

1 **Preventing suicide in community and custodial** 2 **or detention settings**

3 **NICE guideline**

4 **Draft for consultation, February 2018**

5

This guideline covers ways to reduce deaths by suicide and help people bereaved or affected by suicides. This includes families and emergency responders, who may as a result be at risk of harming themselves. It looks at measures that can be used in places where suicide is more likely, and at ways to identify and help people at risk. It also covers how local services can best work together and what plans and training they need to put in place.

It does not cover national strategies, general mental wellbeing, or areas covered by other NICE guidance such as self-harm or mental health conditions.

Who is it for?

- Health and wellbeing boards and local safeguarding boards
- Commissioners in the NHS and local authorities
- Organisations in the public, private and voluntary and community sectors
- Health and social care services, particularly primary care and community services
- Prison and custodial services, detention centres, community rehabilitation companies and the national probation service
- National crime agency, police and emergency services
- Education institutions
- Families, carers and other people who have been bereaved or affected by suicide

This version of the guideline contains:

- the draft recommendations

- recommendations for research
- rationale and impact sections that explain why the committee made the recommendations and how they might affect practice
- the guideline context.

Information about how the guideline was developed is on the [guideline's page](#) on the NICE website. This includes the evidence reviews, the scope, and details of the committee and any declarations of interest.

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1 Recommendations

[Making decisions using NICE guidelines](#) explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

2 **1.1 Suicide prevention partnerships**

3 **Multi-agency partnerships for suicide prevention in the community**

4 1.1.1 Local authorities should work with local organisations to set up and lead a
5 local multi-agency partnership on suicide prevention. The partnership
6 should have clear terms of reference, governance and accountability
7 structures, based on a shared understanding that suicide is preventable.

8 1.1.2 Include representatives from:

- 9 • local public health services
- 10 • clinical commissioning groups
- 11 • primary care providers
- 12 • secondary care providers
- 13 • social care services
- 14 • voluntary and other third-sector organisations
- 15 • secondary mental healthcare providers
- 16 • emergency services
- 17 • criminal justice services
- 18 • people who have attempted or been affected by suicide.

19 **Multi-agency partnerships for suicide prevention in custodial or detention** 20 **settings**

21 1.1.3 Each custodial or detention setting should set up a multi-agency
22 partnership that includes representatives from:

- 23 • prison healthcare staff
- 24 • prison governors

- 1 • prison staff
- 2 • emergency services
- 3 • voluntary and other third-sector organisations
- 4 • probationary and transition services
- 5 • people who have attempted or been affected by suicide.

6 1.1.4 Link the custodial or detention setting's partnership with relevant multi-
7 agency partnerships in the community (see recommendation 1.1.1).

To find out why the committee made the recommendations on suicide prevention partnerships and how they might affect practice, see [the committee's discussion](#).

8 **1.2 *Suicide prevention strategies***

9 1.2.1 Multi-agency partnerships in the community or in a custodial or detention
10 setting should develop a suicide prevention strategy. Specifically:

- 11 • Make it clear who leads on suicide prevention.
- 12 • Engage with stakeholders to share experience and knowledge.
- 13 • Map stakeholders and their suicide prevention activities.
- 14 • Oversee local suicide prevention activities, including awareness raising.
- 15 • Keep up to date with suicide prevention activities in neighbouring
16 areas.
- 17 • Review local and national suicide data to ensure the strategy is as
18 effective as possible.
- 19 • Assess whether initiatives successfully adopted elsewhere are
20 appropriate locally or can be adapted to local needs.
- 21 • Work with transport companies to promote best practice when
22 announcing delays because of a suspected suicide.
- 23 • Work with the media to promote best practice when reporting suicides
24 or suspected suicides (this includes social media, broadcasting and
25 newspapers). For example, see the Samaritan's [Media guidelines for
26 the reporting of suicide](#).

1 1.2.2 Multi-agency partnerships in the community should help local institutions
2 and organisations to prepare contingency plans to respond to a suicide.
3 This includes schools, universities, further and higher education
4 institutions, and workplaces.

5 See Public Health England's resource on [Local suicide prevention planning: a](#)
6 [practice resource](#).

To find out why the committee made the recommendations on suicide prevention strategies and how they might affect practice, see [the committee's discussion](#).

7

8 **1.3 Suicide prevention action plans**

9 1.3.1 Multi-agency partnerships in the community or in a custodial or detention
10 setting should develop a plan to implement the suicide prevention
11 strategy. Include processes to:

- 12 • Collect, analyse and interpret local data to determine local patterns of
13 attempted suicide and suicide (see recommendations 1.4.1 and 1.4.2).
- 14 • Compare local patterns against national trends.
- 15 • Share data between stakeholders so that they can identify local
16 characteristics and needs.

17 1.3.2 Implement the plan based on interpretation of routinely collected data.

18 1.3.3 Multi-agency partnerships in the community should audit the data
19 collected (see recommendations 1.4.1 and 1.4.2) and use the results to
20 improve the local action plan.

21 1.3.4 Multi-agency partnerships in a custodial or detention settings should audit
22 the data collected (see recommendations 1.4.1 and 1.4.3) and use the
23 results to improve the local action plan.

24 See Public Health England's [Local suicide prevention planning: a practice resource](#).

To find out why the committee made the recommendations on suicide prevention action plans and how they might affect practice, see [the committee's discussion](#).

1 **1.4** ***Gathering and analysing suicide-related information***

2 1.4.1 Multi-agency partnerships in the community or in a custodial or detention
3 setting should:

- 4 • Use routinely-collected data to provide information on suicide and self-
5 harm. This could include data on at-risk groups from sources such as
6 Public Health England's [Fingertips tool \(public health profiles\)](#), the
7 [National Probation Service](#) and the [National Offender Management](#)
8 [Service](#)).
- 9 • Carry out periodic audits to collect and analyse local data from different
10 sources, for example reports from local ombudsman, and coroner,
11 prison and probation ombudsman reports.
- 12 • Assess the quality of the data from each source to ensure robust and
13 consistent data collection.
- 14 • Gather data on method of suicide, location, seasonality, details of
15 individual and local circumstances, demographics, occupation, and
16 characteristics protected under the [Equality Act \(2010\)](#).

17 1.4.2 Multi-agency partnerships in the community should consider continuous
18 and timely collection of data ([rapid intelligence gathering](#)) from police,
19 coroners and other sources to identify suspected suicides and potential
20 emerging [suicide clusters](#). This intelligence could also be used to identify
21 people who need support after such events (see [recommendations 1.8.1](#)
22 [and 1.8.5](#)).

23 1.4.3 Custodial and detention settings should collect data on sentence type,
24 offence, length and transition periods when carrying out rapid intelligence
25 gathering in their institutions to identify trends.

26 1.4.4 Ensure staff gathering and analysing this information are given
27 appropriate support and resilience training.

To find out why the committee made the recommendations on gathering and analysing suicide-related information and how they might affect practice, see [the committee's discussion](#).

1

2 **1.5 Awareness raising**

3 **General suicide awareness raising**

4 These recommendations are for multi-agency partnerships.

5 1.5.1 Use [sensitive language](#) and tailor messages for the target group, when
6 planning suicide awareness activities.

7 1.5.2 Consider local activities to raise awareness of suicide risk and prevention.
8 In particular:

- 9 • Address common misconceptions, by emphasising that:
 - 10 – suicide is preventable
 - 11 – it is safe to talk about suicide
 - 12 – suicide is not inevitable.
- 13 • Make people aware of the wider impact of suicide; for example, around
14 60 people may be affected by each death.
- 15 • Make people aware of the support available nationally and locally.
- 16 • Take account of local trends, locations and methods that are often
17 used.
- 18 • Take into account socioeconomic deprivation, mental health status
19 cultural, religious, and social norms about suicide and help-seeking
20 behaviour.

21 1.5.3 Consider encouraging all employers to develop policies to raise suicide
22 awareness and provide support after a suspected suicide (for examples,
23 see Public Health England and Business in the Community's toolkits for
24 [Reducing the risk of suicide: a preventative toolkit for employers and](#)
25 [Crisis management in the event of a suicide](#)).

1 **Suicide prevention campaigns**

2 1.5.4 Suicide prevention campaign messages should:

- 3
- 4 • be tested with the help of a sample of the target audience
 - 5 • be action-oriented, for example, focus on how to get help
 - 6 • encourage people in crisis to use local support services such as
 - 7 primary care and peer-support groups
 - 8 • be delivered in a way that meets the target audience's preferences
 - 9 • include displays at prominent locations, for example schools,
 - 10 universities, higher and further education institutions, pharmacies, on
 - 11 public transport, custody suites and reception areas, and prison visit
 - 12 halls
 - be regularly repeated and changed to keep the audience's attention.

13 1.5.5 Use the same messages and time local campaigns to run at the same

14 time as existing national suicide prevention programmes.

To find out why the committee made the recommendations on awareness raising and how they might affect practice, see [the committee's discussion](#).

15 **1.6 Reducing access to methods of suicide**

16 1.6.1 Use local data including audit, Office for National Statistics and NHS data,

17 as well as [rapid intelligence gathering](#), to:

- 18
- 19 • identify emerging trends in suicide methods and locations
 - 20 • understand local characteristics that may influence the methods used
 - determine when to take action to reduce access to means.

21 See [recommendations 1.4.1 to 1.4.3](#).

22 1.6.2 Comply with national guidance about reducing access to methods of

23 suicide (for example, by implementing the safe cell initiative in custodial

24 settings and restricting access to painkillers in community settings).

1 1.6.3 Reduce the opportunity to attempt suicide in [places where suicide is more](#)
2 [likely](#). (See Public Health England's [Local suicide prevention planning: a](#)
3 [practice resource](#)).

4 1.6.4 Consider other measures to deter people from suicide in places where
5 suicide is more likely. For example, consider:

- 6 • providing information about where and how people can get help when
7 they feel unable to cope
- 8 • using CCTV to allow staff to monitor when someone may need help
- 9 • increasing the number of staff or times when staff are at sites.

To find out why the committee made the recommendations on reducing access to methods of suicide and how they might affect practice, see [the committee's discussion](#).

10

11 **1.7 Training**

12 1.7.1 Ensure suicide awareness and prevention training is provided for people
13 who work with high-risk groups or at [places where suicide is more likely](#).

14 1.7.2 Ensure the training gives skills and confidence to:

- 15 • understand local suicide incidence and its impact
- 16 • encourage people to talk openly about suicidal thoughts
- 17 • encourage those at high risk to seek help (this includes providing
18 details of where they can get this help).

19 1.7.3 Develop training programmes for organisations employing, working with or
20 representing occupational groups at [high suicide risk](#). See
21 recommendation 1.7.2 for the aims of the training.

22 1.7.4 Raise awareness about suicide risks among [gatekeepers](#) so they can
23 identify people at risk.

- 1 1.7.5 Ensure people who provide peer support in custodial settings are trained
2 to provide emotional support.

To find out why the committee made the recommendations on training and how they might affect practice, see [the committee's discussion](#).

3 **1.8 After a suspected suicide**

4 **Supporting people bereaved or affected by a suspected suicide**

- 5 1.8.1 Identify those who may be affected by a suspected suicide or may benefit
6 from bereavement support by using [rapid intelligence gathering](#) (see
7 [recommendations 1.4.2 and 1.4.3](#)) and data from other sources, such as
8 coroners. Those affected may include relatives, friends, classmates, close
9 contacts including cell or prison mates and peer support workers in
10 custodial settings, as well as first responders and other professionals who
11 provided support.
- 12 1.8.2 Provide sensitive, practical and evidence-based early support, such as
13 Public Health England's [Help is at hand](#) guide, which provides support for
14 people bereaved by suicide and also signposts to other services.
- 15 1.8.3 Consider peer support provided by trained people who have been
16 bereaved or affected by a suicide or suspected suicide.
- 17 1.8.4 Consider providing ongoing support for people bereaved or affected by a
18 suicide or suspected suicide if they need this.

19 **Preventing suicide clusters**

- 20 1.8.5 Use information from the action plan and rapid intelligence gathering to
21 identify potential [suicide clusters](#) (see [recommendation 1.3.1](#) and
22 [recommendations 1.4.2 and 1.4.3](#)). Ensure the plan is flexible and can be
23 adapted according to which local agencies are likely to spot emerging
24 clusters.

1 1.8.6 Develop a coordinated approach to mitigate risk of additional suicides.
2 Use Public Health England's [Identifying and responding to suicide and](#)
3 [contagion](#).

4 1.8.7 Develop a standard procedure for reducing or stopping – 'stepping down'
5 – responses to any suspected suicide cluster.

6 1.8.8 Provide ongoing support for those involved, including people directly
7 bereaved or affected and those who are responding to the situation (see
8 recommendations 1.8.1 to 1.8.4).

9 **Media reporting of suicides**

10 1.8.9 The local multi-agency partnership should develop a clear plan for liaising
11 with the media. They should also encourage training for journalists on how
12 sensitive and insensitive reporting on suicide can affect the public. The
13 training should include the need to use [sensitive language](#), reduce
14 speculative reporting and avoid presenting detail on methods.

15 1.8.10 In custodial and detention settings, the multi-agency partnership should
16 ensure national guidelines are followed when engaging with the media to
17 report suicides. The press officer should be given training on suicide
18 reporting both at time of the event and at the inquest, including the need
19 to use sensitive language, reduce speculative reporting and avoid
20 presenting detail on methods.

21 1.8.11 Disseminate guidance on effective media reporting of suicide. Examples
22 include: the World Health Organization's [Preventing suicide: a resource](#)
23 [for media professionals](#); the Samaritans' [Media guidelines for reporting](#)
24 [suicide](#); the Independent Press Standards Organisation's [Editors code of](#)
25 [practice](#); and OFCOM's [Broadcasting code](#).

26 1.8.12 Monitor media coverage of local deaths that are suspected to be suicides
27 and, if necessary, provide feedback to the reporter on the effect of their
28 reporting (see the 'Media guidelines for reporting suicide').

To find out why the committee made the recommendations on after a suspected suicide and how they might affect practice, see [the committee's discussion](#).

1 ***Terms used in this guideline***

2 **Gatekeepers**

3 People in groups that have contact, because of their paid or voluntary work, with
4 people at risk of suicide. People in these groups are often trained to identify people
5 at risk of suicide and refer them to treatment or supporting services as appropriate.

6 They may include:

- 7 • health and social care practitioners
- 8 • staff in prisons, custodial services and detention settings
- 9 • police and emergency services
- 10 • people who provide a paid or voluntary service for the public
- 11 • faith leaders
- 12 • railway and underground station staff
- 13 • staff in educational institutions.

14 **High suicide risk**

15 High suicide risk means that the rate of suicide in a group or setting is higher than
16 the expected rate based on the general population in England.

17 Groups at high risk can include:

- 18 • young and middle-aged men
- 19 • family and friends of those who have died by suicide
- 20 • people who misuse drugs or alcohol
- 21 • people in the LGBT community
- 22 • people in care of mental health services
- 23 • people in contact with the criminal justice system, particularly those in prisons
- 24 • people in detention settings, including immigration detention settings
- 25 • specific occupation groups (see [Suicide by occupation, England: 2011 to 2015](#)
26 Office for National Statistics).

1 **Places where suicide is more likely**

2 These include high buildings such as multi-storey car parks, and places where other
3 means of suicide are accessible, such as medical, veterinary or agricultural settings
4 where human or animal drugs may be readily available. See Public Health England's
5 practice resource on [Preventing suicides in public places](#).

6 **Rapid intelligence gathering**

7 The process of collecting information to inform timely response. This is also known
8 as 'real-time surveillance' or 'real-time monitoring'.

9 **Sensitive language**

10 Language, in the form of written and verbal wording and terms, that is not
11 stigmatising or distressing to people surviving a suicide attempt or bereaved by
12 suicide. Insensitive language should be avoided because it can be a barrier to
13 seeking help, and we encourage more appropriate terminology (see the Samaritans'
14 [Media guidelines for the reporting of suicide](#)).

15 **Suicide clusters**

16 This guideline uses Public Health England's definition of a cluster: a series of 3 or
17 more closely grouped deaths which are linked by space or social relationships. In the
18 absence of transparent social connectedness, evidence of space and time linkages
19 are required to define a cluster. In the presence of a strong demonstrated social
20 connection, only temporal significance is required. (Adapted from Public Health
21 England's 'Identifying and responding to suicide clusters and contagion. a practice
22 resource' [2015]. Available from [www.gov.uk/government/publications/suicide-
23 prevention-identifying-and-responding-to-suicide-clusters](http://www.gov.uk/government/publications/suicide-prevention-identifying-and-responding-to-suicide-clusters).)

24 **Recommendations for research**

25 The guideline committee has made the following high-priority recommendations for
26 research. For details of all the committee's recommendations for research, see the
27 [evidence reviews](#).

1 **1 *Non-clinical interventions***

2 How effective and cost effective are non-clinical interventions to reduce the rate of
3 suicide?

4 **Why this is important**

5 Approximately 6,000 people take their own life each year in the UK. Many are not in
6 contact with mental health services or GPs, so opportunities for clinical interventions
7 are limited. Non-clinical interventions such as telephone or text helplines or
8 volunteer-run face-to-face talking are important to support people with suicidal
9 thoughts and keep them safe. There is increasing demand for non-clinical
10 interventions but little evidence on the benefits. Research is needed to evaluate how
11 effective they are.

12 **2 *Supporting people bereaved or affected by a suicide***

13 How effective and cost effective are interventions to support people who are
14 bereaved or affected by a suicide?

15 **Why this is important**

16 The NHS does not provide a specialist bereavement service for people affected by
17 suicide and many healthcare professionals, including GPs, do not know how to
18 respond to this group. Some services have been developed locally to provide
19 support. But because there is very little evidence on the benefits, local authorities are
20 reluctant to commission such services. Research is needed to build an evidence
21 base on these interventions. This can help with developing effective and cost-
22 effective statutory and voluntary services.

23 **3 *Suicide prevention in custodial and detention settings***

24 What interventions are effective and cost effective in reducing suicide rates in
25 custodial settings?

26 **Why this is important**

27 The number of people dying by suicide in custodial or other detention settings such
28 as prisons, immigration detention centres, young offender institutions and police
29 custody has increased over the past decade. Factors may include staff to prisoner

1 ratio, length of sentence, violence, overcrowding and a rise in the prison population.
2 But there is a lack of evidence on preventive interventions. More research is needed
3 to evaluate the effectiveness of different interventions in a range of custodial
4 settings.

5 ***4 Training***

6 How effective and cost effective is [gatekeeper](#) training in preventing suicides?

7 **Why this is important**

8 The UK evidence base on the effectiveness of gatekeeper training is limited. There
9 are few gatekeeper training programmes for people working with the public. Training
10 for all gatekeepers is important because it may help to increase identification of
11 people at risk of suicide. But research is needed to evaluate how gatekeeper training
12 can help prevent suicide.

13 ***5 Suicide awareness campaigns***

14 What is the effectiveness and cost effectiveness of targeted media campaigns in
15 preventing suicide?

16 **Why this is important**

17 Suicide is preventable. What is the most appropriate form of public messaging on
18 suicide is a key question because there can be a fine line between the helpful or
19 potentially harmful messages. With high-profile national and local campaigns being
20 rolled out, a universal approach to the awareness campaign may not have a direct
21 positive impact. Research on the effectiveness of awareness campaigns on a
22 targeted population is needed to further develop this evidence base.

23 **The committee's discussion**

24 ***Suicide prevention partnerships***

25 The discussion below explains how the committee made [recommendations 1.1.1 to](#)
26 [1.1.4](#).

1 **Recommendations**

2 ***Multi-agency partnerships for suicide prevention in the community***

3 1.1.1 Local authorities should work with local organisations to set up and lead a local
4 multi-agency partnership on suicide prevention. The partnership should have clear
5 terms of reference, governance and accountability structures, based on a shared
6 understanding that suicide is preventable.

7 1.1.2 Include representatives from:

- 8 • local public health services
- 9 • clinical commissioning groups
- 10 • primary care providers
- 11 • secondary care providers
- 12 • social care services
- 13 • voluntary and other third-sector organisations
- 14 • secondary mental healthcare providers
- 15 • emergency services
- 16 • criminal justice services
- 17 • people who have attempted or been affected by suicide.

18 ***Multi-agency partnerships for suicide prevention in custodial or detention*** 19 ***settings***

20 1.1.3 Each custodial or detention setting should set up a multi-agency partnership
21 that includes representatives from:

- 22 • prison healthcare staff
- 23 • prison governors
- 24 • prison staff
- 25 • emergency services
- 26 • voluntary and other third-sector organisations
- 27 • probationary and transition services
- 28 • people who have attempted or been affected by suicide.

1 1.1.4 Link the custodial or detention setting's partnership with relevant multi-agency
2 partnerships in the community (see recommendation 1.1.1).

3 **Why the committee made the recommendations**

4 Many agencies can be involved in preventing suicide at local level in the community.
5 Although the evidence was limited, the committee agreed that these agencies need
6 to work together to focus on the most effective and cost-effective interventions. By
7 combining expertise and resources, partnerships can cover a much wider area more
8 effectively and implement a range of activities. Likewise, partnerships between
9 different services in custodial and detention settings and with their local multi-agency
10 partnership are important.

11 **How the recommendations might affect practice**

12 Multi-agency partnership working is already enshrined in the national suicide
13 prevention strategy entitled [Preventing Suicide in England: a cross-government](#)
14 [outcomes strategy to save lives](#), updated in the [Suicide prevention: third annual](#)
15 [report](#). Most local authorities already have a multi-agency suicide prevention
16 partnership in place, so no additional costs are expected.

17 Full details of the evidence and the committee's discussion are in [evidence review 1:](#)
18 [multi-agency partnership](#).

19 ***Suicide prevention strategies***

20 The discussion below explains how the committee made [recommendations 1.2.1 to](#)
21 [1.2.2](#).

22 **Recommendations**

23 1.2.1 Multi-agency partnerships in the community or in a custodial or detention
24 setting should develop a suicide prevention strategy. Specifically:

- 25 • Make it clear who leads on suicide prevention.
- 26 • Engage with stakeholders to share experience and knowledge.
- 27 • Map stakeholders and their suicide prevention activities.
- 28 • Oversee local suicide prevention activities, including awareness raising.

- 1 • Keep up to date with suicide prevention activities in neighbouring
2 areas.
- 3 • Review local and national suicide data to ensure the strategy is as
4 effective as possible.
- 5 • Assess whether initiatives successfully adopted elsewhere are
6 appropriate locally or can be adapted to local needs.
- 7 • Work with transport companies to promote best practice when
8 announcing delays because of a suspected suicide.
- 9 • Work with the media to promote best practice when reporting suicides
10 or suspected suicides (this includes social media, broadcasting and
11 newspapers). For example, see the Samaritan's [Media guidelines for
12 the reporting of suicide](#).

13 1.2.2 Multi-agency partnerships in the community should help local institutions and
14 organisations to prepare contingency plans to respond to a suicide. This includes
15 schools, universities, further and higher education institutions, and workplaces.

16 See Public Health England's resource on [Local suicide prevention planning: a
17 practice resource](#).

18 **Why the committee made the recommendations**

19 Some evidence and expert opinion showed that having a strategy for how to reach
20 local stakeholders can help to prevent suicide in community and custodial or
21 detention settings. Knowing what is happening in the area or setting, including
22 gathering data on suicide rates, will ensure that the strategy is current,
23 comprehensive and likely to be effective.

24 **How the recommendations might affect practice**

25 The [National Suicide Prevention Strategy](#) includes multi-agency partnerships with
26 suicide prevention strategies. Most local authorities already have suicide prevention
27 partnerships and strategies in place, so no additional costs are expected.

28 Full details of the evidence and the committee's discussion are in [evidence review 1:
29 multi-agency partnership](#).

1 ***Suicide prevention action plans***

2 The discussion below explains how the committee made [recommendations 1.3.1 to](#)
3 [1.3.4](#).

4 **Recommendations**

5 1.3.1 Multi-agency partnerships in the community or in a custodial or detention
6 setting should develop a plan to implement the suicide prevention strategy. Include
7 processes to:

- 8 • Collect, analyse and interpret local data to determine local patterns of
9 attempted suicide and suicide (see recommendations 1.4.1 and 1.4.2).
- 10 • Compare local patterns against national trends.
- 11 • Share data between stakeholders so that they can identify local
12 characteristics and needs.

13 1.3.2 Implement the plan based on interpretation of routinely collected data.

14 1.3.3 Multi-agency partnerships in the community should audit the data collected
15 (see recommendations 1.4.1 and 1.4.2) and use the results to improve the local
16 action plan.

17 1.3.4 Multi-agency partnerships in a custodial or detention settings should audit the
18 data collected (see recommendations 1.4.1 and 1.4.3) and use the results to improve
19 the local action plan.

20 See Public Health England's [Local suicide prevention planning: a practice resource](#).

21 **Why the committee made the recommendations**

22 Having a detailed action plan based on local knowledge can help prevent suicide in
23 the community or in custodial or detention settings The plan will be effective if it is
24 based on knowledge of what is happening in the area or setting, involves
25 stakeholders and is continually improving.

26 **How the recommendations might affect practice**

27 Multi-agency partnership working is already enshrined in the [National Suicide](#)
28 [Prevention Strategy](#). Most local authorities should already have suicide prevention

1 groups and plans in place, so no additional costs are expected. For example, Public
2 Health England's [Suicide Prevention Atlas](#) shows which local authorities have
3 suicide prevention plans.

4 Full details of the evidence and the committee's discussion are in [evidence review 2:
5 local suicide plans](#).

6 ***Gathering and analysing suicide-related information***

7 The discussion below explains how the committee made [recommendations 1.4.1 to
8 1.4.4](#).

9 **Recommendations**

10 1.4.1 Multi-agency partnerships in the community or in a custodial or detention
11 setting should:

- 12 • Use routinely-collected data to provide information on suicide and self-
13 harm. This could include data on at-risk groups from sources such as
14 Public Health England's [Fingertips tool \(public health profiles\)](#), the
15 [National Probation Service](#) and the [National Offender Management
16 Service](#)).
- 17 • Carry out periodic audits to collect and analyse local data from different
18 sources, for example reports from local ombudsman, and coroner,
19 prison and probation ombudsman reports.
- 20 • Assess the quality of the data from each source to ensure robust and
21 consistent data collection.
- 22 • Gather data on method of suicide, location, seasonality, details of
23 individual and local circumstances, demographics, occupation, and
24 characteristics protected under the [Equality Act \(2010\)](#).

25 1.4.2 Multi-agency partnerships in the community should consider continuous and
26 timely collection of data ([rapid intelligence gathering](#)) from police, coroners and other
27 sources to identify suspected suicides and potential emerging [suicide clusters](#). This
28 intelligence could also be used to identify people who need support after such events
29 (see [recommendations 1.8.1 and 1.8.5](#)).

1 1.4.3 Custodial and detention settings should collect data on sentence type, offence,
2 length and transition periods when carrying out rapid intelligence gathering in their
3 institutions to identify trends.

4 1.4.4 Ensure staff gathering and analysing this information are given appropriate
5 support and resilience training.

6 **Why the committee made the recommendations**

7 Good information is essential for planning, monitoring success and improving the
8 strategy and plan. The committee agreed that the information should come from
9 different sources to get a clear picture of what is happening and overcome the
10 shortcomings of each type of source. Although the evidence was limited, the
11 committee agreed with an expert that multi-agency partnerships in the community
12 should consider more rapid and frequent information gathering, which is key for
13 quick interventions such as early detection of suicide clusters. Staff need to be
14 trained and supported to increase their resilience when gathering and analysing
15 information which may expose them to distressing material, for example
16 photographs.

17 **How the recommendations might affect practice**

18 Multi-agency partnership working will involve some additional resources, but most
19 local authorities have suicide prevention groups and plans in place so we do not
20 expect this will have a significant resource impact.

21 Full details of the evidence and the committee's discussion are in [evidence review 1:
22 multi-agency partnership; evidence review 2: local suicide plans.](#)

23 ***Awareness raising***

24 The discussion below explains how the committee made [recommendations 1.5.1 to
25 1.5.5.](#)

26 **Recommendations**

27 ***General suicide awareness raising***

28 These recommendations are for multi-agency partnerships.

1 1.5.1 Use [sensitive language](#) and tailor messages for the target group, when
2 planning suicide awareness activities.

3 1.5.2 Consider local activities to raise awareness of suicide risk and prevention. In
4 particular:

- 5 • Address common misconceptions, by emphasising that:
 - 6 – suicide is preventable
 - 7 – it is safe to talk about suicide
 - 8 – suicide is not inevitable.
- 9 • Make people aware of the wider impact of suicide; for example, around
10 60 people may be affected by each death.
- 11 • Make people aware of the support available nationally and locally.
- 12 • Take account of local trends, locations and methods that are often
13 used.
- 14 • Take into account socioeconomic deprivation, mental health status
15 cultural, religious, and social norms about suicide and help-seeking
16 behaviour.

17 1.5.3 Consider encouraging all employers to develop policies to raise suicide
18 awareness and provide support after a suspected suicide (for examples, see Public
19 Health England and Business in the Community's toolkits for [Reducing the risk of
20 suicide: a preventative toolkit for employers and Crisis management in the event of a
21 suicide](#)).

22 ***Suicide prevention campaigns***

23 1.5.4 Suicide prevention campaign messages should:

- 24 • be tested with the help of a sample of the target audience
- 25 • be action-oriented, for example, focus on how to get help
- 26 • encourage people in crisis to use local support services such as
27 primary care and peer-support groups
- 28 • be delivered in a way that meets the target audience's preferences

- 1 • include displays at prominent locations, for example schools,
2 pharmacies, on public transport, custody suites and reception areas,
3 and prison visit halls
- 4 • be regularly repeated and changed to keep the audience's attention.

5 1.5.5 Use the same messages and time local campaigns to run at the same time as
6 existing national suicide prevention programmes.

7 **Why the committee made the recommendations**

8 ***General suicide awareness raising***

9 The committee agreed that awareness-raising activities and messages, tailored to
10 people's needs and circumstances, can get rid of common misconceptions
11 surrounding suicide and let people know where they can go for help.

12 ***Suicide awareness campaigns***

13 The committee agreed that suicide awareness campaigns are likely to encourage
14 people to seek help.

15 **How the recommendations might affect practice**

16 Setting up and delivering campaigns will involve resource costs, such as staff time
17 and materials. Effective campaigns could encourage more people to seek help and
18 so increase health and social care costs.

19 Full details of the evidence and the committee's discussion are in [evidence review 7:](#)
20 [suicide awareness campaigns](#).

21 ***Reducing access to methods of suicide***

22 The discussion below explains how the committee made [recommendations 1.6.1 to](#)
23 [1.6.4](#).

24 **Recommendations**

25 1.6.1 Use local data including audit, Office for National Statistics and NHS data, as
26 well as [rapid intelligence gathering](#), to:

- 27 • identify emerging trends in suicide methods and locations

- 1 • understand local characteristics that may influence the methods used
2 • determine when to take action to reduce access to means.

3 See [recommendations 1.4.1 to 1.4.3](#).

4 1.6.2 Comply with national guidance about reducing access to methods of suicide
5 (for example, by implementing the safe cell initiative in custodial settings and
6 restricting access to painkillers in community settings).

7 1.6.3 Reduce the opportunity to attempt suicide in [places where suicide is more](#)
8 [likely](#). (See Public Health England's [Local suicide prevention planning: a practice](#)
9 [resource](#)).

10 1.6.4 Consider other measures to deter people from suicide in places where suicide
11 is more likely. For example, consider:

- 12 • providing information about where and how people can get help when
13 they feel unable to cope
14 • using CCTV to allow staff to monitor when someone may need help
15 • increasing the number of staff or times when staff are at sites.

16 **Why the committee made the recommendations**

17 The committee agreed that it was important to identify local suicide trends, including
18 methods often used and [places where suicide is more likely](#), such as bridges and
19 railway stations. That way action can be taken to reduce people's access to both the
20 methods and places.

21 Physical barriers like fences and netting could reduce the number of suicides in
22 places where suicide is more likely because it makes it more difficult for people to
23 put themselves in danger. Evidence showed that if a barrier stops a person from
24 taking their life in one place they will not automatically go somewhere else and try
25 again. The committee agreed that it is worth thinking about implementing these
26 measures because they can sometimes help people to stop and think – and so may
27 prevent deaths. The presence of staff may also give people a chance to reconsider,
28 as well as being able to offer timely support.

1 **How the recommendations might affect practice**

2 In areas where physical barriers or other measures are needed this may have a
3 resource impact in terms of staff time and construction and maintenance costs. An
4 implementation tool will be available to help determine the cost effectiveness of
5 different interventions.

6 Full details of the evidence and the committee's discussion are in [evidence review 6:
7 reducing access to means](#).

8 ***Training***

9 The discussion below explains how the committee made [recommendations 1.7.1 to
10 1.7.5](#).

11 **Recommendations**

12 1.7.1 Ensure suicide awareness and prevention training is provided for people who
13 work with high-risk groups or at [places where suicide is more likely](#).

14 1.7.2 Ensure the training gives skills and confidence to:

- 15 • understand local suicide incidence and its impact
16 • encourage people to talk openly about suicidal thoughts
17 • encourage those at high risk to seek help (this includes providing
18 details of where they can get this help).

19 1.7.3 Develop training programmes for organisations employing, working with or
20 representing occupational groups at [high suicide risk](#). See recommendation 1.7.2 for
21 the aims of the training.

22 1.7.4 Raise awareness about suicide risks among [gatekeepers](#) so they can identify
23 people at risk.

24 1.7.5 Ensure people who provide peer support in custodial settings are trained to
25 provide emotional support.

1 **Why the committee made the recommendations**

2 Some evidence showed that training improves people's knowledge about suicide, the
3 risks and how to prevent it. The committee agreed that it may be effective to train a
4 range of people involved with both the public and with occupational groups known to
5 be at high risk of suicide, because they will help spread the general prevention
6 messages and they can prevent suicide by encouraging specific people to talk and
7 seek help.

8 There is little evidence on the effectiveness of specific training programmes for
9 gatekeepers, including non-healthcare professionals working in the community. So
10 the committee made a recommendation for research on this. See the research
11 recommendation on [training](#).

12 **How the recommendations might affect practice**

13 Training can be costly. But it is expected to be made available through existing
14 continuous professional development programmes, so the costs for professionals
15 and organisations could be minimised.

16 Full details of the evidence and the committee's discussion are in [evidence review 4:
17 information, advice, education and training](#).

18 ***After a suspected suicide***

19 The discussion below explains how the committee made [recommendations 1.8.1 to
20 1.8.12](#).

21 **Recommendations**

22 ***Supporting people bereaved or affected by a suspected suicide***

23 1.8.1 Identify those who may be affected by a suspected suicide or may benefit from
24 bereavement support by using [rapid intelligence gathering](#) (see [recommendations
25 1.4.2 and 1.4.3](#)) and data from other sources, such as coroners. Those affected may
26 include relatives, friends, classmates, close contacts including cell or prison mates
27 and peer support workers in custodial settings, as well as first responders and other
28 professionals who provided support.

1 1.8.2 Provide sensitive, practical and evidence-based early support, such as Public
2 Health England's [Help is at hand](#) guide, which provides support for people bereaved
3 by suicide and also signposts to other services.

4 1.8.3 Consider peer support provided by trained people who have been bereaved or
5 affected by a suicide or suspected suicide.

6 1.8.4 Consider providing ongoing support for people bereaved or affected by a
7 suicide or suspected suicide if they need this.

8 ***Preventing suicide clusters***

9 1.8.5 Use information from the action plan and rapid intelligence gathering to identify
10 potential [suicide clusters](#) (see [recommendation 1.3.1](#) and [recommendations 1.4.2](#)
11 [and 1.4.3](#)). Ensure the plan is flexible and can be adapted according to which local
12 agencies are likely to spot emerging clusters.

13 1.8.6 Develop a coordinated approach to mitigate risk of additional suicides. Use
14 Public Health England's [Identifying and responding to suicide and contagion](#).

15 1.8.7 Develop a standard procedure for reducing or stopping – 'stepping down' –
16 responses to any suspected suicide cluster.

17 1.8.8 Provide ongoing support for those involved, including people directly bereaved
18 or affected and those who are responding to the situation (see recommendations
19 1.8.1 to 1.8.4).

20 ***Media reporting of suicides***

21 1.8.9 The local multi-agency partnership should develop a clear plan for liaising with
22 the media. They should also encourage training for journalists on how sensitive and
23 insensitive reporting on suicide can affect the public. The training should include the
24 need to use [sensitive language](#), reduce speculative reporting and avoid presenting
25 detail on methods.

26 1.8.10 In custodial and detention settings, the multi-agency partnership should
27 ensure national guidelines are followed when engaging with the media to report
28 suicides. The press officer should be given training on suicide reporting both at time

1 of the event and at the inquest, including the need to use sensitive language, reduce
2 speculative reporting and avoid presenting detail on methods.

3 1.8.11 Disseminate guidance on effective media reporting of suicide. Examples
4 include: the World Health Organization's [Preventing suicide: a resource for media](#)
5 [professionals](#); the Samaritans' [Media guidelines for reporting suicide](#); the
6 Independent Press Standards Organisation's [Editors code of practice](#); and OFCOM's
7 [Broadcasting code](#).

8 1.8.12 Monitor media coverage of local deaths that are suspected to be suicides
9 and, if necessary, provide feedback to the reporter on the effect of their reporting
10 (see the 'Media guidelines for reporting suicide').

11 **Why the committee made the recommendations**

12 ***Supporting people bereaved or affected by a suspected suicide***

13 The committee agreed that people affected by a suspected suicide may, as a result,
14 be at risk of harming themselves. These include family members and friends of
15 people who have died, as well as first responders. The committee heard that
16 bereavement support can reduce this risk, especially when tailored to the person's
17 needs. People who had bereavement support were also likely to experience lower
18 levels of depression and anxiety. Some of these benefits were based on personal
19 accounts because the evidence was limited. But the committee agreed that, overall,
20 support for people affected by suicide appeared to have a beneficial effect.

21 They also made 2 recommendations for research to evaluate the effectiveness of:

- 22 • [non-clinical interventions](#)
- 23 • [supporting people bereaved or affected by a suicide](#).

24 ***Preventing suicide clusters***

25 Suicide clusters can emerge quickly and unexpectedly. But an expert told the
26 committee that if the right systems are in place then it is possible to reduce the
27 likelihood of further deaths. This was supported by the committee's own experience.
28 The expert also explained to the committee that police and the coroner's office need
29 to notify agencies as soon as possible that a suspected suicide is being investigated

1 because an inquest to confirm cause of death is usually only held 6 to 12 months
2 after the event. This is too late to prevent new suicides if a cluster is developing.

3 Based on this information and their own experience, the committee agreed that rapid
4 intelligence sharing was important. They also made a research recommendation to
5 evaluate how this affects suicide prevention, and how effective partnership working
6 can be enhanced by sharing local data from different sources to reduce suicide. See
7 the research recommendation on [local suicide plans](#).

8 ***Media reporting of suicides***

9 Irresponsible reporting of suicide may have harmful effects, including potentially
10 increasing the risk of suicide. Reports of the method used seemed to increase the
11 risk of other people copying the suicide – so-called copycat suicides. Areas with
12 suicide clusters had greater newspaper coverage than other areas, possibly implying
13 that they triggered the cluster. And inaccurate media reporting upsets people
14 bereaved by suicide. So steps to encourage responsible reporting could prevent
15 further suicides.

16 Although there was no evidence on personal experiences of suicide or suicidal
17 behaviour shared through social media, the committee agreed that the guidance
18 given to the media should also apply to this type of reporting.

19 **How the recommendations might affect practice**

20 Improved communication and information sharing between statutory agencies and
21 community organisations may have resource implications such as the costs of staff
22 time, communication, interventions, and meetings associated with multi-agency
23 teams. But, providing better information and support to those bereaved or affected
24 by suicide, preventing suicide clusters and media reporting of suicides are already
25 enshrined in the national suicide prevention strategy so no additional costs are
26 expected.

27 Full details of the evidence and the committee's discussion are in [evidence review 5:](#)
28 [postvention](#).

1 Putting this guideline into practice

2 [This section will be finalised after consultation]

3 NICE has produced [tools and resources](#) [link to tools and resources tab] to help you
4 put this guideline into practice.

5 [Optional paragraph if issues raised] Some issues were highlighted that might need
6 specific thought when implementing the recommendations. These were raised during
7 the development of this guideline. They are:

- 8 • [add any issues specific to guideline here]
- 9 • [Use 'Bullet left 1 last' style for the final item in this list.]

10 Putting recommendations into practice can take time. How long may vary from
11 guideline to guideline, and depends on how much change in practice or services is
12 needed. Implementing change is most effective when aligned with local priorities.

13 Changes should be implemented as soon as possible, unless there is a good reason
14 for not doing so (for example, if it would be better value for money if a package of
15 recommendations were all implemented at once).

16 Different organisations may need different approaches to implementation, depending
17 on their size and function. Sometimes individual practitioners may be able to respond
18 to recommendations to improve their practice more quickly than large organisations.

19 Here are some pointers to help organisations put NICE guidelines into practice:

20 1. **Raise awareness** through routine communication channels, such as email or
21 newsletters, regular meetings, internal staff briefings and other communications with
22 all relevant partner organisations. Identify things staff can include in their own
23 practice straight away.

24 2. **Identify a lead** with an interest in the topic to champion the guideline and motivate
25 others to support its use and make service changes, and to find out any significant
26 issues locally.

1 3. **Carry out a baseline assessment** against the recommendations to find out
2 whether there are gaps in current service provision.

3 4. **Think about what data you need to measure improvement** and plan how you
4 will collect it. You may want to work with other health and social care organisations
5 and specialist groups to compare current practice with the recommendations. This
6 may also help identify local issues that will slow or prevent implementation.

7 5. **Develop an action plan**, with the steps needed to put the guideline into practice,
8 and make sure it is ready as soon as possible. Big, complex changes may take
9 longer to implement, but some may be quick and easy to do. An action plan will help
10 in both cases.

11 6. **For very big changes** include milestones and a business case, which will set out
12 additional costs, savings and possible areas for disinvestment. A small project group
13 could develop the action plan. The group might include the guideline champion, a
14 senior organisational sponsor, staff involved in the associated services, finance and
15 information professionals.

16 7. **Implement the action plan** with oversight from the lead and the project group.
17 Big projects may also need project management support.

18 8. **Review and monitor** how well the guideline is being implemented through the
19 project group. Share progress with those involved in making improvements, as well
20 as relevant boards and local partners.

21 NICE provides a comprehensive programme of support and resources to maximise
22 uptake and use of evidence and guidance. See our [into practice](#) pages for more
23 information.

24 Also see Leng G, Moore V, Abraham S, editors (2014) Achieving high quality care –
25 practical experience from NICE. Chichester: Wiley.

26 **Context**

27 The UK suicide rate was 10.4 deaths per 100,000 population in 2016 ([Office for](#)
28 [National Statistics](#)). Suicide is more than 3 times as common in men as in women.

1 People aged 40 to 44 years had the highest suicide rate at 15.3 per 100,000. This
2 age group also had the highest rate among men, at 24.1 per 100,000. For women,
3 50 to 54 year olds had the highest 5-year age group rate of 8.3 per 100,000.

4 Overall, the financial cost of a suicide by someone of working age in the UK is more
5 than £1.6 million ([Evaluation of the first phase of Choose Life: the national strategy
6 and action plan to prevent suicide in Scotland](#) Scottish Executive Social Research).

7 The risk of suicide in the UK prison population is considerably higher than among the
8 general population. The 3-year average rate of self-inflicted deaths by people in
9 prison in England was 69 deaths per 100,000 between 2009 and 2011;
10 approximately 80% received a suicide or open verdict at inquest. There were 80
11 deaths by suicide in prison in 2014 and 62 'apparent suicides following police
12 custody' during 2013/14 in England

13 Suicide and self-harm are major public health problems, with someone who self-
14 harms being at increased risk of suicide ([The Chief Medical Officer annual report:
15 public mental health – investing in the evidence](#), Department of Health).

16 Approximately three-quarters of people who die by suicide have not had recent
17 contact with mental health services at the time of their death. However, most will
18 have seen their GP in the year before they died and others may have been seen in
19 A&E or another setting'.

20 People at risk of dying by suicide may come into contact with a wide range of
21 professionals and others. The government's [Suicide prevention strategy](#) and the
22 Commons Health Committee's report on the [government's suicide prevention
23 strategy](#) highlights the potential role of the community in preventing suicide. For
24 example, people can make contact with suicide prevention services via helplines and
25 support groups (offered by charities such as Samaritans). Or they can speak to a
26 GP.

27 This guideline covers people of all ages but focuses particularly on groups with [high
28 suicide risk](#).

29 It also looks at interventions for people who are, or have been in custodial settings,
30 and those in contact with any branch of the criminal justice system.

1 ***More information***

To find out what NICE has said on topics related to this guideline, see our web page on [depression](#), [self harm](#) and [health of people in the criminal justice system](#) .

2

3 **ISBN:**