Suicide prevention

Consultation on draft quality standard – deadline for comments 5pm on 23/05/19 **email:** QSconsultations@nice.org.uk

	Please read the checklist for submitting comments at the end of this form. We cannot accept forms that are not filled in correctly. We would like to hear your views on these questions: 1. Does this draft quality standard accurately reflect the key areas for quality improvement? If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures? 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 on the NICE website. Examples of using NICE quality standards can also be submitted. 2. Question for statement 1 - Are local authorities the only organisation responsible for setting up suicide prevention partnerships in the community?
Organisation name – stakeholder or respondent (if you are responding as an individual rather than a registered stakeholder please leave blank):	Samaritans
Disclosure Please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry.	No
Name of commentator person completing form:	Jacqui Morrissey
Supporting the quality standard - Would your organisation like to express an interest in formally supporting this quality standard? More information.	Yes
Type	[office use only]

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Comment number	Section	Statement number	Comments Insert each comment in a new row. Do not paste other tables into this table because your comments could get lost – type directly into this table.
1	Statement 1: Multi-agency suicide prevention partnerships (statement)	1	'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*.
2	Statement 1: Multi-agency suicide prevention partnerships (measure c)	1	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'.
3	Statement 1: Multi-agency suicide prevention partnerships (outcomes a, b and c)	1	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.
4	Statement 1: Multi-agency suicide prevention partnerships (outcome c)	1	The data used by Public Health England originates from ONS and can be accessed directly from ONS too. Should this be mentioned?
5	Statement 1: Multi-agency suicide	1	There should be a section for organisations involved in points of transition for young people; for example, schools and universities.

	prevention partnerships (what the quality statement means for different audiences)		
6	Statement 1: Multi-agency suicide prevention partnerships (what the quality statement means for different audiences)	1	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.
7	Statement 1: Multi-agency suicide prevention partnerships (Definition of terms used in this quality statement)	1	It should be specified that 'senior representatives' rather than just 'representatives' should be included.
8	Statement 1: Multi-agency suicide prevention partnerships (Definition of terms used in this quality statement)	1	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.
9	Reducing access to methods of suicide (Quality statement)	2	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".
10	Reducing access to methods of suicide (Rationale)	2	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.

11	Reducing access to methods of suicide (Quality measures, structure, a)	2	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.
12	Reducing access to methods of suicide (Quality measures, structure, a, data source)	2	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)
13	Reducing access to methods of suicide (Quality measures, structure, data sources b and c)	2	These should refer to local suicide prevention action plan', rather than 'suicide action plan' for consistency.
14	Statement 2: Reducing access to methods of suicide (Quality measures, outcome a)	2	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.
15	Statement 2: Reducing access to methods of suicide (What the quality statement means for different audiences)	2	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.
16	Statement 2: Reducing access to methods of suicide (What the quality statement means for different audiences)	2	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.
17	Statement 2: Reducing	2	This should include residential custodial or detention providers. It should also include anyone prescribing medication

	access to methods of suicide (What the quality statement means for different audiences)		which could be used for the purpose of suicide.
18	Statement 3: Media reporting (quality statement)	3	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.
19	Statement 3: Media reporting (rationale)	3	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.
20	Statement 3: Media reporting (outcome, data source)	3	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.
21	Statement 3: Media reporting (What the Quality statement means for different audiences.)	3	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.
22	Statement 3: Media reporting (What the	3	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.'

	Quality statement means for different audiences, local media journalists and editors.)		
23	Statement 3: Media reporting (Definitions of terms)	3	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.'
24	Statement 3: Media reporting (Definitions of terms)	3	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.
25	Statement 4: Involving family or carers (statement, rationale, quality measures, what the quality statement means for different audiences)	4	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.
26	Statement 4: Involving family or carers (outcome, b)	4	The satisfaction of people with suicidal thoughts themselves should be included.
27	Statement 4: Involving family or carers (what the quality statement means for different audiences, service providers)	4	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.
28	Statement 4: Involving family or carers (what the quality statement	4	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

	means for different audiences)		
29	Statement 5: Supporting people bereaved or affected by a suspected suicide (quality statement)	5	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.
30	Statement 5: Supporting people bereaved or affected by a suspected suicide (outcome a)	5	Suggest splitting out satisfaction with information and satisfaction with support as these are very different things
31	Statement 5: Supporting people bereaved or affected by a suspected suicide (what the statement means for different audiences)	5	"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.
32	Statement 5: Supporting people bereaved or affected by a suspected suicide (definition of terms, tailored support)	5	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

Insert extra rows as needed

Checklist for submitting comments

- Use this comment form and submit it as a Word document (not a PDF).
- Complete the disclosure about links with, or funding from, the tobacco industry.
- Include section number of the text each comment is about eg. introduction; quality statement 1; quality statement 2 (measure).
- If commenting on a specific quality statement, please indicate the particular sub-section (for example, statement, measure or audience descriptor).

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- Combine all comments from your organisation into 1 response. We cannot accept more than 1 response from each organisation.
- Do not paste other tables into this table – type directly into the table.
- Underline and highlight any confidential information or other material that you do not wish to be made public.
- Do not include medical information about yourself or another person from which you or the person could be identified.
- Spell out any abbreviations you use
- For copyright reasons, comment forms do not include attachments such as research articles, letters or leaflets (for copyright reasons).We return comments forms that have attachments without reading them. The stakeholder may resubmit the form without attachments, but it must be received by the deadline.

You can see any guidance and quality standards that we have produced on topics related to this quality standard by checking NICE Pathways.

Note: We reserve the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are too long, or publication would be unlawful or otherwise inappropriate.

Comments received from registered stakeholders and respondents during our consultations are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the comments we received, and are not endorsed by NICE, its officers or advisory Committees.