1 2 # NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

3 # Guideline scope

4 # Preventing suicide in the community

5 ## *Topic*

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

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

10 The guideline will be developed using the methods and processes outlined in
11 Developing NICE guidelines: the manual.

12 For more information about why this guideline is being developed, and how
13 the guideline will fit into current practice, see the context section.

14 ## *Who the guideline is for*

15 • Providers of suicide prevention interventions, including NHS and local
16 authorities and third sector organisations.
17 • Health and social care practitioners, in particular those working in primary
18 care and in the community.
19 • Mental health services, particularly those based in the community.
20 • People with a strategic role in assessing and planning local suicide
21 prevention.
22 • Police and emergency services.
23 • Organisations, for example National Rail or car parking providers, with
24 responsibility for settings where suicide could occur, such as railway
25 stations, railway crossings and multi-storey parking facilities.

26 The guideline will also be relevant to:

1 • Families, carers and other members of the public who have been bereaved
2   or affected by suicide.

3 • Commissioners of suicide prevention interventions

4 • Primary, secondary and higher education institutions.

5 NICE guidelines cover health and care in England. Decisions on how they
6 apply in other UK countries are made by ministers in the Welsh Government,
7 Scottish Government, and Northern Ireland Executive.

8 ## *Equality considerations*

9 NICE will carry out an equality impact assessment during scoping. The
10 assessment will:

11 • list equality issues identified, and how they have been addressed
12 • explain why any groups are excluded from the scope.

13 NICE guidelines cover health and care in England. Decisions on how they
14 apply in other UK countries are made by ministers in the Welsh Government,
15 Scottish Government, and Northern Ireland Executive.

16 # 1   What the guideline is about

17 ## *1.1   Who is the focus?*

18 • Adults, young people and children. Specific consideration will be given to
19   the needs of high-risk groups, including those identified by the equality
20   impact assessment.

21 ## *1.2   Settings*

22 **Settings that will be covered**

23 • Community settings in which suicide prevention interventions are delivered.

24 **Settings that will not be covered**

25 • Prisons and young offender institutions.

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 Organisational approaches to preventing suicide at local authority level, such as the use of multi-agency teams or using local audits to develop local suicide prevention plans

2 Interventions to recognise and respond to signs of distress and crisis that may indicate someone is contemplating suicide, for example awareness raising among staff in direct contact with the public. This may include:
   − 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 station staff.

3 Interventions to change or reduce access to high-risk locations. This will include:
   − safety fences
   − more lighting
   − CCTV and suicide patrols, for example at high bridges, buildings and cliffs.

4 Local media awareness campaigns and social media interventions to:
   − reduce the stigma around expressing suicidal thoughts and emotional distress
   − encourage people in a high-risk location who experience a crisis and are in distress to seek help, for example, using posters to promote telephone helplines in locations such as railway stations.

5 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 for individual people, which are covered by the NICE guidance listed in [NICE guidance](). For example:

   − triage for self-harm

   − treatment for depression, schizophrenia and other mental health conditions.

2   National strategies 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   What are effective organisational approaches to suicide prevention at local authority level?

2   How can local audits best be used to develop local suicide prevention plans?

3   What training or education interventions are effective in increasing the ability of staff in direct contact with the public to recognise and respond to someone experiencing a crisis and in distress who may be contemplating suicide?

4   Are interventions to change or reduce access to high-risk locations (such as safety fences, more lighting, CCTV or suicide patrols), effective at preventing suicide?

5   How effective are local media awareness campaigns and social media interventions in:

– reducing the stigma around expressing suicidal thoughts and emotional distress

– encouraging people who experience distress and crisis to seek help?

6   What are the most sensitive and effective approaches to reporting suicide and suicidal behaviour in local print, internet and digital media?

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   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 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 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.

- 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

1 • [Social and emotional wellbeing in secondary education](#) (2009) NICE
2 guideline PH20
3 • [Mental wellbeing in over 65s: occupational therapy and physical activity](#)
4 [interventions](#) (2008) NICE guideline PH16
5 • [Self-harm in over 8s: short-term management and prevention of recurrence](#)
6 (2004) NICE guideline CG16

7 ***In development***

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

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

2.2 NICE quality standards

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

17 • Self-harm (2013) NICE quality standard 34
18 • Drugs use disorders (2012) NICE quality standard 23
19 • Depression in adults (2011) NICE quality standard 8

2.3 NICE Pathways

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

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

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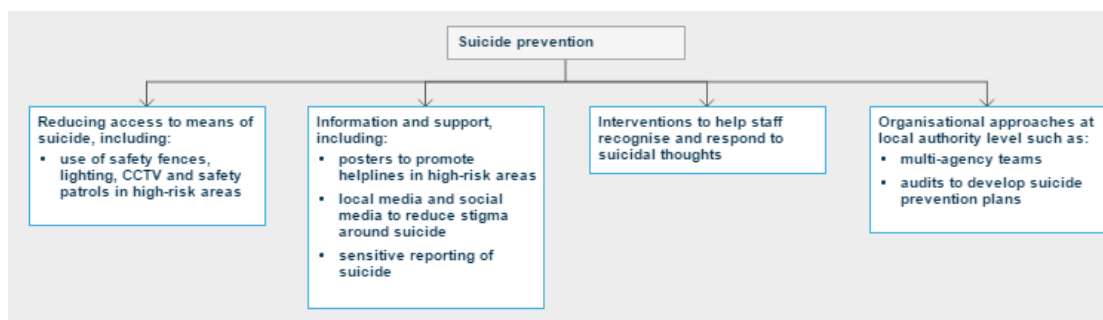
3   Context

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 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. 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 disproportionately affects 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

1 • establishing a multi-agency suicide prevention group.

2 The 'Chief Medical Officer annual report: public mental health – investing in

3 the evidence' makes 14 recommendations focused on:

4 • commissioning and service development

5 • information, intelligence and data

6 • work

7 • workforce training

8 • practice and policy.

9 Closing the gap: priorities essential for change in mental health (Department

10 of Health) outlined the link between self-harm and suicide. This reiterated the

11 advice to A&E departments about referring people who present with self-harm

12 for psychological assessment in NICE's guidelines on self-harm in over-8s:

13 short-term management and prevention of recurrence and self-harm in over-

14 8s: longer term management. The DH paper also outlined a number of actions

15 to prevent suicides, including 'real-time' surveillance pilots in collaboration with

16 the police with the aim of:

17 • providing information to frontline local authority and NHS staff

18 • preventing suicides in public places (including suicide hot spots)

19 • responding to potential suicide clusters by providing advice and practical

20   steps that local areas can take to reduce risk and respond to potential

21   suicide clusters (Suicide prevention: identifying and responding to suicide

22   clusters Public Health England).

23 ## *3.3   Policy, legislation, regulation and commissioning*

24 **Policy**

25 In 2012, the cross-government strategy Preventing suicide in England was

26 developed with the objective of reducing the suicide rate in England and

27 providing better support for people who have been bereaved or affected by

28 suicide. The strategy emphasised reducing the risk in key high-risk groups.

29 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.

A recent systematic review by Daine et al. (The power of the web: a systematic review of studies of the influence of the internet on self-harm and suicide in young people 2013) highlights the positive and negative effects that social media can have on self-harm behaviour, suicidal thoughts and depression, but the strategy acknowledges that the evidence base in this area is still developing.

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

1   people with recent contact from NHS services' (Public Health Outcomes

2   Framework indicator 4.10).

3   The rationale behind this change is the recognition that the NHS can influence

4   outcomes in suicide through contact with people beforehand, for example by

5   effective care planning before discharge from hospital.

6   The Quality Outcomes Framework is a voluntary incentive scheme for GP

7   practices in the UK that seeks to standardise improvements in delivering

8   primary medical services. There are currently 2 specific NICE indicators under

9   negotiation for 'Depression' (NM50 and NM49: NICE 2012) and 12 indicators

10 for 'Mental health' including a specific indicator for 'Depression and anxiety'

11 (NM123: NICE 2015). There are also indicators focusing on specific mental

12 health conditions such as schizophrenia, bipolar affective disorder and other

13 psychoses (NM108: NICE 2015).

14 **4   Further information**

This is the draft scope for consultation with registered stakeholders. The
consultation dates are 27 April to 25 May 2016.

The final scope will take 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.

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