

# NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

## Guideline scope

### Preventing suicide in community and custodial settings

#### *Topic*

The Department of Health in England has asked NICE to develop a guideline on suicide prevention.

This guideline will also be used to develop the NICE quality standard for suicide prevention.

The guideline will be developed using the methods and processes outlined in [Developing NICE guidelines: the manual](#).

For more information about why this guideline is being developed, and how the guideline will fit into current practice, see the [context](#) section.

#### *Who the guideline is for*

- Health and wellbeing boards and local safeguarding boards.
- NHS and local authorities, private sector and voluntary and community organisations.
- Health and social care services, particularly those based in primary care and in the community.
- Prison and other custodial services.
- Community rehabilitation companies and probation services.
- National crime agency, Police forces and emergency services.
- Primary, secondary and higher education institutions.
- Organisations that provide services to the public, such as employment services and those providing debt and housing advice.
- Organisations with responsibility for settings where suicide is more likely to occur, for example, rail companies or multi-storey car parking providers.

- All employers.

The guideline will also be relevant to:

- Families, carers and other members of the public who have been bereaved or affected by suicide.
- Community groups, particularly where members are at high risk of suicide.
- Commissioners of suicide prevention interventions.

NICE guidelines cover health and care in England. Decisions on how they apply in other UK countries are made by ministers in the [Welsh Government](#), [Scottish Government](#), and [Northern Ireland Executive](#).

## ***Equality considerations***

NICE carried out an [equality impact assessment](#) during scoping. The assessment:

- lists equality issues identified, and how they have been addressed
- explains why any groups are excluded from the scope.

# **1 What the guideline is about**

## ***1.1 Who is the focus?***

### **Groups that will be covered**

- Adults, young people and children. Specific consideration will be given to the needs of high-risk groups (for example, men aged 35 to 49, family and friends of those who have died by suicide and people who misuse drugs or alcohol).
- Adults, young people and children in custodial settings.
- Adults, young people and children who are in contact with the criminal justice system. This includes people:
  - in contact with liaison, diversion and street triage services
  - remanded on bail
  - released from prison on licence

- released from prison and in contact with a community rehabilitation company or the probation service
- who have been convicted and are serving a community sentence.

## **1.2 Settings**

### **Settings that will be covered**

- Community settings where suicide prevention interventions are delivered (for example, approved premises, community health and primary care settings, schools and workplaces).
- Custodial settings. This includes:
  - border custody
  - court custody
  - police custody
  - prison
  - young offenders institutions
  - secure training centres
  - secure children's homes.
- Immigration removal centres and short term holding facilities.

### **Settings that will not be covered**

- Military corrective training centres.
- Secondary care settings that are covered by other [NICE guidance](#).

## **1.3 Activities, services or aspects of care**

We will look at evidence on the areas listed below when developing the guideline, but it may not be possible to make recommendations on all the areas.

### **Key areas that will be covered**

- 1 Local approaches to preventing suicide in community and custodial settings:
  - planning and organising multi-agency teams
  - suicide prevention plans (based on local audit and suicide data)

- planning to respond to 'suicide clusters' (situations in which an unusual number of suicides occur, whether in terms of time, place or both).
- 2 Interventions to help staff and members of the public recognise and respond to signs of distress and crisis that may indicate someone is contemplating suicide. This may include providing information and advice, or help to develop the right skills, to:
- families, friends, colleagues and peers
  - health and social care practitioners
  - police, ambulance and fire service staff
  - people who provide a paid or voluntary service to the public, such as debt and housing support
  - railway and underground staff
  - community rehabilitation companies and probation service staff
  - staff in custodial settings
  - staff in primary, secondary and higher education institutions.
- 3 Interventions to support people in community or custodial settings, or who are transferring between settings. This would focus on providing information and arranging support from local services, such as listening and befriending schemes and other community services.
- 4 Interventions to support people who are bereaved or affected by suicide, such as family, friends, colleagues and peers (postventions). This would focus on providing information about grief and bereavement by suicide and what bereavement support services are available.
- 5 Interventions to change or reduce access to the means of suicide. This will include:
- access to medicines
  - safety fences
  - more lighting
  - removing ligature points
  - CCTV and suicide patrols, for example at high bridges, railway stations and cliffs.

- 6 Local media, other awareness campaigns, including social media interventions and face-to-face approaches to:
  - reduce the stigma around expressing suicidal thoughts and emotional distress
  - encourage people who experience a crisis and are in distress to seek help, for example, using posters to promote telephone helplines in high-risk locations such as railway stations.
- 7 Working with local media, for example newspapers, to agree sensitive approaches to reporting suicide and suicidal behaviour.

### **Areas that will not be covered**

- 1 Clinical or therapeutic interventions to treat or manage risk factors for suicide that are covered by other [NICE guidance](#). For example:
  - management of harmful drinking and alcohol dependence
  - triage for self-harm
  - treatment for depression, schizophrenia and other mental health conditions.
- 2 Staffing levels in custodial settings.
- 3 Interventions that aim to promote or protect mental wellbeing.
- 4 National interventions to prevent suicide.

## **1.4 Economic aspects**

We will take economic aspects into account when making recommendations. We will develop an economic plan that states for each review question (or key area in the scope) whether economic considerations are relevant, and if so whether this is an area that should be prioritised for economic modelling and analysis. We will review the economic evidence and carry out economic analyses using NHS and personal social services, public sector, societal or individual perspective, as appropriate

## **1.5 Key issues and questions**

While writing this scope we have identified the following key issues, and key questions related to them:

- 1 How effective and cost effective are local multi-agency teams at preventing suicide? Who needs to be involved?
- 2 How effective and cost effective are local plans for suicide prevention? What components are needed for plans to be effective?
- 3 What are the most effective and cost effective approaches for responding to 'suicide clusters' (situations in which an unusual number of suicides occur, whether in terms of time, place or both)?
- 4 What information, advice, education or training is effective and cost effective at increasing the ability of staff and members of the public to recognise and respond to someone who may be contemplating suicide? What core components would make information, advice, education and training more likely to be effective, and how does effectiveness vary for different components and different audiences?
- 5 What are the most effective and cost effective interventions that provide information and arrange local support for people in community or custodial settings, or who are transferring between settings?
- 6 Are approaches that provide people affected by suicide with information about grief and bereavement and bereavement support services (postventions) effective and cost effective at encouraging those people to seek help?
- 7 Are interventions to change or reduce access to the means of suicide (such as providing safety fences, more lighting, CCTV or suicide patrols), effective and cost effective at preventing suicide?
- 8 How effective are local media, other awareness campaigns, including social media interventions and face-to-face approaches in:
  - reducing the stigma around expressing suicidal thoughts and emotional distress
  - encouraging people who experience distress and crisis to seek help?
- 9 What are the most effective ways for local print, internet and digital media to report suicide and suicidal behaviour without increasing the likelihood of copycat attempts?

The key questions may be used to develop more detailed review questions, which guide the systematic review of the literature.

The main outcomes that will be considered when searching for and assessing the evidence are:

- 1 Local rates of suicide, suicide attempts or self-harm.
- 2 Suicide avoidance or help-seeking behaviour, such as use of telephone helplines or entry into treatment for depression.
- 3 Use of and engagement with health and social care services, for example primary care, emergency services and mental health services.
- 4 Suicidal ideation, ranging from fleeting consideration of suicide to detailed plans to die by suicide.
- 5 Changes in mental health state as assessed by validated measures.
- 6 Views and experiences of professionals and people who are involved with community-based suicide prevention interventions and their families and carers. For example, less stigma attached to suicidal thoughts.

## **2 Links with other NICE guidance, NICE quality standards and NICE Pathways**

### **2.1 NICE guidance**

#### **NICE guidance about the experience of people using NHS services**

NICE has produced the following guidance on the experience of people using the NHS. This guideline will not include additional recommendations on these topics unless there are specific issues related to preventing suicide:

- [Patient experience in adult NHS services](#) (2012) NICE guideline CG138
- [Service user experience in adult mental health](#) (2011) NICE guideline CG136
- [Medicines adherence](#) (2009) NICE guideline CG76

#### **NICE guidance that is closely related to this guideline**

##### ***Published***

NICE has published the following guidance that is closely related to this guideline:

- [Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges](#) (2015) NICE guideline NG11.
- [Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes](#) (2015) NICE guideline NG5.
- [Bipolar disorder: assessment and management](#) (2014) NICE guideline CG185
- [Psychosis and schizophrenia in adults: prevention and management](#) (2014) NICE guideline CG178
- [Antisocial behaviour and conduct disorders in children and young people: recognition and management](#) (2013) NICE guideline CG158
- [Self-harm in over 8s: long-term management](#) (2011) NICE guideline CG133
- [Common mental health problems: identification and pathways to care](#) (2011) NICE guideline CG123
- [Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence](#) (2011) NICE guideline CG115
- [Looked-after children and young people](#) (2010) NICE guideline PH28
- [Alcohol-use disorders: prevention](#) (2010) NICE guideline PH24
- [Borderline personality disorder: recognition and management](#) (2009) NICE guideline CG78
- [Depression in adults with a chronic physical health problem: recognition and management](#) (2009) NICE guideline CG91
- [Depression in adults: recognition and management](#) (2009) NICE guideline CG90
- [Mental wellbeing at work](#) (2009) NICE guideline PH22
- [Social and emotional wellbeing in secondary education](#) (2009) NICE guideline PH20
- [Mental wellbeing in over 65s: occupational therapy and physical activity interventions](#) (2008) NICE guideline PH16
- [Drug misuse: psychosocial interventions](#) (2007) NICE guideline CG51
- [Drug misuse: opioid detoxification](#) (2007) NICE guideline CG52
- [Self-harm in over 8s: short-term management and prevention of recurrence](#) (2004) NICE guideline CG16

### ***In development***

NICE is currently developing the following guidance that is closely related to this guideline:

- [Transition between inpatient mental health settings and community or care home settings](#). NICE guideline. Publication expected August 2016.
- [Mental health of adults in contact with the criminal justice system](#). NICE guideline. Publication expected February 2017.

## **2.2 NICE quality standards**

**NICE quality standards that may need to be revised or updated when this guideline is published**

- [Depression in children and young people](#) (2013) NICE quality standard 48
- [Self-harm](#) (2013) NICE quality standard 34
- [Drug use disorders in adults](#) (2012) NICE quality standard 23
- [Depression in adults](#) (2011) NICE quality standard 8

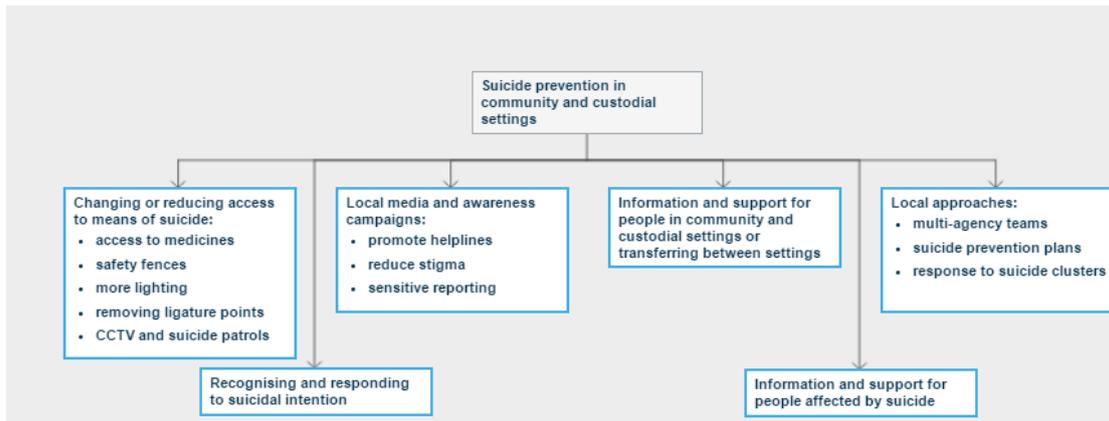
## **2.3 NICE Pathways**

[NICE Pathways](#) bring together all NICE guidance and associated products on a topic in an interactive flowchart.

When this guideline is published, the recommendations will be incorporated into a new pathway on suicide prevention. Links to related pathways such as [depression](#) will be added as needed.

An outline of the new pathway, based on the scope, is included below. It will be adapted and more detail added as the recommendations are written during guideline development.

## Suicide prevention in community and custodial settings overview



### 3 Context

#### 3.1 Key facts and figures

There were 6,122 suicides of people aged 10 and over in the UK in 2014, 120 fewer than in 2013 (a 2% decrease). In 2014, the UK suicide rate was 10.8 deaths per 100,000 population. The male suicide rate in the UK decreased in 2014 from 17.8 to 16.8 deaths per 100,000 population, whereas the female suicide rate increased from 4.8 to 5.2 deaths per 100,000 population ([Suicide occurrences in England and Wales](#) Office for National Statistics). For every suicide that occurs there are many more people who attempt suicide ([Suicide factsheet](#) World Health Organization).

The highest suicide rate, by age and gender, in the UK in 2014 was among men aged 45 to 59, at 23.9 deaths per 100,000. This was slightly lower than in 2013. This age group also had the highest rate among women, at 7.3 deaths per 100,000. Suicide is more than 3 times as common in men as in women. Risk of suicide in the prison population is considerably higher than in the general UK population. The 3-year average rate of self-inflicted deaths by people in prison in England was 69 deaths per 100,000 in 2009–2011; approximately 80% of these deaths receive a suicide or open verdict at inquest. There were 80 deaths by suicide in prison in 2014 and 62 ‘apparent suicides following police custody’ during 2013/14 in England. The 2 most common methods of suicide in the UK are hanging and poisoning ([‘Suicide occurrences in England and Wales’](#)).

The [Chief Medical Officer annual report: public mental health – investing in the evidence](#) (Department of Health) identified suicide and self-harm as major public health problems, with self-harm indicating an increased risk of suicide. However, approximately three-quarters of people who die by suicide are not in current or recent contact with psychiatric services at the time of death and this is particularly the case for men. The overall financial cost of a suicide by someone of working age in the UK was found to exceed £1.6 million.

### **3.2 Current practice**

Preventing suicide is complex and multi-faceted. Describing what is 'usual' in terms of a person's care pathway or the support they receive is difficult given the multiple entry points by which a person can make contact with suicide prevention services. These may include self-initiated contact through helplines and support groups (offered by charities such as [Samaritans](#) and the [Campaign Against Living Miserably](#)) or speaking to a GP.

People at risk of dying by suicide may come into contact with a wide range of professionals and others. So effective suicide prevention needs a many-faceted approach to training and awareness raising.

The cross-government strategy [Preventing suicide in England: two years on](#) highlights the potential role of primary care in preventing suicide. That is because three-quarters of people who die by suicide have not had recent contact with secondary mental health services. Having said that, mental illness has often gone unrecognised in those who die by suicide who have been receiving any kind of primary care treatment.

Primary care practitioners can only treat the people they see. It is important to understand barriers that prevent people at risk using primary care services, and what community-based interventions can do to facilitate this.

The All-Party Parliamentary Group on Suicide and Self-harm Prevention [Inquiry into local suicide prevention plans in England](#) found that around 30% of local authorities in England do not have a local suicide prevention action

plan. Around 40% do not have a multi-agency suicide prevention group and around 30% do not collect local suicide data.

The 'Inquiry into local suicide prevention plans in England' report identified 3 main elements essential to the successful local implementation of the national suicide prevention strategy, based on a survey of local authority suicide prevention plans. These were:

- carrying out 'suicide audits' to collect data on suicides
- developing suicide prevention action plans
- establishing a multi-agency suicide prevention group.

The 'Chief Medical Officer annual report: public mental health – investing in the evidence' makes 14 recommendations focused on:

- commissioning and service development
- information, intelligence and data
- work
- workforce training
- practice and policy.

[Closing the gap: priorities essential for change in mental health](#) (Department of Health) outlined the link between self-harm and suicide. This reiterated the advice to A&E departments about referring people who present with self-harm for psychological assessment in NICE's guidelines on [self-harm in over-8s: short-term management and prevention of recurrence](#) and [self-harm in over-8s: longer term management](#).

Public Health England has provided [guidance for developing a local suicide prevention action plan](#) and a [suicide prevention profile](#) tool on the National Mental Health Intelligence Network to help professionals better understand issues in their areas and respond accordingly. It has also published guidance on [identifying and responding to potential suicide clusters](#) and [preventing suicides in public places](#). It has updated [Help is at hand](#), a guide with practical and emotional support for anyone affected by a suicide.

### **3.3 Policy, legislation, regulation and commissioning**

#### **Policy**

In 2012, the cross-government strategy [Preventing suicide in England](#) was developed with the objective of reducing the suicide rate in England and providing better support for people who have been bereaved or affected by suicide. The strategy emphasised reducing the risk in key high-risk groups. These were identified as:

- young and middle-aged men
- people in the care of mental health services (including inpatients)
- people with a history of self-harm
- people in contact with the criminal justice system
- specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers.

This was followed by [Preventing suicide in England: two years on](#). This highlights the importance of preventing male suicides, because the recent rise among this group is thought to be a major factor in the recent rise in overall suicide rates domestically and globally. This follow-up strategy also highlights the influence of social media.

#### **Legislation, regulation and guidance**

Suicide prevention is part of the [NHS Mandate](#). The [Public Health Outcomes Framework](#) outlines 'suicide rate' as an indicator for the objective of reducing numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities (part of domain 4: healthcare public health and preventing premature mortality). There is now also a 'suicide' indicator in the Department of Health's [NHS Outcomes Framework 2015 to 2016](#) (domain 1: preventing people from dying prematurely).

Previously data on suicide were not fully captured except for people in contact with secondary mental health services ('NHS Outcomes Framework 2015 to 2016'). The frameworks now outline 'reducing premature death in people with

mental illness' (NHS Outcomes Framework indicator 1.5.iii) and make reference to 'suicide and mortality from injury of undetermined intent among people with recent contact from NHS services' (Public Health Outcomes Framework indicator 4.10).

The rationale behind this change is the recognition that the NHS can influence outcomes in suicide through contact with people beforehand, for example by effective care planning before discharge from hospital.

The [Quality Outcomes Framework](#) is a voluntary incentive scheme for GP practices in the UK that seeks to standardise improvements in delivering primary medical services. There are currently 2 [specific NICE indicators](#) under negotiation for 'Depression' (NM50 and NM49: NICE 2012) and 12 indicators for 'Mental health' including a specific indicator for 'Depression and anxiety' (NM123: NICE 2015). There are also indicators focusing on specific mental health conditions such as schizophrenia, bipolar affective disorder and other psychoses (NM108: NICE 2015).

## 4 Further information

This is the final scope, incorporating comments from registered stakeholders during consultation.

It takes Public Health England priorities into account to ensure that associated areas of work carried out by the 2 organisations complement each other.

The guideline is expected to be published in May 2018.

You can follow progress of the [guideline](#).

Our website has information about how [NICE guidelines](#) are developed.