NICE National Institute for Health and Care Excellence

NICE quality standard

Suicide prevention

Quality standard

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Contents

This standard is based on NG105, CG136 and NG225.

This standard should be read in conjunction with QS188, QS163, QS159, QS115, QS48, QS34, QS23, QS11, QS8 and QS116.

Quality statements

Statement 1 Multi-agency suicide prevention partnerships have a strategic suicide prevention group and clear governance and accountability structures.

Statement 2 Multi-agency suicide prevention partnerships reduce access to methods of suicide based on local information.

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 when reporting on suicide and suicidal behaviour.

Statement 4 Adults presenting with suicidal thoughts or plans discuss whether they would like their family, carers or friends to be involved in their care and are made aware of the limits of confidentiality.

Statement 5 People bereaved or affected by a suspected suicide are given information and offered tailored support.

Quality statement 1: Multi-agency suicide prevention partnerships

Quality statement

Multi-agency suicide prevention partnerships have a strategic suicide prevention group and clear governance and accountability structures.

Rationale

By working together, local organisations can combine their expertise and resources to implement a range of interventions to prevent suicide including addressing risk factors such as self-harm.

Partnerships should have a strategic suicide prevention group to identify priorities and manage the overall strategic direction. Organisations that have a key role in suicide prevention should have senior level representation on the strategic suicide prevention group. Although local structures are likely to vary, the group may coordinate the work of a wider network of representatives from specific services and organisations to implement the local suicide prevention strategy.

To promote understanding, partnerships should involve people with personal experience of a suicide attempt, suicidal thoughts and feelings, or a suicide bereavement. Clear terms of reference and governance and accountability structures will improve effectiveness and sustainability.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

a) Evidence that multi-agency suicide prevention partnerships have a strategic suicide prevention group attended by senior level representatives.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by partnership organisations, for example, membership lists, including job titles and responsibilities, and attendance registers.

b) Evidence that multi-agency suicide prevention partnerships have clear governance and accountability structures.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by partnership organisations, for example, terms of reference.

c) Evidence that multi-agency suicide prevention partnerships support people with personal experience of a suicide attempt, suicidal thoughts and feelings, or a suicide bereavement, to be involved in the partnership.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by partnership organisations, for example, programmes of induction and support for people with personal experience who are involved in the partnership.

Outcome

a) Rate of emergency hospital attendance or admission for intentional self-harm.

Data source: The Office for Health Improvement and Disparities' Suicide Prevention Profile includes data on the age-standardised rate of emergency hospital admissions for intentional self-harm in England. NHS Digital's Hospital Episode Statistics includes data on A&E attendances for self-injurious behaviour.

b) Rate of self-harm in the community.

Data source: Local data collection, for example, community or school surveys. Data on

episodes of self-harm in primary care are likely to be available from primary care electronic healthcare record systems.

c) Suicide rate.

Data source: The Office for Health Improvement and Disparities' Suicide Prevention Profile includes data on the rate of suicide in clinical commissioning groups and sustainability and transformation partnerships for different population groups (based on Office for National Statistics source data).

What the quality statement means for different audiences

Lead organisations such as local authorities and residential custodial or detention providers set up a multi-agency suicide prevention partnership with a strategic suicide prevention group that includes senior representatives from key organisations. Lead organisations ensure that representatives on the group can make decisions and commit resources on behalf of their organisation, and have skills and knowledge in line with Health Education England's Self-harm and suicide prevention competence frameworks.

Lead organisations ensure that people with personal experience of a suicide attempt, suicidal thoughts and feelings, or a suicide bereavement who are involved in the partnership can access a programme of induction and support. They identify clear leadership for the partnership and ensure it has clear terms of reference, based on a shared understanding that suicide can be prevented. The terms of reference should:

- clarify local partnership structures, including working arrangements between the strategic suicide prevention group and any wider network or partnership subgroups
- identify clear governance and accountability structures, including oversight from local health and care planning groups such as the health and wellbeing board
- clarify links between suicide prevention partnerships in the local community and those in custodial settings, particularly in relation to managing prisoners and detainees in the community.

Source guidance

Preventing suicide in community and custodial settings. NICE guideline NG105 (2018), recommendations 1.1.1, 1.1.2 and 1.1.4

Definitions of terms used in this quality statement

Multi-agency suicide prevention partnership

Suicide prevention requires work across a range of settings targeting a wide variety of audiences. Given this complexity, the combined knowledge, expertise and resources of organisations across the public, private and voluntary sectors is essential. A wide range of representatives working with adults, children and young people may be brought together to contribute to a multi-agency suicide prevention partnership. [Adapted from Public Health England's Local suicide prevention planning: a practice resource, section 2]

Strategic suicide prevention group

A strategic suicide prevention group in the community could include representatives from the following:

- clinical commissioning groups
- local public health services
- healthcare providers
- social care services
- voluntary and other third-sector organisations, including those used by people in high-risk groups
- emergency services
- criminal justice services
- police and custody suites
- employers

- education providers
- people with personal experience of a suicide attempt, suicidal thoughts and feelings, or a suicide bereavement.

A strategic suicide prevention group in a residential custodial or detention setting could include representatives from the following:

- governors or directors
- healthcare staff (including physical and mental health)
- other staff
- pastoral support services
- voluntary and other third-sector organisations
- escort custody services
- liaison and diversion services
- emergency services
- offender management and resettlement services
- people with personal experience of a suicide attempt, suicidal thoughts and feelings, or a suicide bereavement, to be selected according to local protocols.

[NICE's guideline on preventing suicide in community and custodial settings, recommendations 1.1.3 and 1.1.5 and expert opinion]

Equality and diversity considerations

Multi-agency suicide prevention partnerships should make reasonable adjustments to ensure that people with additional needs such as physical, sensory or learning disabilities, and people who do not speak or read English, or who have reduced communication skills, can participate in the strategic suicide prevention group. People should have access to an interpreter (including British Sign Language) or advocate if needed. For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard.

Quality statement 2: Reducing access to methods of suicide

Quality statement

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

Rationale

Reducing access to common methods of suicide and to places where suicide may be more likely to occur can be an effective way of preventing suicide. A range of measures can be used to interrupt people's plans, giving them time to stop and think, or making it more difficult for them to put themselves in danger. An understanding of local information will help suicide prevention partnerships prioritise the methods and places to focus on locally.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

a) Evidence that multi-agency suicide prevention partnerships collect and analyse local information on methods of suicide and locations.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by partnership organisations, for example, data sharing protocols and a rapid intelligence gathering process.

b) Evidence that multi-agency suicide prevention partnerships identify how they will reduce access to methods of suicide.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by partnership organisations, for example, local suicide prevention action plan.

c) Evidence that multi-agency suicide prevention partnerships review progress in reducing access to methods of suicide at least annually.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by partnership organisations, for example, local suicide prevention action plan progress reports.

Outcome

a) Number of suicides by methods identified in the local suicide prevention action plan.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by partnership organisations, for example, rapid intelligence gathering. Detailed information on methods should not be included in the published suicide prevention action plan.

b) Number of suicides in high-frequency locations.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by partnership organisations, for example, rapid intelligence gathering. Detailed information on locations should not be included in the published suicide prevention action plan.

c) Suicide rate.

Data source: The Office for Health Improvement and Disparities' Suicide Prevention Profile includes data on the rate of suicide in clinical commissioning groups and sustainability and transformation partnerships for different population groups (based on Office for National Statistics source data).

What the quality statement means for different audiences

Multi-agency suicide prevention partnerships gather and analyse information from a range of sources to understand local patterns in suicide method and location. The partnership uses this information to prioritise the methods and locations to focus on. It includes these priorities in the suicide prevention action plan, identifies actions and regularly reviews progress.

The partnership supports partner organisations to ensure that they comply with national guidance on issues such as providing and maintaining safer cells in residential custodial or detention settings and restricting access to painkillers. The partnership also facilitates data sharing protocols between organisations to support timely analysis of data and actions to reduce access to methods of suicide for people in high-risk groups.

People in the community and in custody know that organisations are working together to prevent suicide.

Source guidance

Preventing suicide in community and custodial settings. NICE guideline NG105 (2018), recommendations 1.6.1 to 1.6.3

Definitions of terms used in this quality statement

Reducing access to methods of suicide

Suicide prevention partnerships should ensure local compliance with national guidance:

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

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

- providing information about how and where people can get help when they feel unable to cope
- using CCTV or other surveillance to allow staff to monitor when someone may need help
- increasing the number and visibility of staff, or times when staff are available
- working with planners who have responsibility for designing bridges, multi-storey car parks and other structures that could potentially pose a suicide risk.

[NICE's guideline on preventing suicide in community and custodial settings, recommendations 1.3.2 and 1.6.2 to 1.6.4]

Local information

Suicide prevention partnerships should use local data including audit, Office for National Statistics and NHS data, as well as rapid intelligence gathering, to:

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

[NICE's guideline on preventing suicide in community and custodial settings, recommendation 1.6.1]

Quality statement 3: Media reporting

Quality statement

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

Rationale

Irresponsible reporting of suicide and suicidal behaviour may have harmful effects, including potentially increasing the risk of suicide. By promoting best practice, partnerships can encourage responsible reporting, which can help prevent suicide clusters and avoid further distress being caused to those bereaved or affected by suicide.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

a) Evidence that multi-agency suicide prevention partnerships have a local media plan that identifies how they will encourage best practice in reporting on suicide and suicidal behaviour.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by partnership organisations, for example, a partnership media plan.

b) Evidence that multi-agency suicide prevention partnerships have a named lead for the local media plan.

Data source: No routinely collected national data for this measure has been identified.

Data can be collected from information recorded locally by partnership organisations, for example, description of partnership roles and responsibilities.

c) Evidence that multi-agency suicide prevention partnerships work with other organisations such as the Samaritans to give feedback to local media journalists and editors about reporting on suicide and suicidal behaviour.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by partnership organisations, for example, a feedback log. This may include information on feedback given by other organisations such as the Samaritans.

Outcome

a) Number of local media reports of suicide or suicidal behaviour that do not meet best practice criteria.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by partnership organisations, for example, monitoring records.

b) Suicide rate.

Data source: The Office for Health Improvement and Disparities' Suicide Prevention Profile includes data on the rate of suicide in clinical commissioning groups and sustainability and transformation partnerships for different population groups (based on Office for National Statistics source data).

What the quality statement means for different audiences

Multi-agency suicide prevention partnerships in the community develop a plan for liaising with local media organisations that encourages a positive relationship and promotes best practice when reporting on suicide and suicidal behaviour. Partnerships identify a lead to coordinate the local media plan. Partnerships work with organisations such as the Samaritans to provide feedback to editors and journalists if a report is not consistent with best practice guidelines.

Multi-agency suicide prevention partnerships in residential custodial and detention settings liaise with local media through the Ministry of Justice, if relevant, and encourage Ministry of Justice press officers to follow best practice when reporting on suicide and suicidal behaviour.

Local media journalistsand editors work with the local suicide prevention partnership and other organisations such as the Samaritans to increase awareness of best practice and improve reporting standards.

Source guidance

Preventing suicide in community and custodial settings. NICE guideline NG105 (2018), recommendations 1.10.1, 1.10.2 and 1.10.4

Definitions of terms used in this quality statement

Best practice when reporting on suicide and suicidal behaviour

This includes:

- using sensitive language that is not stigmatising or in any other way distressing to people who have been affected
- reducing speculative reporting
- avoiding presenting detail on methods
- providing stories of hope and recovery including signposting to support.

Refer to: the World Health Organization's Preventing suicide: a resource for media professionals; the Samaritans' Media guidelines for reporting suicide; OFCOM's Broadcasting code; and the Independent Press Standards Organisation (IPSO) [editors' code of practice]. [NICE's guideline on preventing suicide in community and custodial settings, recommendations 1.10.2 and expert opinion]

Quality statement 4: Involving family, carers or friends

Quality statement

Adults presenting with suicidal thoughts or plans discuss whether they would like their family, carers or friends to be involved in their care and are made aware of the limits of confidentiality.

Rationale

Families, carers and friends can help to support a person who has suicidal thoughts or plans. They can also provide valuable input to an assessment of the person's needs to help keep them safe. Involving families, carers or friends can be complex so, providing the person has mental capacity, it is important for them to discuss who they would or would not like to be involved if there is a concern over suicide risk. The person should have the opportunity to discuss information sharing and their right to confidentiality so that they are aware of the circumstances in which confidential information may need to be disclosed to family, carers or friends.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

a) Evidence of local arrangements to provide training on information sharing and confidentiality based on the Department of Health and Social Care's consensus statement on information sharing and suicide prevention to practitioners in contact with adults presenting to health or care services with suicidal thoughts or plans.

Data source: No routinely collected national data for this measure has been identified.

Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, staff training records.

b) Evidence of local processes to ensure that adults presenting with suicidal thoughts or plans discuss whether they would like their family, carers or friends to be involved in their care.

Data source: Local data collection, for example, local service protocol.

c) Evidence of local processes to ensure that adults with suicidal thoughts or plans are made aware of the limits of confidentiality.

Data source: Local data collection, for example, local service protocol.

Process

a) Proportion of adults presenting with suicidal thoughts or plans who discuss whether they would like their family, carers or friends to be involved in their care.

Numerator – the number in the denominator who discuss whether they would like their family, carers or friends to be involved in their care.

Denominator – the number of adults presenting with suicidal thoughts or plans.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, audit of patient records.

b) Proportion of adults presenting with suicidal thoughts or plans who are made aware of the limits of confidentiality.

Numerator – the number in the denominator who are made aware of the limits of confidentiality.

Denominator – the number of adults presenting with suicidal thoughts or plans.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and

provider organisations, for example, audit of patient records.

Outcome

a) Proportion of assessments for adults who presented with suicidal thoughts or plans who wanted their family, carers or friends involved, that involved family, carers or friends.

Numerator – the number in the denominator that involved family, carers or friends.

Denominator – the number of assessments for adults who presented with suicidal thoughts or plans who wanted their family, carers or friends involved.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, audit of patient records.

b) Proportion of family members, carers or friends of adults who presented with suicidal thoughts or plans who are satisfied with information sharing about suicide risk.

Numerator – the number in the denominator who are satisfied with information sharing about suicide risk.

Denominator – the number of family members, carers or friends of adults who presented with suicidal thoughts or plans.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, survey of family members, carers or friends of adults who presented with suicidal thoughts or plans.

c) Suicide rate.

Data source: The Office for Health Improvement and Disparities' Suicide Prevention Profile includes data on the rate of suicide in clinical commissioning groups and sustainability and transformation partnerships for different population groups (based on Office for National Statistics source data).

What the quality statement means for different audiences

Service providers (such as general practices, hospitals, ambulance services, mental health trusts, prisons and social care providers) ensure that processes are in place for adults presenting with suicidal thoughts or plans to discuss whether they would like their family, carers or friends to be involved in their care, and to make them aware of the limits of confidentiality.

Providers ensure that if the person wants their family, carers or friends involved in their care, the nature of their involvement, including how and when information is shared with them, is agreed. Providers ensure that staff are trained and aware of the Department of Health and Social Care's consensus statement on information sharing and suicide prevention.

Health and social care practitioners (such as A&E practitioners, paramedics, first responders, GPs, nurses, social workers, mental health professionals and allied health professionals) discuss with adults presenting with suicidal thoughts or plans whether they would like their family, carers or friends to be involved in their care. They also make them aware of the limits of confidentiality. If the person wants their family, carers or friends involved, health and social care practitioners ensure they agree how they will be involved and when information will be shared with them.

Commissioners (such as local authorities, clinical commissioning groups and NHS England) commission services that discuss with adults presenting with suicidal thoughts or plans whether they would like their family, carers or friends to be involved in their care. They also make them aware of the limits of confidentiality.

Adults who contact a health or care service and feel suicidal discuss whether they would like their family, carers or friends to be involved in their care. If they want their family, carers or friends to be involved, they agree how they will be involved and when information will be shared with them. They are also told about confidentiality and when it may be necessary to share information with their family, carers or friends.

Source guidance

- Self-harm: assessment, management and preventing recurrence. NICE guideline NG225 (2022), recommendations 1.2.4, 1.2.5 and 1.4.1
- Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services. NICE guideline CG136 (2011), recommendations 1.1.4 and 1.1.14

Definitions of terms used in this quality statement

Adults with suicidal thoughts or plans

Adults who disclose suicidal thoughts or plans when asked about suicide ideation and intent. [Expert opinion]

Limits of confidentiality

If a person is at imminent risk of suicide, there may be sufficient doubts about their mental capacity to consent to information about their risk of suicide being shared. In these circumstances, a professional judgement will need to be made, based on an understanding of the person and what would be in their best interest. This should take into account the person's previously expressed wishes and views in relation to sharing information with their family, carers or friends.

The judgement may be that it is right to share critical information. If the purpose of the disclosure is to prevent a person who lacks capacity from serious harm, there is an expectation that practitioners will disclose relevant confidential information, if it is in the person's best interest to do so. Disclosure may also be in the public interest because of the far-reaching impact that a suicide can have on others. [Department of Health and Social Care Information sharing and suicide prevention: consensus statement]

Equality and diversity considerations

Services that support adults with suicidal thoughts or plans should make reasonable adjustments to ensure that people with additional needs such as physical, sensory or learning disabilities, and people who do not speak or read English, or who have reduced

communication skills, can use the service. People should have access to an interpreter (including British Sign Language) or advocate if needed. For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard.

Health and social care practitioners should ensure that adults who temporarily lack mental capacity to consent to information sharing are asked if they want their family, carers or friends to be involved in their care as soon as they are able to give consent.

Quality statement 5: Supporting people bereaved or affected by a suspected suicide

Quality statement

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

Rationale

Children, young people and adults who are bereaved or affected by a suspected suicide are themselves at increased risk of suicide. Providing support after a suspected suicide can reduce this risk, especially when tailored to the person's needs. It is important to identify people who may need support as soon as possible so that they can be given practical information and access support if, and when, they need to.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

a) Evidence of local arrangements to use rapid intelligence gathering to identify people who may be bereaved or affected by a suspected suicide.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by partnership organisations, for example, data sharing agreements and reporting arrangements.

b) Evidence of local processes to give information to people bereaved or affected by a

suspected suicide and to ask if they need help.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by partnership organisations, for example, a local protocol.

c) Evidence of local services that can provide support to people bereaved or affected by a suspected suicide.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by partnership organisations, for example, service specifications and a local directory of information on the services available.

Process

a) Proportion of people bereaved or affected by a suspected suicide who are given information.

Numerator – the number in the denominator who are given information.

Denominator – the number of people bereaved or affected by a suspected suicide.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, audit of case records.

b) Proportion of people bereaved or affected by a suspected suicide who are asked if they need help.

Numerator – the number in the denominator who are asked if they need help.

Denominator – the number of people bereaved or affected by a suspected suicide.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, audit of case records.

c) Proportion of people bereaved or affected by a suspected suicide who access tailored support.

Numerator – the number in the denominator who access tailored support.

Denominator – the number of people bereaved or affected by a suspected suicide.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, monitoring information from local support services.

Outcome

a) Proportion of people bereaved or affected by a suicide who are satisfied with information and support.

Numerator – the number in the denominator who are satisfied with information and support.

Denominator – the number of people bereaved or affected by a suicide.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by partnership organisations, for example, survey of people bereaved or affected by a suicide.

b) Number of suicides among people bereaved or affected by a suicide.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by partnership organisations, for example, rapid intelligence gathering.

What the quality statement means for different audiences

Multi-agency suicide prevention partnerships carry out rapid intelligence gathering to identify children, young people and adults who may be bereaved or affected by a suspected suicide. Partnerships ensure that coordinated processes are in place across

partner organisations to provide information to people who are bereaved or affected by a suspected suicide, to ask them if they need additional help and to signpost them to support if needed.

Partnerships ensure that information and signposting to support is offered to people who are bereaved or affected by a suspected suicide as soon as possible and then at subsequent opportunities to ensure that people can access support when they need it.

Service providers (such as police, hospitals, ambulance services, prisons, general practices, funeral directors, coroners' offices, employers and education providers) ensure that processes are in place to provide information to people who are bereaved or affected by a suspected suicide (including health and care practitioners and first responders), to ask them if they need additional help and to signpost them to support if needed.

Providers ensure that information and signposting to support is offered to people who are bereaved or affected by a suspected suicide as soon as possible and then at other opportunities to ensure that people can access support when they need it.

Practitioners (such as police officers, GPs, nurses, paramedics, mental health practitioners, prison staff, funeral directors, coroner's office staff and human resource managers) provide information to people who are bereaved or affected by a suspected suicide, ask them if they need additional help and signpost them to support if needed. Practitioners who respond to a suspected suicide or provide support to people bereaved or affected by a suspected suicide, are aware of how they can access support to help them cope, if they need it.

Commissioners (such as local authorities, clinical commissioning groups and NHS England) commission services that provide support after a suspected suicide with the capacity and skills to meet the needs of the local population, including children and young people. They also commission services that provide information to people who are bereaved or affected by a suspected suicide, ask them if they need additional help and signpost them to support if needed.

Children, young people and adults who are bereaved or affected by a suspected suicide are given practical information, such as an information booklet, and asked if they want any other help. If they do, they are put in touch with a support service.

Source guidance

Preventing suicide in community and custodial settings. NICE guideline NG105 (2018), recommendation 1.8.2

Definitions of terms used in this quality statement

People bereaved or affected by a suspected suicide

Children, young people and adults who are bereaved or affected by a suspected suicide may include relatives, friends, classmates, colleagues, other prisoners or detainees, as well as first responders and other professionals who provided support. [NICE's guideline on preventing suicide in community and custodial settings, recommendation 1.8.1]

Information

Practical information expressed in a sensitive way that helps people to cope and signposts to other services, such as Support After Suicide Partnership's Help is at hand guide. [Expert opinion and NICE's guideline on preventing suicide in community and custodial settings, recommendation 1.8.2]

Tailored support

Support that is focused on the person's individual needs. As well as professional support, it could include:

- support from trained peers who have been bereaved or affected by a suicide or suspected suicide
- adjustments to working patterns or the regime in residential custodial and detention settings
- other support identified in Public Health England's Support after a suicide: a guide to providing local services and the National Suicide Prevention Alliance's Support after a suicide: developing and delivering local bereavement support services.

[NICE's guideline on preventing suicide in community and custodial settings, recommendation 1.8.3]

Equality and diversity considerations

Information for people bereaved or affected by a suspected suicide should be in a format that suits the person's needs and preferences. It should be accessible to people who do not speak or read English, and it should be culturally appropriate. For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard.

Services that provide support after a suspected suicide should ensure that staff have the skills and knowledge to support children and young people who are bereaved or affected. Services should also ensure that they provide support for people from black, Asian, other minority ethnic groups and people with religious beliefs in a culturally sensitive way.

Services that provide support after a suspected suicide should make reasonable adjustments to ensure that people with additional needs such as physical, sensory or learning disabilities, and people who do not speak or read English, or who have reduced communication skills, can use the service. People should have access to an interpreter (including British Sign Language) or advocate if needed.

Update information

Minor changes since publication

September 2022: Changes have been made to align this quality standard with the updated NICE guideline on self-harm. Links, definitions and source guidance references have been updated throughout.

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about how NICE quality standards are developed is available from the NICE website.

See our webpage on quality standard advisory committees for details of standing committee 3 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available from the webpage for this quality standard.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Resource impact

NICE quality standards should be achievable by local services. The potential resource

impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the resource impact statement for NICE's guideline on preventing suicide in community and custodial settings to help estimate local costs.

Diversity, equality and language

Equality issues were considered during development and equality assessments for this quality standard are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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Endorsing organisation

This quality standard has been endorsed by The Department of Health and Social Care, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- Association of Police and Crime Commissioners
- Royal College of General Practitioners (RCGP)
- Royal College of Paediatrics and Child Health
- National Suicide Prevention Alliance
- Samaritans

- Royal College of Nursing (RCN)