NATIONAL INSTITUTE FOR HEALTH AND   
CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1. Quality standard title

Suicide prevention

Date of quality standards advisory committee post-consultation meeting:   
19th June 2019

1. Introduction

The draft quality standard for suicide prevention was made available on the NICE website for a 4-week public consultation period between 24th April and 23rd May 2019. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 32 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the quality standards advisory committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the committee as part of the final meeting where the committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the committee should read this summary alongside the full set of consultation comments, which are provided in appendices 1 and 2.

1. Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be to be for these to be put in place?

3. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

4. For draft quality statement 1: Are local authorities the only organisation responsible for setting up suicide prevention partnerships in the community?

5. Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the [NICE local practice collection](https://www.nice.org.uk/about/what-we-do/into-practice/local-practice-case-studies/submit-a-case-study-example) on the NICE website. Examples of using NICE quality standards can also be submitted.

1. General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

* Stakeholders were generally supportive of the quality standard and the areas identified for quality improvement.
* There is a need to clarify the description of the scope of the quality standard including the definition of a community setting and that the audience includes voluntary, community and social enterprise organisations.
* It is not clear if children and young people are included.
* The statements are too broad to provide specific guidance for quality improvement.
* More emphasis on the important role of key stakeholders including primary care, employers, trade unions, schools, colleges, and universities is needed.
* More emphasis is needed on the importance of targeting initiatives to groups of people who are known to be vulnerable to suicide.
* It would be helpful to highlight the need to improve the use of language in relation to suicide.
* The wording should be more positive and emphasise the potential for people to recover.
* The Zero Suicide Ambition should be included.
* Additional relevant quality standards were suggested as follows: antenatal and postnatal mental health; personality disorders: borderline and antisocial; eating disorders; psychosis and schizophrenia in adults, and homelessness.

### Consultation comments on data collection

* There was agreement that data for many of the measures would be available although there are some additional requirements for information that may not already be collected.
* It was recognised that there are currently barriers to information sharing between organisations which could make data collection difficult. It was suggested that the quality standard should promote data sharing.

### Consultation comments on resource impact

* There was agreement that the quality standards are achievable providing partners work together and allocate resources to suicide prevention.

### Consultation comments on equality impact assessment

* More emphasis is needed on the need to take gender, social class, ethnicity, sexuality and culture into consideration. It is also important to highlight the complex interplay between these factors.
* It is important to identify that lesbian, gay, bisexual and transgender people with suicidal thoughts can find it difficult to seek help due to stigma and that services need to take steps to reduce that barrier.
* It is important to highlight the importance of supporting all people who find it difficult to communicate, for example, people who have difficulty with understanding, speaking, reading or writing.

1. Summary of consultation feedback by draft statement
   1. Draft statement 1

Multi-agency suicide prevention partnerships have a core group of representatives and clear governance and accountability structures.

### Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

* General
  + There was general agreement that this is an important statement to include.
  + Geographical coverage for multi-agency suicide prevention partnerships needs to be clearer so that there are not multiple plans and partnerships for different parts of the system.
  + It would be helpful to reference Sustainability and Transformation Partnerships/ Integrated Care Systems.
  + It would be helpful to refer to wider engagement with other partners. It was suggested that it should be clearer that a core group and a wider partnership group may be needed.
  + Is the core group in residential custodial and detention settings a sub-group of the wider partnership? The links between partnerships in community and residential custodial and detention settings need to be clearer.
* Statement
  + The wording should be revised to ‘multi-agency suicide prevention groups’ rather than ‘partnerships’ in line with the government’s National Suicide Prevention Strategy and other national guidance.
* Rationale
  + It needs to be clear that community settings include people who are not known to health services.
  + It should be clearer why there is a link to self-harm as an outcome as only a minority of self-harm incidents are suicide attempts.
* Measures
  + Structure a) should be worded to ensure that all key organisations are included. Data source could be terms of reference.
  + Structure c) should ensure that more than one person with personal experience is involved so that there is diversity of experience of suicide and personal background.
  + Peer review was suggested as a method of data collection for structure measures.
  + Additional structure measures were suggested: frequency of meetings, attendance at meetings and an action plan with clear outcomes and progress monitoring.
  + Outcome a) should include A&E presentations. There was a query about whether the terminology ‘intentional’ is appropriate.
  + It was questioned if outcome b) is an appropriate measure. This data is not collected currently so it would be helpful to include guidance on how to collect it. It was suggested that some primary care data may be helpful.
  + The data source for outcome c) should include ONS.
* Audience descriptors
  + It is important to ensure that partnership representatives engage other people in their organisation including frontline staff such as nurses, perinatal mental health practitioners and pharmacists.
* Definitions
  + It should be clearer which specific services should be involved in the partnership e.g. substance misuse, physical and mental health services, perinatal services, and that there should be a balance between the medical and social model of health.
  + Custodial and residential settings should be included on the core group in the community.
  + It should be clear that representatives are ‘senior representatives’.
  + Additional members of the core group were suggested as follows; employers, trade unions, faith groups, schools, colleges, universities, transport providers (including rail), coroners, undertakers, bereavement support services, veteran support groups, sexual assault and referral centres, safeguarding, housing and homelessness teams.
  + It would be helpful to define support for people with personal experience.
* Equality and diversity considerations
  + Should ensure protected groups are represented within the group of people with personal experience of suicide.

### Consultation question 4

Stakeholders made the following comments in relation to consultation question 4:

*Are local authorities the only organisation responsible for setting up suicide prevention partnerships in the community?*

* There was agreement that Local Authorities are not the only organisation responsible, but they do have a key role.
* Custodial settings are also responsible for setting up a partnership that is linked to the local authority partnership.
* Suicide prevention partnerships can be led by a range of organisations and have different functions, aims and structures. There should, however, be clear structures and links to the local authority.
* Other organisations may have more of a focus on suicide prevention and therefore may have more capacity and resources.
* It was suggested that the responsibility for setting up a partnership should be shared between organisations such as the local authority, CCG, mental health provider trusts.
  1. Draft statement 2

Multi-agency suicide prevention partnerships reduce access to methods of suicide based on local intelligence.

### Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

* General
  + There was general support for the quality statement.
  + It should be clearer that partnerships should use local intelligence to prioritise the methods they should focus on but the actions they take should be based on evidence of what works.
* Statement
  + It was suggested that the statement should be re-worded to ‘Multi-agency suicide prevention groups reduce access to methods of suicide used in their locality’.
* Rationale
  + Should acknowledge that reducing access to methods is not always possible but other approaches to prevention are still a priority in those circumstances.
* Measures
  + ‘Suicide audit report’ should be removed as a data source or defined as it can mean different things.
  + ‘Suicide action plan’ should be revised to ‘local suicide prevention action plan’.
  + It would be helpful to reference data sources that could contribute to rapid intelligence gathering such as British Transport Police data on suicide events.
  + It would be helpful to include outcomes for other suicide methods rather than just focussing on high-frequency locations.
* Audience descriptors
  + It should be clear that the descriptor for multi-agency suicide prevention partnerships includes residential custodial or detention providers.
  + ‘Safely prescribing painkillers’ should be amended to ‘restricting access to painkillers’.
  + It would be helpful to suggest that data sharing protocols are in place to allow partnerships to gather and analyse ‘real-time’ data. The importance of sharing data as quickly as possible should be emphasised for all partners including coroners.
  + It would be helpful to identify the need for partnerships to work with national organisations such as Network Rail and Highways England to reduce access to methods of suicide.
  + It was suggested that the descriptor for people in the community is not needed as it could imply that specific locations should be identified which would be risky.
  + It should recognise that people in the community can also be a useful source of intelligence about methods of suicide.
  + A descriptor for healthcare professionals who prescribe or dispense medication should be added.
* Definitions
  + Restricting access to painkillers should include limiting sales in places outside of pharmacy.
  + There should be a wider focus on other medicines that can cause toxicity e.g. tricyclic antidepressants.
  1. Draft statement 3

Multi-agency suicide prevention partnerships have a local media plan that identifies how they will encourage journalists and editors to follow best practice in suicide reporting.

### Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

* General
  + There was agreement that this is an important quality statement.
  + It should be clear how the work in local partnerships fits with the media advice and monitoring from the Samaritans as there is potential for duplication.
* Statement
  + The wording should be changed from ‘best practice in suicide reporting’ to ‘best practice when reporting about suicide and suicidal behaviour’.
  + It was suggested that the statement should go beyond local media to include partner organisation communication and digital and social media.
* Rationale
  + ‘Insensitive reporting’ should be amended to ‘irresponsible reporting’.
* Measures
  + Outcome a) will be resource intensive to collect and duplicates work carried out by the Samaritans (however, data not available).
* Audience descriptors
  + It should be clear that it is detailed depictions of suicide methods that increase risk and that stories of hopeful recovery with signposting to support can help in preventing suicides.
  + It should be clear that partnerships should engage with different community groups to ensure that the media plan ensures suicide is reported in a way that reflects their needs.
* Definitions
  + The definition of best practice should be extended to include the following points and be arranged in priority order, based on evidence:
    - provide stories of hope and recovery and include signposting to support
    - avoid using photos or language that is distressing to people who have been affected
  + It was suggested that the do’s and don’ts from the WHO guidance should be included in the definition rather than just as a link.
  1. Draft statement 4

People with active suicidal thoughts or plans are asked if they would like their family or carers to be involved in their care and made aware of the limits of confidentiality.

### Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

* General
  + There was agreement that it is helpful to include this statement.
  + There was a concern that the statement may be too broad and difficult to measure if it applies to any service that a person may be in contact with.
* Statement
  + Should include friends as well as family or carers.
  + Should specify that the family or carers are contacted if the person agrees they want them to be involved.
  + The statement should only apply to providers who have a statutory duty of care.
* Measures
  + Data collection will need to be developed as information is not currently collected. There was a concern that this could be resource intensive.
  + There was a concern that the data sources for the structure measures will not provide the information required.
  + It would be helpful to add a measure on staff training.
  + Identifying the denominator ‘the number of people with active suicidal thoughts or plans’ for the process measures will be difficult unless coding is developed to capture this data.
  + The satisfaction of the person with suicidal thoughts or plans should also be included.
* Audience descriptors
  + It should be clear that for children under 18, confidentiality can be broken without consent if there is a high risk of suicide.
  + It is important to emphasise the skills and expertise needed to contact family and carers in these circumstances and to assess if it is in the person’s best interest to disclose confidential information.
  + It would be helpful to identify the need for processes to be in place to share information about family and carer involvement across organisations.
  + Providers should be extended to include ambulance services, community pharmacies, schools and colleges.
  + There should be more emphasis on what to do if the person lacks the mental capacity to consent to information sharing.
* Definitions
  + The definition of people with active suicidal thoughts or plans needs to be clearer because active can mean different things in different settings.
  + There was a concern that the consensus statement is not clear enough to support clinicians to change practice. It was also suggested that it needs to be updated to reference GDPR.
  + It would be helpful to define ‘carer involvement in their care’, which includes the need to provide support to family and carers, including young carers.
  1. Draft statement 5

People bereaved or affected by a suspected suicide are given information and offered tailored support.

### Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

* General
  + There was support for this statement although it was suggested that there will need to be an investment in services to ensure that there is capacity to provide the support required.
  + There should be more emphasis on the post-traumatic effects of suicide on healthcare professionals and people working in the voluntary sector.
* Statement
  + It was suggested that the population should be broadened beyond those who are recently bereaved to include everyone who has been bereaved by suicide.
  + It would be helpful to include a sense of timeliness as some people are only offered support after the conclusion of the inquest.
  + Information should be ‘supportive information’.
* Measures
  + Structure c) should include ensuring that practitioners have good knowledge of the support services available including the voluntary and community sector who may be able to meet the needs of specific groups.
  + There should be more guidance on how to identify the denominator of people bereaved or affected by a suspected suicide. Coding will need to be put in place.
  + There was a concern that collecting data for the process measures may be resource intensive.
  + Outcome a) satisfaction with information and satisfaction with support should be split into 2 measures.
* Audience descriptors
  + It should be clear that services should have the skills to support the whole family, including children and young people.
  + It is important to ensure that there are locally coordinated processes for people to be given the information they need without duplication.
  + It would be helpful to suggest that information should be made more widely available so that people can access it when they need to.
  + It would be preferable to indicate that people are ‘signposted’ to support as formal referral processes may not be in place.
  + Ambulance services could provide information.
* Definitions
  + The definition of tailored support should include professional as well as peer support.
  + There should be a direct rather than indirect link to Public Health England’s guidance on providing support after a suicide in the definition of tailored support.
* Equality and diversity considerations
  + It is important to emphasise the importance of providing accessible written and verbal information.
  + The considerations should be extended to include people with communication needs, including people with autism.

1. Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

* Public awareness of suicide and how to prevent it
* Risk assessment and sharing information between mental health, primary and secondary care
* Access to support including crisis support services, intensive community support and support from employers
* Training and skills.

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# Appendix 1: Quality standard consultation comments table – registered stakeholders

| **ID** | **Stakeholder** | **Statement number** | **Comments[[1]](#footnote-1)** |
| --- | --- | --- | --- |
| 1 | Communication Workers Union | General | Introduction  The Communication Workers Union (CWU) is the largest union in the communications sector in the UK, representing approximately 192,000 members in the postal, telecoms, financial services and related industries.  The CWU welcomes the opportunity to respond to the National Institute for Health and Care Excellence (NICE) suicide prevention quality standard consultation. The CWU has campaigned over many years for more action and investment in mental health and suicide prevention services. We have also worked with charities including MIND, Rethink Mental Health, ‘Time to Change’, the Samaritans, CALM and Papyrus to encourage more of our members to get help and support if they have active suicidal thoughts or plans or if they have been affected by suicide.  The CWU has supported and signed the ‘Time to Change’ Charter which commits employers to supporting employees with mental ill-health and opposing stigma. We have also signed the ‘Dying to Work’ Charter to protect workers with a terminal illness diagnosis to ensure they retain the ability to remain in work for as long as they wish. This also avoids additional stress, anxiety and mental health issues being heaped on those affected and risking accelerating the progression of their illness. The CWU signed both Charters with Royal Mail Group and we believe NICE should be recommending that all employers sign up to these charters.  Government austerity, the growth of insecure work, falling living standards, rising inequality and increased debt are pushing more people into depression and despair. Although the overall UK suicide rate has fallen since the 1980s and 1990s, evidence suggests that there has been a rise in work related suicides in the face of growing pressures at work. It is appalling and shameful that there are nearly 6,000 suicides in this country each year. Much more can and must be done to tackle this tragic situation, which is a major public health issue, with suicide the leading cause of death in adults below the age of 50.[[2]](#footnote-2) |
| 2 | Communication Workers Union | General | The need for employer and union involvement in the NICE quality standard  The CWU supports the NICE quality standard and the overall objective for local organisations to combine their expertise and resources to implement a range of interventions to prevent suicide.  In the same way that people with active suicidal thoughts are asked if they would like their family or carers to be involved in their care, those individuals should also be asked if they want their employer to be involved. Where this is the case, there should be an automatic obligation on the employer to take steps to support those who are affected. |
| 3 | Communication Workers Union | General | Work related mental ill health and suicide  Not only are employers well placed to assist in the prevention of suicide, but they should be under an obligation to do so because of the enormous influence of work on mental wellbeing and suicide. Where labour standards are good and workers are treated fairly, work is usually very positive for mental health. Sadly, the opposite is true for too many workers who are in poor quality, precarious, stressful and low paid jobs. A major survey of 44,000 people by the mental health charity Mind last year revealed that poor mental health at work is widespread, with half of all people surveyed saying they have experienced a mental health problem in their current job.[[3]](#footnote-3)  Whilst poor working conditions in the UK have led to suicides, these cases remain officially invisible, as suicide is not recognised in legislation as a work-related accident. Evidence from countries where work related suicides are recorded points to a steep rise in workplace suicides in the context of deteriorating working conditions, increased job insecurity and work intensification. This has been shown in recent studies carried out in the United States (Tiesman et al., 2015), Australia (Routley and Ozanne-Smith, 2012), Japan (Kawanishi, 2008), China (Chan, 2013), India (Agrawal, 2014) and Taiwan (Chen, 2014).[[4]](#footnote-4)  In countries including France and Japan, there are laws in place not only to ensure that work related suicides are recorded, but also to place a responsibility on employers to tackle workplace suicide. In France, hundreds of families of suicide victims have successfully pursued litigation in the courts. In the UK few cases make it to court and when they do, they are rarely successful.  The CWU is campaigning for a change to the law so that workplace suicide is recognised in legislation. We consider that if any employee takes his or her own life in the workplace, or indicators exist to suggest it may be work related, it should be immediately investigated as a potential work-related suicide with the burden of proof being imposed on the employer to demonstrate that the suicide was not work-related. |
| 4 | Communication Workers Union | General | The role of employers in suicide prevention and mental health support  We believe employers have a vital role to play in helping to prevent suicide by creating a supportive environment in which workers are not placed under excessive pressure, where they are encouraged to seek help and support when necessary, where they can report mental health problems without fear for their job or employment prospects, and where they can access professional counselling and other support services.  The CWU is working hard to develop and improve mental health initiatives in companies where our members work. Responsible employers are generally responding well to this, as they increasingly recognise the benefits of addressing mental ill health, a problem that is now recognised as the leading cause of sickness absence in the UK. |
| 5 | Communication Workers Union | General | Stevenson /Farmer ‘Thriving At Work’ Report  The CWU believes that the Stevenson/Farmer review of mental health and employers - ‘Thriving at work’ - needs to be a central focus to NICE guidance.[[5]](#footnote-5) We believe that the link between work and mental health is key to dramatically reducing the proportion of people with a long term mental health condition who leave employment each year and the proportion of those that go on to complete suicide. It is therefore crucial to ensure that all who can benefit from the positive impacts of good work do so. The UK could and should be one of the leading nations in relation to mental health. The UK must prioritise mental health at work, aiming to become a global leader in reducing stigma, improving the mental health of the population, reducing suicides and supporting those who need it. In so doing we can also help to improve the UK’s productivity. We very much hope that the Government implements the recommendations, measures the results and makes a long-term commitment to improving mental health at work. The NICE prevention strategy must dovetail into that ‘holistic’ strategy. |
| 6 | Communication Workers Union | General | ‘Business In The Community’ (BITC) ‘Seizing the Momentum’ Report    Likewise the CWU would point to the Business in the Community (BITC) ‘Seizing the Momentum’ report which concludes that the prevalence and impact of mental health issues in the workplace is severe, and employers must aim to transform the conversation about mental health in the workplace.[[6]](#footnote-6) They must inspire senior leaders to truly connect with all their employees, and equip line managers with the skills to manage mental health effectively and take an active role in supporting good mental health and wellbeing in the workplace by urgently ramping up the breadth and quality of support they’re providing. Unlike physical health, the foundation building blocks for mental health are not yet well established. It is vital these are put in place if real progress is to be made.  There is a lack of measurable evidence of what interventions are effective and no consensus yet regarding guidance on reasonable adjustments for mental health at work. Employers are still ill prepared to accommodate or make reasonable adjustments for those with mental health issues as they do for people with physical health. Employers need to work together to urgently increase the speed of action to ensure mental health is truly embedded into organisational culture and all employees are fully supported if mental health cases and suicide numbers are to reduce. Despite progress, too many employees continue to suffer in silence at work, unable to fulfil their potential through a fear of prejudice and exclusion.  The BITC report finds that three out of five employees (61%) have experienced mental health issues due to work or where work was a related factor. This has remained consistent throughout the last three years.  One in three of the UK workforce have been formally diagnosed with a mental health condition at some point in their lifetime, most commonly depression or general anxiety. Six per cent of employees have been living with a formally diagnosed condition for more than 10 years (including depression, general anxiety, panic attacks and eating disorders).  There is still a disconnect between what senior leaders believe about the support provided to employees and the day-to-day reality. CEOs and board members are more likely than those with no managerial responsibility to believe that their organisation supports its staff. 64% of managers have put the interests of their organisation above staff wellbeing at some point and 12% do so every day. 54% of employees feel comfortable talking generally in the workplace about mental health issues. Just 60% of employees feel their line manager is genuinely concerned for their wellbeing.  Lack of high-quality mental health training for line managers continues to be a pivotal issue. Good employee mental health is crucial to running a successful, sustainable organisation. Those companies taking bold, innovative action to foster good mental health at work are reaping the benefits through improved staff recruitment and retention. But more must be done to ensure that these practices and the positive impact they have are adopted across all UK employers.  Places of work mirror issues in today’s society. Anxiety over financial wellbeing is clearly prevalent, reflecting job insecurity as well as broader concerns about the UK economy. This is having an impact on workplace mental health, and employers must adopt inclusive approaches that work for all. The profile of mental health issues and suicide has never been higher. |
| 7 | Communication Workers Union | General | Where’s Your Head At? Campaign  The CWU fully supports the ‘Where’s Your Head At?’ Campaign to call for change to health and safety law so it protects mental health in the workplace, the same way as physical health. |
| 8 | Communication Workers Union | General | Actions   1. The scale of challenge the nation faces on mental health in the workplace and related suicides cannot be underestimated. Every employer needs to take positive steps to help deliver the change in mental health at work we need. The following actions should be required of all employers:-  * Ensure employers are aware of the issue of suicide and suicide prevention as a workplace issue and that they have accessed appropriate advice and support as a legal requirement. * Employers need to produce, implement and communicate a mental health at work plan in consultation with trade unions; * Develop mental health awareness among employees; * Encourage open conversations about mental health and the support available when employees are struggling; * Provide employees with good working conditions and ensure they have a healthy work life balance and opportunities for development; * Promote effective people management through line managers and supervisors; * Routinely monitor employee mental health and wellbeing working jointly with trade unions and providing adjustments designed to support and maintain their employment. * Ensure provision of tailored in-house mental health first aid and occupational health support and counselling and signposting to clinical help. * Ensure, in consultation with trade unions, that mental health conditions are recognised and appropriately acted upon within processes and procedures, including conduct and attendance. This must include records being kept of any actions including justification of any penalty taken against an individual where a mental health condition was a factor. |
| 9 | Festival of Life and Death | General | I would like to see much more hope and optimism in these guidelines. The power of lived experience is vastly under-estimated and under-stated, as is the potential for people to transform very quickly from struggler to healer. There is evidence that hope and positive thought can have hugely beneficial effects on MH sufferers. I again refer you to Dabrowski/Tillier's Positive Disintegration Theory, and also to Ed Coffey's Zero Suicide model, both of which offer dramatic inspiration and optimism for vast and inexpensive solutions. Look also at Simon Dodds' Complex Adaptive Systems Engineering proven successes in W Mids healthcare quality transformation. These are world-leading transformational works, all highly transferable to mainstream suicide prevention. |
| 10 | Festival of Life and Death | General | Someone senior at NICE must (join with other advisory bodies) put pressure on central government - and educate the voting public - to consider the maths/economics/societal impacts of suicide prevention (and health crisis beneath), and as early/young as possible. It's not a matter of money, because solutions are not expensive; it's a matter of educating society how to be more human, and humane, and also crucially in legislating /regulating corporations to embed suicide prevention into workplaces and products/services. Interestingly doing so will also help correct climate/pollution/inequality, which are three fundamental drivers of suicide at root cause level. |
| 11 | Festival of Life and Death | General | The standards should explore representation in media beyond text/words alone, because many people who can help, and who are part of the solutions understand things better in different media. I don't know what the answer is, but at a fundamental level, perhaps some musicians and artists and nature people should be consulted using a different format altogether, and invited to give their responses in other media. Suicide is such a fantastically intangible concept that words alone are for many people very inadequate as a way to assimilate and give input. There is a risk that with a subject of great mystery that a heavily administrative process will be self-defeating. Somehow we need to widen accessibility and engagement to the maximum. |
| 12 | Festival of Life and Death | General | The NICE approach is necessarily England and Wales in terms of the standards' formal audience, HOWEVER, this must not restrict consultation and input/exploration to Eng/Wales. There is fabulous suicide prevention work happening internationally, and also through international history (for example consider Erik Erikson's work with Native American Indians, and also consider Indian/Asian wisdom of mindfulness, Buddhism, etc. Somehow we must open the innovations to the world, and this will encourage traditional parochialism to be more confident and empowered in looking internationally for ideas and collaborations, etc. Suicide is one of very few major challenges faced by every nation, and the more we can cooperate internationally, the better. |
| 13 | NHS England – Mental Health team | General | Guidance to be considered alongside quality statements should also include:  Antenatal and postnatal mental health: clinical management and service guidance <https://www.nice.org.uk/guidance/cg192>   * Borderline personality disorder: recognition and management <https://www.nice.org.uk/guidance/cg78>)   Wording around suicide prevention partnership should include identifying and carrying out work with specific cohorts that we know are particularly vulnerable to suicide, i.e. women in the perinatal period as suicide is still the highest cause of maternal death and that the time frame from a woman being mentally well to suicidal can be rapid. This would likely fit best in the opening section but depending on how much detail could also be repeated across all statements |
| 14 | Olly’s Future | General | Olly’s Future greatly welcomes this consultation on draft scope for Preventing Suicide in the Community. |
| 15 | Olly’s Future | General | The draft scope does not refer to employers or schools, colleges and universities in ‘Who the guideline is for’. These organisations have a duty of care to their employees/students and should therefore be included.  Furthermore, we feel it should reference the general public whether or not bereaved through suicide, as they may want to follow the practice set out by the guideline. Charities and other voluntary groups concerned with the promotion of suicide prevention should also be included in this section. |
| 16 | Public Health England and NHS England/Improvement | General | Wording starting from ‘This quality standard covers……’ could be clarified. It reads that the quality standard only covers those bereaved by suicide in a community or custodial setting or that the ways to reduce suicide only apply to community and custodial settings. I think that the wording is a bit ambiguous in terms of what the aim is, perhaps two separate sentences in one Statement. Also Community Setting from a health perspective tend to refers to those who are under a community mental or physical health team, however is Community referring to the general public. |
| 17 | Public Health England and NHS England/Improvement | General | Wording starting from ‘It is for ….’ This quality standard should apply to everyone who may have the potential to influence a reduction in suicide and therefore should explicitly include both statutory and VCSE organisations |
| 18 | Public Health England and NHS England/Improvement | General | Depression in Adults – was this not updated in 2018?  Also refer to Suicide Prevention for Community and Custodial Settings, SMI and Psychosis guidance and Eating Disorders. |
| 19 | Royal College of General Practitioners | General | There needs a focus to develop services that will see patients with dual diagnoses (we have commented on recent quality standards in relation to this) as singular services are no longer fit for practice – they do not represent the reality of presentations to healthcare and do not recognise the difficulty people with mental health problems have in continued engagement and attendance of mental health appointments. Self-harm and suicidal thoughts/intent need to be taken seriously by all agencies and services across the health sector. Without this cultural and system change – we will not be able to meet Zero Suicide ambition. |
| 20 | Royal College of Nursing | General | Thank you for the opportunity to review this draft quality standard. At present the RCN do not have any comments to add. |
| 21 | Royal College of Paediatrics and Child Health | General | The reviewer had no further comments to add to this draft standard. |
| 22 | Royal College of Psychiatrists | General | We suggest adding the Clinical Guidance 91 ‘Depression in adults with a chronic physical health problem’ to the list of relevant other guidance or quality standards given the increased risk of suicide in chronic pain and other long term health conditions |
| 23 | The British Psychological Society | General | The Society welcomes the quality standard. We are delighted to see that NICE have taken on board our comments to the previous consultation on Preventing suicide in community and custodial settings, particularly in relation to bereavement support and physical barriers. |
| 24 | Tower Hamlets Public Health, London Borough of Tower Hamlets | General | * Other quality standards that are relevant to suicide prevention and should be considered when commissioning or providing services include: – including Homelessness, substance misuse being considered and the impact that this has on wellbeing. |
| 25 | Bucks New University | General - EIA | All  We would like to see more emphasis on gender, social class, ethnicity, sexuality and culture in the document overall. Both practice of suicide awareness, prevention and research into it needs to take these issues into account. |
| 26 | FFLAG – Families and Friends of Lesbians and Gays | General - EIA | FFLAG is the UK's charity for families with LGBT members. Our focus is on supporting LGBT children (of all ages) to be accepted and affirmed by their family and friends. The main route to achieving this goal is through supporting parents with information and (through telephone and email) direct conversations in which parents who have already experienced this disclosure or discovery about their child can share their reactions and respond to the fears and concerns of parents who are having difficulty coming to terms with this news. We also publish booklets that share parental experience in this matter dating back to the 1960s.  The susceptibility of LGBT people to suicidal ideation and suicide is reflected in the National LGBT Survey published by Government Equalities Office on 3 July 2018. FFLAG believes that the Quality Standard should recognise this fact and raise awareness of the sensitivities involved in dealing with families to whom the LGBT relative may not have "come out" as well as the LGBT person themselves. This belief is reflected in our attached response.  We are surprised that the Equality Impact Assessment makes no mention of the complex interplay between sexual orientation and gender identity on one hand and faith, community and ethnicity on the other. We believe this is a serious omission not only from this document but from the draft Standard itself. Stigma is a serious barrier to seeking help when an LGBT person begins to experience suicidal thoughts; we believe the Standard should make plain the importance of reducing that barrier in service provision. |
| 27 | Royal College of Speech and Language Therapists | General - EIA | In the Equality Impact Assessment the RCSLT recommends that people with communication needs are added.  Although this references people with learning disability it fails to capture the importance of supporting all people with communication needs.   * People with communication needs may have difficulties with understanding, speaking, reading or writing. * People with communication needs deemed at risk of suicide are at far greater risk if their communication difficulties are missed and their ability to seek help via verbal means is reduced.   The RCSLT recommends that the Equality Impact Assessment references people with communication needs as understanding and access to support is critical for suicide prevention. |
| 28 | LGBT Foundation | Question 1 | The key area for quality improvement that is not included in this standard is education. There needs to be improved education offered to a wide range of people on ways to reduce suicide, suicide triggers and how to spot if someone is experiencing suicidal thoughts. This education needs to be provided to a range of professionals.  Furthermore there needs to be improved education surrounding suicide and specific suicide triggers in certain groups, particularly high risk groups. For example the impact of minority stress, a phenomenon specific to marginalised communities referring to poor mental health as a result of discrimination and oppression.  This education should come not only by formal training but by knowledge sharing, further highlighting the importance of including a wide range of people in multi-agency suicide prevention partnerships. |
| 29 | NHS England – Mental Health team | Question 1 | * The Quality Standard does not address issues around risk assessment and sharing of information between mental health teams (e.g. single point of access teams, Crisis Resolution and Home Treatment Team and Improving Access to Psychological Therapies (IAPT)), and primary and secondary care. Clear protocols should be in place to outline onwards referral particularly with when complexity or risk indicated. * The primary care content here is very weak (GP care as well as IAPT, which it doesn’t mention), and needs strengthening. CfMH published a relevant report: <https://www.centreformentalhealth.org.uk/sites/default/files/2019-04/Strengthening%20the%20frontline.pdf> * People with personality disorder are higher risk of suicide and they have not been mentioned. NICE guideline (<https://www.nice.org.uk/guidance/cg78>) and NICE pathway (<https://pathways.nice.org.uk/pathways/personality-disorders>). Also relevant is the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) report, ‘Safer care for patients with personality disorder’, which should be a really useful resource for multi-agency partnerships and includes recommendations for practice: <https://sites.manchester.ac.uk/ncish/reports/safer-care-for-patients-with-personality-disorder/> * The Quality Standard does not mention children or young people. It does not adequately reflect the needs or circumstances of children and young people, nor the benefit of specifically addressing this cohort. As it currently stands, local partnerships may assume that they have covered children and young people, whilst not actually doing so. * The referencing within the Quality Standard does not include enough evidence from children and young people, and schools and colleges are not mentioned among the relevant service, nor any children’s service. The standard may not be intended to include 0-18 but the standards for children and young people need to be slightly different.   The Quality Standard aligns with the main aspects of the suicide prevention programme, and in particular, ensuring multi-agency working and the importance of postvention bereavement support. It is also welcome to see the inclusion of the consensus statement (Quality Statement 4), after discussion on this at the Health Select Committee in January 2019. |
| 30 | Olly’s Future | Question 1 | We would like to see included something on 'Language around Suicide' as this currently is omitted. There is still general usage, even by those in the medical profession, of language such as 'commit suicide’, ‘a failed attempt at suicide' and 'completed suicide' which implies success. (We normally use 'complete' in a positive way ie. 'I have completed my studies' but there is nothing positive around suicide.) We would like to see language such as ‘died by/through suicide’, ‘taken or ended his/her/their own life’ or ‘attempted suicide’ used instead.  This is distinct and goes beyond how suicide is reported in printed material and the media, which should also be included. |
| 31 | Public Health England and NHS England/Improvement | Question 1 | No – Zero Suicide Ambition is not mentioned, which has been mandated by the SoS for HSC is required but needs to be included within the wider plan. |
| 32 | Royal College of Psychiatrists | Question 1 | Yes, they are a good reflection of key areas given the quality standard covers high level processes.  However, existing mental health services play an essential and major role in supporting people with mental health difficulties that could lead to suicidal thoughts and completed suicide. Although there has been increased resources these services are still under resourced regarding addressing the increased demand. Expansion of Crisis services across the age range, intensive community support and involvement of other organisations in the voluntary sector is needed. Focusing on promoting mental health and wellbeing including reducing stigma and more public awareness of suicide and how to prevent it. |
| 33 | Royal College of Speech and Language Therapists | Question 1 | Question 1 -Does this draft quality standard accurately reflect the key areas for quality improvement?  Key themes are identified but it would be difficult to identify actual areas for quality improvement if these standards were being used as a reference point. All the quality statements depend on local data collection as their data source however the standards are too broad (as is the data collection source and examples) to provide enough guidance for local trusts and teams to really identify areas for improvement. For example: ‘Evidence that multi-agency suicide prevention partnerships have a core group of representatives.’ It would be more useful to provide a measure which can be used across services systematically, which actually quantifies this so the outcome isn’t ‘evidence’ or ‘no evidence’ which is not helpful for quality improvement purposes, or comparative purposes.  Furthermore the RCSLT recommends defining quality statements with more focus on people who are at a greater risk of suicide specifically including people in custodial setting, children and young people and people with communication needs.   * These people are more likely to have poor vocabulary skills, unable to grasp abstract language and complex terminology frequently used by professionals (RCSLT, 2017). * Communication needs can be a barrier to accessing and understanding mainstream messaging.   People with communication needs deemed at risk of suicide are at far greater risk if their communication difficulties are missed and their ability to seek help via verbal means is reduced (RCSLT, Response to CAMHS, 2017) |
| 34 | Stoke on Trent and Staffordshire Suicide Prevention Group, Harplands Hospitals | Question 1 | I think the quality standard does accurately reflect the key areas for quality improvement. In terms of the proposed measures, I do feel as though they are all possible however that is assuming that all key partners co-operate and are able to contribute the data needed. |
| 35 | FFLAG – Families and Friends of Lesbians and Gays | Question 2 | Data collection should facilitate monitoring the incidence of suicide driven by sexuality and gender identity where this can be established in order to improve understanding of how this may be reduced. In instances of suicidal ideation where the motive of the person at risk is unclear or apparently confused, professionals should be skilled at providing opportunities for the person to reflect on and disclose any concerns they may have about their gender or sexuality by making clear that no judgement will follow such a disclosure and that it remains confidential. |
| 36 | LGBT Foundation | Question 2 | In terms of data gathering for all these statements there are barriers around information sharing and consent, organisations may not be able to share some information on service users. However usually this can be overcome by not using individual cases unless written permission has been obtained, and ensuring there is no identifying information in evidence provided. |
| 37 | NHS England – Mental Health team | Question 2 | * Shared or access to records is not universally available between primary and secondary care which hinders information sharing such as service involvement or risk management. * Sharing of information needs to include university students whose records may be held in different locations to where care required (term time vs holidays) * Some data collections proposed seem straight forward but are an additional ask, for example, asking providers to report on ensuring all staff are trained and aware of the consensus statement on information sharing and suicide prevention (page 17). |
| 38 | Public Health England and NHS England/Improvement | Question 2 | No – further work is required to ensure that there is a requirement for information to be shared. Suggest working with NCISH to see which RTS models work so that these can be referenced. |
| 39 | Royal College of Psychiatrists | Question 2 | Many of the proposed quality measures would be are available for quality standard 1, 2 and 3 and would seem straightforward to collect.  Data for quality standard 4 measure regarding involving family and carers would require collecting and collating information from multiple sources of professionals who may be in contact with the patient and family.  Data for quality standard 5 measure may also be difficult to collect and collate and decisions would need to be made as to who would be responsible for maintaining the data base for this. |
| 40 | Royal College of Speech and Language Therapists | Question 2 | Question 2 - Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?  Local systems are too variable and it would be more efficient to collect data systematically across systems and structures. If one particular health professional is involved in the care of someone who may be at heightened risk of suicide and is concerned, but their involvement in care has been for another reason (e.g. a neurodevelopmental disability) it is unlikely these professionals have access to the same data or ability to input data in to systems in which the assigned ‘multi-agency teams’ have access to. A centralised registry would reduce this.  The RCSLT is concerned that:   * Organisations do not share information because duty of care and consent gets in the way * People’s needs are often not identified. Communication needs are often unidentified and unsupported * Community mental health services are stretched   Our members report that there little if no transition between child and adult services resulting in crisis points |
| 41 | The British Psychological Society | Question 2 | We believe that the draft quality standard does accurately reflect the key areas for quality improvement. However, it isn’t clear whether there are local systems in place to monitor adherence to Statement 4 in particular.  To ensure best quality data, we would recommend that multi-agency suicide prevention partnerships works closely with local universities and other partners to collect such data. |
| 42 | NHS England – Mental Health team | Question 3 | * Yes, these are achievable provided each suicide prevention partnership has the level of representation recommended in the statements from across sectors and organisations. It may be more difficult if this representation is not maintained or consistent etc. * With regards to children and young people, there do not seem to be any significant resources directed at suicide prevention for this population. Assessment of these requirements will depend on an ambition for children and young people which should be informed by relevant expertise and evidence, and outcomes-oriented. |
| 43 | Public Health England and NHS England/Improvement | Question 3 | Yes – providing the comments above are addressed |
| 44 | Royal College of Psychiatrists | Question 3 | All the quality standards are achievable, the challenge is staff availability and cost in resources especially regarding tailored support to those affected by suicide. This cost is for staff training and supervision. |
| 45 | Network Rail on behalf of the Rail Industry | Question 5 | Network Rail on behalf of the Rail Industry has produced a case study of the Working collaboratively to prevent suicides at Milton Keynes and Bletchley train stations which demonstrates how we as the Rail Industry adopt a multi-agency approach when we identify high risk locations. We are happy to share this to enable it to be used as a reference document. |
| 46 | Public Health England and NHS England/Improvement | Question 5 | Yes – would suggest looking at the <https://www.rcpsych.ac.uk/improving-care/nccmh/national-suicide-prevention-programme> |
| 47 | Bolton Community and Voluntary Services | Statement 1 | This is an important quality standard to include. Without clear accountability structures there can be a lack of ownership and direction to the actions of the partnership board and it can be seen as a lower priority. It may be difficult to measure as many areas are reviewing their internal governance structures particularly with the integration of health and social care and this may delay compliance with this standard. |
| 48 | Bolton Community and Voluntary Services | Statement 1 | Membership could be difficult to measure as the membership list may not reflect those who actually attend regularly or how this information is disseminated further within different organisations. There needs to be a responsibility that partnership group members have internal processes for ensuring their organisation is fully on board and send an alternative representative where this is possible. How to engage with a wider range of representation from smaller voluntary sector organisations also needs to be considered who may not be in a position to attend regular partnership meetings. |
| 49 | Bolton Community and Voluntary Services | Statement 1 | A measurable action plan with clear intended outcomes needs to accompany the partnership group so that progress can be monitored. |
| 50 | Bolton Community and Voluntary Services | Statement 1 | There needs to be consideration of how those with experience of attempted suicide or suicidal thoughts can input into the partnership. Guidance needs to be provided to ensure that this is done in an effective and appropriate way without increasing the vulnerability of the person engaged or others. |
| 51 | Bolton Community and Voluntary Services | Statement 1 | Peer review from different localities should be considered to review compliance with the standards. |
| 52 | Bolton Suicide Prevention Steering Group | Statement 1 | Good representation across all sectors are vital in reducing suicide including all the wide and varied risk factors associated, however I don’t think local authorities are the only organisation that could be responsible for the overall co-ordination of the partnership. Though local authorities are in a good position there are some other organisations have a sole remit around this topic, therefore may have more capacity, resources and valuable insight. The key point is ensuring you have a good representation from all sectors and organisation.  This is an important quality standard to include. Without clear accountability structures there can be a lack of ownership and direction to the actions of the partnership board and it be a lower priority. It may be difficult to measure as many areas are reviewing their internal governance structures particularly with the integration of health and social care and this may delay compliance with this standard. |
| 53 | Bolton Suicide Prevention Steering Group | Statement 1 | Membership could be difficult to measure as the membership list may not reflect those who attend regularly or how this information is disseminated further within different organisations. There needs to be a responsibility that partnership group members have internal processes for ensuring their organisation is fully on board and send an alternative representative where this is possible. How to engage with a wider range of representation from smaller voluntary sector organisations also needs to be considered who may not be able to attend regular partnership meetings. |
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| 56 | Bolton Suicide Prevention Steering Group | Statement 1 | Peer review from different localities should be considered to review compliance with the standards. |
| 57 | Bucks New University | Statement 1 | Measure a)  We would ask for the inclusion of mental health nursing, child nursing and adult nursing lecturers alongside A&E and acute mental health professionals and faith groups into the core group of proposed multi-agency suicide prevention partnerships. A&E nurses and mental health nurses are frequently the first point of contact for people who self-harm and/or are suicidal and we would ask for their inclusion too. Historically, one of the problematic areas in care and prevention has been that of staff attitudes and practices, which can be life-saving but also, on occasion, judgemental and punitive. Research remains patchy in the area of staff/public responses to those who are suicidal/who self-harm. |
| 58 | Bucks New University | Statement 1 | Measure c)  We would agree wholeheartedly that ‘partnerships should also involve people with personal experience of suicide in the core group to promote understanding’ but would go further in saying they need to be central to the process. Our fear is that partnerships become bureaucratic talking shops: ‘best practice’ needs to be operationalised quickly and efficiently. |
| 59 | College of Mental Health Pharmacy | Statement 1 | “Health care professionals” are a listed group in the multi-agency suicide prevention partnerships, please ensure that this extends beyond doctors and nurses, to include pharmacists too. |
| 60 | Communication Workers Union | Statement 1 | However, we consider that the absence of employers and trade unions from the standard represents a major limitation, and we believe it is important that they are involved. Employers - working with trade unions - are extremely well placed to support multi-agency suicide prevention partnerships in the community by sharing information about individuals at risk where their consent is given. They can also help to reduce the risk of suicide amongst their employees by adopting best practice guidelines in the workplace |
| 61 | Communication Workers Union | Statement 1 | Conclusion   1. In conclusion, the CWU supports the NICE suicide prevention quality standard but we believe employers should be involved in this initiative. Work has a huge impact on mental health, and evidence suggests that work related suicides have increased due to the growth of job insecurity and work intensification. Employers have a responsibility to contribute to suicide prevention and it is in their interests to do so. We believe it is reasonable to expect that many employers would be open to being part of a multi-agency suicide prevention partnership. The involvement of trade unions is equally important as the representatives of millions of workers across the UK. |
| 62 | Derbyshire Healthcare NHS Foundation Trust | Statement 1 | Rationale; Meaning for different audiences  Whilst having support and empowerment from senior decision makers and budget holders is important, their involvement and representation on suicide prevention strategy groups should not replace/be seen as more important than that of frontline clinicians, policy makers and managers. As they are best placed to identify and understand issues, and then enact solutions. It is important not to devalue the drive or ownership of frontline/ hands on colleagues. |
| 63 | Festival of Life and Death | Statement 1 | The 'Core group of representatives ' should include several more 'sectors', and there must be prominent linkage to NICE standards for health and suicide prevention in other 'sector' guidelines, e.g., education and workplace. Core group of representatives must include:  a) Local employers and trade associations, because workplaces are crucial in both causing suicides and preventing suicides. In my experience this would be a terrible huge omission and wasted opportunity.  b) Education must also to represented – i.e., schools and FE. Again this would be a huge omission, and for the future an even greater wasted opportunity, because young people are future leaders and transformers, and there is such a fine line between a suicide victim and a suicide prevention role-model/leader. (See 'Theory of Positive Disintegration' (/Dabrowski/Tillier) bit.ly/pos-dis )  c) Transport must also to represented, especially railways, because so many suicides happen involving trains, and also the rail network and railway stations offer so many opportunities to reach people at all stages of suicide crisis/risk. For example Matthew Wakely's fabulous RUOK? suicide prevention scheme, based in Leicester (nominally within Leics Partnership Trust) and rolling out through the railway network.  e) funeral/undertaking and coroners are other big omissions – funeral services must signpost bereaved to support (and are uniquely positioned to do so). Coroners have huge responsibility to improve reporting and connections with other prevention agencies. Coroners are typically secretive, defensive, resistant to change and scrutiny, and yet they are pivotal in improving accuracy of data, without which the leadership and management of transformation is greatly impaired.  f) I suggest there is a '4th sector' – namely the emergent sector of non-constituted communities (rather like a 'neighbourhood watch' for loneliness/suicide risk. Somehow the crucial role of this '4th sector' must be acknowledged and encouraged, and importantly 'reached' and enabled/empowered, because this is one of the big solutions, especially for the elderly and chronically isolated/withrawn people, for whom pro-active neighbourly outreach is the only way to reach/connect/support, when a person becomes gravely at risk. Please understand that community at its most powerful is not constituted, but nevertheless it is a 'core group' than can be represented somehow or other, if we make the space for it. |
| 64 | HMPPS | Statement 1 | This statement implies local authorities are the only organisations needing to set up a partnerships – a multi agency partnership is needed in all custodial settings with a link to LA |
| 65 | Institute for Mental Health, University of Birmingham | Statement 1 | Structure  The core group does not include representatives from the Education sector (schools, colleges and higher education). The Education sector should be represented in the core group e.g. Head of student wellbeing services from local Universities, designated mental health lead from schools and colleges (please refer to Green Paper “Transforming children and young people’s mental health provision”). |
| 66 | Institute for Mental Health, University of Birmingham | Statement 1 | Outcome  The majority of young people who self-harm are in the community and receive different range and type of services and support by the Voluntary Sector. Local data collection (for example, via surveys) regarding self-harm rates should also target voluntary sector organisations. |
| 66 | LGBT Foundation | Statement 1 | Structure a)  In general this this draft quality standard accurately reflects a key area for quality improvement. However this standard needs to go beyond only requiring that the partnerships have a core groups of representatives (structure a). It should be ensured that the core group of representatives contains people from a range of organisations, including voluntary sector organisations, which support a range of different communities. It is particularly important that organisations that support groups who are more likely to die by suicide are represented. This will ensure that examples of best practice for preventing suicide for a range of groups, including high risk groups, can be shared within these partnerships. For example there must be representation from professionals working in organisations that specifically support LGBT (lesbian, gay, bisexual and trans) people as LGBT people are more likely to attempt suicide.  12% of trans people made an attempt to take their own life in the previous year, compared to 2% of LGB people who aren’t trans. According to research for NHS Digital, less than 1% said they attempted to take their own life in the last year. (Bachmann, C and Gooch, B., 2018. ‘LGBT in Britain. Health Report’. Stonewall and YouGov. Available at: <https://www.stonewall.org.uk/system/files/lgbt_in_britain_health.pdf>). |
| 67 | LGBT Foundation | Statement 1 | Structure c)  An addition that should be made to quality measure c is that it should be ensured that there are a diverse range of people with personal experiences of suicide represented in these partnerships. This must include people with different protected characteristics, for example LGBT, disabled people, older people. This must also include people from a range of socio-economic groups. This will work towards building up a better picture of experiences of suicide in different groups and will help ensure a wide range of people are supported. |
| 68 | LGBT Foundation | Statement 1 | In order to be able to measure whether a diverse range of people are represented in both the core group and in the group of people with personal experience (outlined in comment 1 and 2), demographic monitoring of all protected characteristics needs to be carried out.  Demographic monitoring must include sexual orientation and trans status monitoring. To monitor trans status demographic monitoring forms should ask ‘is your gender identity the same as the gender you were assigned at birth?’ an answer of no indicates a person is trans.  If this monitoring reveals that a demographic group is under represented it needs to be ensured that outreach is provided to these communities to encourage involvement in this group. |
| 69 | Maternal Mental Health Alliance (MMHA) | Statement 1 | Definitions - Core Group of Representatives: There needs to be a specific mention of perinatal mental health expertise / membership within the Multi Agency Suicide Prevention Partnership core group because: a) the risk of suicide in the perinatal period, b) 7 out of 10 women underplay / hide the severity of their illness so their needs could be overlooked/forgotten, c) The confidential enquiries into maternal deaths show that general mental health teams are not aware of the specific features of perinatal mental illness, and in particular the rapidity of deterioration. <https://www.npeu.ox.ac.uk/mbrrace-uk/reports> |
| 70 | National Suicide Prevention Alliance (NSPA) | Statement 1 | Statement  As per the Government’s National Suicide Prevention Strategy and the [Local suicide prevention planning: A practice resource](https://www.nspa.org.uk/wp-content/uploads/2016/10/PHE_LA_guidance-NB241016.pdf) document developed by ourselves and PHE, it is important to differentiate local authority-led ‘Multi-agency suicide prevention groups’ and broader ‘suicide prevention partnerships’. The latter can be led by a range of organisations and have different functions, aims and structures. This statement should therefore be re-worded as ‘Multi-agency suicide prevention groups’, and that should be the standard language throughout the document. |
| 71 | National Suicide Prevention Alliance (NSPA) | Statement 1 | Quality measure -structure - c  The statement regarding personal experience: (Evidence that multi-agency suicide prevention partnerships support people with personal experience to be involved in the core group.)  This should include a point on diversity of experience, both in terms of lived experience (as mentioned in the definition), and also of background and life experiences.  It should, as far as reasonably possible, be representative of the community at large regarding gender, race, socio-economic status, and other characteristics. Many suicide prevention groups have ‘someone with lived experience’, but there are severe limitations to that. One person may provide some useful insights, but these will be limited to their experience and background. They may also find it burdensome to be the sole representative of lived experience, and if they need to step back, they leave a big gap. It is also likely that if just one person with lived experience is involved, that they may not represent the groups at highest risk of suicide.  These points should also be reflected under ‘Equality and diversity considerations’. |
| 72 | National Suicide Prevention Alliance (NSPA) | Statement 1 | Quality measure – structure - c and what the quality statement means for local authorities  It would be valuable to have a definition of the word ‘support’ in these section, which will contribute to the above point about diversity. Often those currently involved in multi-agency groups are fortunate to have the time and resources to give to this work, and the confidence that their voice should be heard. This may not be representative of the experiences of a large proportion of those affected by suicide.  There should be a clear process and policy around involving those with lived experience to ensure care is taken of their wellbeing and mental health whilst they are involved in discussion of difficult issues, including: careful screening or selection; induction and training; on-going, pro-active and regular support; and reimbursement not just for travel costs but also for time taken out of work or for childcare.  These points should also be reflected under ‘Equality and diversity considerations’. |
| 73 | National Suicide Prevention Alliance (NSPA) | Statement 1 | Outcomes  Though the existing measurables are useful, we would suggest including some more direct measurables, such as how often the partnerships are meeting, attendance from different members, and whether they have a plan in place that is being monitored for delivery. |
| 74 | Network Rail on behalf of the Rail Industry | Statement 1 | No, it fails to recognise the part businesses/industry has to play in suicide prevention.  In particular on page 7 under ‘core group representatives’ it does not reference for example stakeholder groups such as the rail industry the RNLI and other transport groups that are integral to community life. |
| 75 | NHS England – Mental Health team | Statement 1 | * Outcome   (a) rate of emergency hospital admissions for intentional self-harm   * We recommend that you include A&E presentations with self-harm as ward admissions are a small subset of those who have self-harmed, usually with an overdose requiring medical intervention. Data on this should be able to be collected via A&E. * A&E data is known to have issues around poor coding so until there are improvements in data quality, caution should be taken in interpreting these results. However, inclusion in the quality standards may be a lever to improve data quality.   (b) Rate of self-harm in the community.   * + There is no local mechanism in place for this currently – there would need to be guidance on sampling and statistics to understand if the sample was representative.   + As there is no system in place to do this routinely across the age range, this would be associated with increased cost to implement. Screening on self-harm also requires availability of a clear response and intervention for those who screen positively.   There is currently variable collection, in provision and quality, across the country. Additional resources may be required to help local areas set up and improve the quality of their provision. However, inclusion in the quality standards is also lever to improve data quality. |
| 76 | North West Ambulance Service NHS Trust | Statement 1 | North West Ambulance Service supports the view that multi agency suicide partnerships have a core group of representatives and clear governance and accountability structures. We would advocate that this includes blue light responders who are typically first on scene in the event of a suicide attempt or Mental Health Crisis. |
| 77 | North West Ambulance Service NHS Trust | Statement 1 | North West Ambulance Service believes that it is imperative to involve people with personal experience of suicide as equal partners to promote the effective use of co-production but we would like to see appropriate support for these individuals. |
| 78 | North West Ambulance Service NHS Trust | Statement 1 | Substance Misuse and mental health often co-exist in this patient group. We would suggest involvement of these services is made explicitly clear within the core group of representatives. |
| 79 | North West Ambulance Service NHS Trust | Statement 1 | Bereavement support for those who are close to someone who has died as a result of suicide is essential. We would ask if specialist bereavement services need to part of the core group of representatives. |
| 80 | North West Ambulance Service NHS Trust | Statement 1 | We would ask if the core group of representatives should include organisations which link into high risk areas. An example of this may be Highway Agency or National Rails Services. |
| 81 | North West Ambulance Service NHS Trust | Statement 1 | We would ask if the core group of representatives should include from coronial services. |
| 82 | Olly’s Friendship Foundation | Statement 1 | Definitions  Criminal Justice Services needs to include Coroners |
| 83 | Olly’s Friendship Foundation | Statement 1 | Definitions  People with personal experience of a suicide attempt, suicidal thoughts and feelings, AND a suicide bereavement |
| 84 | Public Health England | Statement 1 | Core Group of representatives – Public Health England (PHE) would suggest that organisations (statutory and/voluntary) that support veterans are included in this group, similar to the focus on other at-risk groups that are highlighted in the second priority area in the national strategy. Veterans with lived experience may not typically engage with this work so it is important they are represented. This can be viewed at: <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/585411/PHE_local_suicide_prevention_planning_practice_resource.pdf>. |
| 85 | Public Health England | Statement 1 | The rate of self-harm is not routinely collected or recorded. This therefore may not be an appropriate measure to use in this case. |
| 86 | Public Health England | Statement 1 | The measures in local partnership plans should include specific, measurable, attainable, realistic, and timely (SMART) objectives which are regularly monitored and resourced. This will ensure the plan remains a ‘live’ document that is regularly revisited and revised to ensure it remains best suited to the current local situation. |
| 87 | Public Health England | Statement 1 | The PHE Fingertips tool will be updated in June 2019 and will include a list of local authorities which have a local suicide prevention plan in place. This was a voluntary process. Local authorities have demonstrated they are well-placed to be the organisation responsible for setting up Suicide Prevention partnerships in the community but the formation of a multi-agency stakeholder group as part of the process remains central to this process. Th fingertips tool can be viewed at: <https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide>. |
| 88 | Public Health England and NHS England/Improvement | Statement 1 | Statement 1 – should this include reference to Sustainability and Transformation Partnerships/Integrated Care Systems? |
| 89 | Public Health England and NHS England/Improvement | Statement 1 | Do we need to clarify what multi-agency should look like? The quality statement could qualify that the core group of representatives should be drawn from health care and social care to prevent the group being ‘lop sided’ or biased in favour of the social model or medical model of health? Do they need links to STPs/ICS structures? |
| 90 | Public Health England and NHS England/Improvement | Statement 1 | What footprints are we referring to when looking at local organisations? Again this is being distilled to those in community and custodial settings when suicide prevention plans should be much broader to include the 50% who are not known to any health services. The rationale should be clear and inclusive so that we do not have multiple plans which are created in isolation for different parts of the system. There is a geographical aspect to this that should be considered. |
| 91 | Public Health England and NHS England/Improvement | Statement 1 | Data source for a) should include Terms of Reference and assurance should be sought that representatives from organisations are attending. |
| 92 | Public Health England and NHS England/Improvement | Statement 1 | Are there two models required, a core group which can manage both the strategic aims, current situations (including monitoring clusters and Real Time Surveillance) and a partnership group which will review the actions and impact of the plan. Most STPs are splitting their groups into two, due to the numbers involved and the sensitivity of some of the information which is being included. Could this reference to section 2 of PHE’s local planning guidance: <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/585411/PHE_local_suicide_prevention_planning_practice_resource.pdf> also on page 19 of the cluster guidance: <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/769469/Identifying_and_responding_to_suicide_clusters_and_contagion.pdf> |
| 93 | Public Health England and NHS England/Improvement | Statement 1 | This is the first time that self harm is discussed in this quality standard and it has not been included within the rationale, therefore the link as to how this would evidence that this is a measure of success for the Quality Statement. Potential for widening why self is a potential indicator could be included in the rationale. |
| 94 | Public Health England and NHS England/Improvement | Statement 1 | There is a risk here of divergent plans, actions and unintended consequences. First of all, should this be at Local Authority Level when most areas are looking to have a whole system approach at an STP level? Some areas have multiple local authorities, therefore monitoring a plan and attending meetings is a strain on already stretched resources. Secondly, most groups also include representatives from custodial and residential settings, as there should be joint working and knowledge of what is happening across the system. Thirdly, there is no mention of the Zero Suicide Ambition Plans, which have also had to be created. Within our area, we have suggested that these plans are included in the overarching governance structure, so that there is oversight of the actions. There should be an overarching STP plan, in line with the national guidance, with sub groups and actions specific to workstreams or organisations produced which can then be governed at a system level. Could a Public Health approach to Suicide Prevention be articulated within the place based approach to allow for these two aspects to be brought together without the risk of duplication. |
| 95 | Public Health England and NHS England/Improvement | Statement 1 | Core Group – Sexual Assault and Referral Centres? Safeguarding? There is a danger that the group is so big that no actions are being taken. Again refer to point 9, where there is an overarching group and a partnership group, which encompasses a wider stakeholder group. Due to confidentiality and sensitivity of the discussions, it may be inappropriate to have some of the discussions in an open forum, which could lead to specific actions not being taken. Areas are starting to either hold two groups or a part A/part B type format. |
| 96 | Public Health England and NHS England/Improvement | Statement 1 | Core Group for custodial settings – this seems to me to be a sub group of the wider STP suicide prevention group, in the same way that providers will have their own meetings as will health and social care. It should cascade up and down the system, with accountability and communication flowing bilaterally. |
| 97 | Public Health England and NHS England/Improvement | Statement 1 | Equality and Diversity considerations – does this need to be included here – should there just be an overarching statement at the beginning stating that any partnership or group meetings should ensure that ‘reasonable adjustments…..’. |
| 98 | Royal College of General Practitioners | Statement 1 | In response to question to statement 1: there needs to be resources and guidance to assist with setting up suicide prevention partnerships across the country. Currently this may be from local authorities but a national guidance may be helpful to ensure consistency, and further improvement. |
| 99 | Royal College of General Practitioners | Statement 1 | Structure  The data about multi‐agency suicide prevention partnerships may not be available |
| 100 | Royal College of General Practitioners | Statement 1 | Outcome a – agree this is an important outcome. However It may be useful to amend the wording and remove ‘intentional’ from the term ‘intentional self-harm’. NICE defines self-harm as ‘irrespective of suicidal intent’ and so ‘intentional’ may need to be removed from ‘intentional self-harm’. |
| 101 | Royal College of General Practitioners | Statement 1 | Outcome b – we are concerned that school surveys could be distressing for the young people involved and so need to be co-produced with young people and piloted. |
| 102 | Royal College of General Practitioners | Statement 1 | Outcome b  ‘Rate of self-harm in the community’ data source – Clinical Practice Research Datalink (CPRD) data can provide evidence of incidence over time and other primary care electronic health care record systems.  E.g. Carr M, Ashcroft DM, Kontopantelis E, Awenat Y, Cooper J, Chew-Graham CA, Kapur N, Roger T Webb. The epidemiology of self-harm in the UK primary care patient population, 2001-2013. BMC Psychiatry (2016) 16:53 DOI 10.1186/s12888-016-0753-5 |
| 103 | Royal College of Occupational Therapists | Statement 1 | Outcome  Not all Intentional self-harm incidents are suicide attempts (in fact very few will be) so is this an accurate measure to use? |
| 104 | Royal College of Psychiatrists | Statement 1 | P7 - We suggest emphasising ‘health care provider’ includes those for mental health and physical health. |
| 105 | Royal College of Psychiatrists | Statement 1 | P10 - Given the noted risk factor of painkiller prescriptions a chronic pain service should be included in the core group stakeholders within statement 1. |
| 106 | Royal College of Speech and Language Therapists | Statement 1 | The RCSLT welcomes a greater focus on local organisations working together. Consideration needs to be given to the sharing of (patient) information and issues of consent and duty of care between partners. Our members report that the sharing of information across boundaries is often limited. |
| 107 | Royal College of Speech and Language Therapists | Statement 1 | The RCSLT welcomes that the prevention partnerships will include custodial staff. However we are concerned that the quality standard suggests that custodial staff will set up a separate partnership, which risks duplication and at worst a lack of information sharing. There must be clear links between community services and custodial services especially critical for entry into and transition from custodial settings.  The RCSLT recommends that the relationship between the two partnerships is strengthened and clear lines of input and contribution are detailed. |
| 108 | Royal College of Speech and Language Therapists | Statement 1 | The RCSLT recommends that the core group of representatives includes healthcare clinicians, not only service planners and managers. Clinicians have first-hand experience of working with people at risk of suicide and are well placed to advice. |
| 109 | Royal College of Speech and Language Therapists | Statement 1 | There is a lack of representatives to the Core Group from education settings and schools and we would recommend that this is added to the core group membership. |
| 110 | Suicide Crisis | Statement 1 | We agree that this is a key area for quality improvement. In Statement 1, NICE gives explicit guidance about who should be included in the core group of representatives in local suicide prevention partnerships. It is particularly significant that NICE has included a) voluntary and third sector organisations and b) people with lived experience.  In our county, as in some other counties, the local authority does not currently include a) voluntary or third sector organisations nor b) people with lived experience in this core group.  It would therefore be extremely helpful to have this NICE guidance recommending their inclusion.  We believe that it is important that lived experience is at the heart of decisions made about suicide prevention at county level. The expertise of people with lived experience should be included.  The absence of third sector representation means that our crisis service has no representation in this core group. We are a registered charity which runs a 24 hour crisis service (a combination of Suicide Crisis Centres, home visits and emergency phone lines for clients at risk of suicide). We frequently need to communicate with the mental health crisis teams and emergency services including the police. We are often working together in situations of immediate risk to life, as were last night. In our opinion, it would be good practice to include us in this core group. This would help facilitate good multi agency working and communication. It would also allow sharing of expertise and resources, which the NICE Quality Standard recognises. We have a zero suicide achievement: we have been providing services for six years and have never had a suicide of a client under our care. We are keen to share learning and gain learning from others in the core group.  The Quality Standard further recognises that organisations which have a “key role in suicide prevention in the community should have senior level representation”. This further emphasises the role of third sector crisis services in the core group.  In our opinion, it would be helpful if both a) people with lived experience of suicide attempts or suicidal thoughts and b) people who have been bereaved by suicide were included in the core group. The draft NICE Quality Statement currently recommends either/or and we would like to see it specified that both groups are included. We consider that the inclusion of both is important because of the different perspectives this may bring. We do recognise, though, that sadly many people will fall into both categories (i.e. they have been bereaved by suicide and have personal experience of suicidal thoughts or attempts). |
| 111 | The Samaritans | Statement 1 | Outcome c  The data used by Public Health England originates from ONS and can be accessed directly from ONS too. Should this be mentioned? |
| 112 | The Samaritans | Statement 1 | Statement  ‘Multi-agency suicide prevention partnerships’ should be re-worded as ‘multi-agency suicide prevention groups’. These groups are specific, local-authority led groups recommended in the Government’s National Suicide Prevention Strategy. There are, by contrast, many local suicide prevention partnerships across voluntary sector and others, which vary in purpose, set-up, and oversight. Our recommended wording is also in line with the PHE/NSPA guidance. [Local suicide prevention planning: A practice resource](https://www.nspa.org.uk/wp-content/uploads/2016/10/PHE_LA_guidance-NB241016.pdf). |
| 113 | The Samaritans | Statement 1 | Measure c  Amend to say “….. support people with a range of personal experience to be involved….”  It will be important for multi-agency groups to have a diversity of experience represented, for example, someone who has had suicidal feelings and attempted suicide, as well as someone who has been bereaved by suicide. It should seek to ensure that those involved are representative of people who take their own life, regarding gender, race, socio-economic status, and other characteristics.  These points should also be reflected under ‘Equality and diversity considerations’. |
| 114 | The Samaritans | Statement 1 | Outcomes a, b and c)  Whilst these measurables (rates of admissions, self-harm and suicide rates) are the ultimate outcome measure for partnerships, it would be useful to include some more direct measurables, such as how often the partnerships are meeting and whether they have a plan in place that is being monitored for delivery. |
| 115 | The Samaritans | Statement 1 | What the quality statement means for different audiences  There should be a section for organisations involved in points of transition for young people; for example, schools and universities. |
| 116 | The Samaritans | Statement 1 | What the quality statement means for different audiences  This should include text on how to safely involve people with lived experience. This means having a screening process in place to try and ensure that involvement will be safe for people, training for people on how to use their personal experience effectively, induction into the group and that there is on-going support for their mental health and well-being. |
| 117 | The Samaritans | Statement 1 | Definition of terms used in this quality statement  It should be specified that ‘senior representatives’ rather than just ‘representatives’ should be included. |
| 118 | The Samaritans | Statement 1 | Definition of terms used in this quality statement  This should include a definition of “support for people with lived experience”, which should include for example payment for time to cover loss of earnings or child care, and travel expenses. This is likely to be a fundamental part of ensuring diversity of membership. |
| 119 | Tower Hamlets Public Health, London Borough of Tower Hamlets | Statement 1 | * Under core groups representatives, there is no mention of the Homelessness Team in Local Authorities and the Supported Accommodation Commissioners (Comment by multi-agency steering group in Tower Hamlets - the Homeless Options Housing Team) |
| 120 | Tower Hamlets Public Health, London Borough of Tower Hamlets | Statement 1 | Outcome b   * It is unclear how the rate of self-harm as an outcome could be used to measure the effectiveness of multi-agency partnerships. * Some aspects of suicide prevention can be delivered effectively at the local level. However, some aspects of suicide prevention are more effective at a sub-regional or regional level. The quality standards should include reference to how partnership and governance arrangements should be established at a local, STP and regional level. * Agreed it is important to have people with lived experience represented on the steering group. Guidance on what would constitute a quality programme of induction and support would be beneficial. |
| 121 | Festival of Life and Death | Statement 1 - Question 4 | ABSOLUTELY NOT. Local authorities are under-funded, under-resourced, and generally not the right organisations to set up and lead suicide prevention partnerships on an exclusive basis. Suicide prevention needs to be joined up, innovative, creative, deeply insightful. For very understandable reasons, local authorities and their leaderships are not characterised by these qualities. If you examine the best practice in suicide prevention it is not led and innovated and provided by institutions, and certainly not by councils or institutional agencies. Suicide prevention is best innovated and served by creatives and empaths, healers and servant leaders, supported by rigorous admin, data, reporting, etc. Of course local authorities need to be deeply involved, but ideally we need a national suicide prevention agency, to join everything together. ThriveLDN.co.uk is perhaps the model. This opportunity is additionally emphasised by the need to 'join up' councils, health services, police, fire, Gps, education, transport, environment, nature/parks, judiciary, BAME, LGBT, youth, arts, religion, lived experience, giftedness/autism/aspergers, dementia, abuse victiims, etc, and especially TO JOIN UP THE TERRIBLY DISJOINTED PAROCHIAL SILO-BASED LOCAL AUTHORITIES (for example 'doughnut' city/county authorities) where generally nobody talks tyo anybody outside of their own department or geographical remit. Local authorities are by nature focused on process within boundaries and budgets, which is not the skill-set required for inspirational humanity-based innovations, coopererations, communications , etc. Suicide prevention and the MH/physical health iceberg beneath it requires a multi dimensional total quality management approach, rather like designing airplanes and running an airline. This is not the culture or skills of local authorities. We will prevent suicides when it becomes everyone's business to share some responsibility for our follow human beings – especially to help people stay well when crisis threatens, and also to support when crisis deepens. There is a vast population of lived experience helpers out there, covering every possible entry combination to suicidal risk. We must be much more creative in empowering this fabulous resource. |
| 122 | Derbyshire Healthcare NHS Foundation Trust | Statement 1 – Question 4 | Local Authorities are not the only organisation type to lead suicide prevention strategy groups e.g. We understand Grassroots lead one in East Sussex, and an individual bereaved by suicide leads Haringey’s strategy group (of which the local authorities are members). |
| 123 | Institute for Mental Health, University of Birmingham | Statement 1 – Question 4 | Local authorities should not be the only organisation responsible for setting up suicide prevention partnerships in the community. For example, healthcare providers such as mental health trusts should also set up suicide prevention partnerships and have a dedicated suicide prevention strategy and action plan. However, these should be linked to the activities of local authorities; there should be clear structure for working with other agencies to support the implementation of a strategy and contribute to the wider local suicide prevention agenda. |
| 124 | LGBT Foundation | Statement 1 – Question 4 | Local authorities should be ultimately responsible for setting up suicide prevention partnerships. However these partnerships should be led based on significant input from actors in the community. It should be ensured that professionals in the voluntary sector are well represented and are able to provide significant input into the groups. It should be ensured that these professionals come from a range of voluntary sector organisations that support a range of groups. It should be ensured that experts by experience have a range of opportunities to feed into and contribute towards these partnerships. Experts by experience must be reimbursed for their travel and time. These meetings must be held at a range of times so that people with a range of employment/ careering/ education commitments are able to attend and contribute. |
| 125 | NHS England – Mental Health team | Statement 1 – Question 4 | * Local authorities are not the only organisation, but they are potentially best placed. This could be with the backing of health and wellbeing boards, which will also have a children and young people’s board. It is essential that there is a specific focus on children and young people if they are to be included. * There should be more mention of the “think family” agenda, particularly where family and/or children are indicated as a protective factor. There is also a need to include universities and university wellbeing services within the suicide prevention partnerships. * Children and Young People's Mental Health Services and MH support teams in schools and colleges should also be involved. * Public Health England may have a role for this in the community. |
| 126 | Royal College of Psychiatrists | Statement 1 – Question 4 | It makes sense for partnerships to be led by local authorities. However other groups and organisations may have delegated roles and responsibilities for example local areas may have existing partnerships established e.g. Healthy London partnership. Also devolved authorities e.g. Manchester have established groups as part of this process including NHS, Social care and voluntary sector organisations. Suicide prevention can be added to existing work of local networks. |
| 127 | Tower Hamlets Public Health, London Borough of Tower Hamlets | Statement 1 – Question 4 | * Are local authorities the only organisation responsible for setting up suicide prevention partnerships in the community, would this not be better as a shared responsibility with the Police, CCG, acute NHS etc? * In reference to are LAs the only ones responsible for setting up partnerships – addressing suicide prevention requires a partnership approach however I think there does need to be shared responsibility for the strategic lead between the CCG and Local Authority |
| 128 | Network Rail on behalf of the Rail Industry | Statement 1- Question 4 | We don’t believe that local authorities are the only organisations that should be drawing multi agency groups together, these can be led by specialist groups to whom suicides present a unique and special challenge at high risk locations e.g. the rail industry.  Currently within the rail industry though resources don’t exist to progress this approach on a large scale although specialist work in this area has taken place and the industry delivers a holistic programme of suicide prevention |
| 129 | Public Health England and NHS England/Improvement | Statement 1- Question 4 | No – this is not solely the responsibility of Local Authorities and therefore should be reflective of the comments above. |
| 130 | Stoke on Trent and Staffordshire Suicide Prevention Group, Harplands Hospitals | Statement 1- Question 4 | I don’t think that Local authorities are the only organisations responsible for setting up suicide prevention partnerships i.e. there are others such as CCGs and Mental health provider trusts etc – however I do feel as though public health teams within local authorities are very well placed to take this role. Mostly since PH teams sit within local authorities, which include commissioners for services such as drug & alcohol prevention/treatment, and links with coroners as well as a variety of other partner organisations,there was no reference to community capacity building or training with GPs etc. |
| 131 | Bolton Community and Voluntary Services | Statement 2 | This can be done in certain cases where the methods of suicide are public, however it may be out of the control of the partnership and difficult to influence. Access to local intelligence may also be delayed. The Quality Standard could include how the partnership influences reducing access to methods of suicide. |
| 132 | Bolton Suicide Prevention Steering Group | Statement 2 | This can be done in certain cases where the methods of suicide are public, however it may be out of the control of the partnership and difficult to influence. Access to local intelligence may also be delayed. The Quality Standard could include how the partnership influences reducing access to methods of suicide.  An understanding of local suicide trends will help suicide prevention partnerships to prioritise what action they need to take. Data systems may cause some challenges, however formal protocols would support in ensuring there is a better co-ordinated approach. This is important for risk reduction and enabling a preventative approach, though requires a true partnership with everybody actively onboard.  Coding for ‘attempted suicides’ and self-harm etc. is pretty good in secondary care data however those individuals who are unfortunately successful in the task of suicide out in the community don’t make it onto the hospital dataset and CCG can’t access the mortality files to get total number.  We need a ‘local’ self-harm/suicide risk register which can be added to by a number of services who feel an individual needs additional support/monitoring.  The ‘register’ could have review periods of weekly monthly quarterly for review and I expect some individuals will remain on the list indefinitely and others may drop off after a stable period e.g. 2 years no concern.  There would need to be a threshold applied to the data as someone self-harming for the first time may not progress to suicidal thoughts but someone who has had 3 or more occurrences within past 2 years could be more likely.  But on the other hand the person showing up in A&E for the first self-harm may be due to them not being caught/injured enough in previous unreported self-harm instances. Tricky to judge who would be added or not.  Anyone who is deemed at risk would need a basic minimum dataset completing about who added them, why they were added, who is reviewing them, when the next review is due, who to contact in emergency, etc..  There may be an option to include people who have recently been removed from or reduced antipsychotic medication who may need to be loosely added for a shorter period to monitor side effects.  The governance of this would be challenging though as nobody at the CCG could potentially use it, the ‘register’ would need to be like the Bolton Care Record and only available to professionals but would need to ‘accept’ people from all providers (e.g. Samaritans) |
| 133 | College of Mental Health Pharmacy | Statement 2 | We agree that local intelligence regarding methods is important. In relation to medicines, there are no clear processes in place for community pharmacists, GPs, hospital or GP pharmacists and A&E practitioners to share these emerging trends at a local level. It is worth exploring whether an existing system (such as error reporting) could be adapted to share this information in real time. |
| 134 | College of Mental Health Pharmacy | Statement 2 | In relation to restricting access to painkillers, we need to think about where these can be obtained outside of pharmacy (e.g. petrol station, supermarket, budget shop) and consider safeguards in place to stop excessive sales (e.g. till alerts). It is worth noting that the CCG guidance you cite to support this statement may not be the best way to describe this. This is more about cost efficiency and if people are not prescribed painkillers, they may legitimately need to buy them. We need to bear this in mind too, for a sensitive risk-benefit balance approach. |
| 135 | Communication Workers Union | Statement 2 | For example, employers can support the aim of reducing access to methods of suicide and reducing the opportunity for suicide in locations where suicide is likely, such as in the workplace. They can assist in providing information about how and where people can get help when they feel unable to cope and taking measures to monitor those who may need help. |
| 136 | LGBT Foundation | Statement 2 | Structure a)  In order for multi-agency suicide prevention partnerships to effectively collect and analyse local data to inform the approach to reducing access to methods of suicide, community asset mapping must be carried out. This will reveal what measures are already in place to reduce access to methods of suicide. What measures have and haven’t worked needs to be looked at and what measures can be improved must be taken into account. This community asset mapping must look at work being done by a range of organisations, including the voluntary sector, in order to get a complete picture. |
| 137 | Maternal Mental Health Alliance (MMHA) | Statement 2 | Audience descriptor: Not specifying the inclusion of people with relevant perinatal mental health expertise is likely to exacerbate the inadequacy of preventive actions. |
| 138 | National Suicide Prevention Alliance (NSPA) | Statement 2 | What the quality statement means for different audiences  There should be reference to multi-agency groups working with national organisations, particularly where the infrastructure used is administered by such an organisation. Such organisations might include our members Network Rail and Highways England, who are already doing work to gather data that would be of help to local multi-agency groups. It might also include private companies responsible for a high-risk location. |
| 139 | National Suicide Prevention Alliance (NSPA) | Statement 2 | Outcomes  The statement only mentions suicides at high-frequency locations, which are only responsible for some deaths. The outcome should recognise other methods, too, for example by using a count of suicides broken down by method should. The data sources for this would be real time surveillance and suicide audits. |
| 140 | National Suicide Prevention Alliance (NSPA) | Statement 2 | What the quality statement means for different audiences  There should be recommendations for health professionals, including those prescribing or dispensing medication which could be used for the purpose of suicide. |
| 141 | Network Rail on behalf of the Rail Industry | Statement 2 | It also ignores that reducing access to methods of suicide is not always possible (Quality statement 2 – page 9).  Subsequently there is a possibility that the methods of prevention in these circumstances will be ignored |
| 142 | Network Rail on behalf of the Rail Industry | Statement 2 | Reference should be made to sources of data that could act as barometers for suicidal behaviour across a community at large.  For example, the British Transport Police collects data on suicide events in real time, and a mechanism exists to share this locally with local authorities when a high-risk location is identified. |
| 143 | NHS England – Mental Health team | Statement 2 | Audience descriptor  More broad information could be added on how suicide prevention partnerships could support individuals (and organisations) to gain access to relevant mental health care from the NHS i.e. identification and signposting in primary care. |
| 144 | North West Ambulance Service NHS Trust | Statement 2 | North West Ambulance Service supports the view that reducing access to methods of suicide is important to include with the quality standards. |
| 145 | North West Ambulance Service NHS Trust | Statement 2 | We would advocate that multi agency suicide prevention partnerships collect and analyse ‘real time local data’ to understand and learn in a timely way with the aim to reduce suicide locally. We also would advocate that a mechanism is in place to learn from local data nationally. |
| 146 | North West Ambulance Service NHS Trust | Statement 2 | North West Ambulance Service would advocate the use of safe and appropriate prescribing of analgesics but feels that consideration should be given to other medicines that would cause toxicity in overdose with this patient group. |
| 147 | Public Health England and NHS England/Improvement | Statement 2 | This is assuming that there is local intelligence, either through Real Time Surveillance or with cooperation with the Coronial processes. Each Coroner approaches this in a different way, some will not allow suicide audits to be completed, some will not allow the police to share information to agencies around suspected suicides until a Coroner rules. Some however have in place RTS and review all suspected suicides, to support Postvention Bereavement Support and the identification of clusters, themes, methods and locations. There should be clarity within the quality standard for the requirement of information sharing sooner rather than later for the reasons included above. There is agreement with the Rationale and Quality Measures, however until the need for data to be shared is explicit and timely, many areas will struggle meeting this Statement. It may be that there are more informal ways of gathering information or working with first responders. |
| 148 | Royal College of General Practitioners | Statement 2 | What the quality statement means for different audiences  We suggest amending ‘safely prescribing painkillers’ to ‘restricting access to painkillers’  Reducing prescribing of Tricyclic antidepressants could also be referred to here  Chew-Graham CA, Morgan C, Webb RT, Emery E, Carr MJ, Kontopantelis E, Yung AR and Ashcroft DM. Reducing risk following self-harm – the need for careful prescribing Br J Gen Pract 2019; 69 (682): 224 225. DOI: <https://doi.org/10.3399/bjgp19X702317> |
| 149 | Suicide Crisis | Statement 2 | We consider this Quality Statement to be of vital importance. |
| 150 | Suicide Crisis | Statement 2 | Audience  We would just like to make a comment about the role of the public. As well as suicide prevention partnerships informing the public that local organisations are working together to prevent suicide in locations where particular risks have been identified, and are working to reduce access to suicide methods, the public can also be a vital part of the local intelligence gathering about access to suicide methods. They can play an active role. This may happen in local psychiatric hospitals, for example, where it is vital to reduce access to items which could be harmful or indeed lethal for patients on the wards. A parent or carer visiting the ward may express a concern that there are items which are being routinely used on the ward which could be harmful (or which could be used as a suicide method). Or they may see that such items are being regularly brought onto the ward by visitors.  This intelligence from a member of the public may be communicated to statutory or third sector organisations but could be communicated by the member of public directly to the suicide prevention partnership.  In 2017 it was identified by a jury at an inquest that an item routinely used on a psychiatric hospital ward was one of two items used by a patient to end her life. This shows that a hospital may not itself identify the risk or the need to limit access to an item. The item has now been removed from the psychiatric hospital and is no longer used there.  Subsequently, a parent visiting the psychiatric hospital noticed that there appeared to be an omission on the list of restricted items for visitors to the psychiatric intensive ward (PICU). He was aware that visitors sometimes bring onto the wards items similar to the one which was used by the patient who had died by suicide. He raised this with us and the hospital.  From time to time clients of ours (or their families and carers) communicate information to our organisation about access to potentially lethal means in a variety of settings. This includes information about safe/unsafe prescribing. Therefore we see clients and their families as playing a vital role in relation to this issue. |
| 151 | The Samaritans | Statement 2 | Quality statement  The phrase “reduce access to methods of suicide based on local intelligence” is misleading. There is a clear evidence base around how to reduce access to certain methods of suicide which should be used to inform action. Local intelligence is useful to inform which particular methods are used in that community. Therefore the statement should be reworded as “Multi-agency suicide prevention groups reduce access to methods of suicide used in their locality”. |
| 152 | The Samaritans | Statement 2 | Rationale  The same point made above applies. The “local suicide trends will help suicide prevention groups to prioritise what action they need to take” – this should be reworded as “local suicide trends will help suicide prevention groups to prioritise what methods they should focus on”. The action taken should be informed by the evidence base around what works. |
| 153 | The Samaritans | Statement 2 | Quality measures, structure, a  The same point made above applies: the approach should be informed by the existing evidence base. The local data should be used to inform which methods to focus on. |
| 154 | The Samaritans | Statement 2 | Quality measures, structure, a, data source  In the same section, under ‘Data source’, we recommend that ‘suicide audit report’ is removed or that it is included in “definition of term”. The PHE/NSPA local suicide prevention planning guidance recognises that “’The term suicide audit can mean different things. Some people use the term to describe the analysis of any available data on their local area. For others, a local suicide audit involves a review of coroners’ records, often supplemented by collection of data from primary and secondary care and other services” (p24) |
| 155 | The Samaritans | Statement 2 | Quality measures, structure, data sources b and c  These should refer to local suicide prevention action plan’, rather than ‘suicide action plan’ for consistency. |
| 156 | The Samaritans | Statement 2 | Quality measures, outcome a  The statement only mentions suicides at high-frequency locations. Many suicides occur away from high-frequency locations. The outcome should recognise these other methods, too. A count of suicides broken down by method should be used. The data sources for this would be real time surveillance and suicide audits. |
| 157 | The Samaritans | Statement 2 | What the quality statement means for different audiences  There should be reference to multi-agency groups working with national organisations, where the infrastructure used is administered by such an organisation. Such organisations might include Network Rail, Highways England, or a private company managing a space where there is access to a large drop that can be used for suicide attempts. |
| 158 | The Samaritans | Statement 2 | What the quality statement means for different audiences  Under the same heading, in the section on ‘people in the community’: we do not agree that members of the community need to know that people are being kept safe at places where suicide is more likely. This could be interpreted as needing to publicise actions being taken at these places. The evidence shows that this is risky and locations should not be advertised. It is not clear that the section for this audience is required at all. |
| 159 | The Samaritans | Statement 2 | What the quality statement means for different audiences  This should include residential custodial or detention providers. It should also include anyone prescribing medication which could be used for the purpose of suicide. |
| 160 | Tower Hamlets Public Health, London Borough of Tower Hamlets | Statement 2 | * Access to data is a significant inhibiter to action on suicide prevention in Tower Hamlets. Greater clarity on the role of the coroner to work in real time to identify local patterns in suicide method and location would be welcome. * Thrive London were due to launch an information sharing hub in Spring 2019. This hub will be the first of its kind in London and has been developed with partners to enable agencies in London to more effectively: (1) Provide bereavement support; (2) Plan and implement short-term interventions and (3) Plan and implement long-term preventative interventions. The launch of this data hub is understood to have been delayed owing to GDPR and uncertainty around data sharing with relatives of the deceased. * Noted also that Thrive London do not seem to have been listed as partner to have contributed to the quality statement development, but are a key partner in delivering Statement 2 for London. |
| 161 | Bolton Community and Voluntary Services | Statement 3 | This should be included in any quality framework – as it has a significant influence on how people perceive and respond to suicide within communities. We need to change the conversation and respond to suicides in a different way in the media and in our conversations. It would be possible to measure the existence of a local media plan but more difficult to measure its effectiveness and whether a different approach was being taken. This quality standard could go beyond traditional local media and consider how organisations across the sectors report and discuss suicide. |
| 162 | Bolton Suicide Prevention Steering Group | Statement 3 | This should be included in any quality framework – as it has a significant influence on how people perceive and respond to suicide within communities. We need to change the conversation and respond to suicides in a different way in the media and in our conversations. It would be possible to measure the existence of a local media plan but more difficult to measure its effectiveness and whether a different approach was being taken. This quality standard could go beyond traditional local media and consider how organisations across the sectors report and discuss suicide.  This standard is important and can have both a positive or negative impact on communities. There is enough guidance on sensitive suicide media reporting to develop a very simple training/awareness induction for all staff working in marketing and communication and the media. This should be mandatory on recruitment of a post. |
| 163 | Gloucestershire County Council | Statement 3 | Measure - outcome  This outcome might be difficult to quantify due to the amount of resources needed to audit local media reports to identify those that meet best practice. Will a definitive document on what amounts to best practice be produced, or will it be the Samaritans Media Guidelines? Will the requirement for articles to meet best practice be championed by NICE and other equivalent organisations to help local suicide prevention partnerships? Also, with digital media, it could mean that articles are updated after they have been audited and no longer meet best practice. Will the auditing of articles be a mandatory requirement? |
| 164 | LGBT Foundation | Statement 3 | An additional measure that needs to be added to statement 3 is that it needs to be ensured that local media plans are created based on significant input from a range of diverse actors in the community. This is to ensure that media plans are as comprehensive as possible and will ensure that the media is able to report suicide in a way that is respectful to a range of people and identities.  For example LGBT people and organisations need to have an input to ensure that when the media discusses the suicide of an LGBT person this is done following best practice. For example it needs to be ensured that LGBT identities are not pathologised. The narrative that someone has died by suicide because they are LGBT needs to be moved away from. Instead, when relevant, it needs to be made clear that people die by suicide due to poor treatment and discrimination based on their LGBT identity.  The recent Greater Manchester suicide prevention campaign ‘Shining a Light on Suicide’ is a great example of best practice of a media campaign on suicide. It engaged with experts from experience, worked to break down stigma and encouraged people to talk. This campaign included a diverse range of people and included examples of what causes people to contemplate suicide. Although this was a campaign and not a media report it contained stories from people who had been affected by suicidal thoughts, therefore when media plans are created this can be an example of a good way in which to talk about and report suicide. |
| 165 | Maternal Mental Health Alliance (MMHA) | Statement 3 | Definitions - Best Practice: The media must be guided to not use the term ‘committed’ suicide and instead use an alternative method of reporting for example ‘died by’ suicide or another description |
| 166 | National Suicide Prevention Alliance (NSPA) | Statement 3 | What the quality statement means for different audiences  For ‘Multi-agency suicide prevention partnerships [groups]’ there should be recognition that the evidence shows that it is detailed depictions of suicide methods, or inclusion of novel suicide methods, that increase risk, and that stories of hopeful recovery with signposting to support can be helpful in preventing suicides. |
| 167 | National Suicide Prevention Alliance (NSPA) | Statement 3 | Definitions of terms  The order of the bullet points should reflect priority according to the best available evidence. We suggest:   * avoid presenting detail on methods; * reduce speculative reporting; * provide stories of hope and recovery and include signposting to support; * use sensitive language that is not stigmatising; * avoid using photos or language that is distressing to people who have been affected. |
| 168 | North West Ambulance Service NHS Trust | Statement 3 | North West Ambulance Service would support the view that Multi Agency Suicide Prevention Partnerships have a local media plan that identifies how they would share information and that this is based on best practice. We would suggest that one organisation takes the lead for this area and communicates with other agencies that are in the partnership. |
| 169 | Olly’s Friendship Foundation | Statement 3 | Definitions  Use sensitive language that is not stigmatising or JUDGEMENTAL or in any way distressing to people who have been affected |
| 170 | Olly’s Friendship Foundation | Statement 3 | Definitions  ADD –Consult with the bereaved at inquests etc to obtain any special requests from them before reporting |
| 171 | Public Health England and NHS England/Improvement | Statement 3 | Should the risk factors from the WHO guidance be included within this document? |
| 172 | Public Health England and NHS England/Improvement | Statement 3 | Agree with this statement however there is a resource required, not just to have a media plan but also to actively monitor media reporting. There is some confusion around the role of the Samaritans, given that they have a media unit, however through discussions with them, they have confirmed that there is not enough resource to review all publications locally. Therefore there could be some confusion around who should provide feedback and what the messages should be. |
| 173 | Royal College of General Practitioners | Statement 3 | The focus appears to be on local media here, more consideration needs to be given to national media and social media. As mentioned, important for local media to receive specific training. |
| 174 | Royal College of Speech and Language Therapists | Statement 3 | We recommend that the local media plan must consider both hard and electronic media. |
| 175 | Royal College of Speech and Language Therapists | Statement 3 | Best practice in suicide reporting needs to highlight the need to write in an accessible manner that people can access and understand which is especially important for people with communication difficulties or low health literacy. At-risk people are vulnerable and care must be taken in the language used. |
| 176 | Royal College of Speech and Language Therapists | Statement 3 | Messaging needs to be tailored and adapted for children and young people and people in custodial settings who have lower vocabulary skill levels. |
| 177 | The British Psychological Society | Statement 3 | We acknowledge that internet safety is covered elsewhere, but we believe that Statement 3 could be amended to include all types of reporting, including online. |
| 178 | The Samaritans | Statement 3 | What the Quality statement means for different audiences, local media journalists and editors.  Change to: ‘Editors and journalists work with Samaritans Media Advisory team and the local suicide prevention group media lead, to increase awareness of best practice and improve reporting standards.’ |
| 179 | The Samaritans | Statement 3 | Quality statement  Instead of ‘Multi-agency suicide prevention partnerships have a local media plan that identifies how they will encourage journalists and editors to follow best practice in suicide reporting’ the words after ‘best practice’ should be replaced with ‘when reporting about suicide and suicidal behaviour’. This more accurately describes the sort of reporting that is relevant. |
| 180 | The Samaritans | Statement 3 | Rationale  The phrase ‘insensitive reporting’ should be changed to ‘irresponsible reporting.’ Insensitive reporting may be distressing to readers and whilst this is important, ‘irresponsible reporting’ is a more accurate phrase for material which may influence further deaths because it gives information on methods, glamorises suicide, or is otherwise dangerous. |
| 181 | The Samaritans | Statement 3 | Outcome, data source  Samaritans monitors local, regional and national media and maintains a data set of media reports about suicide and suicidal behaviour. We already get in touch with journalists and editors when reporting is irresponsible. Partnerships should be working with Samaritans when they have concerns, rather than duplicating the monitoring and engagement work we already carry out. |
| 182 | The Samaritans | Statement 3 | What the Quality statement means for different audiences  Under ‘Multi-agency suicide prevention partnerships in the community’ there should be recognition that the evidence shows that it is detailed depictions of suicide methods, or inclusion of novel suicide methods, that increase risk, and that stories of hopeful recovery with signposting to support can be helpful in preventing suicides.  We recommend the last sentence be amended to ‘Partnerships engage with journalists and editors to provide positive stories of actions in place to prevent suicide and stories of hope and recovery. Partnerships engage with Samaritans Media Advisory Service where reports include details that may increase risk of suicide contagion, and also to ensure local media is being trained in responsible reporting.  We are concerned that any contact following up articles focuses on evidenced risk and avoids the possibility of editors and journalists feeling “harangued” which may lead to disengagement of media. |
| 183 | The Samaritans | Statement 3 | Definitions of terms  The order of the bullet points should be changed to reflect the evidence base, as follows: “avoid presenting detail on methods; reduce speculative reporting; provide stories of hope and recovery and include signposting to support; use sensitive language that is not stigmatising; avoid using photos or language that is distressing poses risk to people who have been affected.’ |
| 184 | The Samaritans | Statement 3 | Definitions of terms  The order of resources referred to on page 14 should be changed, so that the WHO guidance is last, given the greater relevance of UK resource for this audience. |
| 185 | Tower Hamlets Public Health, London Borough of Tower Hamlets | Statement 3 | * Resources would also include the ongoing funding for a role to review the media and undertake regular audits to identify irresponsible reporting. |
| 186 | Bolton Community and Voluntary Services | Statement 4 | People with active suicidal thoughts or plans are asked if they would like their family or carers to be involved in their care and made aware of the limits of confidentiality. This should be included in the quality standards but would again be difficult to measure. We also need to consider how staff are trained to have these conversations. It needs to be clearer who would be required to ask this questions – statutory mental health services, community and voluntary sector mental health services? How are Carers involved in a meaningful way and given the right support? |
| 187 | Bolton Suicide Prevention Steering Group | Statement 4 | People with active suicidal thoughts or plans are asked if they would like their family or carers to be involved in their care and made aware of the limits of confidentiality. This should be included in the quality standards but would again be difficult to measure. We also need to consider how staff are trained to have these conversations. It needs to be clearer who would be required to ask these questions – statutory mental health services, community and voluntary sector mental health services? How are Carers involved in a meaningful way and given the right support? Family and carers involved in the care and support of their loved ones is positive if the relationships are good, therefore confidentiality should always be adhered to. However, if those with suicidal thoughts consent to their loved ones being involved, families and carers should be supported on how to have positive conversations and how to access appropriate and timely support. Families and carers could also feel the emotional stress of their loved ones. Support to also be offered to families. |
| 188 | College of Mental Health Pharmacy | Statement 4 | It is very helpful to have guidance regarding confidentiality and involving families and carers. This also links to safeguarding. Can we please urge the relevant processes and contacts (including safeguarding) to be disseminated to all healthcare sites and for a process to be in place out of hours? For example, a community pharmacist might be the only healthcare professional available out of hours. |
| 189 | Derbyshire Healthcare NHS Foundation Trust | Statement 4 | Process  Whether people experiencing suicidal thoughts have been asked about family and carer involvement is not currently measureable. Direction of what data to record and when will need to be made explicit to care providers (e.g. through professional body guidelines/standards) and data sharing agreements set up to allow the sharing of aggregated data between care providers and the suicide prevention strategy group lead organisations. Audits of patient records would find that data was missing in the majority of cases and care would need to be taken not to interpret missing as not offered/discussed. |
| 190 | FFLAG – Families and Friends of Lesbians and Gays | Statement 4 | Rationale and process  Family rejection, or fear of family rejection, with concomitant feelings of worthlessness or shame, is a significant driver of suicidal impulse in LGBT people, especially the young. Involving family and carers where rejection is feared by the person at risk (especially if this information is shared against the person’s wishes) needs co-ordinated and specialist support to deal with potentially adverse reactions. |
| 191 | Gloucestershire County Council | Statement 4 | Statement  This statement needs to be clearer. Who do you mean by ‘people with active suicide thoughts or plans’ are you talking about people open to mental health services? If so this needs to be a quality standard which is owned by the provider, or the commissioners of the provider (CCG), through the zero suicide ambition rather than the wider suicide prevention strategy. Or do you mean anyone who has come into contact with any service (e.g. hospital, primary care, voluntary sector, school nursing). If so this will be very difficult to influence all of this and collect data on it – what is the incentive for providers to inform us? The data collection would require a lot of resource. We also question whether the consensus statement is fit for purpose, as it is not clear enough to support clinicians to change practice around information sharing. |
| 192 | Gloucestershire County Council | Statement 4 | Process – involving parents/carers in their care  This process might be difficult to quantify due to the amount of resources needed to audit patient records to identify those patients that have been asked if they would like their families/carers involved in their care. This would also require change with each professional supporting individuals to ensure that this question is asked and that the patient’s response is recorded in their records. Will the auditing of patients records be a mandatory requirement? |
| 193 | Gloucestershire County Council | Statement 4 | Process – making aware of the limits of confidentiality  This process might be difficult to quantify due to the amount of resources needed to audit patient records to identify those patients that have been made aware of the limits of confidentiality. This would also require change with each professional supporting individuals to ensure that patient has been informed and that this is recorded in their records. Will the auditing of patients records be a mandatory requirement? |
| 194 | Institute for Mental Health, University of Birmingham | Statement 4 | Structure  Our research (Michail et al, 2016) has identified that GPs face particular challenges in two areas: 1) building rapport with young people at-risk of suicide; and, finding the most appropriate way of asking sensitive questions about suicide risk particularly when young people were accompanied by a parent; 2) balancing confidentiality and disclosure of risk when  working with at-risk young people, particularly those under 16. The educational resource we have developed in collaboration with the RCGP titled “Suicide in Children and Young People: Tips for GPs”, which can be accessed here https://www.rcgp.org.uk/clinical-and-research/about/clinical-news/2018/february/mental-health-in-young-people-top-tips-  for-gps.aspx), provides evidence-based recommendations to GPs about information sharing and confidentiality in consultations with vulnerable young people. We recommend that all GPs use this resource in clinical practice. |
| 195 | LGBT Foundation | Statement 4 | Rationale  In order for this statement to accurately and fully reflect a key area for quality improvement it must be stated that when involving families, partners and carers the potential presence of domestic abuse must be considered. If this is the case involving families or carers may not be appropriate and could worsen the situation. This must be considered in same gender relationships where signs may be harder to spot, partly due to assumptions that domestic abuse is only perpetrated by men and only women experience domestic abuse. |
| 196 | LGBT Foundation | Statement 4 | Rationale  It must be ensured that adequate care is offered to carers and families who may need support, this is especially important for young carers. |
| 197 | Maternal Mental Health Alliance (MMHA) | Statement 4 | Measures and audience descriptor: The specific needs of the whole family unit and/or carers with reference to maternal suicide prevention requires specific expertise. |
| 198 | National Suicide Prevention Alliance (NSPA) | Statement 4 | Statement, rationale, quality measures, what the quality statement means for different audiences  Neither in the statement (People with active suicidal thoughts or plans are asked if they would like their family or carers to be involved in their care and are made aware of the limits of confidentiality) nor in the rationale or quality measures it is mentioned that, having asked about family or carers being involved, that someone should be responsible for making that contact, if appropriate. It is the first outcome measure, but would be valuable to be part of the standard itself and quality measures. |
| 199 | National Suicide Prevention Alliance (NSPA) | Statement 4 | Audiences  Under ‘service providers’: this should only apply to those providers who have a statutory duty of care. Many of our voluntary sector members have different policies in place around confidentiality, for good reasons, that enable people to reach out to and work with them when they may have concerns about the statutory sector. |
| 200 | National Suicide Prevention Alliance (NSPA) | Statement 4 | Statement  The quality statement could have the addition ‘and if there is agreement to involve family or carers, it is clear who will contact them’ |
| 201 | National Suicide Prevention Alliance (NSPA) | Statement 4 | Rationale  A sentence could be added, such as ‘Contacting family and carers, if agreed to, is a delicate but crucial action, and responsibility for that needs to be clear, and held by someone with the appropriate skills and information.’ |
| 202 | National Suicide Prevention Alliance (NSPA) | Statement 4 | Quality measures, structure  Item d) could be: Evidence of local processes to ensure that any agreement is recorded and acted upon by a suitable individual. |
| 203 | National Suicide Prevention Alliance (NSPA) | Statement 4 | Quality measures, process  Item d) could be: Proportion of families or carers contacted, if agreement to do so given or deemed appropriate |
| 204 | National Suicide Prevention Alliance (NSPA) | Statement 4 | What the quality statement means for different audiences  For service providers, the sentence ‘Providers ensure that if the person wants their family or carers involved in their care, the nature of their involvement, including how and when information is shared with them, is agreed’ ends with the phrase ‘is agreed, recorded and acted upon’ added. |
| 205 | National Suicide Prevention Alliance (NSPA) | Statement 4 | Outcomes  The satisfaction of people with suicidal thoughts or plans themselves should be included, either in outcome c) or in a separate outcome. |
| 206 | NHS England – Mental Health team | Statement 4 | * Structure   (a) Data source: Local data collection, for example, staff training records   * + Staff training records would not contain the necessary information.   (b) Data source: Local data collection, for example, local protocol and  (c) Data source: Local data collection, for example, local protocol   * + Local protocols do not demonstrate implementation.   Process of sampling case notes – identification of suitable cases is difficult, and the methodology is not feasible in identifying a denominator (the number of people with suicidal thoughts) |
| 207 | NHS England – Mental Health team | Statement 4 | Audience descriptor   * More broad information could be added on how suicide prevention partnerships could support individuals (and organisations) to gain access to relevant mental health care from the NHS i.e. identification and signposting in primary care. |
| 208 | North West Ambulance Service NHS Trust | Statement 4 | North West Ambulance Service strongly believe that people with active suicidal thoughts or plans are asked if they would like their family or carers involved in their care and are made aware of the limits of confidentiality. In terms of what the quality statement means for different people, North West Ambulance Service feels that Ambulance Providers should be included. We would advocate that consideration is given in relation to how this information is shared across organisations. |
| 209 | North West Ambulance Service NHS Trust | Statement 4 | In terms of limits of confidentiality we would advocate that this guidance considers the sharing of information on risk with those close to the patient even if the patient is assessed to have capacity (Within the context of legislation) |
| 210 | Olly’s Friendship Foundation | Statement 4 | What the quality statement means for different audiences  There is a distinct conflict between confidentiality and the possible inability of the person feeling suicidal, at that time, to assess information and make rational decisions. An amendment is required to each of these clauses so that Parents are informed as they may be able to provide additional information and support. This would also help to prevent the situation where the first the Parents know about the situation is when a policeman knocks at the door to say they have found the body of their son or daughter. |
| 211 | Olly’s Friendship Foundation | Statement 4 | People who feel suicidal  ADD- A person feeling suicidal needs to be treated with compassion, understanding and kindness and families and carers need to feel supported and able to challenge the system where this is not happening. |
| 212 | Public Health England | Statement 4 | Involving family or carers – PHE recommends providing another option that is for contact to be made to a trusted friend, who is neither family nor carer. |
| 213 | Public Health England and NHS England/Improvement | Statement 4 | Statement 4 – People with ‘active’ suicidal thoughts – does this mean individuals who have actively made attempts or is it that they have suicidal ideation. Could we clarify as active could mean different things in different settings. |
| 214 | Public Health England and NHS England/Improvement | Statement 4 | Again, there is clarification around ‘active’, should this be removed? Whilst there is agreement with this statement, the Consensus Statement has been around for a long time, however there is very little awareness of it with practitioners. Therefore there needs to be an element to this quality statement around training and awareness for all staff who may come into contact with individuals with suicidal ideation. Therefore, could it be expanded to include a quality measure around training or that the organisations involve their Data Protection/IG Leads to include this requirement within localised awareness. Again, the BMA/NMC have a role to play in this as well, in terms of ensuring that training requirements for new staff include this. It is also suggested that the Consensus Statement is updated to make reference to GDPR, as some staff may feel it no longer applies due to the legislation change. |
| 215 | Royal College of General Practitioners | Statement 4 | The proportion of people with active suicidal thoughts or plans who are made aware of the limits of confidentiality may be difficult to assess if coding is not developed and implemented to capture this data. |
| 216 | Royal College of Speech and Language Therapists | Statement 4 | For children under 18 the assumption must be that families are informed of at risk children. |
| 217 | Royal College of Speech and Language Therapists | Statement 4 | It needs to be recognised that people:   * have differences in communicating and interacting with other people * may find it difficult to verbally communicate their feelings   may not talk about their feelings |
| 218 | Royal College of Speech and Language Therapists | Statement 4 | The audience lists on page 17 fails to highlight the role that schools and colleges could have in this area to support young people who may have no contact with the health service. |
| 219 | The Samaritans | Statement 4 | Statement, rationale, quality measures, what the quality statement means for different audiences  It may be helpful to clarify that this refers to adults and is about professionals asking.  There needs to be the inclusion of the importance of actioning the agreement to involve families/carers within this whole section. At the moment, the emphasis is on the asking, and there needs to be more recognition of the importance of following through on the answer. |
| 220 | The Samaritans | Statement 4 | Outcome, b)  The satisfaction of people with suicidal thoughts themselves should be included. |
| 221 | The Samaritans | Statement 4 | What the quality statement means for different audiences, service providers  This should only apply to those providers who have a statutory duty of care. Voluntary sector providers may have different policies in place around confidentiality. |
| 222 | The Samaritans | Statement 4 | What the quality statement means for different audiences  It should also be clear that for U18s, confidentiality can be broken without patients consent where it is deemed there is high risk of suicide or self harm |
| 223 | Tower Hamlets Public Health, London Borough of Tower Hamlets | Statement 4 | I have to say that personally when exploring suicidality with a patient in primary care I will normally ask what their support network is, are they talking to anyone etc. Rightly or wrongly I do not tend to explicitly ask do they want their family/ carer involved in their care... as a very initial reflection it may be because the commonest cohort of patient I see tend to be from a background where there can be cultural/ religious challenges about how the family might view mental health issues. Often I see the patient alone and don’t have sight of said family members and can’t make a judgement call if they would be able to support the patient or not...”  (I’m referring to adults here) |
| 224 | Bolton Community and Voluntary Services | Statement 5 | People bereaved or affected by a suspected suicide are given information and offered tailored support – There would need to be an investment to ensure that this support is available. It is the right thing to include but it will be difficult to access this in a timely way with local services capacity levels. Support that can be accessed from the community and voluntary sector should be included- this would also need further investment if there was to be increased capacity. |
| 225 | Bolton Suicide Prevention Steering Group | Statement 5 | People bereaved or affected by a suspected suicide are given information and offered tailored support – There would need to be an investment to ensure that this support is available. It is the right thing to include but it will be difficult to access this in a timely way with local services capacity levels. Support that can be accessed from the community and voluntary sector should be included- this would also need further investment if there was to be increased capacity.  Service could potentially have more of an input here as the bereavement side of things for families could really be pushed to help prevent other family members from also considering suicide. Employment is another side effect of a loved ones suicide as many family members fail to return to work. |
| 226 | Bucks New University | Statement 5 | Measures a)- c)  We would like to see more emphasis on the post-traumatic effects of suicide on professionals, on issues of the ethics of suicide, on shame, guilt and compulsion, and on seasonal/geographical/chronological variations |
| 227 | College of Mental Health Pharmacy | Statement 5 | Please ensure that there is recognition that health care professionals, emergency services, voluntary workers etc. may themselves be affected by suicide. They may also need the support listed. Please refer to the work by Dr Sharon McDonnell and Suicide Bereavement UK which is pioneering in this field. |
| 228 | FFLAG – Families and Friends of Lesbians and Gays | Statement 5 | Rationale and process  In cases where the deceased cites concern about their sexuality or gender identity as a motive for their action, the bereaved family are likely to require support to process the own feelings of responsibility to see this in the wider context of societal expectations and pressures. Siblings are more likely to share the same sexuality or gender identity concerns than the general population and it is vital that they observe in their family a willingness to provide better support from their family for their sexuality or gender identity han was available to the deceased sibling. |
| 229 | Gloucestershire County Council | Statement 5 | Process – given information  This process might be difficult to quantify due to the amount of resources needed to audit case records to identify people affected or bereaved by a suspected suicide that have been given information. Will the auditing of case records be a mandatory requirement? |
| 230 | Gloucestershire County Council | Statement 5 | Process – asked if they need help  This process might be difficult to quantify due to the amount of resources needed to audit case records to identify people affected or bereaved by a suspected suicide that have been asked if they need help. Will the auditing of case records be a mandatory requirement? |
| 231 | LGBT Foundation | Statement 5 | Structure c)  It needs to be ensured that service providers and practitioners have good knowledge of the different services where people who have been affected by bereavement can receive support. This must include knowledge of support offered by the voluntary and community sector as some people may be best suited to receive support from this sector. This can be for a whole range of reasons, for example some people may be reluctant to access mainstream services. LGBT people are more likely to be reluctant to access mainstream services and so may wish to receive support in an LGBT affirmative environment. Therefore service providers and practitioners must have good knowledge of local LGBT organisations that they can refer people to if needed.  LGBT Foundation’s internal data demonstrates that currently these referrals are not being adequately carried out. At LGBT Foundation we deliver NICE approved therapy through IAPT. The overwhelming majority (88%) of clients self-refer to our counselling services, with only 7.7% of clients referred by their GP or other health care services. Highlighting the need for greater integration, knowledge and cross referral of services, which is something that should be highlighted in this quality standard. |
| 232 | Maternal Mental Health Alliance (MMHA) | Statement 5 | Measures and audience descriptor: Again the specific support needs of the whole family unit and/or carers requires specific expertise |
| 233 | National Suicide Prevention Alliance (NSPA) | Statement 5 | Statement, Rationale, quality measures  This statement would benefit from a sense of timeliness – currently some people are only offered support after the conclusion of the inquest, which leaves them unsupported for far too long. |
| 234 | National Suicide Prevention Alliance (NSPA) | Statement 5 | Statement  The statement itself could be reworded to “People bereaved or affected by a suspected suicide are given timely information and offered tailored support.” |
| 234 | National Suicide Prevention Alliance (NSPA) | Statement 5 | Rationale  The sentence “Providing support after a suicide can reduce this risk, especially when tailored to the person’s needs” could be amended to “Providing support within 72 hours after a suspected suicide…” |
| 235 | National Suicide Prevention Alliance (NSPA) | Statement 5 | Quality measures  The word ‘timely’ would be usefully added to Structure item b) and Process item a) |
| 236 | National Suicide Prevention Alliance (NSPA) | Statement 5 | Definitions  It would be helpful to define ‘timely’ to mean ‘within 72 hours after a suspected suicide’. |
| 237 | National Suicide Prevention Alliance (NSPA) | Statement 5 | Definitions  In Tailored support, we would add the value of professional as well as peer support, as both can be valuable. The first bullet point could be “support from professionals with experience in this area or from trained peers who have been bereaved or affected by a suicide or suspected suicide.” |
| 238 | NHS England – Mental Health team | Statement 5 | * Process (a) to (c)   Denominator – the number of people bereaved or affected by a suspected suicide.  Data source: Local data collection, for example, audit of case records   * + This methodology would be difficult to implement and there is a question of identifying a denominator (all the family members, friends, colleagues, etc affected by suicide). There should be more guidance on the definition on the denominator of people bereaved or affected by suspected suicide, so the data may be more able to be compared between services or geographical areas.   It is not clear what 0-18 data will be collected, nor that it will be essential to separate and respond to the data by age. Self-harm rates are increasing particularly amongst young women and teenagers. This data may be highly relevant to planning to reduce the incidence of self-harm and the risk of subsequent suicide. When they are identified, children and young people presenting with self-harm or as a mental health crisis should be responded to as an opportunity to make a long-term intervention. |
| 239 | NHS England – Mental Health team | Statement 5 | Audience descriptor  Bereaved children and young people, through suicide or otherwise, are supported by non-mental health adult services whose skills to support the whole family, including children, can be limited. The need for skills development within adult services should be identified, without a resort to specialist CYPMHS.  Public Health England’s guidelines on providing local services should be explicitly mentioned, rather than a link via the National Suicide Prevention Alliance.  <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/590838/support_after_a_suicide.pdf> |
| 240 | North West Ambulance Service NHS Trust | Statement 5 | We agree as North West Ambulance Service that people bereaved or affected by a suspected suicide are given information and offered tailored support. |
| 241 | North West Ambulance Service NHS Trust | Statement 5 | In terms of Practitioner, we would advocate that Ambulance Providers are in a position to provide information, but we feel that this needs to be determined locally to avoid duplication of information. |
| 242 | North West Ambulance Service NHS Trust | Statement 5 | North West Ambulance Service advocates that a bereavement service is funded within all localities to ensure all individuals regardless of geographical locality are afforded the same service provision. |
| 243 | Olly’s Friendship Foundation | Statement 5 | People who are bereaved or affected by a suspected suicide  Unlike other forms of unexpected deaths eg an accident, people bereaved by a suicide are immediately shamed and shocked and, in some cases, judged. Most want to justify and value the life of their lost loved one. The help that people want is very varied as some want to talk and others just can’t. It is also very difficult for local communities – what can they say – as nothing changes the horror of it, but just having someone being there to listen can help. A visit by a peer support individual can help.  ADD – This clause needs amending to make information about useful booklets and supportive local services much more widely available and where to find them and how to access them when required. At present you often discover organisations that might help too late or not at all. |
| 244 | Public Health England and NHS England/Improvement | Statement 5 | To ensure that this could be offered to everyone, not just the recently bereaved could this be reworded to ‘People who are bereaved or affected by suicide or a death where suicide is suspected should be given information and support which is tailored to their needs’. Also, there is a requirement in the long term plan around the commissioning of Postvention Bereavement Support, should this be referenced? Again this links to RTS, which if not in place then areas will struggle to fulfil this. Also mention Support After Suicide as a resource. |
| 245 | Royal College of General Practitioners | Statement 5 | Processes a,b & c  The data may not be available here – coding arrangements need to be in place to collect this data. |
| 246 | Royal College of General Practitioners | Statement 5 | Process a  It would be good to be more specific here on what the information should consist of |
| 247 | Royal College of General Practitioners | Statement 5 | Definitions  People bereaved or affected by a suspected suicide – it is important to include children of the person who has died by suicide or attempted suicide here as they may require support. |
| 248 | Royal College of Speech and Language Therapists | Statement 5 | The RCSLT recommends that a greater focus is given to accessible information.  All information must be accessible, which includes both written and verbal information. This needs to take into account people with poor health literacy and must use plain English and avoid technical vocabulary. Accessible information is especially important for people with communication needs who have difficulties with understanding, speaking, reading or writing (RCSLT, 5 good communication standards) |
| 249 | Royal College of Speech and Language Therapists | Statement 5 | The RCSLT recommends that the reasonable adjustments should be offered to support both written and verbal communication. |
| 250 | Royal College of Speech and Language Therapists | Statement 5 | Under quality measure (b) we recommend adding:- evidence of local processes which provide accessible information to people who are bereaved or affected by a suspected suicide. |
| 251 | Royal College of Speech and Language Therapists | Statement 5 | The ‘equality and diversity considerations’ currently omits people with communication needs.   * People with communication problems, such as people with autism, are at greater risk of suicide than the general population (Autistica, 2019). * People with communication needs will require support with verbal and written communication and require reasonable adjustments * People with communication needs deemed at risk of suicide are at far greater risk if their communication difficulties are missed and their ability to seek help via verbal means is reduced.   The RCSLT recommends that people with communication needs are added. |
| 252 | The Samaritans | Statement 5 | Quality statement  This needs a time in the statement – there are a lot of people in the country bereaved and affected by suspected suicide but these suicides may have occurred some time ago. Suggest reword to “People bereaved or affected by a suspected suicide are given timely information and offered …”  Also suggest “adding “supportive” information. |
| 253 | The Samaritans | Statement 5 | Outcome a  Suggest splitting out satisfaction with information and satisfaction with support as these are very different things |
| 254 | The Samaritans | Statement 5 | What the statement means for different audiences  “Refer” may be understood to mean a formal referral process. The audiences mentioned will not all be able to “refer” people to support. They may be able to suggest or signpost support instead. |
| 255 | The Samaritans | Statement 5 | Definition of terms, tailored support  It is unclear why peer support is pulled out specifically, rather than for example, professional counselling, or anything else.  It would also be useful to include a definition of ‘timely’. For example, to include within 72 hours, or a statement of expected time-frame |
| 256 | Tower Hamlets Public Health, London Borough of Tower Hamlets | Statement 5 | * As stated - access to data is a significant inhibiter to action on suicide prevention in Tower Hamlets. This includes identifying those bereaved or affected by suicide. |

## Registered stakeholders who submitted comments at consultation

* Bolton Community and Voluntary Services
* Bolton Suicide Prevention Steering Group
* Bucks New University
* College of Mental Health Pharmacy
* Communication Workers Union
* Derbyshire Healthcare NHS Foundation Trust
* FFLAG – Families and Friends of Lesbians and Gays
* Festival of Life and Death
* Gloucestershire County Council
* HMPPS
* Institute for Mental Health, University of Birmingham
* LGBT Foundation
* Maternal Mental Health Alliance (MMHA)
* National Suicide Prevention Alliance (NSPA)
* Network Rail on behalf of the Rail Industry
* NHS England – Mental Health team
* North West Ambulance Service NHS Trust
* Olly’s Friendship Foundation
* Olly’s Future
* Public Health England
* Public Health England and NHS England/Improvement (South West)
* Royal College of General Practitioners
* Royal College of Nursing
* Royal College of Occupational Therapists
* Royal College of Paediatrics and Child Health
* Royal College of Psychiatrists
* Royal College of Speech and Language Therapists
* Stoke on Trent and Staffordshire Suicide Prevention Group, Harplands Hospitals
* Suicide Crisis
* The British Psychological Society
* The Samaritans
* Tower Hamlets Public Health, London Borough of Tower Hamlets

1. PLEASE NOTE: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees. [↑](#footnote-ref-1)
2. Suicides in the UK: 2017 registrations, Office for National Statistics, 4th September 2018; and Suicide by Occupation, England: 2011 to 2015, Office for National Statistics, 17th March 2017 [↑](#footnote-ref-2)
3. Half of workers have experience poor mental health in current job, Mind, 11 September 2018, accessed on 17th May 2019 at: <https://www.mind.org.uk/news-campaigns/news/half-of-workers-have-experienced-poor-mental-health-in-current-job/> [↑](#footnote-ref-3)
4. Waters, S, Karanikolos, M and McKee, M (2016) When work kills, Journal of Public Mental Health, 15 (4).pp 229-234 [↑](#footnote-ref-4)
5. Thriving at work, The Stevenson/Farmer review of mental health and employers, Lord Dennis Stevenson and Paul Farmer, October 2017, accessible at: <https://www.gov.uk/government/publications/thriving-at-work-a-review-of-mental-health-and-employers> [↑](#footnote-ref-5)
6. Seizing the Momentum, Mental Health at Work Report 2018, Business in the Community, October 2018, accessible at: <https://wellbeing.bitc.org.uk/system/files/research/mental_health_at_work_-_survey_report_2018_-_23oct2018new.pdf> [↑](#footnote-ref-6)