Green Paper on Prevention and the comprehensive spending review.

1. **Suicide rates**

Suicide is a major public health problem. Someone takes their own life every 90 minutes, with around 6,000 lives lost in the UK every year.[[1]](#footnote-1) The effects of these suicides are devastating, felt across the wider community, by family, friends, colleagues and witnesses, often shattering lives.

Figures released in 2018 by the Office for National Statistics (ONS) show that male suicide is at its lowest in more than thirty years. The total number of both male and female suicides in 2017 was 5,821 compared with 5,965 in 2016, a fall of 144 or just over 2.4%. While this reduction is very welcome, men are still three times more likely to die by suicide than women and the highest rate of suicide is still among men aged 45-49.[[2]](#footnote-2) Early indications from ONS suggest that the overall downward trend may be reversed for some groups in 2018 figures but the annual rates for 2018 are unlikely to be published until September 2019 (based on previous publication dates).

Additionally, there is evidence of a rising incidence of suicide amongst 15-19-year olds in the UK in recent years and rises in depression and self-harm amongst UK adolescents, particularly amongst young women and girls.[[3]](#footnote-3),[[4]](#footnote-4) While they are still not the highest risk group for suicide, it is extremely concerning that this group’s risk seems to be increasing, and there is a lack of evidence about the reasons behind this.

Suicide remains an inequality issue. There is a well-established link between suicide and poor economic circumstances: men in the lowest social class living in the most deprived areas are up to ten times more likely to end their lives by suicide than those in the highest social class living in the most affluent areas.[[5]](#footnote-5) Research shows that people who are unemployed are two to three times more likely to die by suicide than people in employment, that recessions are linked to an increase in suicide rates and that personal debt problems are associated with mental health problems and suicidal thoughts. [[6]](#footnote-6) There is also evidence that some occupations are at higher risk, with low-skilled male labourers, particularly in construction, being three times more likely to take their own lives.[[7]](#footnote-7)

**Recommendations:**

1. **Real-time surveillance needs to be nationally supported and locally led.** We must improve the timeliness of local data collection, enabling areas to identify and respond to emerging trends and issues and provide rapid support for people bereaved by suicide.
2. **At risk groups need more focus**. To reach middle-aged men who are most at risk, much more focus is needed on interventions that seek to reach those who are the most disengaged with their communities and services and are often living with multiple risk factors like unmanageable debt, relationship breakdown or poor housing.
3. **More needs to be done to look at suicide as an inequality issue.** Interventions and policy need to be designed to reach people on the lowest incomes in high risk groups. This should include working across communities using established channels to reach people, such as debt advisers and housing associations.
4. **We need improved data and research into risk factors and high risk groups.** We have increasing knowledge of different high risk groups, but more evidence is still needed to effectively prevent suicides.For instance, it’s becoming evident that gambling is linked to suicide, but much more needs to be known about it, as well as the ways that it interacts and combines with other risk factors. More research is also needed into the factors behind the rising rates amongst young people, in relation to both suicide and self-harm.

**2. National suicide prevention plan and delivery**

**Leadership and ambition are still lacking, despite high-level prioritisation**

Samaritans welcomed the publication of the Government’s fourth annual report on suicide prevention and the publication of a cross-government workplan.[[8]](#footnote-8) Good progress has been made in establishing a national delivery group and we are pleased the National Suicide Prevention Alliance (NSPA) is representing the voluntary sector on this group. However, despite the delivery group having representation from across government, we have concerns about the level of priority that attendance is given by all government departments. The workplan only contains commitments by the Department for Health and Social Care (DHSC), Department for Education (DfE) and the Ministry of Justice (MoJ), which is extremely concerning, given that it is a cross-government strategy. We also remain concerned that the workplan is not ambitious enough and that it is lacking resource, detail and integration across government departments. The impact of not having clear milestones and lack of accountability has been clearly illustrated by the 18-month gap between the “annual,” progress reports.

As recognised by the Committee in the previous Inquiry, a preventative, whole-community approach to suicide reduction is crucial, given that two thirds of people who take their own life aren’t in contact with mental health services in the year prior to their death.[[9]](#footnote-9) While it is of course critical to reduce suicides among people under the care of mental health services, we need a clear vision and plan to reach the other two-thirds. Suicide needs to be tackled as a joined-up public health priority, with an ambitious and properly resourced workplan that includes all government departments. Much more funding, resource and strategic national oversight is needed to facilitate a proactive community-based response to suicide prevention, that reaches those that are at the highest risk.

**Current targets could be stronger and more ambitious**

Good progress has been made towards the Government’s target to reduce suicide rates by 10% by 2020/21, although it is unclear whether this progress will be sustained in 2018/19 figures. We know it’s a complex picture and therefore, we need more detailed targets for individual high risk groups in order to better track progress. While the target of 10% is useful there is still no clear sense of where these lives are going to be saved.

The NHS ten-year plan was a missed opportunity. The plan contains some positive commitments on suicide prevention, but we were disappointed that it didn’t include an increased ambition for suicide prevention, such as a 10% further reduction in the suicide rate by 2028.

**People with lived experience are not being effectively engaged in suicide prevention policy**

We know the power of lived experience, and yet locally and nationally, only a small number of people with lived experience, often bereaved parents, are being engaged in suicide prevention policy. The National Suicide Prevention Alliance (NSPA) has run workshops across the country with nearly 100 people with a wide range of lived experience, including people who have been bereaved, people living with suicidal thoughts and people who support those living with suicidal thoughts. This includes professionals and non-professionals, from a diverse range of backgrounds, some of whom had never knowingly met anyone else affected by suicide. During the workshops it was clear that people had powerful experiences to share and that they wanted to get involved in improving suicide prevention policy and practice, but that they wanted this involvement to feel safe and supported, at a level and in a way that works for them.

To effectively involve people with lived experience and harness their passion and expertise, engagement needs to go much further than discussion with, “one local expert.” The National Suicide Prevention Strategy Advisory Group should be consulting with a wider, diverse group of people with lived experience that is representative of those who have suicidal thoughts and have died by suicide. The NSPA has over 400 members which includes local and national organisations from across the public, private and voluntary sector, as well as individuals with a wide range of experience. The government should be prioritising the development and engagement of an NSPA lived experience network.

**National data and evidence are not being effectively collated or disseminated to local areas**

We are concerned that resources and time are being unintentionally duplicated at a local level and that nationally, data is not being effectively collated or disseminated to local areas. There is a lack of intelligence and information sharing. A good example is high risk locations - public locations which are used multiple times for suicidal behaviour. Local areas are often great at recognising these locations and putting interventions in place, and the Public Health England (PHE) guidance around public places is certainly helpful, with a limited evidence base around what works. However, we only have a national picture of suicidal behaviour in rail locations, due to data held by Network Rail and the British Transport Police. There is no national picture of other high risk locations, such as tall buildings and car parks, although we understand that Highways England is trying to improve its data of suicidal behaviour on the strategic road network. Given the number of interventions that are being put in place across the country around high risk locations, it is an area where there is significant need to improve monitoring and evaluation, collation of a national data set and sharing of best practice. We should be setting a national target for reduction of suicide in high risk places, and then providing local areas with the data and support to achieve this.

**Recommendations:**

1. **A comprehensive, ambitious and cross-government workplan is still needed.** Currently the work plan is a collation of a small number of government department activities, with no clear thread pulling it together across national and local government. We need a collective vision of the change that is needed, with the resources and prioritisation to achieve this.
2. **More ambitious targets should be put in place for the next ten years.** As well as more specific targets that measure progress in at risk groups, around high risk locations and risk factors linked with suicide, such as self-harm.
3. **Much more engagement is needed with people with lived experience.** The National Suicide Prevention Strategy Advisory Group should be consulting with a wider, diverse group of people with lived experience and government should be supporting this national and local involvement with a safe, supported lived experience network.
4. **Improved national data and evidence collation is needed to support local areas.** Particularly in regard to interventions and best practice that is happening in multiple locations across the country.
5. **Local plans**

**National oversight of local plans is still limited**

The All-Party Parliamentary Group report in 2015 is the most recent comprehensive overview of local authority activity to prevent suicide.[[10]](#footnote-10) While the Department of Health 2017 annual report referenced that they would “work with local authorities in assuring the quality of their plans against PHE’s guidance”, we are concerned about the length of time it has taken to make progress on this.

We understand that a report will be published in Spring 2019 by the Association of Directors of Public Health, the Local Government Association and PHE, that provides insights into the content of local plans, highlights good practice and looks at challenges faced locally. Samaritans is pleased to have been commissioned with the University of Exeter to undertake this work and has already seen an excellent response from the vast majority of local authorities who are taking part in this research voluntarily.

Our experience with local areas shows a willingness and commitment to work to prevent suicide within a context of reducing resources and competing priorities. However, much stronger national oversight is required to support local areas to implement and deliver local plans. In particular, national support should be directed towards local scrutiny boards to ensure they have the skills and expertise on suicide prevention to effectively scrutinise local plans.

**Duplication in local activity is limiting impact and effectiveness**

The £25 million funding that NHS England has allocated for suicide prevention from 2018-2021 is a positive step. In 2018, £5 million was allocated to the eight Sustainability and Transformation Partnerships (STPs) with the highest rates of suicide, and in 2019/20 and 2020/21 a further £10 million each year will be allocated. We remain disappointed that funding isn’t being specifically targeted at local authorities but are pleased that NHS England have recognised the importance of this funding reaching public health.

It’s critical that this funding reaches local areas, however we are concerned that the current approach is resulting in inefficiencies and duplication. For instance, many of the areas getting funding in the first wave allocation are funding training and developing local campaigns. While we strongly welcome both these measures, the replication of activity in different local areas is likely to be leading to inefficiencies and duplication of efforts, particularly regarding evidence collation, commissioning of training, market research and message development.

**Further national evaluation is needed, with a specific public health focus**

There is a real opportunity now for high quality national evaluation of the work funded by NHS England as well as a strong quality improvement programme to support local areas. We look forward to seeing the results of the evaluation which has been commissioned around the use of the NHS England funding and hope that the evaluators have sufficient expertise in evaluation of public health and suicide prevention for this to be a high-quality evaluation.

It’s essential that this evaluation is used to support local areas to learn from each other and utilise existing expertise across the sector. To do this each local area needs to be supported to deliver planned and impactful activity, which is rooted in a strong understanding of public health and suicide. We are concerned that the initial quality improvement work by NHS England around this funding had a clinical focus on mental health patients, when much of the funding is going towards public health activities.

**Wider funding for public health services is likely to be limiting impact**

The current funding situation for public health remains short-sighted, with many of the services needed to tackle the determinants of suicide being cut back year on year. Analysis by the Kings Fund shows that spending per person on public health will fall by nearly a quarter between 2015/16 and 2019/20.[[11]](#footnote-11) Robust and effective public health services are fundamental to suicide prevention. For instance, the link between alcohol misuse and suicide is well established: it’s estimated the risk of suicide when a person is currently abusing alcohol is eight times greater than if they were not abusing alcohol.[[12]](#footnote-12) Effective local substance misuse services, that are targeted to people at the highest risk of suicide, play a crucial role in preventing suicide. Despite this, specific budgets for the treatment and prevention of alcohol misuse have been cut nationally, including significant cuts for local areas that experience high levels of alcohol-related harm.[[13]](#footnote-13) The challenges in public health funding show little sign in relenting, with the Government’s 2018 budget confirming that the non-NHS parts of the Department of Health and Social Care, including public health, will be cut by around £1 billion a year.[[14]](#footnote-14) This is likely to further impact the effectiveness of both national and local public health policy.

We urge the government to use the upcoming Green Paper on Prevention in 2019 and the comprehensive spending review to set out a sustainable funding solution for public health provision. As well as details on funding for suicide prevention after 2021.

**Recommendations:**

1. **More national guidance and resources are required for local areas** so that suicide prevention funding is spent in the areas where it has the most impact.
2. **Evaluation of local plans should be shared widely** with recommendations for local areas and further evaluation should be commissioned that takes a wider public health approach.
3. **The upcoming Green Paper on Prevention and the Comprehensive Spending Review should be used as opportunities to set out a sustainable funding** solution for public health, as well as details on suicide prevention funding after 2021.
4. **Media**

**Our media advisory work**

As recognised by the Committee in the previous inquiry, Samaritans has been working closely with the media for over two decades, to advise on how to safely cover suicide. A core part of this work is promoting our Media Guidelines for Reporting Suicide[[15]](#footnote-15) and providing training to the media. The press has been largely receptive to working with us to improve coverage.

We were pleased the Government recognised the importance of Samaritans media advisory work in their response to the Committee’s previous inquiry. We are working closely with DHSC and PHE to ensure they are updated on our work in this area, whilst recognising that it is important for Samaritans to play an independent role from government in this work.

Since the last inquiry, we have agreed a protocol with PHE for cases where we believe there is value in additional input. We work closely with PHE to educate and inform key non-media stakeholders and share the latest intelligence on current issues. For instance, there have been recent concerns around online gaming challenges and we worked with PHE to disseminate briefings to local areas to provide information and guidance on this issue and how to safely communicate it. This has helped ensure that often well-intentioned local communications don’t turn into national media stories that are often unhelpful.

**National support without national funding**

Samaritans carries out training for media which is very successful, but challenges remain with local groups and communicators unintentionally providing unsafe communications (which in turn can feed media). We’ve seen an increase in demands for our support in this area locally which we strongly welcome, and while there is support nationally for our media advisory work, the structure of local funding means we have to negotiate separately with each local area to progress work. This carries a considerable time and resource burden both for Samaritans and for local areas.

**The IPSO Editors’ code and the Ofcom broadcasting code is not strong enough**

As we outlined to the Committee in 2017, a particular concern is the introduction and growth of new and emerging methods of suicide. Several studies carried out in other countries have highlighted this risk following widespread media coverage. News reporting in cases involving new and emerging suicide methods, as well as programmes involving methods, requires a greater level of scrutiny and care. The IPSO Editors’ Code of Practice clause on suicide does not sufficiently protect against the introduction of new methods in England, due to the inclusion of the term “excessive detail”.[[16]](#footnote-16) *Any* mention of the method carries the risk of increasing public awareness.

While it’s good that IPSO regulation which provides minimum requirements for suicide reporting are rarely, if ever, broken now, we are very disappointed that IPSO didn’t strengthen the suicide clause in their Editors’ Code following consultation on changes in 2017. We were pleased IPSO has produced further guidance, but ultimately, the code itself is still not strong enough. We would also like to see Ofcom strengthen its broadcasting code.

**Recommendations:**

1. **Local areas should be provided with national support and resources** to work with Samaritans on responsible communication and reporting of suicide.
2. **The IPSO Editors’ Code of Practice clause on suicide and the Ofcom broadcasting code needs to be strengthened**, to recommend that no mention of suicide method is reported.
3. **Online environment**

**Our research**

As referenced by the Committee in the last inquiry, Samaritans carried out a research study on the internet and suicide with Bristol University in 2017. [[17]](#footnote-17) Our research found that people use the internet to discuss suicidal feelings, to search for information on suicide, to visit help sites and to look for information on method.[[18]](#footnote-18) But that usage differs depending on how suicidal they are. Suicide-related internet use could be a marker of severity and potential risk. People at a lower level of suicidality use the internet to understand and manage feelings and explore suicide, whereas at a higher level of suicidality, they are using it very deliberately to find method information.

In other research, correlations have been found between internet use and self-harm, particularly more violent methods, suicidal ideation and depression among young people.[[19]](#footnote-19) Suicide-related use is also more prevalent amongst young people and more often included the use of social media. And we remain concerned that harmful material is abundant and easily accessed online.

Challenges around harmful content in the online environment and social media need to be tackled as part of a broader approach to children and young people’s mental health, rooted in public health. For many, it is an ordinary part of their lives and therefore can’t be tackled in isolation. Teachers, clinicians, and other professionals working with children all have a role to play in understanding children and young people’s digital use and helping them to keep themselves safe.

**The draft Internet Safety Strategy doesn’t go far enough**

Despite this, much of the Government’s policy agenda focuses on abuse and bullying, which is of course very important, but does not cover the availability of harmful material online – for example, detailed instructions on how to construct suicide devices. We need the Government to take a stronger approach to suicide related harmful content, and we hope to see this in the upcoming White Paper on Internet Safety.

The Government’s draft Code of Practice for social media platforms[[20]](#footnote-20) needs to go further and include the prohibition of harmful suicide-related content in terms of use and mechanisms for the reporting and removal of harmful suicide-related content. But, we must also ensure that this work recognises the nuances in content and usage, with a grey area of content, that may be harmful for some and not for others. Research into this area needs to be prioritised.

**There are untapped opportunities to use the online environment to provide help-seeking**

When carefully managed and designed, the online environment can provide a supportive forum for people to seek help when they have suicidal thoughts, as well as to interact and build relationships that could help build their emotional resilience. Samaritans’ “Digital Futures,” report sets out some of the ways social media can facilitate this process.[[21]](#footnote-21) The Government should be putting more resource and funding towards exploring technological solutions to both minimising harmful content, and positive ways online platforms can be used for help-seeking.

**The social media industry should go further in promoting safe use of content**

govThere remains much more that the social media industry could do. It has a responsibility to promote safe use by ensuring that harmful suicide-related content is prohibited in their rules for contributors and that there are processes by which users can report harmful suicide-related content to be considered for removal. These processes need to be robust and widely advertised to ensure that all users know about them and how to use them. Additionally, social media platforms should be investing in research, and working with researchers, government and the voluntary sector to come up with technological solutions to managing harmful content.

**Recommendations:**

1. **The Government’s draft Code of Practice for social media platforms should be extended to include the prohibition of harmful suicide-related content,** in terms of use and mechanisms for the reporting and removal of harmful suicide-related content.
2. **Further research into online help-seeking tools is needed,** as well as the impact of grey area content on different online users.
3. **Government and social media platforms** should work together to fund research into technological solutions to manage harmful online content.

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