NICE National Institute for Health and Care Excellence

Public Health England

NICE guideline

Preventing suicide in community and custodial settings

NICE guideline

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Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

All problems (adverse events) related to a medicine or medical device used for treatment or in a procedure should be reported to the Medicines and Healthcare products Regulatory Agency using the Yellow Card Scheme.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

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This guideline is the basis of QS189.

Overview

This guideline covers ways to reduce suicide and help people bereaved or affected by suicides. It aims to:

- help local services work more effectively together to prevent suicide
- identify and help people at risk
- prevent suicide in places where it is currently more likely.

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

This guideline should be read in conjunction with Public Health England's guidance on suicide prevention: developing a local action plan.

Who is it for?

- Health and wellbeing boards and local safeguarding boards
- Commissioners in the NHS and local authorities and others working in health and social care in particular, primary care and community services
- Organisations in the public, private, voluntary and community sectors
- People working in: prisons (public and contracted out), children and young people's secure estate, immigration removal centres (IRCs), probation services and community rehabilitation services
- National crime agency, police and emergency services
- Education institutions
- Families, carers and others who have been bereaved or affected by suicide

Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in NICE's information on making decisions about your care.

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.

This guideline should be read in conjunction with Public Health England's Local suicide prevention planning: a practice resource.

1.1 Suicide prevention partnerships

1.1.1 Local authorities should work with local organisations to:

- Set up a multi-agency partnership for suicide prevention. This could consist of a core group and a wider network of representatives.
- Identify clear leadership for the partnership.
- Ensure the partnership has clear terms of reference, based on a shared understanding that suicide can be prevented.

1.1.2 Ensure the partnership has clear governance and accountability structures. Include oversight from local health and care planning groups, for example health and wellbeing boards.

Multi-agency partnerships in the community

1.1.3 Include representatives from the following in the partnership's core group:

- clinical commissioning groups

- local public health services
- healthcare providers
- social care services
- voluntary and other third-sector organisations, including those used by people in high-risk groups
- emergency services
- criminal justice services
- police and custody suites
- people with personal experience of a suicide attempt, suicidal thoughts and feelings, or a suicide bereavement.

Multi-agency partnerships in residential custodial and detention settings

1.1.4 Set up a multi-agency partnership for suicide prevention in residential custodial and detention settings. This could consist of a core group and a wider network of representatives. Ensure the partnership has:

- clear leadership
- clear terms of reference, based on a shared understanding that suicide can be prevented
- clear governance and accountability structures.

1.1.5 Include representatives from the following in the partnership's core group:

- governors or directors in residential custodial and detention settings
- healthcare staff in residential custodial and detention settings
- staff in residential custodial and detention settings
- pastoral support services

- voluntary and other third-sector organisations
- escort custody services
- liaison and diversion services
- emergency services
- offender management and resettlement services
- people with personal experience of a suicide attempt, suicidal thoughts and feelings, or a suicide bereavement, to be selected according to local protocols.

1.1.6 Link the partnership with other relevant multi-agency partnerships in the community.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact on suicide prevention partnerships.

Full details of the evidence and the committee's discussion are in:

- evidence review 1: multi-agency partnerships
- evidence review 9: preventing suicides in residential custodial and detention settings.

1.2 Suicide prevention strategies

1.2.1 Develop a multi-agency strategy based on the principles of the Department of Health and Social Care's suicide prevention strategy for England and other relevant strategies. It should emphasise that suicide is preventable, and it is safe to talk about it.

1.2.2 Identify clear leadership for the multi-agency strategy.

1.2.3 Consider how to measure activities to prevent suicide. Include the introduction of constructive, meaningful preventive activities (for

example, education and physical activity) rather than focusing on suicide numbers alone.

1.2.4 Review local and national data on suicide and self-harm to ensure the strategy is as effective as possible (see recommendation 1.4.2).

1.2.5 Assess whether initiatives successfully adopted elsewhere are appropriate locally or can be adapted to local needs, or whether previously successful initiatives can be reintroduced.

1.2.6 Oversee provision and delivery of training and evaluate effectiveness.

Multi-agency partnerships in the community

1.2.7 Consider collaborating with neighbouring local authorities to deliver a single strategy.

1.2.8 Consider advising local institutions and organisations on what to include in their contingency plans for responding to a suicide. This includes: schools, universities, further and higher education institutions, and workplaces.

Multi-agency partnerships in residential custodial and detention settings

1.2.9 Identify and manage risk factors and behaviours that make suicide more likely.

1.2.10 Consider collaborating with neighbouring residential custodial and detention organisations to deliver a single strategy.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact on suicide prevention strategies.

Full details of the evidence and the committee's discussion are in evidence review 1: multi-agency partnerships.

1.3 Suicide prevention action plans

1.3.1 Develop and implement a plan for suicide prevention and for after a suspected suicide. Ensure the approach can be adapted according to which agencies are likely to spot emerging suicide clusters:

- Identify clear leadership for the action plan.
- Interpret data to determine local patterns of suicide and self-harm, particularly among groups at high suicide risk.
- Compare local patterns with national trends.
- Prioritise actions based on the joint strategic needs assessment and other local data to ensure the plan is tailored to local needs.
- Map stakeholders and their suicide prevention activities (including support services for groups at high risk).
- Share experience and knowledge between stakeholders. Also share data, subject to local information sharing agreements.
- Keep up to date with suicide prevention activities by organisations in neighbouring settings.
- Oversee local suicide prevention activities, including awareness raising and crisis planning.
- Review the action plan at a time agreed at the outset by the multi-agency partnership.

Multi-agency partnerships in the community

1.3.2 In addition to recommendation 1.3.1, set out how to:

- Promote evidence-based best practice with rail, tram and underground train companies.
- Work with planners who have responsibility for designing bridges, multi-storey car parks and other structures that could potentially pose a suicide risk.
- Collaborate with coroners to provide a context for local suicide data and help interpret inquest conclusions.
- Build relationships with the media (including social media, broadcasting and newspapers) to promote best practice when reporting suicides or suspected suicides.

Multi-agency partnerships in residential custodial and detention settings

1.3.3 In addition to recommendation 1.3.1, set out how to:

- Work with the Prison and Probation Ombudsman and coroners to ensure recommendations from investigations and inquests are implemented.
- Implement recommendations from internal investigations of instances of self-harm.
- Assess suicide and self-harm prevention procedures (for example, HM Prison and Probation Service's Assessment Care in Custody and Teamwork and Assessment care-planning system, and the Home Office's Assessment Care in Detention and Teamwork case management systems).
- Interpret and act on the findings.
- Ensure systems for identifying risk, information sharing and multidisciplinary working put the emphasis on 'early days' and transitions between estates or into the community.
- Monitor the impact of restricted regimes on suicide risk.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact on suicide prevention action plans.

Full details of the evidence and the committee's discussion are in:

- evidence review 2: local suicide plans
- evidence review 9: preventing suicides in residential custodial and detention settings.

1.4 Gathering and analysing suicide-related information

1.4.1 Use routinely collected data from sources such as Public Health England's Fingertips tool (public health profiles) or HM Prisons and Probation Service.

1.4.2 Collect and analyse local data on suicide and self-harm. This could include data on: method, location, timing, details of individual and local circumstances, demographics, occupation and characteristics protected under the Equality Act 2010. Sources could include reports from:

- the local ombudsman
- the Parliamentary and Health Service Ombudsman
- coroners
- the Prison and Probation Ombudsman
- the voluntary sector.

1.4.3 For community settings, also use rapid intelligence gathering (continuous and timely collection of data) to identify suspected suicides, emerging methods and potential suicide clusters. This intelligence could also be used to identify people who need support after such events (see

recommendation 1.8.1 and recommendation 1.9.1). Collect this local data from a range of sources including:

- police and transport police
- prisons
- immigration removal centres (IRCs)
- coroners.

1.4.4 For residential custodial and detention settings, also collect data on:

- sentencing or placement patterns
- sentence type
- offence
- length of detention
- transition periods (for example, 'early days' and transitions between estates or into the community).

1.4.5 Assess the quality of data from each local source to ensure data collection is robust and consistent.

1.4.6 Ensure staff gathering and analysing this information are given resilience training and other support as needed.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact on gathering and analysing suicide-related information.

Full details of the evidence and the committee's discussion are in:

- evidence review 1: multi-agency partnerships
- evidence review 2: local suicide plans
- evidence review 9: preventing suicides in residential custodial and detention settings.

1.5 Awareness raising by suicide prevention partnerships

1.5.1 Consider local activities to:

- raise community awareness of the scale and impact of suicide and self-harm
- reduce the stigma around suicide and self-harm
- address common misconceptions by emphasising that:
  - suicide is not inevitable and can be prevented
  - asking someone about suicidal thoughts does not increase risk
- make people aware of the support available nationally and locally
- encourage help-seeking behaviours
- encourage communities to recognise and respond to a suicide risk.

1.5.2 For residential custodial and detention settings, also consider raising awareness of:

- the risk associated with 'early days' and transitions between estates or into the community

- the value of peer support, for example the Samaritans' Listener scheme
- the need for institutional support, such as safer custody teams (see HM Prisons and Probation Service and the Ministry of Justice's Prison Service Instructions 2011 on the management of prisoners at risk of harm to self, to others and from others).

1.5.3 Take into account socioeconomic deprivation, disability, physical and mental health status, and cultural, religious and social norms about suicide and help-seeking behaviour, particularly among groups at high suicide risk.

1.5.4 Ensure the language and content of any awareness-raising materials is:

- appropriate for the target group
- sensitive and compliant with media reporting guidelines, such as the Samaritans' media guidelines for the reporting of suicide.

1.5.5 Coordinate local activities and ensure they are consistent, and coordinated, with national initiatives.

1.5.6 Consider encouraging employers to develop policies to raise suicide awareness and provide support after a suspected suicide. For example, see Public Health England and Business in the Community's toolkits.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact on awareness raising by suicide prevention partnerships.

Full details of the evidence and the committee's discussion are in:

- evidence review 8: suicide awareness campaigns
- evidence review 9: preventing suicides in residential custodial and detention settings.

1.6 Reducing access to methods of suicide

1.6.1 Use local data including audit, Office for National Statistics and NHS data, as well as rapid intelligence gathering to:

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

1.6.2 Ensure local compliance with national guidance to reduce access to methods of suicide:

- In custodial settings, for example, provide safer cells (see the Ministry of Justice's Quick-time learning bulletin on safer cells).
- In the community, for example, restrict access to painkillers (see NHS England's Items which should not be routinely prescribed in primary care: guidance for CCGs, the Medicines and Healthcare products Regulatory Agency's Best practice guidance on the sale of medicines for pain relief (appendix 4 in the Blue guide), and the Faculty of Pain Medicine's Opioids Aware resource).

1.6.3 Reduce the opportunity for suicide in locations where suicide is more likely, for example, by erecting physical barriers. Also see Public Health England's Preventing suicide in public places: a practice resource.

1.6.4 Consider other measures to reduce the opportunity for suicide. For example, at locations where suicide is more likely, consider:

- providing information about how and where people can get help when they feel unable to cope
- using CCTV or other surveillance to allow staff to monitor when someone may need help
- increasing the number and visibility of staff, or times when staff are available.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact on how suicide prevention partnerships can reduce access to methods of suicide.

Full details of the evidence and the committee's discussion are in:

- evidence review 6: reducing access to means
- evidence review 9: preventing suicides in residential custodial and detention settings.

1.7 Training by suicide prevention partnerships

1.7.1 Ensure training is available for:

- those in contact with people or groups at high suicide risk
- people working at locations where suicide is more likely
- gatekeepers
- people who provide peer support in residential custodial and detention settings
- people leading suicide prevention partnerships
- people supporting those bereaved by suicide.

1.7.2 Offer training to organisations employing, working with or representing groups at high suicide risk.

1.7.3 Provide generic and specialist training as needed for specialists and non-specialists.

1.7.4 Ensure suicide awareness and prevention training helps people to:

- understand local suicide incidence and its impact, and know what support services are available

- encourage others to talk openly about suicidal thoughts and to seek help (this includes providing details of where they can get this help)
- take into account socioeconomic deprivation, disability, physical and mental health status, and cultural, religious and social norms about suicide and help-seeking behaviour, particularly among groups at high suicide risk.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact on training by suicide prevention partnerships.

Full details of the evidence and the committee's discussion are in:

- evidence review 4: information, advice, education and training
- evidence review 9: preventing suicides in residential custodial and detention settings.

1.8 Supporting people bereaved or affected by a suspected suicide

1.8.1 Use rapid intelligence gathering and data from other sources, such as coroners to identify anyone who may be affected by a suspected suicide or may benefit from bereavement support. Those affected may include relatives, friends, classmates, colleagues, other prisoners or detainees, as well as first responders and other professionals who provided support.

1.8.2 Offer those who are bereaved or affected by a suspected suicide practical information expressed in a sensitive way, such as Public Health England's Help is at hand guide (this also signposts to other services). Ask them if they need more help and, if so, offer them tailored support.

1.8.3 Consider:

- providing support from trained peers who have been bereaved or affected by a suicide or suspected suicide
- whether any adjustments are needed to working patterns or the regime in residential custodial and detention settings.

  See also the National Suicide Prevention Alliance's resources on support after a suicide.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact on how suicide prevention partnerships can support people bereaved or affected by a suspected suicide.

Full details of the evidence and the committee's discussion are in:

- evidence review 5: interventions to support people bereaved or affected by a suspected suicide
- evidence review 9: preventing suicides in residential custodial and detention settings.

1.9 Preventing and responding to suicide clusters

1.9.1 Use information from the action plan and rapid intelligence gathering to identify and prevent potential suicide clusters (see recommendation 1.3.1).

1.9.2 After a suspected suicide in residential custodial and detention settings, undertake a serious incident review as soon as possible in partnership with the health providers. Identify how:

- to improve the suicide prevention action plan
- to help identify emerging clusters
- others have responded to clusters.

1.9.3 Develop a coordinated approach to reduce the risk of additional suicides.

1.9.4 Develop a standard procedure for reducing, or 'stepping down', responses to any suspected suicide cluster.

1.9.5 Provide ongoing support for those involved, including people directly bereaved or affected and those who are responding to the situation.

See Public Health England's identifying and responding to suicide clusters and contagion: a practice resource.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact on preventing and responding to suicide clusters.

Full details of the evidence and the committee's discussion are in:

- evidence review 3: local approaches to suicide clusters
- evidence review 9: preventing suicides in residential custodial and detention settings.

1.10 Reducing the potential harmful effects of media reporting of a suspected suicide

1.10.1 Develop a clear plan for liaising with the media. Identify someone in the multi-agency partnership as the lead.

1.10.2 For community settings, promote guidance on best practice for media reporting of suicide (including providers of social media platforms). Highlight the need to:

- use sensitive language that is not stigmatising or in any other way distressing to people who have been affected
- reduce speculative reporting

- avoid presenting detail on methods.

  See: the World Health Organization's preventing suicide: a resource for media professionals, the Samaritans' media guidelines for reporting suicide, OFCOM's Broadcasting code and the Independent Press Standards Organisation (IPSO).

1.10.3 For residential custodial and detention settings, where a suspected suicide would be reported via the Ministry of Justice, ensure Ministry of Justice press officers follow good practice in suicide reporting.

1.10.4 Monitor media coverage of suspected suicides locally. If necessary, provide feedback to the journalist or editor in relation to their reporting (see the Samaritans' media guidelines for reporting suicide).

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact on reducing the potential harmful effects of media reporting of a suspected suicide.

Full details of the evidence and the committee's discussion are in evidence review 7: local media reporting of suicides.

Terms used in this guideline

This section defines terms that have been used in a particular way for this guideline. For other definitions, see the NICE glossary or, for public health and social care terms, the Think Local, Act Personal Care and Support Jargon Buster.

Gatekeepers

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

They may include: health and social care practitioners, criminal justice and detention settings staff, police and emergency services, people who provide a paid or voluntary service for the public, faith leaders, railway and underground station staff, and staff in educational institutions.

High suicide risk

High suicide risk means that the rate of suicide in a group or setting is higher than the expected rate based on the general population in England. Groups at high risk can include: young and middle-aged men, people who self-harm, people in care of mental health services, family and friends of those who have died by suicide, people who misuse drugs or alcohol, people with a physical illness, particularly older adults, people in the LGBT community, people with autism, people in contact with the criminal justice system, particularly those in prisons, people in detention settings, including immigration detention settings, and specific occupation groups (see the Office for National Statistics' suicide by occupation, England: 2011 to 2015).

Locations where suicide is more likely

These include high buildings such as multi-storey car parks, railways and bridges and places where other means of suicide are accessible, such as medical, veterinary or agricultural settings where human or animal drugs may be readily available. See Public Health England's preventing suicides in public places: a practice resource.

Restricted regimes

Reduced access to time out of cell and purposeful activity, usually as a result of short staffing or serious incidents.

Suicide clusters

A series of 3 or more closely grouped deaths linked by space or social relationships. In the absence of transparent social connectedness, evidence of space and time linkages are needed to define a cluster. In the presence of a strong demonstrated social connection, only temporal significance is needed. (Adapted from Public Health England's identifying and responding to suicide clusters and contagion: a practice resource.)

Recommendations for research

The guideline committee has made the following recommendations for research.

1 Non-clinical interventions

How effective and cost effective are non-clinical interventions to reduce suicidal behaviours?

For a short explanation of why the committee made this recommendation for research, see the rationale section on awareness raising by suicide prevention partnerships.

Full details of the evidence and the committee's discussion are in:

- evidence review 8: suicide awareness campaigns
- evidence review 9: preventing suicides in residential custodial and detention settings.

2 Supporting people bereaved or affected by a suicide

How effective and cost effective are interventions to support people in the community who are bereaved or affected by a suicide?

For a short explanation of why the committee made this recommendation for research, see the rationale section on awareness raising by suicide prevention partnerships.

Full details of the evidence and the committee's discussion are in:

- evidence review 5: interventions to support people bereaved or affected by a suspected suicide
- evidence review 9: preventing suicides in residential custodial and detention settings.

For a short explanation of why the committee made this recommendation for research, see the rationale section on how suicide prevention in custodial and detention settings.

Full details of the evidence and the committee's discussion are in:

- evidence review 5: interventions to support people bereaved or affected by a suspected suicide
- evidence review 9: preventing suicides in residential custodial and detention settings.

3 Suicide prevention in custodial and detention settings

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

For a short explanation of why the committee made this recommendation for research, see the rationale section on awareness raising by suicide prevention partnerships.

Full details of the evidence and the committee's discussion are in:

- evidence review 8: suicide awareness campaigns
- evidence review 9: preventing suicides in residential custodial and detention settings.

4 Training

How effective and cost effective is gatekeeper training in preventing suicides?

For a short explanation of why the committee made this recommendation for research, see the rationale section on training by suicide prevention partnerships.

Full details of the evidence and the committee's discussion are in:

- evidence review 4: information, advice, education and training
- evidence review 9: preventing suicides in residential custodial and detention settings.

Rationale and impact

These sections briefly explain why the committee made the recommendations and how they might affect practice. They link to details of the evidence and a full description of the committee's discussion.

Suicide prevention partnerships

Recommendations 1.1.1 to 1.1.6

Why the committee made the recommendations

Approximately 6,000 people take their own life each year in the UK. The risk of suicide in the UK prison population is considerably higher than among the general population. The number of people dying by suicide in custodial or other detention settings such as prisons, immigration detention centres, young offender institutions and police custody has increased over the past decade.

Many local agencies can be involved in preventing suicide in the community. Although the evidence was limited, the committee felt strongly that these agencies need to work together to focus on the most effective and cost-effective interventions. By combining expertise and resources, partnerships can cover a much wider area more effectively and implement a range of activities.

Likewise, different services within residential custodial and detention settings can be more effective if they work together in a local multi-agency partnership and with similar partnerships in the community.

How the recommendations might affect practice

Improved communication and information sharing between statutory agencies and community organisations may have resource implications. For example, the costs of staff time, communication, interventions and the meetings associated with multi-agency teams.

But multi-agency partnership working is already enshrined in the Department of Health and Social Care's suicide prevention strategy for England, updated in the Department of

Health and Social Care's suicide prevention: third annual report. As a result, multi-agency suicide prevention partnerships have been set up in most community and residential custodial and detention settings, so no additional costs are expected.

Return to recommendations

Suicide prevention strategies

Recommendations 1.2.1 to 1.2.10

Why the committee made the recommendations

Some evidence and expert opinion showed that having a strategy for how to connect local organisations can help prevent suicide in community and residential custodial and detention settings. For general reasons why we have made the recommendations, see the rationale section on suicide prevention partnerships.

If the strategy has clear leadership and is based on what is currently happening in the area or setting, it is likely to be effective. This involves gathering data on suicide rates and sharing best practice. A strategy may also help to ensure organisations are prepared to respond to a suicide.

Expert opinion showed that when partnerships share knowledge and experience, this is of greater benefit than working individually. It may include collaborating with neighbouring organisations in the same setting to develop a shared strategy.

How the recommendations might affect practice

Improved communication and information sharing between statutory agencies and community organisations may have resource implications. For example, the costs of staff time, communication, interventions and the meetings associated with multi-agency teams.

But the Department of Health and Social Care's suicide prevention strategy for England advocates multi-agency partnerships, and suicide prevention strategies have been set up in most community and residential custodial and detention settings. So no additional costs are expected.

Return to recommendations

Suicide prevention action plans

Recommendations 1.3.1 to 1.3.3

Why the committee made the recommendations

Having a detailed action plan based on local knowledge and clear leadership can help prevent suicide in the community and in residential custodial or detention settings. The plan will be effective if it is based on knowledge of what is happening in the area or setting, involves stakeholders and is adaptable. (For general reasons why we have made the recommendations, see the rationale section on suicide prevention partnerships.)

How the recommendations might affect practice

Multi-agency suicide prevention action plans have been set up in most community and residential custodial and detention settings, so no additional costs are expected. For example, Public Health England's Suicide Prevention Profile shows which local authorities have suicide prevention plans.

Return to recommendations

Gathering and analysing suicide-related information

Recommendations 1.4.1 to 1.4.6

Why the committee made the recommendations

Good information is essential for planning, monitoring success and improving the strategy and plan for all settings. The committee agreed that the information should come from different sources to get a clear picture of what is happening. But they also agreed that it is important to make sure the local data collected is as reliable as possible, so that the strategy and plan is as effective as possible.

Although the evidence was limited, the committee agreed with an expert that more rapid and frequent information gathering (rapid intelligence gathering) is important, for example for early detection of suicide clusters.

The committee also agreed that because analysing information on suicides may expose staff to some distressing material, training and support is essential to help them cope.

How the recommendations might affect practice

Gathering and analysing data may involve some additional resources. But most multi-agency suicide prevention partnerships have some work already in place. So we do not expect this will have a significant resource impact.

Return to recommendations

Awareness raising by suicide prevention partnerships

Recommendations 1.5.1 to 1.5.6

Why the committee made the recommendations

Many people who take their own lives are not in contact with mental health services and may not necessarily be in contact with a GP, so opportunities for clinical interventions can be limited. Non-clinical interventions, such as telephone or text helplines or volunteer-run face-to-face talking are important to support people with suicidal thoughts and keep them safe.

There is increasing demand for non-clinical interventions but little evidence on the benefits. Research is needed to evaluate how effective they are (see the recommendation for research on non-clinical interventions).

The committee agreed that awareness-raising activities and messages, tailored to people's needs and circumstances, can help get rid of common misconceptions about suicide and self-harm and let people know where they can go for help. They also agreed that increasing local awareness of suicide and the support available is likely to encourage people to seek help. But there can be a fine line between helpful and potentially harmful

messages (see the recommendation for research on supporting people bereaved or affected by a suicide).

In residential custodial and detention settings, they agreed that extra support during particularly vulnerable times, such as 'early days', might reduce the risk of suicide. Peer support, along with measures such as the provision of 'safer cells', might also help to act as deterrents. But there is a lack of evidence and more research is needed to evaluate the effectiveness of different interventions in a range of custodial settings (see the recommendation for research on suicide prevention in custodial and detention settings).

How the recommendations might affect practice

Increasing local awareness of suicide and the support available could encourage more people to seek help and so increase health and social care costs.

Return to recommendations

How suicide prevention partnerships can reduce access to methods of suicide

Recommendations 1.6.1 to 1.6.4

Why the committee made the recommendations

The committee agreed that it is important to identify local suicide trends, including common methods and locations where suicide is more likely, such as bridges and railway stations. That way action can be taken to reduce people's access to both the methods and places.

Physical barriers like fences and netting could reduce the number of suicide deaths in places where suicide is more likely because it makes it more difficult for people to put themselves in danger. Evidence showed that if a barrier stops a person from taking their life in one place, they will not automatically go somewhere else and try again.

Similarly, compliance with national guidance, for example on safer cells in custodial settings (see the Ministry of Justice's Quick-time learning bulletin on safer cells) and restrictions on painkiller sales in the community can act as an effective deterrent.

The committee agreed that, despite the lack of evidence, it may be worth thinking about implementing these measures because they can sometimes give people time to stop and think – and so may prevent deaths. The presence of staff at high-risk locations may also give people a chance to reconsider, as well as being a source of timely support.

How the recommendations might affect practice

Where physical barriers or other measures are needed this may have a resource impact in terms of staff time and construction and maintenance costs. NICE has an implementation tool to help determine the cost effectiveness of different interventions.

Return to recommendations

Training by suicide prevention partnerships

Recommendations 1.7.1 to 1.7.4

Why the committee made the recommendations

Some evidence showed that training improves people's knowledge about suicide, the risks and how to prevent it. The committee agreed that it may be effective to train a range of people involved with both the public and with occupational groups known to be at high risk of suicide. That way they can help spread general prevention messages and encourage people at risk to talk and seek help.

But UK evidence on the effectiveness of gatekeeper training is limited and there are only a few specific training programmes available. Training for all gatekeepers is important because it may help to identify more people at risk of suicide. But research is needed to evaluate how effective it is (see the recommendation for research on training).

How the recommendations might affect practice

Training can be costly. But it is expected to be made available through existing continuous professional development programmes, so the costs for professionals and organisations could be minimised. For example, Health Education England has developed generic and specialist competencies for people working with adults and children with suicidal behaviour or ideas, and for non-specialists working in community settings.

Return to recommendations

How suicide prevention partnerships can support people bereaved or affected by a suspected suicide

Recommendations 1.8.1 to 1.8.3

Why the committee made the recommendations

The committee agreed that people affected by a suspected suicide may, as a result, be at risk of harming themselves. This includes family members and friends of people who have died, as well as first responders.

The committee heard that bereavement support can reduce this risk, especially when tailored to the person's needs. People who had bereavement support were also likely to experience lower levels of depression and anxiety. Some of these benefits were based on personal accounts because the evidence was limited.

Some services have been developed locally to provide this type of support. But because there is very little evidence on the benefits, local authorities are reluctant to commission such services. Research is needed to build an evidence base on these interventions for people in the community so that effective and cost-effective statutory and voluntary services can be developed (see the recommendation for research on supporting people bereaved or affected by a suicide).

How the recommendations might affect practice

The committee recognised that providing support for people affected by suicide may be cost effective from a societal perspective, when the costs of productivity losses are taken into account. However, because of the lack of evidence this supposition needs to be treated with caution.

Return to recommendations

Preventing and responding to suicide clusters

Recommendations 1.9.1 to 1.9.5

Why the committee made the recommendations

Suicide clusters can emerge quickly and unexpectedly. But an expert told the committee that if the right systems are in place, then it is possible to reduce the likelihood of further deaths.

This was supported by the committee's own experience. An expert also explained to the committee that the police and the coroner's office need to notify agencies as soon as possible when a suspected suicide is being investigated. That is because an inquest to confirm cause of death is usually only held 6 to 12 months after the event. This is too late to prevent new suicide deaths if a cluster is developing. Residential custodial and detention settings have a duty to undertake and learn from reviews of incidents of self-harm to prevent future occurrences and make custody safer.

Based on this information and their own experience, the committee agreed that rapid intelligence sharing is important.

How the recommendations might affect practice

Improved communication and information sharing between statutory agencies and community organisations may have resource implications. For example, the costs of staff time, communication, interventions and the meetings associated with multi-agency teams.

Return to recommendations

Reducing the potential harmful effects of media reporting of a suspected suicide

Recommendations 1.10.1 to 1.10.4

Why the committee made the recommendations

Irresponsible reporting of suicide may have harmful effects, including potentially increasing the risk of suicide.

Reports of the method used in a suspected suicide seems to increase the risk of other people copying the suicide – so-called copycat suicides. And inaccurate media reporting

upsets people bereaved by suicide. So steps to encourage responsible reporting could prevent further suicide deaths.

Although there was little evidence on the personal effect of suicide or suicidal behaviour being shared through social media, the committee agreed that the guidance given to the media should also apply to social media.

To combat the harmful effects of irresponsible reporting, the committee agreed that it is important to promote best practice and also monitor media coverage.

How the recommendations might affect practice

Providing training for journalists may have cost implications. But better reporting generally has beneficial outcomes.

Return to recommendations

Context

The UK suicide rate was 10.4 deaths per 100,000 population in 2016 (see the Office for National Statistics suicides in the UK: 2016 registrations). Suicide is more than 3 times as common in men as in women. People aged 40 to 44 had the highest suicide rate at 15.3 per 100,000. This age group also had the highest rate among men, at 24.1 per 100,000. For women, 50- to 54-year-olds had the highest rate of 8.3 per 100,000.

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

The risk of suicide in the UK prison population is considerably higher than among the general population. The 3-year average rate of self-inflicted deaths by people in prison in England was 69 per 100,000 between 2009 and 2011; approximately 80% received a suicide or open verdict at inquest. There were 62 'apparent suicides following police custody' during 2013/14 in England and 119 deaths by suicide in prison in England and Wales in 2016.

Suicide and self-harm are major public health problems, with someone who self-harms being at increased risk of suicide (see the Department of Health and Social Care's Chief Medical Officer annual report 2013: public mental health priorities). Approximately three-quarters of people who die by suicide have not had recent contact with mental health services at the time of their death. However, many may have seen their GP in the year before they died and others may have been seen in A&E or another setting.

People at risk of dying by suicide may come into contact with a wide range of professionals and others. The Department of Health and Social Care's suicide prevention strategy for England and the House of Commons report on the government's suicide prevention strategy highlight the potential role of the community in preventing suicide. For example, people can make contact with suicide prevention services through helplines and support groups (offered by charities such as Samaritans), or they can speak to a GP.

This guideline covers people of all ages but focuses particularly on groups with high suicide risk.

It also looks at interventions for people who are, or have been in custodial settings, and

those in contact with any branch of the criminal justice system.

Suicide prevention in mental health settings is not covered by this guideline. For further information on preventing suicide in mental health services see the reports from the University of Manchester's National Confidential Inquiry into Suicide and Safety in Mental Health.

Finding more information and resources

To find NICE guidance on related topics, including guidance in development, see the NICE topic pages on depression, self-harm, alcohol-use disorders, drug misuse and prisons and other secure settings.

For full details of the evidence and the guideline committee's discussions, see the evidence reviews. You can also find information about how the guideline was developed, including details of the committee.

NICE has produced tools and resources to help you put this guideline into practice. For general help and advice on putting NICE guidelines into practice, see resources to help you put guidance into practice.

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