Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developers response
Association of Directors of Public Health	Full	12	6	We are concerned that this recommendation does not provide enough detail about what this support should entail. There should be a further recommendation around the need for IAPT services to adapt their offer and speed of access for those bereaved by suicide.	Thank you for your comment. We have amended the recommendation as follows to include tailored support, which may include IAPT services if appropriate " 1.8.2 Offer those who are bereaved or affected by a suspected suicide practical information expressed in a sensitive way, such as Public Health England's Help is at hand guide. (This also signposts to other services.) Ask them if they need more help and, if so, offer them tailored support."
Association of Directors of Public Health	Full	12	6	QUESTION 2: This recommendation will have significant cost implications.	Thank you for your response. We will pass this information to our resource impact team for their information.
Association of Directors of Public Health	Full	17	3	The guidance has missed key partners including transport agencies, the coroner's office and safeguarding boards.	Thank you for your comment. The committee agree and were mindful of the fact that different groups of people could be included in the wider network, depending on local circumstances and settings. As such the committee drafted a recommendation for the partnership as follows "1.1.1 This could consist of a core group and a wider network of representatives." The committee have also provided a link to Public Health England's resource on 'Local suicide prevention planning: a practice resource' provides further information on this.
Association of Directors of Public Health	Full	21	9	This section of the guidance should include a recommendation around the collection of information on attempted suicides, as this will ensure a fuller picture of suicidality.	Thank you for your comment. The committee drafted the following recommendation as follows "1.4.2 Collect and analyse local data on suicide and self-harm. This could include data on: method, location, timing, details of individual and local circumstances, demographics, occupation and characteristics protected under the Equality Act (2010). Sources could include reports from: • the local ombudsman • the Parliamentary and Health Service Ombudsman • coroners • the Prison and Probation Ombudsman • the voluntary sector."
Association of Directors of Public Health	Full	28	21	This should be both a local and national recommendation, and should be linked to colleges of journalism. At present, this is left to local areas to lead on, which is not sufficient.	Thank you for your comment. The committee agree that the content of information delivered in colleges of journalism will be covered by national policy and as such is outside of scope for this guideline.
Association of Directors of Public Health	Full	28	21	This should be both a local and national recommendation, and should be linked to colleges of journalism. At present, this is left to local areas to lead on, which is not sufficient.	Thank you for your comment. The committee agree that the content of information delivered in colleges of journalism will be covered by national policy and as such is outside of scope for this guideline.
Autistica	Full	General	General	Terminology when talking about autistic people For reference, please note that there is a general preference for identity-first language rather than person-first language in the adult autistic community.218 We therefore advise using the terms "autistic people" and "autistic adults" rather than "people/adults with autism" where possible. Similarly the "autism community" is a useful term for referring to autistic people, families, charities and professionals that work with autistic people, whereas "autistic community" is used to indicate autistic people only.	Thank you for your comment. We have used the term "people with autism" in this guideline.

				218Kenny L, et al. (2015). Which terms should be used to describe autism? Perspectives from the UK autism community. Autism Vol 20 (4): 442-462.	
Autistica	Full	14-16	Entire "Recommendations for research" section	We strongly recommend that this guidance highlights the need for research into suicide and autism; particularly in designing and testing suicide prevention strategies that are appropriate for autistic people. There is extensive evidence that autistic people are at particular risk of taking their own lives172,173,174,175,176,177,178 and ongoing research suggests that autistic people may account for 11% of deaths by suicide in the UK, even though only 1% of the population are on the autistic spectrum.179,180 This matches international findings that autistic people without a learning disability are nine times more likely to die by suicide compared to the general population and those with a learning disability are twice as likely.181,182 172Balfe M, et al. (2010). A descriptive social and health profile of a community sample of adults and adolescents with Asperger syndrome. BMC Research Notes, 3: 300 173Raja M (2014) Suicide risk in adults with Asperger's syndrome. Lancet Psychiatry. 1(2), 99-101 174Segers M, Rawana J (2014) What do we know about suicidality in autism spectrum disorders? A systematic review. Autism Research, 5;7(4):507-21 175Cassidy, S. et al. (2014). Suicidal ideation and suicide plans or attempts in adults with Asperger's syndrome attending a specialist diagnostic clinic: a clinical cohort study. Lancet Psychiatry 1, 2, 142-7. 176Mayes SD (2013) Suicide ideation and attempts in children with autism. Research in Autism Spectrum Disorders. 7 (1), 109-19. 177Pelton MK and Cassidy S (2017). Are autistic traits associated with suicidality? A test of the interpersonal-psychological theory of suicide in a non-clinical young adult sample. Autism Res. 10(11):1891-1904 178Chen MH, et al. (2017). Risk of Suicide Attempts Among Adolescents and Young Adults With Autism Spectrum Disorder: A Nationwide Longitudinal Follow-Up Study. J Clin Psychiatry. 78(9):e1174-e1179. 179Autistica (2017). Our current research projects – understanding suicide in autism. 180Brugha T, et al. (2011). Epidemiology of Autism Spectrum Disorders in Adults in the Community in England. Archives of General Psychiatry. 68 (5), 459-66 181Hirvikoski T. et al. (2016). Premature mortality in autism spectrum disorder. The British Journal of Psychiatry, 207(5), 232-8. 182Autistica (2016). Personal tragedies, public crisis: The urgent need for a national response to early death in Autism. London: Autistica. Crucially, it is believed that suicide prevention strategies used in the general population might not be appropriate for supporting autistic people.183 Although research is beginning to identify the risk factors for suicide amongst autistic people.184 Autistica is not aware of any existing research to design or pilot suicide prevention strategies targeted at autistic people. 183Cassidy S and Rodgers J (2017). Understanding and prevention of suicide in autism. The Lancet Psychiatry, Vol 4. Issue 5 ell. 184Autistica (2017). Our current research projects – understanding suicide in autism. Suggested research questions The following research question was proposed during the international summit on suicide and autism in June 2017, as publicised in the Lancet.185 It was developed further in a second collaborative workshop on mental health with	Thank you for your comment. All of our research recommendations include all population groups as we have not specified any subgroups. We have not included the references as we did not prioritise a review question on groups at high suicide risk at scoping. We will pass your comment and references to the surveillance team at NICE. In addition, Public Health England are updating their suicide prevention guidance later this year and are planning to add more information on autism following discussions with Autistica.

				autistic people, clinicians and researchers in October 2017: 185Cassidy S and Rodgers J (2017). Understanding and prevention of suicide in autism. The Lancet Psychiatry, Vol 4. Issue 5 ell. What adjustments should be made to help autistic people at risk of suicide to reach support when they are at a crisis point? Other key research areas identified at those collaborative workshops include: What are the risk factors for suicide and suicidality in autism? What is the developmental trajectory of suicidality and suicide risk in autism? How does gender relate to suicidality in autism? How does help-seeking behaviour differ between autistic people and non-autistic people? A priority setting partnership completed in 2016 – before much of the evidence around suicide and autism was commonly known – found that mental health was the autism community's overwhelming top priority for research.186 186Autistica and the James Lind Alliance (2016). Your questions: shaping future autism research. London: Autistica. A large portion of autistic people consider or attempt suicide Multiple studies have found high rates of suicide ideation amongst autistic people. Between a third and two-thirds of autistic adults (without a learning disability) have considered or attempting ending their own life.187,188,189,190 One study found that this was also true for 14% of children and young people on the autism spectrum, compared to just 0.5% of their non-autistic peers.191 There is growing evidence to consider autism or autistic traits as an independent risk factor for suicide.192,193 187Balfe M, et al. (2010). A descriptive social and health profile of a community sample of adults and adolescents with Asperger syndrome. BMC Research Notes, 3: 300 188Raja M (2014) Suicide risk in adults with Asperger's syndrome. Lancet Psychiatry. 1(2), 99-101 189Segers M, Rawana J (2014) What do we know about suicidality in autism spectrum disorders? A systematic review. Autism Research, 5;7(4):507-21 190Cassidy, S. et al. (2014). Suicidal ideation and suicide plans or attempts in adults with Asperger's syndrome attending a specialist diagnostic clinic: a clinical cohort study. Lancet Psychiatry 1, 2, 142-7. 191Mayes SD (2013) Suicide ideation and attempts in children with autism. Research in Autism Spectrum Disorders. 7 (1), 109-19. 192Pelton MK and Cassidy S (2017). Are autistic traits associated with suicidality? A test of the interpersonal-psychological theory of suicide in a non-clinical young adult sample. Autism Res. 10(11):1891-1904 193Chen MH, et al. (2017). Risk of Suicide Attempts Among Adolescents and Young Adults With Autism Spectrum Disorder: A Nationwide Longitudinal Follow-Up Study. J Clin Psychiatry. 78(9):e1174-e1179. Autistic people account for a significant proportion of suicides in the UK	

				Research suggests that autistic people account for a significant and disproportionate number of people who take their own lives. In 2016 a large population study from Sweden found that autistic people were on average seven times more likely to die by suicide than the general population.194,195 The two-thirds of autistic people who do not have a co-occurring learning disability were found to be at particularly high risk, with rates nine times that of the general population. Suicide was the second leading cause of death for this group, behind heart disease, and the area where autistic people without a learning disability had the highest relative risk of mortality compared to the general population. Autistic people with a learning disability were still twice as likely to die by suicide as the general population. 194Hirvikoski T. et al. (2016). Premature mortality in autism spectrum disorder. The British Journal of Psychiatry, 207(5), 232-8. 195Autistica (2016). Personal tragedies, public crisis: The urgent need for a national response to early death in Autism. London: Autistica. Autistic people are significantly under-represented in national and local datasets concerning suicide because, for historical reasons, the majority of autistic adults are not diagnosed. However, preliminary findings from the ongoing Psychological Autopsy study that Autistica is funding – which is being conducted by the University of Nottingham across Cambridgeshire and Derbyshire – indicate that autistic people may account for 11% of deaths by suicide in the UK,196 even though only 1% of the population are on the spectrum.197 196Autistica (2017). Our current research projects – understanding suicide in autism. 197Brugha T, et al. (2011). Epidemiology of Autism Spectrum Disorders in Adults in the Community in England. Archives of General Psychiatry. 68 (5), 459-66 Suicide prevention strategies may need to be adapted to support autistic people Initial evidence suggests that the trends relating to suicidality in the autistic population may differ from the general population. For example, autistic women appear to be more likely to take their own lives than autistic men.198,199 Anecdotal evidence indicates that suicide prevention strategies used in the general population might not be appropriate for supporting autistic people.200 Autistica's ongoing Psychological Autopsies study will look into the risk factors for suicide amongst autistic people.201 This information could help inform and improve the effectiveness of local suicide prevention measures, so it is vital that organisations responsible for local suicide prevention strategies keep up-to-date with ongoing and upcoming research/initiatives. 198Hirvikoski T. et al. (2016). Premature mortality in autism spectrum disorder. The British Journal of Psychiatry, 207(5), 232-8. 199Cassidy, S. et al. (2014). Suicidal ideation and suicide plans or attempts in adults with Asperger's syndrome attending a specialist diagnostic clinic: a clinical cohort study. Lancet Psychiatry 1, 2, 142-7. 200Cassidy S and Rodgers J (2017). Understanding and prevention of suicide in autism. The Lancet Psychiatry, Vol 4. Issue 5 ell. 201Autistica (2017). Our current research projects – understanding suicide in autism. Mental health interventions often need adapting for autistic people Autistic people are disproportionately affected by mental health problems. 70% of autistic children and 79% of autistic adults experience at least one mental health	

				problem.202,203 For some mental health conditions, autistic people represent a major proportion of the affected population. For example, there is strong evidence that between 20% and 30% of women with anorexia nervosa are autistic.204,205,206 202Lever AG, Geurts HM (2016) Psychiatric Co-occurring Symptoms and Disorders in Young, Middle-Aged, and Older Adults with Autism Spectrum Disorder. Journal of utism and Developmental Disorders. 46, 6, 1916–30. 203Simonoff, et al. (2008). Psychiatric disorders in children with autism spectrum disorders: prevalence, comorbidity, and associated factors in a population-derived sample. Journal of the American Academy of Child and Adolescent Psychiatry. 47(8): 921-9. 204Huke V, et al. (2013). Autism Spectrum Disorders in Eating Disorder Populations: A Systematic Review. European Eating Disorders Review: The Journal of the Eating Disorders Association, 21(5), 345–351. 205Treasure J (2013). Coherence and other autistic spectrum traits and eating disorders: building from mechanism to treatment. The Birgit Olsson lecture. Nordic Journal of Psychiatry, 67(1), 38–42. 206Westwood H, et al. (2017). Clinical evaluation of autistic symptoms in women with anorexia nervosa. Molecular Autism, 8, 12. It is increasingly clear that some mental health interventions do not work for autistic people in the same way that they do for neurotypical people; for example, the importance of adapting CBT protocols for autistic people with anxiety is now well documented.207,208,209,210 Finding interventions which are effective in improving autistic people's mental health is the autism community's number one priority for research.211 Work is currently underway to develop and test more effective methods for identifying and intervening in mental health problems with autistic people.212,213,214,215,216,217 Similar research needs to begin into suicide prevention strategies for autistic people at high risk of taking their own life. 207Cooper K., et al. (2018). Adapting psychological therapies for autism. Research in Autism Spectrum Disorders, Vol 45: 43-50. 208Rodgers J and Ofield A (2018). Understanding, recognising and treating co-occurring anxiety in autism. Curr Dev Disord Rep, 5: 58. 209Zaboski B and Storch E (2018). Comorbid autism spectrum disorder and anxiety disorders: a brief review. Future Neurology. Vol.13(1). 210Lietz P, et al. (2018). Protocol for a systematic review: Interventions for anxiety in school-aged children with autism spectrum disorder (ASD). Campbell Collaboration. 211Autistica and the James Lind Alliance (2016). Your questions: shaping future autism research. London: Autistica. 212Autistica (2017). Our current research projects – Treating anorexia in autistic women [webpage]. 213Autistica (2017). Our current research projects – Anxiety and depression in autistic people who speak few or no words [webpage]. 214Autistica (2017). Our current research projects – Addressing intolerance of uncertainty in children with autism: an intervention feasibility trial [webpage]. 215Autistica (2017). Our current research projects – Elucidating the relationship and co-evolution of sensory reactivity and mental health symptoms in autism [webpage]. 216Autistica (2017). Our current research projects –A personalised anxiety	

				treatment for autistic adults. 217NIHR (2017). Themed Call Mental health portfolio October 2017.	
Autistica	Full	5	19-20	This recommendation will be particularly important for ensuring that suicide prevention strategies are effective in supporting autistic people. Locally, autistic people are likely to be one of the groups at highest risk of suicide44,45,46,47,48,49,50,51,52,53 and suicide prevention measures may need to be adapted to support them more effectively.54 Research is currently looking at the risk factors for suicide amongst autistic people.55 Initiatives may be developed in the near future to test the effectiveness of tailored suicide prevention measures amongst autistic people. Organisations responsible for developing and delivering local suicide prevention strategies should keep up-to-date with ongoing work on this topic. 44Autistica (2017). Our current research projects – understanding suicide in autism. 45Balfe M, et al. (2010). A descriptive social and health profile of a community sample of adults and adolescents with Asperger syndrome. BMC Research Notes, 3: 300 46Raja M (2014) Suicide risk in adults with Asperger's syndrome. Lancet Psychiatry. 1(2), 99-101 47Segers M, Rawana J (2014) What do we know about suicidality in autism spectrum disorders? A systematic review. Autism Research, 5;7(4):507-21 48Cassidy, S. et al. (2014). Suicidal ideation and suicide plans or attempts in adults with Asperger's syndrome attending a specialist diagnostic clinic: a clinical cohort study. Lancet Psychiatry 1, 2, 142-7. 49Mayes SD (2013) Suicide ideation and attempts in children with autism. Research in Autism Spectrum Disorders. 7 (1), 109-19. 50Hirvikoski T. et al. (2016). Premature mortality in autism spectrum disorder. The British Journal of Psychiatry, 207(5), 232-8. 51Autistica (2016). Personal tragedies, public crisis: The urgent need for a national response to early death in Autism. London: Autistica. 52Pelton MK and Cassidy S (2017). Are autistic traits associated with suicidality? A test of the interpersonal-psychological theory of suicide in a non-clinical young adult sample. Autism Res. 10(11):1891-1904 53Chen MH, et al. (2017). Risk of Suicide Attempts Among Adolescents and Young Adults With Autism Spectrum Disorder: A Nationwide Longitudinal Follow-Up Study. J Clin Psychiatry. 78(9):e1174-e1179. 54Cassidy S and Rodgers J (2017). Understanding and prevention of suicide in autism. The Lancet Psychiatry, Vol 4. Issue 5 ell. 55Autistica (2017). Our current research projects – understanding suicide in autism. A large portion of autistic people consider or attempt suicide Multiple studies have found high rates of suicide ideation amongst autistic people. Between a third and two-thirds of autistic adults (without a learning disability) have considered or attempting ending their own life.56,57,58,59 One study found that this was also true for 14% of children and young people on the autism spectrum, compared to just 0.5% of their non-autistic peers.60 There is growing evidence to consider autism or autistic traits as an independent risk factor for suicide. 61,62 56Balfe M, et al. (2010). A descriptive social and health profile of a community sample of adults and adolescents with Asperger syndrome. BMC Research Notes, 3: 300	Thank you for your comment. The committee have added "people with autism" to the list of "high suicide risk" in the terms used in the guideline. However we have not included the references as we did not prioritise a review question on groups at high suicide risk at scoping We will pass your comment and references to the surveillance team at NICE. In addition, Public Health England are updating their suicide prevention guidance later this year and are planning to add more information on autism following discussions with Autistica. Suicide prevention action plans may need to be adapted to support autistic people. We have included the following recommendation to support this "1.3.1 Prioritise actions based on the joint strategic needs assessment and other local data to ensure the plan is tailored to local needs" Mental health interventions are out of scope for this guideline and therefore we can not include any adaptations that may be needed for autistic people

				57Raja M (2014) Suicide risk in adults with Asperger's syndrome. Lancet Psychiatry. 1(2), 99-101 58Segers M, Rawana J (2014) What do we know about suicidality in autism spectrum disorders? A systematic review. Autism Research, 5;7(4):507-21 59Cassidy, S. et al. (2014). Suicidal ideation and suicide plans or attempts in adults with Asperger's syndrome attending a specialist diagnostic clinic: a clinical cohort study. Lancet Psychiatry 1, 2, 142-7. 60Mayes SD (2013) Suicide ideation and attempts in children with autism. Research in Autism Spectrum Disorders. 7 (1), 109-19. 61Pelton MK and Cassidy S (2017). Are autistic traits associated with suicidality? A test of the interpersonal-psychological theory of suicide in a non-clinical young adult sample. Autism Res. 10(11):1891-1904 62Chen MH, et al. (2017). Risk of Suicide Attempts Among Adolescents and Young Adults With Autism Spectrum Disorder: A Nationwide Longitudinal Follow-Up Study. J Clin Psychiatry. 78(9):e1174-e1179. Autistic people account for a significant proportion of suicides in the UK Research suggests that autistic people account for a significant and disproportionate number of people who take their own lives. In 2016 a large population study from Sweden found that autistic people were on average seven times more likely to die by suicide than the general population.63,64 The two-thirds of autistic people who do not have a co-occurring learning disability were found to be at particularly high risk, with rates nine times that of the general population. Suicide was the second leading cause of death for this group, behind heart disease, and the area where autistic people without a learning disability had the highest relative risk of mortality compared to the general population. Autistic people with a learning disability were still twice as likely to die by suicide as the general population. 63Hirvikoski T. et al. (2016). Premature mortality in autism spectrum disorder. The British Journal of Psychiatry, 207(5), 232-8. 64Autistica (2016). Personal tragedies, public crisis: The urgent need for a national response to early death in Autism. London: Autistica. Autistic people are significantly under-represented in national and local datasets concerning suicide because, for historical reasons, the majority of autistic adults are not diagnosed. However, preliminary findings from the ongoing Psychological Autopsy study that Autistica is funding – which is being conducted by the University of Nottingham across Cambridgeshire and Derbyshire – indicate that autistic people may account for 11% of deaths by suicide in the UK,65 even though only 1% of the population are on the spectrum.66 65Autistica (2017). Our current research projects – understanding suicide in autism. 66Brugha T, et al. (2011). Epidemiology of Autism Spectrum Disorders in Adults in the Community in England. Archives of General Psychiatry. 68 (5), 459-66 Suicide prevention strategies may need to be adapted to support autistic people Initial evidence suggests that the trends relating to suicidality in the autistic population may differ from the general population. For example, autistic women appear to be more likely to take their own lives than autistic men.67,68 Anecdotal evidence indicates that suicide prevention strategies used in the general population might not be appropriate for supporting autistic people.69 Autistica's ongoing Psychological Autopsies study will look into the risk factors for suicide	

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Autistica	Full	5	12	This recommendation will be particularly important for ensuring that suicide prevention strategies are effective in supporting autistic people. Locally, autistic people are likely to be one of the groups at highest risk of suicide 1,2,3,4,5,6,7,8,9,10 and suicide prevention measures may need to be adapted to support them more effectively.11 Research is currently looking at the risk factors for suicide amongst autistic people.12 Organisations responsible for developing and delivering local suicide prevention strategies should keep up-to-date with ongoing and upcoming research in this area to ensure the support they are offering can meet local need. A large portion of autistic people consider or attempt suicide Multiple studies have found high rates of suicide ideation amongst autistic people. Between a third and two-thirds of autistic adults (without a learning disability) have considered or attempting ending their own life. 13, 14,15, 16 One study found that this was also true for 14% of children and young people on the autism spectrum, compared to just 0.5% of their non-autistic peers.17 There is growing evidence to consider autism or autistic traits as an independent risk factor for suicide.18,19 [1]Autistica (2017). Our current research projects – understanding suicide in autism. 2Balfe M, et al. (2010). A descriptive social and health profile of a community sample of adults and adolescents with Asperger syndrome. BMC Research Notes, 3: 300 3Raja M (2014) Suicide risk in adults with Asperger's syndrome. Lancet Psychiatry. 1(2), 99-101 4Segers M, Rawana J (2014) What do we know about suicidality in autism spectrum disorders? A systematic review. Autism Research, 5;7(4):507-21 5Cassidy, S. et al. (2014). Suicidal ideation and suicide plans or attempts in adults with Asperger's syndrome attending a specialist diagnostic clinic: a clinical cohort study. Lancet Psychiatry 1, 2, 142-7. 6Mayes SD (2013) Suicide ideation and attempts in children with autism. Research in Autism Spectrum Disorders. 7 (1), 109-19. 7Hirvikoski T. et al. (2016). Premature mortality in autism spectrum disorder. The British Journal of Psychiatry, 207(5), 232-8.	Thank you for your comment. The committee have added "people with autism" to the list of "high suicide risk" in the terms used in the guideline. However we have not included the references as we did not prioritise a review question on groups at high suicide risk at scoping. We will pass your comment and references to the surveillance team at NICE. In addition, Public Health England are updating their suicide prevention guidance later this year and are planning to add more information on autism following discussions with Autistica. Suicide prevention action plans may need to be adapted to support autistic people. We have included the following recommendation to support this "1.3.1 Prioritise actions based on the joint strategic needs assessment and other local data to ensure the plan is tailored to local needs" Mental health interventions are out of scope for this guideline and therefore we can not include any adaptations that may be needed for autistic people

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				Suicide prevention strategies may need to be adapted to support autistic people Initial evidence suggests that the trends relating to suicidality in the autistic population may differ from the general population. For example, autistic women appear to be more likely to take their own lives than autistic men.24,25 Anecdotal evidence indicates that suicide prevention strategies used in the general population might not be appropriate for supporting autistic people.26 Autistica's ongoing Psychological Autopsies study will look into the risk factors for suicide amongst autistic people.27 This information could help inform and improve the effectiveness of local suicide prevention measures, so it is vital that organisations responsible for local suicide prevention strategies keep up-to-date with ongoing and upcoming research/initiatives. Mental health interventions often need adapting for autistic people Autistic people are disproportionately affected by mental health problems. 70% of autistic children and 79% of autistic adults experience at least one mental health problem.28,29 For some mental health conditions, autistic people represent a major proportion of the affected population. For example, there is strong evidence that between 20% and 30% of women with anorexia nervosa are autistic.30,31,32 It is increasingly clear that some mental health interventions do not work for autistic people in the same way that they do for neurotypical people; for example, the importance of adapting CBT protocols for autistic people with anxiety is now well documented.33,34,35,36 Finding interventions which are effective in improving autistic people's mental health is the autism community's number one priority for research.[i] Work is currently underway to develop and test more effective methods for identifying and intervening in mental health problems with autistic people.38,39,40,4142,43 Similar progress needs to begin being made into suicide prevention strategies for autistic people at high risk of taking their own life. 20Hirvikoski T. et al. (2016). Premature mortality in autism spectrum disorder. The British Journal of Psychiatry, 207(5), 232-8. 21Autistica (2016). Personal tragedies, public crisis: The urgent need for a national response to early death in Autism. London: Autistica. 22Autistica (2017). Our current research projects – understanding suicide in autism. 23Brugha T, et al. (2011). Epidemiology of Autism Spectrum Disorders in Adults in the Community in England. Archives of General Psychiatry. 68 (5), 459-66 24Hirvikoski T. et al. (2016). Premature mortality in autism spectrum disorder. The British Journal of Psychiatry, 207(5), 232-8. 25Cassidy, S. et al. (2014). Suicidal ideation and suicide plans or attempts in adults with Asperger's syndrome attending a specialist diagnostic clinic: a clinical cohort study. Lancet Psychiatry 1, 2, 142-7. 26Cassidy S and Rodgers J (2017). Understanding and prevention of suicide in autism. The Lancet Psychiatry, Vol 4. Issue 5 ell. 27Autistica (2017). Our current research projects – understanding suicide in autism. 28Lever AG, Geurts HM (2016) Psychiatric Co-occurring Symptoms and Disorders in Young, Middle-Aged, and Older Adults with Autism Spectrum Disorder. Journal of utism and Developmental Disorders. 46, 6, 1916–30. 29Simonoff, et al. (2008). Psychiatric disorders in children with autism spectrum disorders: prevalence, comorbidity, and associated factors in a population-	

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Autistica	Full	10	Dec-13	This guidance should consider the potential need for training staff within suicide prevention services about some basic groundwork for engaging with autistic people. Locally, autistic people are likely to be one of the groups at highest risk of suicide87,88,89,90,91,92,93,94,95,96 and suicide prevention measures may need to be adapted to support them more effectively.97 Although every autistic person is different, there is recognised best practice in engaging with autistic people. For example, it is advisable to keep language as literal as possible (avoiding metaphors), to ask direct and closed questions and to give autistic people additional time to process a question/comment and form a response. The autism toolkit developed by the Royal College of General Practitioners has a number of resources that may be useful.98 87Autistica (2017). Our current research projects – understanding suicide in autism. 88Balfe M, et al. (2010). A descriptive social and health profile of a community sample of adults and adolescents with Asperger syndrome. BMC Research Notes, 3: 300 89Raja M (2014) Suicide risk in adults with Asperger's syndrome. Lancet Psychiatry. 1(2), 99-101 90Segers M, Rawana J (2014) What do we know about suicidality in autism	Thank you for your comment. We have acknowledged that different groups require different levels of training " 1.7.3 Provide generic and specialist training as needed for specialists and non-specialists." The committee have added "people with autism" to the list of "high suicide risk" in the terms used in the guideline. However we have not included the references as we did not prioritise a review question on groups at high suicide risk at scoping. Suicide prevention action plans may need to be adapted to support autistic people. We have included the following recommendation to support this "1.3.1 Prioritise actions based on the joint strategic needs assessment and other local data to ensure the plan is tailored to local needs" Mental health interventions are out of scope for this guideline and therefore we can not include any adaptations that may be needed for autistic people

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				times more likely to die by suicide than the general population.106,107 The two-thirds of autistic people who do not have a co-occurring learning disability were found to be at particularly high risk, with rates nine times that of the general population. Suicide was the second leading cause of death for this group, behind heart disease, and the area where autistic people without a learning disability had the highest relative risk of mortality compared to the general population. Autistic people with a learning disability were still twice as likely to die by suicide as the general population. 106Hirvikoski T. et al. (2016). Premature mortality in autism spectrum disorder. The British Journal of Psychiatry, 207(5), 232-8. 107Autistica (2016). Personal tragedies, public crisis: The urgent need for a national response to early death in Autism. London: Autistica. Autistic people are significantly under-represented in national and local datasets concerning suicide because, for historical reasons, the majority of autistic adults are not diagnosed. However, preliminary findings from the ongoing Psychological Autopsy study that Autistica is funding – which is being conducted by the University of Nottingham across Cambridgeshire and Derbyshire – indicate that autistic people may account for 11% of deaths by suicide in the UK,108 even though only 1% of the population are on the spectrum.109 108Autistica (2017). Our current research projects – understanding suicide in autism. 109Brugha T, et al. (2011). Epidemiology of Autism Spectrum Disorders in Adults in the Community in England. Archives of General Psychiatry. 68 (5), 459-66 Suicide prevention strategies may need to be adapted to support autistic people Initial evidence suggests that the trends relating to suicidality in the autistic population may differ from the general population. For example, autistic women appear to be more likely to take their own lives than autistic men.110,111 Anecdotal evidence indicates that suicide prevention strategies used in the general population might not be appropriate for supporting autistic people.112 Autistica's ongoing Psychological Autopsies study will look into the risk factors for suicide amongst autistic people.113 This information could help inform and improve the effectiveness of local suicide prevention measures, so it is vital that organisations responsible for local suicide prevention strategies keep up-to-date with ongoing and upcoming research/initiatives. 110Hirvikoski T. et al. (2016). Premature mortality in autism spectrum disorder. The British Journal of Psychiatry, 207(5), 232-8. 111Cassidy, S. et al. (2014). Suicidal ideation and suicide plans or attempts in adults with Asperger's syndrome attending a specialist diagnostic clinic: a clinical cohort study. Lancet Psychiatry 1, 2, 142-7. 112Cassidy S and Rodgers J (2017). Understanding and prevention of suicide in autism. The Lancet Psychiatry, Vol 4. Issue 5 ell. 113Autistica (2017). Our current research projects – understanding suicide in autism. Mental health interventions often need adapting for autistic people Autistic people are disproportionately affected by mental health problems. 70% of autistic children and 79% of autistic adults experience at least one mental health problem.114,115 For some mental health conditions, autistic people represent a major proportion of the affected population. For example, there is strong evidence that between 20% and 30% of women with anorexia nervosa are	

				autistic.116,117,118 114Lever AG, Geurts HM (2016) Psychiatric Co-occurring Symptoms and Disorders in Young, Middle-Aged, and Older Adults with Autism Spectrum Disorder. Journal of utism and Developmental Disorders. 46, 6, 1916–30. 115Simonoff, et al. (2008). Psychiatric disorders in children with autism spectrum disorders: prevalence, comorbidity, and associated factors in a population-derived sample. Journal of the American Academy of Child and Adolescent Psychiatry. 47(8): 921-9. 116Huke V, et al. (2013). Autism Spectrum Disorders in Eating Disorder Populations: A Systematic Review. European Eating Disorders Review: The Journal of the Eating Disorders Association, 21(5), 345–351. 117Treasure J (2013). Coherence and other autistic spectrum traits and eating disorders: building from mechanism to treatment. The Birgit Olsson lecture. Nordic Journal of Psychiatry, 67(1), 38–42. 118Westwood H, et al. (2017). Clinical evaluation of autistic symptoms in women with anorexia nervosa. Molecular Autism, 8, 12. It is increasingly clear that some mental health interventions do not work for autistic people in the same way that they do for neurotypical people; for example, the importance of adapting CBT protocols for autistic people with anxiety is now well documented.119,120,121,122 Finding interventions which are effective in improving autistic people's mental health is the autism community's number one priority for research.123 Work is currently underway to develop and test more effective methods for identifying and intervening in mental health problems with autistic people.124,125,126,127,128,129 Similar progress needs to begin being made into suicide prevention strategies for autistic people at high risk of taking their own life. 119Cooper K., et al. (2018). Adapting psychological therapies for autism. Research in Autism Spectrum Disorders, Vol 45: 43-50. 120Rodgers J and Ofield A (2018). Understanding, recognising and treating co-occurring anxiety in autism. Curr Dev Disord Rep, 5: 58. 121Zaboski B and Storch E (2018). Comorbid autism spectrum disorder and anxiety disorders: a brief review. Future Neurology. Vol.13(1). 122Lietz P, et al. (2018). Protocol for a systematic review: Interventions for anxiety in school-aged children with autism spectrum disorder (ASD). Campbell Collaboration. 123Autistica and the James Lind Alliance (2016). Your questions: shaping future autism research. London: Autistica. 124Autistica (2017). Our current research projects – Treating anorexia in autistic women [webpage]. 125Autistica (2017). Our current research projects – Anxiety and depression in autistic people who speak few or no words [webpage]. 126Autistica (2017). Our current research projects – Addressing intolerance of uncertainty in children with autism: an intervention feasibility trial [webpage]. 127Autistica (2017). Our current research projects – Elucidating the relationship and co-evolution of sensory reactivity and mental health symptoms in autism [webpage]. 128Autistica (2017). Our current research projects –A personalised anxiety treatment for autistic adults. 129NIHR (2017). Themed Call Mental health portfolio October 2017.	
Autistica	Full	13	14-26	We strongly recommend that this guidance should note autistic people (particularly those without a learning disability) as a "group at high risk". There is	Thank you for your comment. The committee have added "people with autism" to the list of "high suicide risk" in the terms used in the guideline. However we have

				extensive and growing evidence to show both that suicide is a particular risk for autistic people 130,131,132,133,134,135,136and that autistic people may account for a significant proportion of total suicides in the UK.137,138,139 Crucially, it may also be the case that suicide prevention measures need to be adapted or re-designed to support autistic people more effectively140 so awareness of the high-risk nature of this group will be directly relevant to local service providers, commissioners or partners. 130Balfe M, et al. (2010). A descriptive social and health profile of a community sample of adults and adolescents with Asperger syndrome. BMC Research Notes, 3: 300 131Raja M (2014) Suicide risk in adults with Asperger's syndrome. Lancet Psychiatry. 1(2), 99-101 132Segers M, Rawana J (2014) What do we know about suicidality in autism spectrum disorders? A systematic review. Autism Research, 5;7(4):507-21 133Cassidy, S. et al. (2014). Suicidal ideation and suicide plans or attempts in adults with Asperger's syndrome attending a specialist diagnostic clinic: a clinical cohort study. Lancet Psychiatry 1, 2, 142-7. 134Mayes SD (2013) Suicide ideation and attempts in children with autism. Research in Autism Spectrum Disorders. 7 (1), 109-19. 135Pelton MK and Cassidy S (2017). Are autistic traits associated with suicidality? A test of the interpersonal-psychological theory of suicide in a non-clinical young adult sample. Autism Res. 10(11):1891-1904 136Chen MH, et al. (2017). Risk of Suicide Attempts Among Adolescents and Young Adults With Autism Spectrum Disorder: A Nationwide Longitudinal Follow-Up Study. J Clin Psychiatry. 78(9):e1174-e1179. 137Hirvikoski T. et al. (2016). Premature mortality in autism spectrum disorder. The British Journal of Psychiatry, 207(5), 232-8. 138Autistica (2016). Personal tragedies, public crisis: The urgent need for a national response to early death in Autism. London: Autistica. 139Autistica (2017). Our current research projects – understanding suicide in autism. 140Cassidy S and Rodgers J (2017). Understanding and prevention of suicide in autism. The Lancet Psychiatry, Vol 4. Issue 5 ell. A large portion of autistic people consider or attempt suicide Multiple studies have found high rates of suicide ideation amongst autistic people. Between a third and two-thirds of autistic adults (without a learning disability) have considered or attempting ending their own life.141,142,143,144 One study found that this was also true for 14% of children and young people on the autism spectrum, compared to just 0.5% of their non-autistic peers.145 There is growing evidence to consider autism or autistic traits as an independent risk factor for suicide.146,147 141Balfe M, et al. (2010). A descriptive social and health profile of a community sample of adults and adolescents with Asperger syndrome. BMC Research Notes, 3: 300 142Raja M (2014) Suicide risk in adults with Asperger's syndrome. Lancet Psychiatry. 1(2), 99-101 143Segers M, Rawana J (2014) What do we know about suicidality in autism spectrum disorders? A systematic review. Autism Research, 5;7(4):507-21 144Cassidy, S. et al. (2014). Suicidal ideation and suicide plans or attempts in adults with Asperger's syndrome attending a specialist diagnostic clinic: a clinical cohort study. Lancet Psychiatry 1, 2, 142-7.	not included the references as we did not prioritise a review question on groups at high suicide risk at scoping. We will pass your comment and references to the surveillance team at NICE. In addition, Public Health England are updating their suicide prevention guidance later this year and are planning to add more information on autism following discussions with Autistica. Suicide prevention action plans may need to be adapted to support autistic people. We have included the following recommendation to support this "Prioritise actions based on the joint strategic needs assessment and other local data to ensure the plan is tailored to local needs" Mental health interventions are out of scope for this guideline and therefore we can not include any adaptations that may be needed for autistic people

				145Mayes SD (2013) Suicide ideation and attempts in children with autism. Research in Autism Spectrum Disorders. 7 (1), 109-19. 146Pelton MK and Cassidy S (2017). Are autistic traits associated with suicidality? A test of the interpersonal-psychological theory of suicide in a non-clinical young adult sample. Autism Res. 10(11):1891-1904 147Chen MH, et al. (2017). Risk of Suicide Attempts Among Adolescents and Young Adults With Autism Spectrum Disorder: A Nationwide Longitudinal Follow-Up Study. J Clin Psychiatry. 78(9):e1174-e1179. Autistic people account for a significant proportion of suicides in the UK Research suggests that autistic people account for a significant and disproportionate number of people who take their own lives. In 2016 a large population study from Sweden found that autistic people were on average seven times more likely to die by suicide than the general population.148,149 The two-thirds of autistic people who do not have a co-occurring learning disability were found to be at particularly high risk, with rates nine times that of the general population. Suicide was the second leading cause of death for this group, behind heart disease, and the area where autistic people without a learning disability had the highest relative risk of mortality compared to the general population. Autistic people with a learning disability were still twice as likely to die by suicide as the general population. 148Hirvikoski T. et al. (2016). Premature mortality in autism spectrum disorder. The British Journal of Psychiatry, 207(5), 232-8. 149Autistica (2016). Personal tragedies, public crisis: The urgent need for a national response to early death in Autism. London: Autistica. Autistic people are significantly under-represented in national and local datasets concerning suicide because, for historical reasons, the majority of autistic adults are not diagnosed. However, preliminary findings from the ongoing Psychological Autopsy study that Autistica is funding – which is being conducted by the University of Nottingham across Cambridgeshire and Derbyshire – indicate that autistic people may account for 11% of deaths by suicide in the UK,150 even though only 1% of the population are on the spectrum.151 150Autistica (2017). Our current research projects – understanding suicide in autism. 151Brugha T, et al. (2011). Epidemiology of Autism Spectrum Disorders in Adults in the Community in England. Archives of General Psychiatry. 68 (5), 459-66 Suicide prevention strategies may need to be adapted to support autistic people Initial evidence suggests that the trends relating to suicidality in the autistic population may differ from the general population. For example, autistic women appear to be more likely to take their own lives than autistic men.152,153 Anecdotal evidence indicates that suicide prevention strategies used in the general population might not be appropriate for supporting autistic people.154 Autistica's ongoing Psychological Autopsies study will look into the risk factors for suicide amongst autistic people.155 This information could help inform and improve the effectiveness of local suicide prevention measures, so it is vital that organisations responsible for local suicide prevention strategies keep up-to-date with ongoing and upcoming research/initiatives. 152Hirvikoski T. et al. (2016). Premature mortality in autism spectrum disorder. The British Journal of Psychiatry, 207(5), 232-8. 153Cassidy, S. et al. (2014). Suicidal ideation and suicide plans or attempts in	

				adults with Asperger's syndrome attending a specialist diagnostic clinic: a clinical cohort study. Lancet Psychiatry 1, 2, 142-7. 154Cassidy S and Rodgers J (2017). Understanding and prevention of suicide in autism. The Lancet Psychiatry, Vol 4. Issue 5 ell. 155Autistica (2017). Our current research projects – understanding suicide in autism. Mental health interventions often need adapting for autistic people Autistic people are disproportionately affected by mental health problems. 70% of autistic children and 79% of autistic adults experience at least one mental health problem.156,157 For some mental health conditions, autistic people represent a major proportion of the affected population. For example, there is strong evidence that between 20% and 30% of women with anorexia nervosa are autistic.158,159,160 156Lever AG, Geurts HM (2016) Psychiatric Co-occurring Symptoms and Disorders in Young, Middle-Aged, and Older Adults with Autism Spectrum Disorder. Journal of utism and Developmental Disorders. 46, 6, 1916–30. 157Simonoff, et al. (2008). Psychiatric disorders in children with autism spectrum disorders: prevalence, comorbidity, and associated factors in a population-derived sample. Journal of the American Academy of Child and Adolescent Psychiatry. 47(8): 921-9. 158Huke V, et al. (2013). Autism Spectrum Disorders in Eating Disorder Populations: A Systematic Review. European Eating Disorders Review: The Journal of the Eating Disorders Association, 21(5), 345–351. 159Treasure J (2013). Coherence and other autistic spectrum traits and eating disorders: building from mechanism to treatment. The Birgit Olsson lecture. Nordic Journal of Psychiatry, 67(1), 38–42. 160Westwood H, et al. (2017). Clinical evaluation of autistic symptoms in women with anorexia nervosa. Molecular Autism, 8, 12. It is increasingly clear that some mental health interventions do not work for autistic people in the same way that they do for neurotypical people; for example, the importance of adapting CBT protocols for autistic people with anxiety is now well documented.161,162,163,164 Finding interventions which are effective in improving autistic people's mental health is the autism community's number one priority for research.165 Work is currently underway to develop and test more effective methods for identifying and intervening in mental health problems with autistic people.166,167,168,169,170,171 Similar progress needs to begin being made into suicide prevention strategies for autistic people at high risk of taking their own life. 161Cooper K., et al. (2018). Adapting psychological therapies for autism. Research in Autism Spectrum Disorders, Vol 45: 43-50. 162Rodgers J and Ofield A (2018). Understanding, recognising and treating co-occurring anxiety in autism. Curr Dev Disord Rep, 5: 58. 163Zaboski B and Storch E (2018). Comorbid autism spectrum disorder and anxiety disorders: a brief review. Future Neurology. Vol.13(1). 164Lietz P, et al. (2018). Protocol for a systematic review: Interventions for anxiety in school-aged children with autism spectrum disorder (ASD). Campbell Collaboration. 165Autistica and the James Lind Alliance (2016). Your questions: shaping future autism research. London: Autistica. 166Autistica (2017). Our current research projects – Treating anorexia in autistic	

				women [webpage]. 167Autistica (2017). Our current research projects – Anxiety and depression in autistic people who speak few or no words [webpage]. 168Autistica (2017). Our current research projects – Addressing intolerance of uncertainty in children with autism: an intervention feasibility trial [webpage]. 169Autistica (2017). Our current research projects – Elucidating the relationship and co-evolution of sensory reactivity and mental health symptoms in autism [webpage]. 170Autistica (2017). Our current research projects –A personalised anxiety treatment for autistic adults. 171NIHR (2017). Themed Call Mental health portfolio October 2017.	
British Psychological Society				References Berkowitz, L., McCauley, J., Schuurman, D.L. & Jordan, J.R. (2011). Organisational postvention after suicide death. In. J.R. Jordan & J.L. McIntosh (Eds.) Grief after suicide. London: Routledge. British Psychology Society (2017). Position Statement: Understanding and preventing suicide: A psychological perspective. Leicester: BPS. Coppens, E., Van Audenhove, C., Iddi, S., Arensman, et al. (2014). Effectiveness of community facilitator training in improving knowledge, attitudes, and confidence in relation to depression and suicidal behavior: Results of the OSPI-Europe intervention in four European countries. Journal of Affective Disorders, 165, 142–50. Cox, G.R., Bailey, E., Jorm, A.F. et al. (2016). Development of suicide postvention guidelines for secondary schools: A delphi study. BMC Public Health, 16, 180. Grad, O. (2011). The sequelae of suicide: Survivors. In R. O'Connor, S. Platt & J. Gordon (Eds.) International Handbook of Suicide Prevention. Chichester: Wiley-Blackwell. Hawton, K., Witt, K.G., Taylor Salisbury, T.L., et al. (2015). Interventions for self-harm in children and adolescents. Cochrane Database of Systematic Reviews, 12. Hegerl, U., Rummel-Kluge, C., Värnik, A. et al. (2013). Alliances against depression – A community based approach to target depression and to prevent suicidal behaviour. Neuroscience and Biobehavioral Reviews, 37(10 Pt. 1), 2404–2409. Humber, N., Hayes, A., Senior, J., Fahy, T., & Shaw, J. (2011). Identifying, monitoring and managing prisoners at risk of self-harm/suicide in England and Wales. The Journal of Forensic Psychiatry & Psychology, 22(1), 22-51). APPG Suicide and Self-Harm Prevention. (2015) Inquiry into Local Suicide Prevention Plans in England. Joiner, T.E. (2005). Why people die by suicide. Cambridge, MA: Harvard University Press. Jordan, J. (2001). Is suicide bereavement different? A reassessment of the literature. Suicide and Ilfe-threatening behavior, 31, 91–102. Mann, J.J., Apter, A., Bertolote, J. et al. (2005). Suicide prevention strategies: A systematic review. Journal of the American Medical Association, 294(16), 2064–74. Melhelm, N.M., Day, N., Shear, K. et al. (2004.) Predictors of complicated grief among adolescents exposed to a peer's suicide. Journal of Loss and Trauma, 9,	Thank you for providing these references. We have dealt with these in the comments below.

				21–34. Niederkrotenhaler, T., Uoracek, M., Herberth, A. et al. (2010). Role of media reports in completed and prevented suicide- Werther v. Papageneo effects. British Journal of Psychiatry, 197, 234–243. O'Connor, E., Gaynes, B., Burda. B.U. et al. (2013). Screening for suicide risk in primary care: A systematic evidence review for the U.S. Preventative Services Task Force. Rockville (MD): Agency for Healthcare Research and Quality; 2013. Apr. Report No.: 13-05188-EF-1. Office of National Statistics, Suicides in Great Britain: 2016 registrations. Pitman, A. L., Osborn, D. P., Rantell, K., & King, M. B. (2016) Bereavement by suicide as a risk factor for suicide attempt: a cross-sectional national UK-wide study of 3432 young bereaved adults. BMJ open, 6(1), Public Health England (2016) Local suicide prevention planning – A practice resource. Robinson, J., Cox, G., Bailey, E. et al. (2016). Social media and suicide prevention: a systematic review. Early Intervention in Psychiatry, 10(2), 103–121. Rodway, C., Tham, S.G., Ibrahim, S., Turnbull, P., Windfuhr, K., Shaw, J., Kapur, N. and Appleby, L., 2016. Suicide in children and young people in England: a consecutive case series. The Lancet Psychiatry, 3(8), pp.751-759 Salmon, G., (2004). Multi-agency collaboration: the challenges for CAMHS. Child and Adolescent Mental Health, 9(4), 156-161. Szekely, A., Konkoly, T.B., Mergl, R. et al. (2013). How to decrease suicide rates in both genders? An effectiveness study of a community-based intervention (EAAD). PLoS ONE, 8(9), e75081 Szumilas, M. & Kutcher, S. (2011). Post-suicide intervention programs: A systematic review. Canadian Journal of Public Health, 102(1), 18–29. Wasserman, D., Rihmer, Z., Rujescu, D. et al. (2012). The European Psychiatric Association (EPA) guidance on suicide treatment and prevention. European Psychiatry, 27(2), 129–41. World Health Organization. (2014). Suicide prevention – A global imperative. Geneva, Switzerland: WHO. Zalsman, G., Hawton, K., Wasserman, D., van Heeringen, K., Arensman, E., Sarchiapone, M., Carli, V., Höschl, C., Barzilay, R., Balazs, J. and Purebl, G. (2016) Suicide prevention strategies revisited: 10-year systematic review. The Lancet Psychiatry, 3(7), pp.646-659	
British Psychological Society	NICE guideline - full	General	General	The Society welcomes the draft NICE guideline on Preventing suicide in community and custodial or detention settings, and the opportunity to contribute to the consultation.	Thank you for your interest in this guideline.
British Psychological Society	NICE guideline - full	General	General	Suicide is preventable and it is unacceptable that 5965 people died by suicide in the UK in 2016 (Office of National Statistics, Suicide in the UK, 2015 registrations). Men, particularly those aged 20–29 years and those aged 40–49 years, are most at risk of suicide, but the rising rates of suicide by women and	Thank you for your comment. The committee took these into account when drafting recommendations.

				those in the criminal justice system are extremely concerning (Office of National Statistics, Suicide in the UK, 2016 registrations). The early identification of suicidal thoughts and behaviour, and effective care for those of us at risk, are crucial in ensuring people receive the care they need. Action at an early stage is core to any strategy for suicide prevention. Although the causes of suicide are many, understanding the psychological processes underlying suicidal thinking and the factors that lead to people acting on their thoughts of suicide is vital to enabling the development and implementation of effective prevention and intervention techniques. This includes understanding the social factors and health inequalities that lead to a sense of hopelessness and despair, and understanding how we as individuals make sense of and respond to challenges in our lives. Psychologists have made significant contributions to our understanding of the interconnected nature of the causes of suicidal behaviour. 'Every 40 seconds a person dies by suicide somewhere in the world and many more attempt suicide.'(WHO, 2014, p.3) Suicide and non-fatal suicidal behaviour are major public health concerns. Suicide is the 14th leading cause of death worldwide, responsible for 1.5 per cent of all mortality (O'Connor & Nock, 2014) and it is the leading cause of death among young and middle-aged men in the UK (ONS, 2015). However, despite the prevalence of suicide, it '…has remained a low public health priority. Suicide prevention and research on suicide have not received the financial or human investment they desperately need.' (WHO, 2014, p.13) Suicidal behaviour refers to thoughts and behaviours related to suicide and self-harm that don't have a fatal outcome. These thoughts include the more specific outcomes of suicidal ideation (an individual having thoughts about intentionally taking their own life); suicide plan (the formulation of a specific action by a person to end their own life) and suicide attempt (engagement in a potentially self-injurious behaviour in which there is at least some intention of dying as a result of the behaviour). Although suicide usually occurs in the context of mental health conditions (e.g. depression) there are many risk factors for suicide (Turecki & Brent, 2015; Hawton et al., 2012). Indeed, a past history of suicidal behaviour or self-harm is one of the strongest predictors of death by suicide (Carroll et al., 2014). Self-harm is defined as intentional self-poisoning or self-injury, irrespective of motive (NICE, 2011). As a result, much research and clinical attention has focused on those who self-harm as the latter is an important predictor of suicide irrespective of whether the previous self-harm had a suicidal motive or not (Cooper et al., 2005). While much research has been conducted to determine the causes of suicidal behaviour, what lies behind the decision to end one's life is not fully understood. Nevertheless, it is well recognised that a range of complex factors influence this behaviour. Identifying the mechanisms by which various factors are associated with an increase in suicidal behaviour is a way of working towards effective prevention and intervention. 'Suicide is perhaps the cause of death most directly affected by psychological factors because a person makes a conscious decision to end his or her own life.' (O'Connor & Nock, 2014). Therefore, psychology is central to understanding and preventing suicide.	

British Psychological Society	NICE guideline - full	General	General	There is an absence of any psychological first-principles, psychological or social psychological theory, and particularly cognitive, social cognitive and cognitive behavioural theory in the document. The Society believes that the guidance would be strengthened by drawing upon the appropriate evidence-base.	Thank you for your comment. This guideline provides practical recommendations to reduce rates of suicidal behaviour, and is not a textbook.
British Psychological Society	NICE guideline - full	General	General	In each Evidence Review (1 to 9) there is weak evidence for the effectiveness of 1. Multi-agency partnerships; 2. Local suicide plans; 3. Local approaches to suicide clusters (contagion); 4. Information, advice, education and training; 5. Post-vention (support / treatment for the bereaved by suicide); 6. Prevention or restriction of means; 7. Media reporting of suicides; 8. Suicide awareness campaigns; and 9. Preventing suicides in custodial and residential settings.	Thank you for your comment. The NICE process as laid out in the NICE Manual affords the opportunity to draft recommendations based on limited evidence by using expert testimony and committee consensus.
British Psychological Society	NICE guideline - full	General	General	The document lacks detail in terms of specific guidance. It is unclear how this contributes to the National Suicide Prevention Strategy. There should be clear guidance for service commissioners. There is also no mention or reference to the National Suicide Prevention Alliance's 'Call to Action for Suicide Prevention'. There is a wealth of good practice guidance athttp://www.nspa.org.uk/home/our-work/joint-work/	Thank you for comment. The committee were aware of the National Suicide Prevention Strategy when drafting recommendations. This guideline lists commissioners in the NHS and local authorities under the heading 'Who is it for'.
British Psychological Society	NICE guideline - full	General	General	Please note the Zero Tolerance Approach to Suicide adopted by Merseyside NHS trust (http://www.merseycare.nhs.uk/media/3190/sd38-v2-zero-suicide-uploaded-29-nov-16-review-oct-19.pdf). This work was detailed, evidence-based, underpinned by theory and applicable when piloted and developed in Detroit by Dr Ed Coffey.	Thank you for your comment. We will pass this case study to the System Engagement team at NICE.
British Psychological Society	NICE guideline - full	General	General	For examples of good practice please see: The Scottish Prison Service's "Talk to Me". http://www.sps.gov.uk/Corporate/Publications/Publication-4678.aspx, the Welsh Government's, Talk to me 2 Strategyhttp://gov.wales/docs/dhss/publications/150716strategyen.pdf, and Public Health England's, Local suicide prevention planning A practice resource (October 2016) https://www.gov.uk/government/publications/suicide-prevention-developing-a-local-action-plan Furthermore, please see the APPG on Suicide and Self-Harm Prevention's report, Inquiry into Local Suicide Prevention Plans in England. (January, 2015).http://www.samaritans.org/sites/default/files/kcfinder/files/APPG-SUICIDE-REPORT.pdf	Thank you for your comment. The committee were aware of Public Health England's, Local suicide prevention planning a practice resource and the APPG on Suicide and Self-Harm Prevention's report, Inquiry into Local Suicide Prevention Plans in England when drafting recommendations.
British Psychological Society	NICE guideline - full	General	General	There is no distinction in the recommendations between adults or young people. Please note the growing evidence base on what works related to suicide prevention in schools that could be used to make clear recommendations for commissioners and services. (Zalsman, G., et al. 2016). The Society believes that guidance should be developed for high risk groups, such as young people in families where there has been attempted or completed suicidesand looked after children, or young people involved with the youth justice system etc. (Pitman, A. L., et al., 2016; Rodway, C., et al, 2016)	Thank you for your comment. This guideline is for adults and young people. The committee were aware of those groups at high risk of suicide and referenced throughout the guideline.
British Psychological Society	NICE guideline - full	General	General	Custodial and detention: There is a need for a specific large scale epidemiological study on suicides in all custodial, detention and secure mental-health settings, which focusses on 18-25 year old males. This research should fully account for variables such as maturation (physical and psychological / emotional), bullying (by other inmates and staff), over-crowding, environmental distress, lack of evidence-based interventions, drug-use and drug availability. For understanding and prediction we recommend research onReaching a consensus about terminology and phenomenology in respect of all self-injurious behaviours	Thank you for your interest in this guideline. The committee has drafted a recommendation to collect data in these settings as follows "1.4.3 For residential custodial and detention settings, also collect data on: • sentencing or placement patterns • sentence type • offence • length of detention • transition periods (for example, 'early days' and transitions between estates or into the community)."

				Testing psychological models and risk factors to predict suicide attempt and death. Incorporating psychological factors into national, linkage databases and psychological autopsy studies. Improved understanding of factors that distinguish those who attempt suicide from those who think seriously about it and those who repeatedly attempt suicide. Integration of experimental, naturalist, clinical and non-clinical research findings. The comprehensive testing of psychological models of suicidal behaviour. Psychological factors that protect against suicide. The better understanding of the psychology of method selection. Participants from across the lifespan, from different ethnic backgrounds and countries. For interventions and prevention we recommend research onClinical trials of psychological treatments to reduce suicidal ideation, attempts, and suicide. Innovative brief psychosocial interventions (employing a range of delivery modalities) to reduce suicidal ideation, attempts and suicide. The better understanding of how different types of media representation of suicide and self-harm increase risk of suicidal behaviour and suicide clusters. An improved understanding of the barriers to help-seeking. Integrating advances in psychological science into suicide prevention and intervention programmes. The development of public health interventions to promote resilience.	The committee has also drafted a research recommendation to examine the effectiveness of interventions in these settings.
British Psychological Society	NICE guideline - full	4	04-Jul	Multi-agency partnerships:Please provide further detail describing what a multi-agency partnership should consisted of, and what activities it would be engaged in.	Thank you for your comment. The committee have drafted recommendations for who should be in a multi-agency partnership (see recommendations in section 1.1) and activities of the multi-agency partnership in recommendations in sections 1.2, 1.3, 1.4, 1.5, 1.6, 1.7, 1.8, 1.9 and 1.10.
British Psychological Society	NICE guideline - full	4	21	Custody or detention: There should be a clear lead agency within multi-agency any partnership.	Thank you for your comment. We have amended the recommendation as follows " 1.1.4 Set up a multi-agency partnership for suicide prevention in residential custodial and detention settings. This could consist of a core group and a wider network of representatives. Ensure the partnership has: •clear leadership •clear terms of reference, based on a shared understanding that suicide can be prevented •clear governance and accountability structures."
British Psychological Society	NICE guideline - full	5	01-May	Custody or detention: There should be a clear lead agency within multi-agency any partnership.	Thank you for your comment. The recommendation for multi-agency partnerships in residential custodial and detention settings states that the partnership should ensure "clear leadership"
British Psychological Society	NICE guideline - full	6	Aug-24	Suicide prevention action plans:Please outline what a suicide prevention plan consists of, and its proposed activities.	Thank you for your comment. The recommendations have been amended and the guideline has been restructured following committee discussion and the committee are confident that the guideline includes what a suicide prevention plan should consist of and its proposed activities.
British Psychological Society	NICE guideline - full	6	8 to 24	Suicide prevention action plans:The Society also supports the use of, Public Health England (2016) Local suicide prevention planning – A practice resource.	Thank you for your comment. We have the reference for 'Public Health England's resource on Local suicide prevention planning: a practice resource' at the start of the recommendations.
British Psychological Society	NICE guideline - full	7	1 to 27	Gathering and analysing suicide-related information:The Society welcomes the collection of better data at local and national levels, which can be used for the reduction of suicide, including current UK epidemiology, risk-factor analysis (in community and custodial settings), risk-reduction and zero-tolerance approaches. The Society recommends collecting data not only in relation to sentence and transition but also as regards: *mental health data, engagement with services, segregations, engagement with mental health provisions within the*	Thank you for your comment. The data items suggested to be collected are covered under the categories in the following recommendation "1.4.2 Collect and analyse local data on suicide and self-harm. This could include data on: method, location, timing, details of individual and local circumstances, demographics, occupation and characteristics protected under the Equality Act (2010). Sources could include reports from: • the local ombudsman • the Parliamentary and Health Service Ombudsman

				establishments given that these are known to be significant issues within the custodial estate (Humber, N., et al, 2011)For statistical data on the number of people dying by suicide please see Office of National Statistics, Suicides in Great Britain: 2016 registrations. Also see Prison Reform Trust,http://www.prisonreformtrust.org.uk/Portals/0/Documents/Bromley%20Briefings/Autumn%202017%20factfile.pdf Please also see the Howard League for Penal Reform,https://howardleague.org/wp-content/uploads/2016/05/Preventing-prison-suicide.pdf https://howardleague.org/wp-content/uploads/2016/03/The-cost-of-prison-suicide.pdf https://howardleague.org/wp-content/uploads/2016/11/Preventing-prison-suicide-report.pdf https://howardleague.org/wp-content/uploads/2017/02/Preventing-prison-suicide.-Staff-perspectives.pdf	• coroners • the Prison and Probation Ombudsman • the voluntary sector."
British Psychological Society	NICE guideline - full	8	2 to 25	Awareness raising:There is emerging evidence for increasing awareness via public information campaigns (Szekely et al, 2013; Hegerl et al, 2013; Harris et al, 2016).	Thank you for your comment. The recommendations on suicide campaign messages have been removed. The committee agreed that it was more appropriate for suicide prevention campaigns to run at a national level and focus on activities to raise awareness of suicide at a local level. Thank you for the references. We will pass these to the surveillance team at NICE.
British Psychological Society	NICE guideline - full	11	3 to 18	After a suspected suicide:There has been increased recognition of the importance of supporting vulnerable populations, such as bereaved families and friends, following suicides (WHO, 2014). The research demonstrates that people who are exposed to suicide deaths are at increased risk of complicated grief, traumatic grief and PTSD (Melhelm et al., 2004). Furthermore, the relatives and friends of the deceased may be particularly vulnerable to suicidal thoughts and behaviour (Joiner, 2005). Psychologists have a key role in providing support and interventions to those affected by the death and psychological models may be applied to understand how individuals manage grief and adjustment following a death by suicide. There is emerging evidence supporting beneficial effects of a number of interventions, including counselling postvention for survivors and outreach at the scene of suicide (Szumilas & Kutcher, 2011). In addition, evidence-based guidelines for responding to suicide in a secondary school setting have been published recently (Cox et al, 2016). However, further research is required into the effectiveness of postvention services and interventions on reducing suicide and attempted suicide/self-harm. Suicide deaths are often incredibly traumatic, the method of death is frequently violent and survivors are often plagued with the “re-experiencing” symptoms of trauma, such as flashbacks, nightmares and intrusive thoughts. These can occur even if the survivor did not witness the death scene. Re-experiencing, when accompanied with avoidance and hypervigilance symptoms, is characteristic of PTSD, and therefore counsellors need to be equipped to recognise and manage these symptoms or refer the person for trauma-focused cognitive therapy or another recognised PTSD treatment (NICE, 2005). Suicide survivors may also be at risk of comorbid alcohol and other substance disorders, which may require treatment. Suicide has a huge impact on social relationships, there can be feelings of rejection and abandonment in addition to the burden of the loss. The death can also have a detrimental impact on social relationships and isolation	Thank you for your comment. The committee agreed and have drafted the following recommendation " 1.8.2 Offer those who are bereaved or affected by a suspected suicide practical information expressed in a sensitive way, such as Public Health England's Help is at hand guide. (This also signposts to other services.) Ask them if they need more help and, if so, offer them tailored support.” Please also see NICE guideline “Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence” and Public Health England’s “Better care for people with co-occurring mental health, and alcohol and drug use conditions” for further information. Thank you for providing these references. We will forward these to the surveillance team at NICE for future updates.

				due to the stigma surrounding the death and others' beliefs about causes and blame. Individuals who are bereaved by suicide can feel unable to accept support and those close to suicide survivors often have difficulty responding appropriately and may even withdraw from the survivor (Grad, 2011). Therapeutic interventions should include helping the survivor manage and navigate social interactions, harness support networks and foster connectedness. Group support from other suicide survivors, or programmes which link survivors to others who have had a similar loss may be particularly useful for this reason (Jordan, 2011). The planned interventions with individuals and groups affected by a suicide death in a school or workplace are known as organisational postvention. Organisational postvention is a significant challenge and it is recommended that plans and protocols are put in place prior to a death. The goal of this type of postvention is in providing support to the bereaved, respecting their wish to honour the life of the deceased, without glamourising the death in a way that increases the risk of further suicidal acts. It is also important to do this in a way that respects the community's cultural and religious beliefs, does not further contribute to the stigma of suicide or leave the bereaved feeling that the deceased has been demonised or punished (Berkowitz et al., 2011). Postvention response plans typically include the coordination of resources, dissemination of information and the provision of support for those most affected by the death, or at risk of contagion. Psychoeducation regarding grief, depression and PTSD is an important component of postvention for those affected by the death. Organisational postvention should also include screening and case finding to detect people who are at higher risk of suicide, who may not come forward. Several screening and case finding tools are available for use in educational settings, however the identification of suicide risk based on screening tools is fraught with difficulties and many high risk individuals do not screen positive using such instruments (O'Connor et al., 2013). It is therefore important to foster an ethos of help seeking and compassionate peer support so that people can identify when others may be at risk and help them to seek support through clear support and referral structures. In the longer term, postvention should include the provision of opportunities for safe commemoration. It is advised that whilst commemoration should be no different for individuals who have died by any cause, permanent memorials, or events/awards in the memory of the deceased should be avoided, again to prevent contagion (Berkowitz et al., 2011). Broader mental health and resilience programmes may also be helpful in group settings such as schools, however these need to be selected carefully and implemented alongside effective referral pathways (Hawton, et al., 2015; Wasserman et al., 2012). The Society recommends that NICE develop guidelines for stepped intervention and postvention support. Also see Support After Suicide Partnershiphttps://supportaftersuicide.org.uk/	
British Psychological Society	NICE guideline - full	12	Sep-28	Media reporting of suicides:The importance of responsible media reporting of suicide in print, broadcast, internet, and social media is underlined by Niederkrotenthaler et al. (2014). The role of mass media has been shown to be effective in reducing stigma and increasing help seeking behaviour. There are also indications of promising results based on multi-level suicide prevention programmes (Niederkrotenthaler et al., 2014). A systematic review covering 30 studies on social media sites for suicide prevention (Robinson et al, 2016) showed that social media platforms can reach large numbers of individuals and	Thank you for your comment. The committee recognised the importance of responsible media reporting. However this guideline is not in a position to make recommendations to Ofcom to update their guidance.

				may allow others to intervene following expression of suicidal behaviour. However, reported challenges include lack of control over user behaviour, possibility of suicide contagion, limitations in accurately assessing suicide risk, and issues relating to privacy and confidentiality. The Society recommends that OfCOM (with the Society and the Samaritans) strengthen the guidelines for the media on the reporting of suicide.	
British Psychological Society	NICE guideline - full	9 10	15 to 24 1 to 10	Reducing access to methods of suicide:More detail is required for: '1.6.3 Reduce the opportunity to attempt suicide in places where suicide is more likely'; AND l.9 'increasing the number of staff or times when staff are at sites.' Restricting access to means involves implementation of measures to reduce availability of and access to frequently used means of suicide. Internationally, there is consistent evidence that restricting access to lethal means is associated with a decrease in suicide and that substitution to other methods is limited (Zalsman et al, 2016). Please add a new bullet point: providing physical barriers at danger points such as railway tracks, cliffs and bridges.	Thank you for your comment. We have added more information to both of these recommendations as follows "1.6.3 Reduce the opportunity for suicide in locations where suicide is more likely for example, by erecting physical barriers. Also see Public Health England's Preventing suicide in public places: a practice resource." "1.6.4 Consider other measures to reduce the opportunity for suicide. For example, at locations where suicide is more likely, consider: • providing information about where and how people can get help when they feel unable to cope at locations where suicide is more likely. • 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 at locations."
British Psychological Society	NICE guideline - full	10 11	11 to 23 1 to 2	Training:Educating health care and community-based professionals to recognise depression and early signs of suicidal behaviour is important for determining the level of care and referral for treatment, and subsequent prevention of suicidal behaviour (Wasserman et al, 2012; Coppens et al, 2014). Sustainability and capacity building of trainers and benefits in terms of knowledge, attitudes and confidence can be achieved via a Train-The-Trainer model (Coppens et al, 2014; Isaac et al, 2009). There are some indications for a link between improvements in intermediate outcomes (e.g. improved knowledge, attitudes and confidence) among health care and community-based professionals and primary outcomes, e.g. reduced suicide and self-harm rates (Mann et al, 2005; Hegerl et al, 2011; Zalsman et al, 2016). The Society supports the mandatory training of GPs.	Thank you for your comment. Recognising depression and early signs of suicidal behaviour is outside the scope of this guideline, however we have cross-referenced relevant NICE guidelines. Thank you for providing these references. We will pass them to the surveillance team at NICE for future updates, as we did not have risk identification in this guideline.
British Psychological Society	NICE guideline - full	22	7	The Society acknowledges that creatingstructures to address the long-term work of prevention, which can also respond quickly in crises is a difficult task. We recommend the multi-agency partnerships ensures all local services have crisis plans in place to respond quickly to crises. Local services should lead the response as they are more appropriately placed to do this, such as: mental health/social care services/schools.	Thank you for your comment. The committee acknowledge this and have included the following recommendation as part of the suicide prevention action plans "1.2.6 Oversee local suicide prevention activities, including awareness raising and crisis planning."
British Psychological Society	NICE guideline - full	11 12	19 to 24 1 to 8	Preventing Suicide Clusters:Numerous international studies have shown that there is a risk of contagion following a suicide death. Known as the "Werther effect", the reporting of suicide can increase suicide risk for those exposed to the death. Social learning and modelling may provide an explanation for this copycat behaviour. The type of language used to describe the death, information about the circumstances surrounding the death, and the use of prominent photos of the deceased may serve to "glamourise" the death, lead to identification with the deceased and increase the risk of those who may already be vulnerable. Information about the method of suicide is said to increase capability to enact suicidal behaviour. Young people and adolescents are believed to be particularly vulnerable to contagion. In the light of this evidence organisations such as the International Association for Suicide Prevention, the World Health Organisation, and Samaritans, have produced guidance for the reporting of suicide and for dealing with the aftermath of suicides in organisations such as schools,	Thank you for your comment. The section 'Media reporting of suicides' includes recommendations on best practice for media reporting of suicide including hyperlink to relevant organisations guidance " 1.10.2 For community settings, promote guidance on best practice for media reporting of suicide (including providers of social media platforms). Include Highlight the need to: •use sensitive language that is not stigmatising or in any other way distressing to people who have been affected •reduce speculative reporting avoid presenting detail on methods. See: the World Health Organization's Preventing suicide: a resource for media professionals; the Samaritans' Media guidelines for reporting suicide; OFCOM's Broadcasting code and the Independent Press Standards Organisation (IPSO)."

				workplaces and sports clubs. More recently, the “Papageneo effect” has also been described in the literature, this is the finding that the portrayal of alternatives to suicide and social modelling of recovery can increase a person’s capacity to seek help when faced with suicidal thoughts (Neiderkrotenthaler et al., 2010). The guidelines for the reporting and management of suicides emphasise that the cause of the suicide should not be over-simplified, and that the links with mental illness, the importance of help-seeking and the efficacy of treatments and interventions should be highlighted. Details of the method of death and the circumstances surrounding the death (such as the location, recent life events etc.) should not be reported (World Health Organisation and the International Association for Suicide Prevention, 2008). In secure settingsPrison Chaplains have a key role in providing support to bereaved families.	
Child Bereavement UK	Full	11	General	Child Bereavement UK welcomes the focus placed on supporting those bereaved and affected by suicide. There are a number of challenge: · The training of those best placed to identify those at increased risk (e.g via PABBS training). This requires investment · The majority of bereavement support is provided via the voluntary sector. There is limited statutory funding for bereavement support and this again requires investment as obtaining charitable funding is increasingly challenging	Thank you for your comment. We will pass this information to our resource impact team for their information.
Child Bereavement UK	Full	15	General	Child Bereavement UK welcomes the focus place on research into the effectiveness of bereavement support for those bereaved by suicide. There are a number of challenges: The impact of grief is long-term and therefore longitudinal research requires to be funded The impact of bereavement by suicide on children and young people is a particularly neglected area of research · University research ethics committees can at times be overly cautious about research in this field. More guidance on sensitive and safe research in this field is required.	Thank you for your comment. The committee acknowledge these challenges and have not specified any subgroups in the research recommendations.
Childhood Bereavement Network / National Bereavement Alliance	Evidence review 7	6	13	We would argue that distress to bereaved people is a further outcome relevant to this evidence review. The Editor’s Code of Practice includes guidance on avoiding intrusion into grief and shock separately from the clauses on reporting suicidehttps://www.ipso.co.uk/editors-code-of-practice/#IntrusionIntoGriefOrShock	Thank you for your comment. The committee acknowledged this and in addition, it is included in the committee discussion as follows "Furthermore, the committee agreed that inaccurate media reporting, for example by misquoting or speculation, causes distress among people bereaved by suicide and increased dissatisfaction with the media in general (Chapple et al 2013)."
Childhood Bereavement Network / National Bereavement Alliance	Evidence review 5	6	32	While draft guideline 1.8.4 (which we support) recommends ‘ongoing support for people bereaved or affected by a suicide or suspected suicide, if they need it’, we were slightly unclear about the rationale in the evidence review for excluding studies on certain types of support or intervention. Specifically, we are not clear about the justification for excluding therapeutic approaches apart from those delivered in community settings such as people’s homes. These inclusion/exclusion criteria may mean that some potentially relevant and useful studies have been excluded, such asBraiden, HJ and others (2009) ‘Piloting a therapeutic residential for children, young people and families bereaved through suicide in Northern Ireland’, Child Care in Practice, 15(2), 81–93.	Thank you for your comment. The review protocol states that “The guideline would not be looking at one-to-one support or therapy (individual approaches)” and following a discussion with the committee, it was agreed that any therapeutic interventions that were provided in hospitals are out of the scope. In addition, this guideline is specifically for preventing suicides in the community setting, therefore the committee agreed that therapeutic interventions (that provided by healthcare professionals such as nurses or psychologists) could be included if interventions were provided in the community setting (such as participants’ homes). The suggested study, Braiden et al, would have been excluded from this review as the intervention was provided in a residential setting, hence not in a community setting.
Childhood Bereavement Network /	Draft guideline	11	11	We recommend inserting the words ‘Those affected may include children and young people as well as adults’ at the end of this paragraph. The needs of bereaved children and young people can be overlooked within the family and	Thank you for your comment. The committee noted that the recommendation on identifying who may be affected or benefit from postvention covers children and young people, as well as adults.

National Bereavement Alliance				they may be dependent on other family members to recognise their needs and access support on their behalf. We believe children and young people should be explicitly included in this paragraph rather than implicitly included among relatives, friends and classmates.	
Childhood Bereavement Network / National Bereavement Alliance	Draft guideline	11	17	We believe children and young people should have a specific mention in this paragraph	Thank you for your comment. The committee noted that the recommendation on identifying who may be affected or benefit from postvention covers children and young people, as well as adults.
Childhood Bereavement Network / National Bereavement Alliance	Draft guideline	11	17	Again, children and young people should have a specific mention in this paragraph	Thank you for your comment. The committee noted that the recommendation on identifying who may be affected or benefit from postvention covers children and young people, as well as adults.
Childhood Bereavement Network / National Bereavement Alliance	Draft guideline	11	5 to 18	It may be helpful for this section to reference other NICE guidelines which make recommendations about different components of general bereavement support, in particular Supportive and Palliative Care (2004). These have been expanded by the National Bereavement Alliance, setting out the support which should be available in each area. See pp 13-17 ofhttp://nationalbereavementalliance.org.uk/wp-content/uploads/2017/07/A-Guide-to-Commissioning-Bereavement-Services-in-England-WEB.pdf	Thank you for your comment. We have cross-referenced other relevant NICE guidance in the guideline and the recommendations in the NICE care pathway will link to other recommendations, where appropriate.
Childhood Bereavement Network / National Bereavement Alliance	Draft guideline	15	22	Either here or in evidence review 5, we suggest that the guideline includes some specific ways in which future studies could be strengthened. These could include Qualitative studies with people bereaved by suicide to develop consensus on the outcomes which matter the most Agreement on which outcome measures should be used to capture changes, to enable more comparative work. We note that across the seven quantitative studies included in evidence review 5, 21 different outcome measures were used, of which only two were used in more than one study. This seriously hampers the ability to draw conclusions about which interventions help who the most. Collaborative, multi-site studies using the outcome measures, which could help to overcome some of the difficulties with generalizability of findings and low statistical power	Thank you for your comment. We have added a new research recommendation and included qualitative component, in evidence review 5. In each of the research recommendations, we have specified outcomes of interest and where relevant, we have indicated an appropriate comparator.
Childhood Bereavement Network / National Bereavement Alliance	Evidence review 5	16	234	Prior qualitative work with bereaved people to identify which outcomes matter most may be needed	Thank you for your comment. We have added a new research recommendation to reflect this.
Childhood Bereavement Network / National Bereavement Alliance	Evidence review 5	17	236	It is not clear whether this recommendation relates to strengthening outcome evaluation, or process evaluation, or both. We would suggest that both are needed.	Thank you for your comment. We have added "effectiveness and cost-effectiveness of bereavement services" as an outcome to the question "What factors can affect uptake and access to bereavement services among people who are bereaved or affected by a suicide?" in the evidence review 5.
Childhood Bereavement Network / National Bereavement Alliance		20	328	This raises an important question of the need for generic (any cause) bereavement support vs suicide-specific bereavement support. Both may be required, to meet different people's needs. The Support After Suicide Partnership and the National Bereavement Alliance are considering this question in relation to the development of guidelines for group support for bereaved people.	Thank you for your comment. The committee agreed that this was a difficult area and consider that your guidelines in development would be of interest. Your comments will be considered by NICE where relevant support activity is being planned.

City of London Corporation	Full	General	General	It's unclear how the local area multiagency suicide prevention partnerships will work with the custodial and detention suicide prevention partnerships and whether they should both be accountable to the Health and Wellbeing Board	Thank you for your comment. The committee have recognised that there needs to be links between the partnerships and have drafted the following recommendations "1.1.6 Link the partnership with other relevant multi agency partnerships in the community." "1.1.2 Ensure the partnership has clear governance and accountability structures. Include oversight from local health and care planning groups for example, health and wellbeing boards.
City of London Corporation	Full	General	General	The recommendations are not particularly focused towards the custodial settings or the fact that the population in a custodial setting may not actually live in the borough of the setting.	Thank you for your comment. We have now added distinct recommendations for residential custodial and detention settings, for example " 1.1.4 Set up a multi-agency partnership for suicide prevention in residential custodial and detention settings. This could consist of a core group and a wider network of representatives. Ensure the partnership has: •clear leadership •clear terms of reference, based on a shared understanding that suicide can be prevented •clear governance and accountability structures."
City of London Corporation	Full	General	General	Many of the recommendations will be challenging in practice as there is no clear guidance over who should take ownership of the multi-agency group nor any funding sources identified. E.g. providing training for those who work with high risk groups would have significant cost implications.	Thank you for your comment. The committee have recognised this and drafted the following recommendations "1.1.1 Local authorities should work with local organisations to: • Set up a multi-agency partnership for suicide prevention. This could consist of a core group and a wider network of representatives. • Identify clear leadership for the partnership. • Ensure the partnership has clear terms of reference, based on a shared understanding that suicide can be prevented. " " 1.1.4 Set up a multi-agency partnership for suicide prevention in residential custodial and detention settings. This could consist of a core group and a wider network of representatives. Ensure the partnership has: •clear leadership •clear terms of reference, based on a shared understanding that suicide can be prevented •clear governance and accountability structures."
City of London Corporation	Full	General	General	More examples of best practice/ signposting to examples of best practice, such as Local Government Association reports, would be helpful to better illustrate some of the recommendations. Also the National Suicide Prevention Alliance isn't mentioned, It should be a recommendation for LAs/ local stakeholders to become members.	Thank you for your comment. Additional support will be provided on the "into practice" pages and a hyperlink to this is provided in this section.
City of London Corporation	Full	General	General	Importance of planning and design is barely mentioned. This should be made a lot stronger with regards to local authorities' ability to work with planning teams to ensure design/ refurbishment of buildings/ other infrastructure minimises opportunities for people to make an attempt on their life.	Thank you for your comment. The committee have drafted the following recommendation "1.3.2 Work with planners who have responsibility for designing bridges, multi-storey car parks and other structures that could potentially pose a suicide risk.
City of London Corporation	Full	General	General	There is not enough focus on interventions during custodial settings' sentences - i.e. the effects of isolation, lack of purpose etc.	Thank you for your comment. General interventions during custodial settings' sentences is out of scope for this guideline, however the committee have drafted the following recommendation to judge the impact of such practices. "1.3.3 Monitor the impact of 'restricted regimes' on suicide risk."

City of London Corporation	Full	General	General	There is not enough focus on transition periods (custodial settings) - whether this be in or out - how these periods should be managed, what plans should be made and what action(s) should be taken	Thank you for your comment. We have added additional information for custodial and detention settings in the suicide prevention action plan as follows "1.5.2 For residential custodial and detention settings, also consider raising awareness of: • the risk associated with 'early days' and transitions between estates or into the community"
City of London Corporation	Full	General	General	Not enough focus on online communities or social media	Thank you for your comment. The committee acknowledge this and have included providers of social media platforms with regards to best practice of media reporting in the following recommendation " 1.10.2 For community settings, promote guidance on best practice for media reporting of suicide (including providers of social media platforms). "
City of London Corporation	Full	4	8	The guidance is very vague on other members of a multiagency group and could be more specific, e.g. local barbers and other “non-conventional” stakeholders, etc.	Thank you for your comment. The committee agree and were mindful of the fact that different groups of people (for example local barbers) could be included in the wider network, depending on local circumstances and settings. As such the committee drafted a recommendation as follows "1.1.1 Set up a multi-agency partnership for suicide prevention. This could consist of a core group and a wider network of representatives." We have referenced Public Health England guidance at the start of the guideline provides further information on this.
City of London Corporation	Full	7	14-16	This recommendation will be challenging in practice as much of this information is only available from the coroner who does not always provide all the information. For example, in Hackney this information isn’t shared at all by the Coroner. A stronger emphasis on the importance of the Coroner sharing this information and working collaboratively with the multi-agency group would be beneficial.	Thank you for your comment. The committee acknowledge the challenges of this in practice and therefore have recommended the coroner reports as an example of local data to be collected, in the following recommendation "1.4.2 Collect and analyse local data on suicide and self-harm. This could include data on: method, location, timing, details of individual and local circumstances, demographics, occupation and characteristics protected under the Equality Act (2010). Sources could include reports from: •the local ombudsman •the Parliamentary and Health Service Ombudsman •coroners •the Prison and Probation Ombudsman •the voluntary sector.”
City of London Corporation	Full	8	16-17	The City of London can provide an example of good practice of running an initiative based on local methods.	Thank you for your response. We will pass this information to our local practice collection team. More information on local practice can be found here: https://www.nice.org.uk/about/what-we-do/into-practice/local-practice-case-studies.
City of London Corporation	Full	8	21	PHE/ Business in the Community’s suicide postvention toolkit should be referenced Employers developing policies is important, but they should also be encouraged to be more proactive and take part in/ offer training	Thank you for your comment. It is referenced in the following recommendation "1.5.6 Consider encouraging employers to develop policies to raise suicide awareness and provide support after a suspected suicide. For example, see Public Health England and Business in the Community's toolkits"
City of London Corporation	Full	9	13-14	In addition to timing local campaigns to coincide with national campaigns, local multiagency groups should be encouraged to liaise with leads of national campaigns to see how they can be amplified locally (this could be more effective in reach and engaging people, as well as potentially reducing costs). Where local	Thank you for your comment. The recommendations on suicide campaign messages have been removed. The committee agreed that it was more appropriate for suicide prevention campaigns to run at a national level and focus on activities to raise awareness of suicide at a local level. In addition, we have

				suicide prevention campaigns are developed, this should be done in a collaborative manner and all available channels through multiagency group and respective networks should be engaged	added a new recommendation as follows "1.5.5 Coordinate local activities and ensure they are consistent – and coordinated – with national initiatives."
City of London Corporation	Full	12	Oct-14	Not sure how effective local approaches to media training on reporting of suicides are/ can be. This approach means mostly fire-fighting rather than tackling the issue at its source. This would be better at a national level, which would cover national news outlets, and would mean engaging education institutions and inclusion within the curriculum on journalism degrees/ courses, induction training, and journalist codes of practice, etc.	Thank you for your comment. The committee has now amended this recommendation and removed the text on training. It reads as follows "1.10.1 Develop a clear plan for liaising with the media. Identify someone in the multi-agency partnership as the lead. "
City of London Corporation	Full	11 and 12	19-24 and 1-8	It would be useful to provide guidance on how of identify suicide clusters across boroughs. Currently identifying them even within boroughs often depends on word of mouth.	Thank you for your comment. The committee have drafted the following recommendation to provide guidance on identifying suicide clusters "1.9.1 Use information from the action plan and rapid intelligence gathering to identify and prevent potential suicide clusters (see recommendation 1.3.1 and section 1.4)."
Clinks	Short	4	14	We strongly support the inclusion of the voluntary sector in suicide prevention partnerships. In order to ensure that this includes voluntary sector organisations working in criminal justice it should be made more specific to read: voluntary and other third sector organisations including those working with people who have had contact with, or are at risk of having contact with, the criminal justice system.	Thank you for your comment. We have amended the recommendation to include "voluntary and other third-sector organisations"
Clinks	Short	4	17	We agree that criminal justice services should be included in suicide prevention partnerships but what is meant by criminal justice services should be clarified to ensure all services working in criminal justice are included. This should read: criminal justice services, including Community Rehabilitation Companies, the National Probation Service, prisons, police and courts.	Thank you for your comment. We have added this to the section of the guideline 'Who is this for.'
Clinks	Short	5	3	We support this. The voluntary sector are important partners to help support a safer, more rehabilitative culture. Through their work with people in contact with the criminal justice system, voluntary sector organisations often have better contact and relationships with people who are seen as 'hard to reach' and therefore can act as an important source of information as to who might be at risk and therefore need additional support. To do this the sector needs to be seen as an integral part of the system. However, due to resource pressures in custodial and detention settings, there are often challenges to implementing this kind of partnership working. Between September 2016 and October 2017 Clinks supported a voluntary sector member of staff in three prisons to implement a bespoke model of voluntary sector coordination reflective of the needs of each prison's population. This helped contribute to a safer prison environment in two key ways. Firstly, the project improved information about and access to support services for prisoners. HMP Exeter now includes the voluntary sector directory in all its Assessment, Care, Custody and Teamwork documents. This gives staff immediate access to information on support services that can contribute to care plans. Secondly, the project ensured that partners have a good knowledge of safer custody processes and procedures. It did this through establishing formalised induction processes and regular training for voluntary sector staff and volunteers. At HMP Dartmoor the project encouraged the introduction of a computer located outside the prison in the Prison Officer Association Learning Centre where voluntary sector staff could access information about policies, such as the health	Thank you for your comment and your support for this guideline.

				and safety policy.1 1Clinks (2018) The good prison	
Clinks	Short	5	4	For clarity we would suggest that the guidelines specify what is meant by transition services; this should specify through the gate services for people leaving prison. It should read: probationary and through the gate services for people leaving prison.	Thank you for your comment. In response to your comment and other stakeholder comments, we have updated the term "probationary and transition services" to "offender management and resettlement services"
Clinks	Short	5	5	Multi-agency partnerships should also include people who have lived experience of the criminal justice system and their families. There should be another bullet point which reads: people with experience of the criminal justice system including custodial and community settings. The voluntary sector is a good vehicle for involving the people and families who have experience of the criminal justice system and those who have attempted or been affected by suicide in these settings. These 'experts by experience' are a vital source of intelligence about how the system can be safeguarded to protect against suicide and self-harm. Clinks has published case studies of voluntary sector organisations involving people with lived experience of the criminal justice system, which highlight the added value that this involvement can have in developing and commissioning services. 2 2 Clinks (2016) Good practice in service user involvement. Online: https://www.clinks.org/sites/default/files/clinks_good-practice-sui_final.pdf (last accessed 06.04.2018)	Thank you for your comment. The committee agree that people who have lived experience of the criminal justice system may be included under the following representatives "people with personal experience of a suicide attempt, suicidal thoughts and feelings, or a suicide bereavement" "pastoral support services" Thank you for these case studies. We have forwarded these to our System Engagement team.
Clinks	Short	5	6	We strongly support this, especially given recent evidence of the rise in suicide rates among people recently released from prison. It is important for people to receive continuity of care as they move from prison into the community and for this to be properly considered by those providing through the gate services.	Thank you for your comment and your support for this guideline.
Clinks	Short	5	11	We suggest that further specified detail is included in the bullet points regarding suicide prevention strategies in custodial settings. In a custodial setting, there should be a person responsible for suicide prevention of all staff and prisoners in the setting. They should be the first point of call if someone has a concern that someone is at risk of suicide and everybody who works in the setting (including people from outside organisations that come into the prison) must be aware of who this person is. In our paper on how to improve care and support for people at risk of suicide and self-harm in prison, we recommend that every contact and every relationship should count. Every person who comes into contact with a person who may be at risk of self-harm or suicide in prison needs to know how to respond, who to tell if they have concerns, and what support is available.3 3Clinks (2017) RR3 special interest group on effective care and support for people at risk of suicide and self-harm in prison. Online:https://www.clinks.org/sites/default/files/basic/files-downloads/rr3_sig_suicide_self_harm_key_messages_v2.pdf(last accessed 06.04.2018)	Thank you for your comment. We have the following recommendation to ensure responsibility "Identify clear leadership for the multi-agency strategy and action plan. " We have also noted that in the training recommendations, training should cover "1.7.4 Ensure suicide awareness and prevention training helps people to: •understand local suicide incidence and its impact, and know what support services are available •encourage others to talk openly about suicidal thoughts and to seek help (this includes providing details of where they can get this help) take into account socioeconomic deprivation, disability, physical and mental health status, and cultural, religious and social norms about suicide and help-seeking behaviour, particularly among groups at high suicide risk." Thank you for providing this reference. We will pass it on to the surveillance team at NICE.
Clinks	Short	5	12	We agree with this. Stakeholder engagement must include the voluntary sector and this should be specified as in our experience they are often forgotten in partnership arrangements, especially in custodial settings. Voluntary sector	Thank you for your comment and support for this guideline.

				organisations need to be an integral part of the prison system as they are a key partner in keeping people safe. The voluntary sector can bring professional expertise, energy, resource and creativity to bear and encourage a positive prison culture more conducive to safety and rehabilitation.4 4Clinks (2017) RR3 special interest group on effective care and support for people at risk of suicide and self-harm in prison. Online:https://www.clinks.org/sites/default/files/basic/files-downloads/rr3_sig_suicide_self_harm_key_messages_v2.pdf(last accessed 06.04.2018) This should read: Engage with stakeholders, including the voluntary sector, to share experience and knowledge.	Thank you for providing this reference. We will pass it on to the surveillance team at NICE.
Clinks	Short	5	13	It should be made clear how this would be implemented in a custodial setting. It should say: Map stakeholders and their suicide prevention activities. In custodial settings this should involve a clear plan of who is responsible for supporting people at different risk points. These include: reception and first night staff when a person first arrives in prison and dedicated officers once a person is transferred to a standard wing. Other prison department staff, healthcare and voluntary sector services, volunteers and peer supporters also need to be included and supported to understand relevant policies and procedures. There needs to be an understanding that risk is dynamic and any person can become vulnerable, regardless of whether they have previously been assessed as at risk. These are recommendations we make in our paper on how to improve care and support for people at risk of suicide and self-harm in prison.5 5Clinks (2017) RR3 special interest group on effective care and support for people at risk of suicide and self-harm in prison. Online:https://www.clinks.org/sites/default/files/basic/files-downloads/rr3_sig_suicide_self_harm_key_messages_v2.pdf(last accessed 06.04.2018)	Thank you for your comment. The committee have retained the wording and have supported it with recommendations on data collection, training and support to be provided. The committee did not make a recommendation on identifying those at increased risk, beyond identifying the high-risk groups, for example screening and case finding is outside of scope for this guideline.
Clinks	Short	5	19	This should be amended to also include previous successful initiatives. There are many successful initiatives which have worked well in the past to help in keeping people safe, as well as innovative approaches being developed now. We need to look at the evidence we already have for what works, and how to revive or scale these up.6 It should say: Assess whether initiatives successfully adopted elsewhere are appropriate locally or can be adapted to local needs or whether previously successful initiatives can be reintroduced. 6Clinks (2017) RR3 special interest group on effective care and support for people at risk of suicide and self-harm in prison. Online:https://www.clinks.org/sites/default/files/basic/files-downloads/rr3_sig_suicide_self_harm_key_messages_v2.pdf(last accessed 06.04.2018)	Thank you for your comment. We have amended the recommendation as follows "1.2.5 Assess whether initiatives successfully adopted elsewhere are appropriate locally, can be adapted to local needs or whether previously successful initiatives can be reintroduced" Thank you for this reference. We will pass it to the surveillance team at NICE.
Clinks		5	26	There should be an additional bullet point to say: Consider how to measure activities to prevent suicides, with a focus on encouraging and incentivising positive activities rather than simple measurement of suicide numbers. Simply measuring the rates of self-harm and suicide at different establishments risks creating perverse incentives. Positive measures such as the number of peer supporters employed; number of staff receiving mental health training; or health and social care qualifications awarded, encourage investment in those things which are known to be effective in caring for people at risk of suicide and self-harm.7 Arts interventions are also important preventative mechanisms, giving people an improved sense of wellbeing and worth. In May 2014, the National	Thank you for your comment. We have added the following recommendation "1.2.3 Consider how to measure activities to prevent suicide. Include the introduction of constructive, meaningful preventive activities (for example, education and physical activity) rather than focusing on suicide numbers alone." Thank you for providing this reference. We will forward it to the surveillance team for consideration for future updates. Thank you for providing this reference. We will forward it to the surveillance team for consideration for future updates.

				Criminal Justice Arts Alliance carried out a survey of people in prison about their views on the use of arts in custody. One person said: “Art [..] is also a great help for someone like me who has attempted suicide in prison and I am a self-harmer at times. Art relieves me of a lot of stress and is also a form of escapism. Much better than any drug”.8 7Clinks (2017) RR3 special interest group on effective care and support for people at risk of suicide and self-harm in prison. Online:https://www.clinks.org/sites/default/files/basic/files-downloads/rr3_sig_suicide_self_harm_key_messages_v2.pdf(last accessed 06.04.2018) 8National Criminal Justice Arts Alliance (2014) Response by the Arts Alliance to the Independent Review into Self-Inflicted Deaths in NOMS Custody of 18-24 year olds. Online:http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2015/07/Harris-Review-submission-from-Arts-Alliance.pdf(last accessed 11.04.2018)	
Clinks	Short	6	15	This should include specific reference to the voluntary sector. Both the statutory sector and the voluntary sector have data that would be useful for each other but voluntary sector organisations are often excluded from data sharing arrangements. It should say: Share data between stakeholders, including the voluntary sector, so they can identify local characteristics and needs.	Thank you for your comment. We acknowledge that there are various stakeholders that can be involved in data sharing arrangements, including the voluntary sector therefore it would be inappropriate to put the focus on a particular sector.
Clinks		7	11	There may also be opportunities to consider data from voluntary sector sources and multi-agency partnerships should work with voluntary sector organisations to explore the best mechanism for gathering this information. This should read: Carry out periodic audits to collect and analyse local data from different 10 sources, for example reports from local ombudsman, and coroner, 11 prison and probation ombudsman reports and the voluntary sector.	Thank you for your comment. The committee have drafted the following recommendation " 1.4.2 Collect and analyse local data on suicide and self-harm. This could include data on: method, location, timing, details of individual and local circumstances, demographics, occupation and characteristics protected under the Equality Act (2010). Sources could include reports from: • the local ombudsman • the Parliamentary and Health Service Ombudsman • coroners • the Prison and Probation Ombudsman • the voluntary sector."
Clinks	Short	7	27	There should be an additional point at the end of this which says: Data and reports should be shared with relevant organisations, including voluntary organisations that work with people in prison or those on probation licence. This will enable them to better support the people they work with.	Thank you for your comment. The committee have drafted the following recommendation "1.3.1 Share experience and knowledge between stakeholders. Also share data, subject to local information sharing agreements."
Clinks	Short	10	13	Voluntary sector staff and volunteers working in prison, who may not be employees of the prison itself should receive this training. The Good Prisons Project, where Clinks supported a voluntary sector member of staff in three prisons between September 2016 and October 2017, showed what an impact this can have. The project ensured that voluntary sector staff and volunteers working in prison had a good knowledge of safer custody processes and procedures, through establishing formalised induction processes and regular training.9 9Clinks (2018) The good prison 1.7.1 should read: Ensure suicide awareness and prevention training is provided for people who work with high-risk groups or at places where suicide is more likely, including voluntary sector workers and volunteers.	Thank you for your comment. The committee have reworded this recommendation and it now reads as follows. Voluntary sector workers and volunteers are included under gatekeepers. "1.7.1 Ensure training is available for: • those in contact with people or groups at high suicide risk • people working at locations where suicide is more likely • gatekeepers • people who provide peer support in residential custodial and detention settings • people leading suicide prevention partnerships • people supporting those bereaved by suicide."
Clinks	Short	10	18	There should be two additional bullet points here: manage their own health and well-being; and understand safeguarding and the impact of trauma on people’s lives and how it presents in terms of mental health. People supporting people in	Thank you for your comment. The committee agree that this is outside of scope for this guideline.

				prison being able to manage their own health and well-being and understand the impact of trauma will impact the quality of services provided to people in prison.	
Clinks	Short	10	22	This should be strengthened and made clear how this should be implemented in a custodial setting. It should read: Every gatekeeper should have training which sets out how to recognise signs that someone is at risk and what action to take to support them. In custodial settings, every person who comes into contact with a person who may be at risk of self-harm or suicide in prison needs to know how to respond, who to tell if they have concerns, and what support is available.10 10Clinks (2017) RR3 special interest group on effective care and support for people at risk of suicide and self-harm in prison. Online:https://www.clinks.org/sites/default/files/basic/files-downloads/rr3_sig_suicide_self_harm_key_messages_v2.pdf(last accessed 06.04.2018)	Thank you for your comment. The committee agreed to remove this recommendation and have replaced it with the following recommendation "1.7.4 Ensure suicide awareness and prevention training helps people to: • understand local suicide incidence and its impact, and know what support services are available • encourage others to talk openly about suicidal thoughts and to seek help (this includes providing details of where they can get this help) • take into account socioeconomic deprivation, disability, physical and mental health status, cultural, religious and social norms about suicide and help-seeking behaviour. "
Clinks	Short	11	2	A line should be added which reads: As well as training, prison officers need support in managing their own health and wellbeing, and in their role in caring for vulnerable people. This will have a direct impact on service users within the prison.11 The system is under particular pressure at the moment in terms of staff shortages 12, although the Ministry of Justice has committed to raising the number of prison officers to 2,500 by the end of 2018.13 11Clinks (2017) RR3 special interest group on effective care and support for people at risk of suicide and self-harm in prison. Online:https://www.clinks.org/sites/default/files/basic/files-downloads/rr3_sig_suicide_self_harm_key_messages_v2.pdf(last accessed 06.04.2018) 12Clinks (2017) Clinks submission to the Justice Committee inquiry into the prison population. Online:https://www.clinks.org/sites/default/files/basic/files-downloads/clinks_submission_to_the_justice_committee_inquiry_into_the_prison_population.pdf(last accessed 06.04.2018) 13Ministry of Justice (2018) Prisons reform speech. Online:https://www.gov.uk/government/speeches/prisons-reform-speech(last accessed 06.04.2018)	Thank you for your comment. The committee agreed that this was outside of scope for this guideline.
Clinks	Short	15	23	We support this. The Howard League for Penal Reform have published a report called ‘Cost of prison suicide’14 which could contribute to this. A range of other voluntary sector organisations who provide mental health and suicide support in criminal justice settings could provide evidence for this and Clinks would be happy to facilitate contact with those organisations. 14The Howard League for Penal Reform (2016) The cost of prison suicide. Online:https://howardleague.org/wp-content/uploads/2016/03/The-cost-of-prison-suicide.pdf(last accessed 06.04.2018)	Thank you for your comment and your support of this guideline.
Clinks	Short	27	15	Another way of minimising costs in custodial settings is through providing training via video. Voluntary organisations with expertise in suicide prevention could be approached to co-create this. It could then be used in a range of settings.	Thank you for your response. We will pass this information to our resource impact team for their information.
College of Mental Health Pharmacy	Full	9	24	We think this consultation is an opportunity to review the accessibility of painkillers from budget shops which promote combinations in excess of the number of paracetamol or ibuprofen legally allowed in GSL transactions. QUESTION 1. This would be challenging to implement as there is a balance between accessibility & avoidance of overburdening of the healthcare system. QUESTION 2. Budget shops should be targeted to reduce the number of painkillers purchased from these settings. We understand that painkillers could	Thank you for your comment. The committee recognised this an issue and have drafted the following recommendation in relation to this comment "1.6.2 Ensure local compliance with national guidance to reduce access to methods of suicide: • In custodial settings, for example, provide safer cells (see the Ministry of Justice's Quick-time learning bulletin: safer cells).

				be brought from other GSL settings (e.g. supermarkets) but these often have strict till settings to prevent excessive numbers being brought, whereas budget shops promote multi-pack purchasing.	• In the community, for example, restrict access to painkillers (see NHS England's Items which should not be routinely prescribed in primary care: guidance for CCGs, Medicines and Healthcare products Regulatory Agency's Best practice guidance on the sale of medicines for pain relief and Faculty of Pain Medicine's Opioids Aware)."
College of Mental Health Pharmacy	Full	10	22-23	We agree that the pharmacy teams, in all settings, have the potential to be suicide gatekeepers and that this potential has not yet been realised. Raising awareness of suicide risk will require additional training. Dr Hayley Gorton is leading a programme of research at the University of Manchester to explore the training needs for community pharmacy staff on suicide and self-harm awareness and prevention. Data analysis is underway and being prepared for publication. Initial results suggest that pharmacy teams would like more training on suicide prevention, including understanding clear referral pathways. Dr Gorton has also received a travel scholarship from the Winston Churchill Memorial Trust (WCMT) where she will visit research groups in Canada & USA regarding this matter, and report back to NICE if requested. QUESTION 1. This recommendation will be challenging as it will require all pharmacy teams, under the umbrella of health & social care gatekeepers, to have increased awareness but without indication of funding and time to ensure an adequate & standardised approach to training.	Thank you for your comment. We will pass this information to our resource impact team for their information.
College of Mental Health Pharmacy	Full	16	11	We agree that any implemented training measures require evaluation to contribute to the evidence base.	Thank you for your comment.
College of Mental Health Pharmacy	Full	24	2	We agree that community pharmacy teams might be an appropriate place to display information about suicide, and the Healthy Living Pharmacy format could facilitate this. QUESTION 1: However, we feel that the level of training of pharmacy staff in this area should be increased so they are able to have meaningful conversations, which may be prompted by these displays, and have appropriate support resources; and timely and appropriate referral and signposting.	Thank you for your comment. The recommendations on suicide campaign messages have been removed. The committee agreed that it was more appropriate for suicide prevention campaigns to run at a national level and focus on activities to raise awareness of suicide at a local level. The committee agreed that training should be provided for pharmacy staff, included under gatekeepers, in the following recommendation under training "1.7.1 Ensure training is available for: • those in contact with people or groups at high suicide risk • people working at locations where suicide is more likely • gatekeepers • people who provide peer support in residential custodial and detention settings • people leading suicide prevention partnerships • people supporting those bereaved by suicide."
Department of Health and Social Care	General	General	General	Thank you for the opportunity to comment on the draft for the above clinical guideline. I wish to confirm that the Department of Health and Social Care has no substantive comments to make, regarding this consultation.	Thank you for your comment.
Derbyshire Healthcare NHS Foundation Trust	Full	General	General	2. Terminology: a. The guidance uses the term “attempted suicide” rather than “self-harm”. Within the research community, “self-harm” is the accepted terminology in England for an act of harm to the self, irrespective of outcome (fatal/non-fatal) or motivation. Using the term “attempted suicide” leaves room for individuals to make subjective decisions around the “seriousness” or “notability” of an act of self-harm. And given the significant link between self-harm and future suicide, all self-harm acts should be seen as a sign of distress or despair, an opportunity for intervention and therefore be taken seriously regardless of the perceived motivation/intent of the current self-harm act. Article exploring concerns around distinguishing	Thank you for your comment. A. We have amended guideline to use the term 'self harm' rather than 'attempted suicide.' b. We have amended the list of people that training should be made available to, and this may include non-clinical staff " Ensure training is available for: • those in contact with people or groups at high suicide risk • people working at locations where suicide is more likely • gatekeepers

				between non suicidal self-harm (NSSI) and self-harm with suicidal intent (attempted suicide) : o Kapur, N., Cooper, J., O'Connor, R. C., & Hawton, K. (2013). Non-suicidal self-injury v. attempted suicide: new diagnosis or false dichotomy?. The British Journal of Psychiatry, 202(5), 326-328. b. “Gatekeepers” – the list does not highlight the importance of training non-clinical staff in health and social care organisations e.g. receptionists c. “People affected by suicide” There needs to be a definition of the term. This may include gatekeepers. And there needs to be support/training before rather than just following a suicide. d. “High risk groups” – those who self-harm are not listed here despite the significant amount of evidence demonstrating they are a group most at risk of suicide. It is noted that there are separate NICE guidelines around self-harm but this document will be the first or only go to document for those looking to improve their suicide prevention efforts – so if the link between self-harm and suicide is not highlighted here, this group will not be looked at within suicide prevention approaches – despite the abundant evidence demonstrating that people who self-harm are the most at risk of future suicide. Evidence to support inclusion: o Named as high risk group in National Suicide Prevention Strategy – Third Progress update 2017 (https://www.gov.uk/government/publications/suicide-prevention-third-annual-report) o Hawton, K., Bergen, H., Cooper, J., Turnbull, P., Waters, K., Ness, J., & Kapur, N. (2015). Suicide following self-harm: findings from the multicentre study of self-harm in England, 2000–2012. Journal of Affective Disorders, 175, 147-151. o Hawton, K., Linsell, L., Adeniji, T., Sariaslan, A., & Fazel, S. (2014). Self-harm in prisons in England and Wales: an epidemiological study of prevalence, risk factors, clustering, and subsequent suicide. The Lancet, 383(9923), 1147-1154. o Gairin, I., House, A., & Owens, D. (2005). Attendance at the Accident and Emergency Department in the Year before Suicide: Retrospective Study. Year Book of Psychiatry & Applied Mental Health, 2005, 206. o Zahl, D. L., & Hawton, K. (2004). Repetition of deliberate self-harm and subsequent suicide risk: long-term follow-up study of 11 583 patients. The British Journal of Psychiatry, 185(1), 70-75.	• people who provide peer support in residential custodial and detention settings • people leading suicide prevention partnerships • people supporting those bereaved by suicide." c. We have changed this term to "people with personal experience of a suicide attempt, suicidal thoughts and feelings, or a suicide bereavement" d. We have now included "people who self-harm" in this list. We have also included a recommendation to interpret data on suicide and self-harm in the suicide prevention action plan, analyse data on suicide and self-harm in gathering and analysing suicide-related information and raise awareness of suicide and self-harm. Thank you for these references. We have not included the references as we did not prioritise a review question on groups at high suicide risk at scoping. We will pass your comment and references to the surveillance team at NICE.
Derbyshire Healthcare NHS Foundation Trust	Full	General	General	General language/Inferences These guidelines make a distinction (albeit implicit) between a population who are at risk of suicide and ‘others’, when in fact all people are at risk of suicide as they may fall into one of the “at risk groups” at some time in their lives. For example there is an implicit assumption that “gatekeepers” are not at risk of suicide themselves, with no consideration to the additional support they may need to help promote their own resilience.	Thank you for your comment.
Derbyshire Healthcare NHS Foundation Trust	Full	6	15	Some guidance/signposting to guidance around the practicalities/legalities of this need to be provided – this is perceived to be a major barrier by organisations. Furthermore, NHS organisations have no legal basis to freely have access to cause of death data for their patients – so how are they supposed to investigate all deaths as decreed by CQC and NHS England - https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf	Thank you for your comment. The committee have drafted the following recommendation to address the practicalities and legalities of data sharing "1.3.1 Share experience and knowledge between stakeholders. Also share data, subject to local information sharing agreements."
Derbyshire Healthcare NHS Foundation Trust	Full	8	General	It is not stated that there is a significant need to raise awareness about the link between self-harm and suicide. Evidence to support inclusion: o Named as high risk group in National Suicide Prevention Strategy – Third	Thank you for your comment. The committee agree with this comment and have expanded in the recommendation as follows "1.5.1 Consider local activities to: • raise community awareness of the scale and impact of suicide and self-harm

				Progress update 2017 (https://www.gov.uk/government/publications/suicide-prevention-third-annual-report) o Hawton, K., Bergen, H., Cooper, J., Turnbull, P., Waters, K., Ness, J., & Kapur, N. (2015). Suicide following self-harm: findings from the multicentre study of self-harm in England, 2000–2012. Journal of Affective Disorders, 175, 147-151. o Hawton, K., Linsell, L., Adeniji, T., Sariaslan, A., & Fazel, S. (2014). Self-harm in prisons in England and Wales: an epidemiological study of prevalence, risk factors, clustering, and subsequent suicide. The Lancet, 383(9923), 1147-1154. o Gairin, I., House, A., & Owens, D. (2005). Attendance at the Accident and Emergency Department in the Year before Suicide: Retrospective Study. Year Book of Psychiatry & Applied Mental Health, 2005, 206. Zahl, D. L., & Hawton, K. (2004). Repetition of deliberate self-harm and subsequent suicide risk: long-term follow-up study of 11 583 patients. The British Journal of Psychiatry, 185(1), 70-75.	• reduce the stigma around suicide and self-harm • address common misconceptions by emphasising that: - suicide is not inevitable and can be prevented -asking someone about suicidal thoughts does not increase risk • make people aware of the support available nationally and locally • encourage help-seeking behaviours • encourage communities to recognise and respond to a suicide risk." Thank you for providing these references. We did not have a review question on the epidemiology of suicide, however we will provide these to the surveillance team at NICE for future updates.
Derbyshire Healthcare NHS Foundation Trust	Full	9	8	Advice around where displays should be does not include any non-statutory locations. Two thirds of all people who die by suicide are not open to mental health services – we need to go beyond healthcare and other statutory settings to reach people. Evidence for inclusion: National Confidential Inquiry into Suicide and Homicide by people with mental illness. Making Mental Health Care Safer: Annual Report and 20 year Review. October 2016, University of Manchester. Available at http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/2016-report.pdf	Thank you for your comment. The recommendations on suicide campaign messages have been removed. The committee agreed that it was more appropriate for suicide prevention campaigns to run at a national level and focus on activities to raise awareness of suicide at a local level. Thank you for the reference. We will pass this reference to the surveillance team at NICE.
Derbyshire Healthcare NHS Foundation Trust	Full	10	12	Also need to increase awareness in those working in places where means can be accessed and taken elsewhere e.g. pharmacies – not just at places where suicide may happen. The second most common method of suicide in the UK is poisoning. Office of National Statistics (2016) Suicides in the UK: 2016 registrations. Registered deaths in the UK from suicide analysed by sex, age, area of usual residence of the deceased and suicide method. Available at: www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/ bulletins/suicidesintheunitedkingdom/2016registrations#suicide-methods	Thank you for your comment. The committee have drafted the following recommendation for people working in places where means can be accessed "1.7.1 Ensure training is available for: • those in contact with people or groups at high suicide risk • people working at locations where suicide is more likely • gatekeepers • people who provide peer support in residential custodial and detention settings • people leading suicide prevention partnerships • people supporting those bereaved by suicide."
Gables Medical Offender Health Ltd	Full	4	2	There has to be a lead agency – perhaps the Mental Health Team or Safer Custody. This has to be spelled out in the guidelines. I believe this should be the Mental Health Team – they have access to both SystmOne and C-NOMIS records. However, our Mental Health Team refuse to take this on, it is currently in limbo with no leadership and renders the whole process ineffectual. I note the need for leadership is suggested on Page 18, line 25 – it needs to be promoted throughout the document. This role probably needs to be addressed through commissioning?	Thank you for your comment. We have amended the recommendation as follows "1.1.1 Local authorities should work with local organisations to: • Set up a multi-agency partnership for suicide prevention. This could consist of a core group and a wider network of representatives. • Identify clear leadership for the partnership. • Ensure the partnership has clear terms of reference, based on a shared understanding that suicide can be prevented. "
Gables Medical Offender Health Ltd	full	4	21	Involving multiple agencies is only effective if the information is readily available to everyone and is clearly documented in the patient's records. In Prisons at this time, most data on SystmOne is free text and so is not visible unless searched for (usually after the suicide). There needs to be a National template recording "High suicide risk" and making it clear whether this is 1. Historic (but may occur again), 2. Current (needing active support), or 3 future (high risk dates, events and anniversaries & needing proactive support planning). The documentation on the template would need to be visible when transferring between prisons and when re-entering prison. It should be shared with the community GP and other agencies. The template needs to be linked to a very	Thank you for your comment. Whilst we recognise that having standards or templates for data recording is aspirational, the committee considered that this guideline did not need to specify a template as they have outlined the data that should be recorded. The committee also did not consider that it was appropriate to specify data collection software, as the onus is on the multi-agency partnership to liaise with other similar partnerships, when considering collecting and sharing data. The committee have made specific recommendations covering this point in the

				visible warning on SystmOne (pop up box?). There needs to be a recall/review process linked to the template that prompts when a review is due. Recording of ACCTs could be linked to the template. (currently there is no process to make show an ACCT has been opened). The information needs to come from all agencies interacting with the prisoner, including those outside the prison such as the family. The agency leading on the management needs to have access to these records – either on C-NOMIS or SystmOne – or ideally, both. There needs to be both regular and emergency multi-agency meetings to review those at high risk of suicide, both reactively and better, proactively.	following sections "1.2.1 Develop a multi-agency strategy based on the principles of the Department of Health and Social Care's suicide prevention strategy for England and other relevant strategies. It should emphasise that suicide is preventable, and it is safe to talk about it." "1.3.1 Develop and implement a plan for suicide prevention and for after a suspected suicide. Ensure the approach can be adapted according to which agencies are likely to spot emerging clusters: • Identify clear leadership for the action plan. • Interpret data to determine local patterns of suicide and self-harm, particularly among groups at high suicide risk (see section 1.4). • Compare local patterns with national trends. • Prioritise actions based on the joint strategic needs assessment and other local data to ensure the plan is tailored to local needs. • Map stakeholders and their suicide prevention activities (including support services for groups at high risk). • Share experience and knowledge between stakeholders. Also share data, subject to local information sharing agreements. • Keep up-to-date with suicide prevention activities by organisations in neighbouring settings. • Oversee local suicide prevention activities, including awareness raising and crisis planning. • Review the action plan at a time agreed at the outset by the multiagency partnership."
Gables Medical Offender Health Ltd	Full	6	8	Having a template and clear records with an MDT approach would facilitate proactive and reactive management of high suicide risk prisoners. It would facilitate data gathering and auditing. It would facilitate development of action plans involving more than just the one prison. Multi-prison meetings would facilitate developing a uniform supportive approach.	Thank you for your comment. The committee were not aware of any standard template that could be used. The committee did however recommend the following for residential custodial and detention settings which will facilitate data sharing based on local data-sharing agreements " 1.1.6 Link the partnership with other relevant multi agency partnerships in the community."
Gables Medical Offender Health Ltd	Full	8	13	Promote group session in prisons – perhaps Peer Mentor lead	Thank you for your comment. The committee agree with this comment and have drafted the following recommendation "1.7.1 Ensure training is available for: • those in contact with people or groups at high suicide risk • people working at locations where suicide is more likely • gatekeepers • people who provide peer support in residential custodial and detention settings • people leading suicide prevention partnerships • people supporting those bereaved by suicide."
Gables Medical Offender Health Ltd	Full	10	11	All staff/gatekeepers need training to raise awareness of risk factors in general, and how to act if they have concerns. ACCTS are opened readily for relatively high risk, but action should also be taken at lower level of concern. Multi-source low level concerns should prompt supportive action. Its shouldn't be all about ACCTs.	Thank you for your comment. The recommendation on gatekeeper training is provided to all those at risk.
Gables Medical Offender Health Ltd	Full	14	1	Places AND TIMES. Gatekeepers need to be proactive in considering when prisoners will be at increased risk of suicide – first time in prison, transfers, pre-release etc	Thank you for your comment. The term has been changed to 'locations where suicide is more likely' and therefore we have not included 'time' in this. However, the committee recognise that timing in residential custodial and detention settings is important and have included a recommendation as follows

					"1.4.2 Collect and analyse local data on suicide and self-harm. This could include data on: method, location, timing, details of individual and local circumstances, demographics, occupation and characteristics protected under the Equality Act (2010)."
Gables Medical Offender Health Ltd	Full	17	18	Please emphasise the need for leadership	Thank you for your comment. The committee agree and have added a bullet to the recommendations for both community and residential and custodial detention settings to identify clear leadership for the partnerships.
Gables Medical Offender Health Ltd	Full	23	24	The prison population has multiple high risk groups – this needs spelling out, otherwise it will be done differently in every prison. These high risk groups could be targeted as part of the induction process in every prison by all the agencies involved.	Thank you for your comment. The recommendations on suicide campaign messages have been removed. The committee agreed that it was more appropriate for suicide prevention campaigns to run at a national level and focus on activities to raise awareness of suicide at a local level. In addition, the committee have added new recommendations specifically for residential custodial and detention settings as follows " 1.5.2 For residential custodial and detention settings, also consider raising awareness of: •the risk associated with 'early days' and transitions between estates or into the community •the value of peer support for example, The Listener Scheme •the need for institutional support, such as safer custody teams (see HM Prisons and Probation Service's Prison Service Instructions 2011 on the management of prisoners at risk of harm to self, to others and from others)."
Gables Medical Offender Health Ltd	Full	26	13	Places AND TIMES	Thank you for your comment. The term has been changed to 'locations where suicide is more likely' and therefore we have not included 'time' in this. However the committee have considered 'time' in relation to access to means, in the following recommendation "1.6.4 Consider other measures to reduce the opportunity for suicide. For example, at locations where suicide is more likely, consider: • providing information about where and how people can get help when they feel unable to cope at locations where suicide is more likely. • 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. "
Gables Medical Offender Health Ltd	Full	31	1	The guidance will only work if it addresses data recording and visibility, awareness of individuals at high risk, data transfer between prisons and between prisons and community and leadership. If the recommendations are left vague, they are unlikely to happen in a uniform manner and the result will be a patchwork and less effective response. Better to have a robust & clear plan to be implemented across the Prison Estate. This needs to be linked to the commissioning process?	Thank you for your comment. We will forward this to the NICE Implementation team.
Gloucestershire County Council	Full	4	4	QUESTION 1: This recommendation will have the biggest impact on practice because our view is that effective partnerships are the foundations of all of the recommendations in this draft guideline. The implementation of recommendations without a robust partnership will be extremely challenging.	Thank you for your comment. Your comments will be considered by NICE where relevant support activity is being planned.
Gloucestershire County Council	Full	4	4	QUESTION 3: Gloucestershire has a long standing, proactive multi-agency partnership which includes people who have attempted or been affected by suicide. We would be willing to submit our experiences to the NICE shared learning database. Please contact suicideprevention@gloucestershire.gov.uk	Thank you for your comment. We will pass this information to our local practice collection team. More information on local practice can be found here: https://www.nice.org.uk/about/what-we-do/into-practice/local-practice-case-studies.
Gloucestershire County Council	Full	7	1	QUESTION 3: Our local partnership has experience of carrying out a Suicide Audit to inform local practice and would be willing to submit our experiences to the NICE shared learning database. Please contact suicideprevention@gloucestershire.gov.uk	Thank you for your comment. We have forwarded this to our System Engagement team.

Gloucestershire County Council	Full	11	20	QUESTION 1: This recommendation will be a challenge to implement. Although continuous and timely collection of data is starting to have a positive impact in Gloucestershire in terms of identifying trends more quickly, identifying potential suicide clusters is challenging to implement in the context of connections that span county and national boundaries (e.g. through social media).	Thank you for your response. We will pass this information to our resource impact team for their information.
Gloucestershire County Council	Full	12	11	QUESTION 1 & 2: This is challenging because there is a high turnover of journalists on local newspapers so implementation of this training would require frequent training events at a cost to local partners. Building this into journalists' training at colleges and universities would help reduce the cost implication and ensure that all future journalists have received the training.	Thank you for your comment. The statement on training for journalists has been removed from this recommendation. This recommendation has been amended to the following **"**1.10.2 For community settings, promote guidance on best practice for media reporting of suicide (including providers of social media platforms). Highlight the need to: •use sensitive language that is not stigmatising or in any other way distressing to people who have been affected •reduce speculative reporting •avoid presenting detail on methods." We will pass this information to our resource impact team for their information.
Gloucestershire County Council	Full	12	21	QUESTION 1: This recommendation will be challenging because although there is evidence that tackling insensitive reporting would have an impact, the existing guidelines and codes of practice do not provide a sufficiently adequate tool for addressing poor standards of reporting.	Thank you for your comment. The statement on training for journalists has been removed from this recommendation. This recommendation has been amended to the following "1.10.2 For community settings, promote guidance on best practice for media reporting of suicide (including providers of social media platforms). Highlight the need to: •use sensitive language that is not stigmatising or in any other way distressing to people who have been affected •reduce speculative reporting •avoid presenting detail on methods." We will pass this information to our resource impact team for their information.
Gloucestershire County Council	Full	24	15	QUESTION 3: Given the limited evidence of effectiveness, the potential to cause harm and financial implications for local partners the provision of campaign materials/messages by approved/national organisations could help with the implementation of effective campaigns.	Thank you for your comment. The committee agreed to remove recommendations on media campaigns as these are best delivered on a national level.
Gloucestershire County Council	Full	27	13	QUESTION 1 & 2: This recommendation will have a cost implication and would be challenging to implement due to several reasons. Firstly some organisations have limited capacity (for example primary care), also many organisations have limited training budgets (some of the evidence-based training models are expensive to deliver), for example voluntary and public sector organisations. Finally, in some organisations there can be a lack of corporate 'buy-in' by senior management, for example private car park operators.	Thank you for your response. We will pass this information to our resource impact team for their information.
Hampshire County Council	Full	General	General	This guidance does not give enough specifics about the role of specialist mental health services	Thank you for your comment. The role of specialist mental health services is out of scope for this guideline.
Hampshire County Council	Full	General	General	This guidance does not give enough specifics about the role of Primary Care in identification and prevention of suicide	Thank you for your comment. The committee agree that Primary Care Providers are key gatekeepers for suicide prevention and with specific recommendations for this group of people.
Hampshire County Council	Full	4	8	We are concerned that this recommendation misses out key partners including transport agencies; the coroner office; safeguarding boards/partnerships who are key for suicide prevention	The committee agree and were mindful of the fact that different groups of people could be included in the wider network, depending on local circumstances and settings. As such the committee drafted a recommendation as follows

					"1.1.1 Set up a multi-agency partnership for suicide prevention. This could consist of a core group and a wider network of representatives." We have referenced Public Health England guidance at the start of the guideline provides further information on this.
Hampshire County Council	Full	7	4	The guidance recommends collecting data on self harm, further details on how this could be collected in a robust way is needed	Thank you for your comment. We have added a link to 'Public Health England's resource on Local suicide prevention planning: a practice resource' at the start of the recommendations for further information and exemplars.
Hampshire County Council	Full	9	15	Reducing access to methods of suicide This section does not give enough details as to what is effective in line with key methods of suicide	Thank you for your comment. The following recommendations states measures that could be effective "1.6.3 Reduce the opportunity for suicide in locations where suicide is more likely, for example, by erecting physical barriers. Also see Public Health England's Preventing suicide in public places: a practice resource." "1.6.4 Consider other measures to reduce the opportunity for suicide. For example, at locations where suicide is more likely, consider: • providing information about where and how 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/or visibility of staff or times when staff are available. "
Hampshire County Council	Full	9	15	Gathering and analysing suicide-related information This section should include a recommendations about collect information about attempted suicides as this ensures a fuller picture of suicidality	Thank you for your comment. The committee agreed to include collection of data on self-harm in these recommendations.
Hampshire County Council	Full	11	4	This recommendation will be a challenging change in practice because as there are cost implications that have not been funded.	Thank you for your response. We will pass this information to our resource impact team for their information.
Hampshire County Council	Full	11	4	This recommendation does not give enough specifics about what this support should entail. The guidance says that Local Authorities are reluctant to commission bereavement services. We are concerned that this recommendation may imply it is the role of the Local Authority when the responsibility may not be for Local Authority to undertake or commission.	Thank you for your comment. Specifics regarding support cannot be given as the support is tailored for each individual. The recommendation has been amended as follows " 1.8.2 Offer those who are bereaved or affected by a suspected suicide practical information expressed in a sensitive way, such as Public Health England's Help is at hand guide. (This also signposts to other services.) Ask them if they need more help and, if so, offer them tailored support."
Hampshire County Council	Full	11	4	We are concerned that this recommendation may not be clear about the role for IAPT services and the need to adapt their offer and speed of access for those bereaved by suicide	Thank you for your comment. We have amended the recommendation as follows to include tailored support, which may include IAPT services if appropriate " 1.8.2 Offer those who are bereaved or affected by a suspected suicide practical information expressed in a sensitive way, such as Public Health England's Help is at hand guide. (This also signposts to other services.) Ask them if they need more help and, if so, offer them tailored support."
Hampshire County Council	Full	12	General	This should be a local and a national recommendation linking to colleges of journalism at present this is left to local areas to lead which is not sufficient to change practice	Thank you for your comment. The committee agree that the content of information delivered in colleges of journalism will be covered by national policy and as such is outside of scope for this guideline.
Health Education England	Full	4	8	The list here includes those affected by suicide –this may need to be clearer in showing that this includes family members, but does it also include those who have witnessed a suicide or suicide attempt? As this may include general members of the public as well. Just mentioning as	Thank you for your comment. We have included family members under "people with personal experience of a suicide attempt, suicidal thoughts and feelings, or a suicide bereavement" The committee agree and were mindful of the fact that different groups of people (for example general members of the public) could be included in the wider

				may need to more clearly define this group to ensure that members are able to meaningfully contribute to this agenda.	network, depending on local circumstances and settings. As such the committee drafted a recommendation as follows "1.1.1 Set up a multi-agency partnership for suicide prevention. This could consist of a core group and a wider network of representatives." We have referenced Public Health England guidance at the start of the guideline provides further information on this.
Health Education England	full	4	19	Will there not also be staff who in reach into the prison to support Mental Health needs of prisoners who will need to be included in this list? Does police custody count as a custodial setting? If so police and liaison and diversion staff need to be involved here	Thank you for your comment. The committee agree that staff who reach into the prison to support mental health needs of prisoners are covered under "healthcare staff in residential custodial and detention settings". The committee acknowledged that police custody is not included in custodial settings and have added "residential" to the term "custodial and detention settings" to emphasise this distinction. We have added "liaison and diversion services" to the list of core representatives as suggested.
Health Education England	Full	8	34	Also need to be aware of different languages, that might be due to members of the community for who English isn't their first language, or more local alterations in language which need to be considered when providing such awareness raising. Also need to ensure that all that is produced is accessible and this may include producing documents and training either in easy read or some other easy to understand format including being accessible for	Thank you for your comment. The committee drafted the recommendation as follows "1.5.4 Ensure the language and content of any awareness-raising materials is: • appropriate for the target group • sensitive and compliant with media reporting guidelines, such as the Samaritans' Media guidelines for the reporting of suicide."
Health Education England	Full	10	4	Does this mean geographical locations? Such as bridges etc.? or in a prison/custodial setting? It isn't clear and each could have a different response. For example a geographical location could also have some self help literature or a phone linked to Samaritans in the same way that when you break down on the motor way you can call for help	Thank you for your comment. We have amended this to "locations where suicide is more likely" and provided a definition in terms used in the guideline section as follows "These include high buildings such as multi-storey car parks, railways and bridges and places where other means of suicide are accessible, such as medical, veterinary or agricultural settings where human or animal drugs may be readily available. See Public Health England's practice resource on Preventing suicides in public places."
Health Education England	Full	10	11	Re suicide awareness training this reads as if the training will be delivered in the geographical locations where suicide is most likely for example on a bridge, I am assuming this isn't the idea, instead you mean training with staff groups where it is more likely? For example staff who work in custodial settings and I would include police cells and also courts in this list as well as these are invariably settings where people will be hearing bad news and feeling very distressed, which means they are at higher risk of suicide.	Thank you for your comment. The committee have reworded this recommendation as follows "1.7.1 Ensure training is available for: • those in contact with people or groups at high suicide risk • people working at locations where suicide is more likely • gatekeepers • people who provide peer support in residential custodial and detention settings • people leading suicide prevention partnerships • people supporting those bereaved by suicide."
Health Education England	Full	10	14	This training will also need to give staff the skills and confidence to start to have this sort of conversation, as staff often report this as the greatest barrier to raising the issue of suicide with people. There will also need to be tiered levels of training with some needing only awareness raising and those working in high risk areas needing a higher level of training which will include not only having conversations, but also work around how to observe non verbal cues and observations that would indicate increased risk of suicide and what to do to reduce this risk when it is observed	Thank you for your comment. The committee have included this in the following recommendation "1.7.4 Ensure suicide awareness and prevention training helps people to: • understand local suicide incidence and its impact, and know what support services are available • encourage others to talk openly about suicidal thoughts and to seek help (this includes providing details of where they can get this help) take into account socioeconomic deprivation, disability, physical and mental health status, and cultural, religious and social norms about suicide and help-seeking behaviour, particularly among groups at high suicide risk."

					The committee have drafted the following recommendation to cover tiered training "1.7.3 Provide generic and specialist training as needed for specialists and non-specialists."
Health Education England	full	10	19	This will also need to link to employers policies so staff feel supported by their employer and that there is some guarantee of privacy	Thank you for your comment. The committee have drafted the following recommendation on employer policies "1.5.6 Consider encouraging employers to develop policies to raise suicide awareness and provide support after a suspected suicide. For example, see Public Health England and Business in the Community's toolkits."
Health Education England	Full	10	22	Gatekeepers will also need to be able to manage such risks as well	Thank you for your comment. The committee agreed to remove this recommendation and have replaced it with the following recommendation "1.7.4 Ensure suicide awareness and prevention training helps people to: •understand local suicide incidence and its impact, and know what support services are available •encourage others to talk openly about suicidal thoughts and to seek help (this includes providing details of where they can get this help) take into account socioeconomic deprivation, disability, physical and mental health status, and cultural, religious and social norms about suicide and help-seeking behaviour, particularly among groups at high suicide risk."
Health Education England	Full	11	1	What does emotional support mean? This needs clarifying and there will also be a need to ensure that peer workers will have adequate support for their own emotional needs	Thank you for your comment. The committee agreed to remove emotional support and reworded as follows "1.7.1 Ensure training is available for: • those in contact with people or groups at high suicide risk • people working at locations where suicide is more likely • gatekeepers • people who provide peer support in residential custodial and detention settings • people leading suicide prevention partnerships • people supporting those bereaved by suicide."
Health Education England	Full	11	17	Is there criteria that outlines who will need further support?	Thank you for your comment. We are not aware of any criteria that can be used to outline who will need further support.
Health Education England	Full	13	2	Is there a need for services to identify gatekeepers? As in some services all the staff may be coming into contact with people who are at high risk, and there will be a need to have people who have a higher skill set and they would be the gatekeepers. This would mean that in each service there will be very highly trained people who can identify and address high risk issues	Thank you for your comment. The committee noted that is difficult to be specific over defining gatekeepers as this depends on each individual setting and service in question. However the committee noted that all gatekeepers should receive training. It is up to the individual service who should be offered training.
Her Majesty's Inspectorate of Prisons	Draft guideline	4	4	Guideline 1.1.1 HMIP believe that the multi-agency partnership on suicide prevention could sit well within The Crisis Care Concordat meeting structure. This may increase engagement and result in better coordination of activities.	Thank you for your comment. We have added further information on this in the discussion section of the evidence review 1 Multi-agency partnerships.
Her Majesty's Inspectorate of Prisons	Draft guideline	4	21	Guideline 1.1.3 The suggestion for a multi-agency partnership in custodial or detention settings to address suicide prevention is currently theoretically covered by safer custody committees who also address wider issues such as violence reduction. It may therefore be more helpful to recommend that each establishment's effective multi-agency partnership prioritises suicide prevention planning. Further, inspectors often find that establishments who actively include representatives from community organisations, significantly strengthen their partnership working and effectively inform actions. To this end, we recommend that the multi-agency partnership should also, and specifically, include	Thank you for your comment. The committee acknowledge that many systems are already in place and that multi-agency partnerships in these settings could be based on existing systems. The committee agree and have now added the following new recommendations for multi-agency partnerships in residential custodial and detention settings "1.1.5 Include representatives from the following in the partnership's core group: • governors or directors • healthcare staff in residential custodial and detention settings • staff in residential custodial and detention settings

				representatives from the chaplaincy, the Listeners Scheme and the local Samaritans branch.	• 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."
Her Majesty's Inspectorate of Prisons	Draft guideline	5	4	Guideline 1.1.3 We recommend replacing the phrase 'probationary and transition services' with 'offender management and resettlement services' as the latter refers to specific responsible departments.	Thank you for your comment. In response to your comment and other stakeholder comments, we have updated the term "probationary and transition services" to "offender management and resettlement services"
Her Majesty's Inspectorate of Prisons	Draft guideline	5	9	Guideline 1.2.1 The contents of this guideline focus exclusively on suicide. However, in custodial settings, wider issues including deliberate self-harm and near misses are also important potential predictors. We therefore recommend that the strategy should include the identification and management of risk factors and behaviours that make suicide more likely. The strategy should also be cross-referenced with strategies for violence reduction and substance misuse. It is also important to note that in custodial settings, purposeful activity, positive social activities and timely access to mental health are also pertinent to this issue.	Thank you for your comment. This guideline covers suicide and self-harm. We have included the following recommendation to cover identification and management of risk factors and behaviours in residential community and detention settings and have recommended the collection of data to facilitate risk identification " 1.2.9 Identify and manage risk factors and behaviours that make suicide more likely." The committee have drafted the following recommendation to cover this "1.2.3 Consider how to measure activities to prevent suicide. Include the introduction of constructive, meaningful preventive activities (for example, education and physical activity) rather than focusing on suicide numbers alone"
Her Majesty's Inspectorate of Prisons	Draft guideline	6	9	Guideline 1.3.1 HMIP recommend that the guideline includes regular reviews of action plans and that action plans should also be put in place to prevent deliberate actions of self-harm. Her Majesty's Prisons and Probation Service (HMPPS) data indicates that although the number of self-inflicted deaths in custodial establishments has been reducing from a record high, the number of near misses and incidences of self-harm have not been reducing. HMIP therefore support the emphasis in this section on attempted suicide as well as suicide. HMIP note that there is no direct reference to Death in Custody reports and near miss reviews in this section of the guidelines. HMIP Inspectors regularly find that recommendations from the Prisons and Probation Ombudsman (PPO) and Clinical Reviews are poorly implemented in detention and custodial settings, and this is often reflected in poor practice in suicide prevention and management of those at risk. We therefore suggest that the guidelines state that action plans should also include recommendations from the PPO and Clinical Reviews and are informed by serious incidents such as following a near miss.	Thank you for your comment. The committee drafted the following recommendation in relation to regular reviews of action plans "1.3.1 Review the action plan at a time agreed at the outset by the multiagency partnership." The committee have also drafted a recommendation to state that action plans should include recommendations from the PPO "1.3.3 Work with the Prison and Probation Ombudsman and coroners to ensure recommendations from investigations and inquests are implemented."
Her Majesty's Inspectorate of Prisons	Draft guideline	7	7	Guideline 1.4.1 This recommendation directs readers to data at the National Offender Management Service (NOMS) website. NOMS had now been renamed to Her Majesty's Prisons and Probation Service. The link should reflect this new name and lead to the HMPPS website:https://www.gov.uk/government/organisations/her-majestys-prison-and-probation-service	Thank you for your comment. This has been updated as suggested.

Her Majesty's Inspectorate of Prisons	Draft guideline	7	23	Guideline 1.4.3 HMIP recommends that this guideline should also include the collection of data on: The location where the attempt or the death took place as for example, the segregation unit carries additional risk factors linked to isolation; How many days the individual had spent in custody, as early days are often a key risk time; If the individual had a history of self-harm; If the individual had a history of mental health problems; If the individual had a history of drug and alcohol abuse.	Thank you for your comment. The committee agree with the points raised in the comment and believe that they are covered in the following recommendation "1.4.2 Collect and analyse local data on suicide and self-harm. This could include data on: method, location, timing, details of individual and local circumstances, demographics, occupation and characteristics protected under the Equality Act (2010)."
Her Majesty's Inspectorate of Prisons	Draft guideline	8	7	Guideline 1.5.2 HMIP suggest that this guideline also include awareness raising of mental health issues, as this is an important context within which to raise awareness around suicide. Both are also equally important to support staff to identify and support those at risk.	Thank you for your comment. The committee agree with this comment and drafted the following recommendation to include mental health status " 1.7.4 Ensure suicide awareness and prevention training helps people to: •understand local suicide incidence and its impact, and know what support services are available •encourage others to talk openly about suicidal thoughts and to seek help (this includes providing details of where they can get this help) take into account socioeconomic deprivation, disability, physical and mental health status, and cultural, religious and social norms about suicide and help-seeking behaviour, particularly among groups at high suicide risk."
Her Majesty's Inspectorate of Prisons	Draft guideline	9	22	Guideline 1.6.2 HMIP recommend that this guideline also reference the use of gated cells and constant supervision to keep those at highest risk of suicide safe.	Thank you for your comment. The committee have drafted the following recommendation to include safer cells and provided a hyperlink to the relevant document " 1.6.2 Ensure local compliance with national guidance to reduce access to methods of suicide: • In custodial settings, for example, provide safer cells (see the Ministry of Justice's Quick-time learning bulletin: safer cells)."
Her Majesty's Inspectorate of Prisons	Draft guideline	10	4	Guideline 1.6.4 The considerations identified in this guideline are appropriate but could be strengthened by increasing the visibility and accessibility of staff and other forms of support such as helplines. HMIP also recommend including in the guideline a proactive approach by staff to identify and support those that may be at higher risk.	Thank you for your comment. We have added more information to the following recommendation "increasing the number and/or visibility of staff or times when staff are at locations". We have also included gatekeepers in the list of people that suicide awareness and training should be provided for. There is further information in the committee discussion around the effectiveness of encouraging help-seeking, and this includes the use of crises telephones. However, the committee noted that the pooled results did not show any benefit effect of this type of intervention in preventing suicide and suggested that the encouragement of help seeking at high frequency sites such as the use of signposts and crisis telephones may be an area where further research is needed, given heterogeneity across included studies regarding types of help-seeking interventions and there delivery methods.
Her Majesty's Inspectorate of Prisons	Draft guideline	10	22	Guideline 1.6.2 HMIP recommend that this guideline specifically state that detention and custody staff must be trained to spot risk factors during early days as this is a high-risk period for prisoners and detainees.	Thank you for your comment. We have now removed this recommendation. Prisoners and detainees are included in the high suicide risk group and the recommendation on training ensures suicide and awareness training is available for "people in contact with high-risk groups or individuals". Therefore staff in these settings would receive appropriate training.
Her Majesty's Inspectorate of Prisons	Draft guideline	11	1	Guideline 1.7.5 HMIP finds that this practice already takes place. Individuals on the Listeners Scheme are already trained by Samaritans to provide confidential emotional support.	Thank you for your comment.
Her Majesty's Inspectorate of Prisons	Draft guideline	11	3	Section 1.8 This section focuses specifically on suicide; however, it is important to note that issues highlighted also apply in cases of attempted suicide and near miss.	Thank you for your comment. This section focuses on 'After a suspected suicide.' Therefore it would not be appropriate to include an attempted suicide in this recommendation.

Her Majesty's Inspectorate of Prisons	Draft guideline	11	9	Guideline 1.8.1 HMIP recommend that the phrase 'cell or prison inmates' is replaced with 'other prisoners' as any individual in the prison might be affected by the death.	Thank you for your comment. We have amended as suggested.
Her Majesty's Inspectorate of Prisons	Draft guideline	11	17	Guideline 1.8.4 We recommend that focus also be given to processes that take place after a suicide, for example, investigations and coroners court as these can be stressful for those affected. Support for staff beyond the immediate aftermath is also key as supported staff with greater resilience will be able to better support those in care.	Thank you for your comment. The committee recognised that there is no timescale for when support should be offered as it is on a case by case basis. As such, the committee drafted the following recommendation outlining that support should be tailored and ongoing if needed " 1.8.2 Offer those who are bereaved or affected by a suspected suicide practical information expressed in a sensitive way, such as Public Health England's Help is at hand guide. (This also signposts to other services.) Ask them if they need more help and, if so, offer them tailored support."
Her Majesty's Inspectorate of Prisons	Draft guideline	11	20	Guideline 1.8.5 It is important to recognise in this guideline, that within custodial settings a PPO investigation and Clinical Review often take several months to complete. Establishments must ensure that they undertake a timely and thorough serious incident review in partnership with the health providers to identify initial learning which would then inform the immediate suicide prevention action plan.	Thank you for your comment. The committee have acknowledged this and drafted the following recommendation to cover this "1.9.2 After a suspected suicide in residential custodial and detention settings, undertake a serious incident review as soon as possible in partnership with the health providers. Identify how: • to improve the suicide prevention action plan • to help identify emerging clusters • others have responded to clusters."
Her Majesty's Prison and Probation Service (HMPPS)	Full	17-30	acy	This section is repetitive of the early content of the document as it re-lists the recommendations in their full form. Readers may not take in the new material/content within the sections 'Why the committee made the recommendations' and 'How the recommendations might affect practice'. You may wish to capture the recommendations in short-form allowing the reader to understand which recommendation is being referred to whilst focusing on the new material/content. For example for the first recommendations linked to multi-agency partnerships remove lines 3 – 17 and lines 20 – 28 on page 17 and line 1-2 on page 18 leaving just line 2 and 18-19 moving straight into line 3 on page 18.	Thank you for your comment. The recommendations have been removed from this section and only appear once at the front of the guideline.
Her Majesty's Prison and Probation Service (HMPPS)	Full	4	17	You may wish to consider clearly listing prisons/detention setting under the bullet point 'criminal justice services'. We know many prisons are not currently part of community multi-agency partnerships for suicide prevention and there is sometimes a misconception that prisons are not part of the local community they are located in so may not be invited to be members of such partnerships.	Thank you for your comment. The committee agree that prisons are implicitly included under "criminal justice services" and therefore we have not explicitly added them. The committee have included "criminal justice services" in both the community and residential custodial and detention settings partnerships to facilitate close communication between prisons and each of the partnerships. This will accommodate community partnerships that have a prison in their local area and also those that do not have a prison.
Her Majesty's Prison and Probation Service (HMPPS)	Full	7	24	We suggest that the term 'transition periods' is explained. Are you referring to transitions like transfer, approaching discharge, parole etc.? This could be made clearer.	Thank you for your comment. The committee agree and have added further information to the recommendation as follows "the risk associated with 'early days' and transitions between estates or into the community"
Her Majesty's Prison and Probation Service (HMPPS)	Full	9	11	Perhaps rather than use the language 'prison visits halls' you could reword this to 'prison visits locations', many prisons are trying to soften language and make visits as 'family friendly' as possible, softer language can help this.	Thank you for your comment. The recommendations on suicide campaign messages have been removed. The committee agreed that it was more appropriate for suicide prevention campaigns to run at a national level and focus on activities to raise awareness of suicide at a local level.
Her Majesty's Prison and Probation	Full	9	23	The term 'safe cell' should not be used: it is our view that no cell can be deemed as completely 'safe' only 'safer'. It is not clear what the 'initiative' to which you refer is. Please consider changing "implementing the safe cell initiative" to "ensuring the provision of safer cells".	Thank you for your comment. We have amended the recommendation as follows "1.6.2 Ensure local compliance with national guidance to reduce access to methods of suicide:

Service (HMPPS)					• In custodial settings, for example, provide safer cells (see the Ministry of Justice's Quick-time learning bulletin: safer cells)."
Her Majesty's Prison and Probation Service (HMPPS)	Full	11	1	Please consider rewording 'Ensure people who provide peer support…..' to something like 'Ensure people in custody who provide peer support….' to help reinforce that this refers to prisoners in peer support roles	Thank you for your comment. The committee have reworded the recommendation to incorporate this as follows "1.7.1 Ensure training is available for: • those in contact with people or groups at high suicide risk • people working at locations where suicide is more likely • gatekeepers • people who provide peer support in residential custodial and detention settings • people leading suicide prevention partnerships • people supporting those bereaved by suicide."
Her Majesty's Prison and Probation Service (HMPPS)	Full	13	17	We suggest rewording this line to something such as 'Groups at high-risk can include (but are is not limited to):' Although the text is meant to imply that this is not an exhaustive list, individuals can sometimes only choose to focus on the risk factors listed. We think it is advisable to be exceptionally clear that the list is not exhaustive.	Thank you for your comment. We have retained the current wording "Groups at high risk can include" as it is implicit that it is not limited to groups on this list.
Her Majesty's Prison and Probation Service (HMPPS)	Full	14	15	We suggest also giving the prison suicide cluster definition: · two self-inflicted deaths within a rolling eight-week period OR · three self-inflicted deaths within a rolling 12-month period	Thank you for your comment. We will use the definition for suicide clusters, as accepted by Public Health England. In addition, the committee discussion (evidence review 3) states that "During expert testimony it was noted that although people often refer to 3 or more closely related deaths, 2 or more suicides may be classified as a cluster or contagion if they occur in a specific community or setting and are related through geographical, time or social factors."
Her Majesty's Prison and Probation Service (HMPPS)	Full	15	2-3, 13-14, 24-25	The recommendations currently read as if they are questions. We suggest rewording to make clearer they are recommendations for example change 'How effective and cost effective are non-clinical interventions to reduce the rate of suicide?' to 'Explore how effective…..' or change 'What interventions are effective and cost effective in reducing suicide rates in custodial sentences' to ''Identify interventions that are effective……'	Thank you for your comment. The research recommendations included in this guideline are indicators of research to update this guideline. As such, how this research is planned is decided by the individual investigator and/or funders.
Her Majesty's Prison and Probation Service (HMPPS)	Full	16	6, 14-15	The recommendations currently read as if they are questions. We suggest rewording to make clearer they are recommendations for example change 'How effective and cost effective are non-clinical interventions to reduce the rate of suicide?' to 'Explore how effective…..' or change 'What interventions are effective and cost effective in reducing suicide rates in custodial sentences' to ''Identify interventions that are effective……'	Thank you for your comment. The research recommendations included in this guideline are indicators of research to update this guideline. As such, how this research is planned is decided by the individual investigator and/or funders.
Indivior Uk Limited	Full	general	general	We note that there is limited mention of specific strategies to lessen the impact drug and alcohol use disorders have on suicide. A meta-review of cohort studies on victims of suicide found that heroin users had a 13.5-fold increase in standardized mortality ratios for suicide. (Wilcox HC, Conner KR, Caine ED. Association of alcohol and drug use disorders and completed suicide: an empirical review of cohort studies. Drug Alcohol Depend. 2004;76:S11–S19.) Additionally people who use drugs aged 45 and over are more likely to die from self-harm or suicide, rather than accidental overdose (Ghodse, H., Corkery, J., Oyefoso, A., et al (2009) Drug-related Deaths in the UK. International Centre for Drug Policy.).	Thank you for your comment. Strategies for drug and alcohol use disorders is out of scope for this guideline. Please also see NICE guideline "Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence" and Public Health England's "Better care for people with co-occurring mental health, and alcohol and drug use conditions" for further information.
Indivior Uk Limited	Full	4	8	Consider the inclusion of representatives from drug and alcohol services.	Thank you for your comment. Representatives from drug and alcohol services are covered under "healthcare providers" in the list.
Janssen	Full and short	General	General	Janssen thanks NICE for the opportunity to comment on the draft guideline for 'Preventing suicide in community and custodial or detention settings.' We are	Thank you for your comment and support for the guideline.

				supportive of the recommendations contained in the short guideline. We welcome the development of a guideline on the prevention of suicide, given the significant impact that suicide has on people at risk of suicide, their families, friends and on society in general.	
Janssen	Full and short	General	General	We would suggest to NICE that there is also an urgent need to review the evidence regarding the treatment strategies for people who are imminent risk of suicide or who have attempted suicide. There is currently little consensus regarding best practice for these people. There is also a significant variation in the treatments and strategies that these patients receive locally. Accordingly, we would urge NICE to consider looking at the treatment of patient with imminent risk of suicide or who have attempted suicide, as future topic to support healthcare professionals in providing high quality care to support these people.	Thank you for your comment. Treatment strategies and imminent risk of suicide or who have attempted suicide are outside of scope for this guideline.
Janssen	Short	7	1 TO 7	We welcome the recommendation 1.4 on Gathering and analysing suicide related information. We believe that this strongly supports the appropriate planning to prevent suicide. However, we note that there is no mention of how to assess the risk of suicide and we believe the guideline is currently unclear regarding how to define the risk of suicide beyond identifying some groups of people who are at higher risk than average. Putting specific recommendations regarding the assessment of suicide, based on disease outcomes or use of technology (e.g. apps) to support the appropriate collection of data to identify high risk individuals at imminent risk of suicide, could help develop effective targeted strategies to prevent suicides. We suggest to NICE that *a recommendation is added regarding the collection of relevant data to assess and identify high-risk cohorts and use this data to support better planning of suicide prevention.*	Thank you for your comment. There was no review question on risk assessment and therefore we cannot make any recommendations on this topic. The committee drafted a recommendation for the collection of relevant data that will help inform action plans and suicide prevention activities.
Janssen	Short	8	1 to 25	We suggest to NICE that it would be crucial to raise community awareness of people who are at high risk suicide so that people can better understand, how to identify and support these people and have a heightened awareness of the support services available within the NHS. Currently there is no recommendation regarding the identification of these high-risk groups and this could lead to people in a community or custodial setting being unaware of which people might be at higher risk of committing suicide.	Thank you for your comment. The committee have drafted the following recommendation for awareness raising to highlight those groups at high suicide risk " 1.5.3 Take into account socioeconomic deprivation, disability, physical and mental health status, and cultural, religious and social norms about suicide and help-seeking behaviour, particularly among groups at high suicide risk." Assessing risk is out of scope for this guideline however the committee have drafted recommendations on gathering and analysing suicide-related information (section 1.4) which will enable those high-risk groups to be identified.
Janssen	Short	10	11 to 25	We note that there is no specific recommendation around training people who work with high risk groups regarding how to identify those high-risk individuals. We believe that there should be a clearer recommendation to help people identify those individuals. Without receiving training on this, people who work with these high-risk groups will not be able effectively carry out the other recommendations, such as 'encouraging those at high risk to seek help.'	Thank you for your comment. There was no review question on risk assessment and therefore we cannot make any recommendations on this topic. The committee drafted a recommendation for the collection of relevant data that will help inform action plans and suicide prevention activities.
Meriden Family Programme	Full	General	General	Our team has links with NHS Trusts nationally and mental health organisations internationally. We train clinicians in working with families, either in an evidence based model of family work, or in enabling mental health services to be more inclusive of families. Our experience has been that, in the area of suicide and serious incidents, a lack of family involvement has been a consistent factor which may have had an impact on these incidents occurring. If families are not involved in the care of their relative, this will lead to services not having the full picture in terms of risk factors and changes to someone's mental health and suicidality, which should inform how services respond in times of	Thank you for your comment. Suicide assessment is out of scope for this guideline as it falls under secondary care.

				crisis. Confidentiality is an issue that clinicians struggle with on a regular basis, but the impact of information not being shared between families, services and service users can be serious. Clinicians can sometimes assume that families and carers are/should be aware of risk factors, or can limit the time they spend exploring these views with families. I would like to have seen some more detail about the need to involve families when suicide is being assessed. This is from a perspective of not only getting information from families about their views and concerns, but also ensuring families have sufficient information about risk and suicidality to ensure they respond in the most appropriate way when supporting their relative. This should be an integral part of any training on this issue when training professionals.	
National Suicide Prevention Alliance	Draft guideline	5	12-14, 21-26	This section seems to conflate various levels and areas of action: - Some would fit better in a section about how to develop a strategy: engage stakeholders, map stakeholders and activities - Others could sit under 1.1 or in another section with details on what the multi-agency partnership does: oversee local activities - Finally, some could sit under 1.3, suicide prevention action plans: work with transport companies, work with the media For more detail on developing a strategy and action plan, and what could sit at each level, please refer to the Public Health England/National Suicide Prevention Alliance guidance for local authorities on local suicide prevention planning:http://www.nspa.org.uk/wp-content/uploads/2016/10/PHE_LA_guidance-NB241016.pdf	Thank you for your comment. The committee have now restructured the sections of the guideline to make it clear who is involved in the partnership, what strategies the partnership should develop and actions the partnership should undertake. We have referenced Public Health England guidance at the start of the guideline.
National Suicide Prevention Alliance	Draft guideline	4 section 1.1.2	Sep-18	Add coroners to this list	Thank you for your comment. The committee have the understanding the PPO are responsible for this function in residential custodial and detention settings.
National Suicide Prevention Alliance	Draft guideline	6	15	It is vital to be clear about the appropriate level of information sharing when working with multi-agency groups, particularly in relation to details of methods – these should only be shared where necessary and in confidence, due to the risks of information on methods being publically available.	Thank you for your comment. We have amended the recommendation as follows "1.3.1 Share experience and knowledge between stakeholders. Also share data, subject to local information sharing agreements."
National Suicide Prevention Alliance	Draft guideline	6	16	Add new line that says 'there needs to be clear responsibility assigned for each element of the plan, with adequate resourcing, delivery timescales and a regular review of progress'.	Thank you for your comment. The committee have drafted the following recommendation to cover this "1.1.1 Local authorities should work with local organisations to: • Set up a multi-agency partnership for suicide prevention. This could consist of a core group and a wider network of representatives. • Identify clear leadership for the partnership. • Ensure the partnership has clear terms of reference, based on a shared understanding that suicide can be prevented."
National Suicide Prevention Alliance	Draft guideline	5 section 1.2.1	21	Add that the suicide prevention strategy should be approved and regularly reviewed by the Health and Wellbeing Board and approved by the Director of Public Health.	Thank you for your comment. We have included this in the suicide prevention partnership section in the following recommendation "1.1.2 Ensure the partnership has clear governance and accountability structures. Include oversight from local health and care planning groups for example, health and wellbeing boards."
National Suicide Prevention Alliance	Draft guideline	7	20	Add ‘and emerging methods’.	Thank you for your comment. The committee agreed and amended recommendation 1.4.4 to include "emerging methods."
National Suicide Prevention Alliance	Draft guideline	6 section 1.3	15	“share data between stakeholders”. It will be important to include some guidance/signposting to guidance around the practicalities and legalities of this. It is often perceived to be a major barrier by organisations. Also, it is our	Thank you for your comment. The committee have drafted the following recommendation to address the practicalities and legalities of data sharing

				understanding that NHS organisations have no legal basis to freely have access to cause of death data for their patients – so how are they supposed to investigate all deaths as decreed by Care Quality Commission and NHS England -https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf	"1.3.1 Share experience and knowledge between stakeholders. Also share data, subject to local information sharing agreements."
National Suicide Prevention Alliance	Draft guideline	8	13-14	Recommendation 1.5.2 – gives example that '60 people may be affected by a suicide'. More recent research suggests that 135 people are exposed to a suicide (i.e. knew the person). Cerel, J., Brown, M., Maple, M., Singleton, M., Van de Venne, J., Moore, M., Flaherty, C. (2018) How Many People Are Exposed to Suicide? Not Six. Suicide and Life-Threatening Behavior,https://doi.org/10.1111/sltb.12450	Thank you for your comment. This recommendation has been removed and the following information has been incorporated into recommendation 1.5.1 "Consider local activities to: • raise community awareness of the scale and impact of suicide and self-harm"
National Suicide Prevention Alliance	Draft guideline	8	16	Awareness raising should never sensationalise, glorify or romanticise suicide. It is also important that the guidance is clearer that local activities should not include information on method.	Thank you for your comment. The committee agree with this comment and have now amended the recommendations in this section and included the Samaritans Media guidelines as an example "1.5.4 Ensure the language and content of any awareness-raising materials is: • appropriate for the target group • sensitive and compliant with media reporting guidelines, such as the Samaritans' Media guidelines for the reporting of suicide."
National Suicide Prevention Alliance	Draft guideline	9	12	Should only be regularly repeated if there's evidence that they are working. Therefore also need to add – be monitored and evaluated so that changes can be made during the campaign if necessary.	Thank you for your comment. The recommendations on suicide campaign messages have been removed. The committee agreed that it was more appropriate for suicide prevention campaigns to run at a national level and focus on activities to raise awareness of suicide at a local level.
National Suicide Prevention Alliance	Draft guideline	9	14	Change to campaigns (not programmes)	Thank you for your comment. The recommendations on suicide campaign messages have been removed. The committee agreed that it was more appropriate for suicide prevention campaigns to run at a national level and focus on activities to raise awareness of suicide at a local level.
National Suicide Prevention Alliance	Draft guideline	8, section 1.5	3	Awareness raising – Need to add the need to raise awareness about the link between self-harm and suicide, but this needs to be done with care to avoid risk of harm. Guidance should be provided on this. Evidence to support inclusion: · Named as high risk group in National Suicide Prevention Strategy – Third Progress update 2017 (https://www.gov.uk/government/publications/suicide-prevention-third-annual-report) · Hawton, K., Bergen, H., Cooper, J., Turnbull, P., Waters, K., Ness, J., & Kapur, N. (2015). Suicide following self-harm: findings from the multicentre study of self-harm in England, 2000–2012. Journal of Affective Disorders, 175, 147-151. · Hawton, K., Linsell, L., Adeniji, T., Sariaslan, A., & Fazel, S. (2014). Self-harm in prisons in England and Wales: an epidemiological study of prevalence, risk factors, clustering, and subsequent suicide. The Lancet, 383(9923), 1147-1154. · Gairin, I., House, A., & Owens, D. (2005). Attendance at the Accident and Emergency Department in the Year Before Suicide: Restrospective Study. Year Book of Psychiatry & Applied Mental Health, 2005, 206. Zahl, D. L., & Hawton, K. (2004). Repetition of deliberate self-harm and subsequent suicide risk: long-term follow-up study of 11 583 patients. The British Journal of Psychiatry, 185(1), 70-75.	Thank you for your comment. The committee agree with this comment and have expanded in the recommendation as follows "1.5.1 Consider local activities to: • raise community awareness of the scale and impact of suicide and self-harm • reduce the stigma around suicide and self-harm • address common misconceptions by emphasising that: - suicide is not inevitable and can be prevented -asking someone about suicidal thoughts does not increase risk • make people aware of the support available nationally and locally • encourage help-seeking behaviours • encourage communities to recognise and respond to a suicide risk." Thank you for providing these references. We did not have a review question on the epidemiology of suicide, however we will provide these to the surveillance team at NICE for future updates.
National Suicide Prevention Alliance	Draft guideline	8, section 1.5.3	24	These links do not take you straight to the toolkits, instead:https://wellbeing.bitc.org.uk/all-resources/toolkits/suicide-prevention-toolkitfor the prevention toolkit andhttps://wellbeing.bitc.org.uk/all-resources/toolkits/suicide-postvention-toolkitfor the postvention toolkit	Thank you for your comment. The hyperlinks have been amended as suggested.
National Suicide Prevention Alliance	Draft guideline	9, section 1.5.4	8	Examples of display locations should also include non-statutory locations.	Thank you for your comment. The recommendations on suicide campaign messages have been removed. The committee agreed that it was more

					appropriate for suicide prevention campaigns to run at a national level and focus on activities to raise awareness of suicide at a local level.
National Suicide Prevention Alliance	Draft guideline	11	11	Add importance of postvention for settings with young people	Thank you for your comment. The committee noted that the recommendation on identifying who may be affected or benefit from postvention covers children and young people, as well as adults.
National Suicide Prevention Alliance	Draft guideline	10, section 1.7.1	13	1. Add places where means can be accessed e.g. pharmacies	Thank you for your comment. The committee have retained the current wording because the definition of 'Locations where suicide is more likely.' includes places where means can be accessed.
National Suicide Prevention Alliance	Draft guideline	12	14	Add: Local multi-agency partnerships should agree a communications plan and messaging for what they will say to the media in the event of a local suicide death. This can reduce the risk of media being given detailed information about method, for example, that may lead to irresponsible reporting. Local multi-agency partnerships should apply Samaritans media guidelines to their own communication channels, ensuring that local social media feeds, for example, share information responsibly.	Thank you for your comment. This is covered in the following recommendation "1.10.1 Develop a clear plan for liaising with the media. Identify someone in the multi-agency partnership as the lead. " "1.10.2 For community settings, promote guidance on best practice for media reporting of suicide (including social media). Include the need to: • use sensitive language that is not stigmatising or in any other way distressing to people who have been affected • reduce speculative reporting • avoid presenting detail on methods. See: the World Health Organization's Preventing suicide: a resource for media professionals; the Samaritans' Media guidelines for reporting suicide; OFCOM's Broadcasting code and the Independent Press Standards Organisation (IPSO)."
National Suicide Prevention Alliance	Draft guideline	11, section 1.8	4	Include link to PHE and NSPA's guidance on providing local bereavement support services:http://www.nspa.org.uk/home/our-work/joint-work/support-after-a-suicide-providing-local-services/	Thank you for your comment. We have now added as suggested.
National Suicide Prevention Alliance	Draft guideline	11, section 1.8	4	Include link to PHE and NSPA's guidance on providing local bereavement support services:http://www.nspa.org.uk/home/our-work/joint-work/support-after-a-suicide-providing-local-services/	Thank you for your comment. We have added a link to the National Suicide Prevention Alliance's resources at the end of the section. We have included a link to Public Health England's resource on 'Local suicide prevention planning: a practice resource' at the start of the recommendations.
National Suicide Prevention Alliance	Draft guideline	11, section 1.8.1	12	Amend to: Provide proactive, sensitive, practical….. .. services. Add: This should be offered to everyone bereaved or affected by suicide or suspected suicide with a few days of the death.	Thank you for your comment. This recommendation has been amended as follows to include the need for tailored support for those affected "Offer everyone who is bereaved or affected practical information expressed in a sensitive way, such as Public Health England's Help is at hand guide. (This also signposts to other services.) Ask them if they need more help and, if so, offer them tailored support."
National Suicide Prevention Alliance	Draft guideline	11, section 1.8.1	12	Amend to: Provide proactive, sensitive, practical….. .. services. Add: This should be offered to everyone bereaved or affected by suicide or suspected suicide with a few days of the death.	Thank you for your comment. The committee have amended the recommendation as follows " 1.8.2 Offer those who are bereaved or affected by a suspected suicide practical information expressed in a sensitive way, such as Public Health England's Help is at hand guide. (This also signposts to other services.) Ask them if they need more help and, if so, offer them tailored support."
National Suicide Prevention Alliance	Draft guideline	13		The guidance uses the term "attempted suicide" rather than "self-harm". Self-harm is the accepted terminology in England for an act of harm to the self, irrespective of outcome (fatal/non-fatal) or motivation. Using the term "attempted suicide" leaves room for individuals to make subjective decisions around the "seriousness" or "notability" of an act of self-harm. And given the significant link between self-harm and suicide, all self-harm acts should be taken seriously regardless of the perceived current motivation/intent.	Thank you for your comment. We have amended the term "attempted suicide" to "self-harm" throughout the guideline.
National Suicide Prevention Alliance	Draft guideline	13	7	"Gatekeepers" – this should also include non-clinical staff in health and social care organisations	Thank you for your comment. We have added the following to the definition to ensure clarity amended the term as follows "They may include: health and social care practitioners, criminal justice and detention settings staff, police and emergency services, people who provide a paid or voluntary service for the public, faith leaders, railway and underground station staff and staff in educational institutions."

National Suicide Prevention Alliance	Draft guideline	13	18	“High risk groups” – this should also include those who self-harm. Evidence to support inclusion as per comment 8	Thank you for your comment. We have now included "people who self-harm" to the groups of people at high suicide risk.
National Suicide Prevention Alliance	Draft guideline	14	1	Rail suicide are about 5% of all suicides and therefore should also be mentioned.	Thank you for your comment. We have added "railways" to Locations where suicide is more likely.
National Suicide Prevention Alliance	Draft guideline	16	14	Provide more clarity that campaigns can be delivered through a range of media (eg posters, beer mats, newspaper coverage, social media) Need to use outcome measures directly related to the specific aims of the campaign Reference: Pirkis, J, RossettoA, Nicholas, a. Ftanou, M, Robinson, J, Reavley, N (2017)Suicide Prevention Media Campaigns: A Systematic Literature Reviewhttps://www.tandfonline.com/doi/full/10.1080/10410236.2017.1405484?scroll=top&needAccess=true	Thank you for your comment. The committee agree with this comment however after discussion the committee removed the recommendation section on campaigns as they decided that guidance on this area is more appropriate to come from a national level. We have now removed this research recommendation as a result of this change.
Network Rail	Full	4	General	Transport operators should be referenced directly in our view because of the: likely intelligence they will hold regarding suicides control some have in relative to the means of suicide e.g. rail infrastructure strategies they are likely to already have in place to prevent suicides footprint and influence they may have within communities	Thank you for your comment. The committee agree with you and other stakeholders that a wider network of representatives may need to be involved in the multi-agency partnership and have made a new recommendation and also provided a link to Public Health England's resource on 'Local suicide prevention planning: a practice resource' provides further information on this. The new recommendation reads as follows "1.1.1 Set up a multi-agency partnership for suicide prevention. This could consist of a core group and a wider network of representatives.”
Network Rail	Full	5	21	In terms of the rail industry changing announcements is a complex issue and not something that will be influenced locally. Any change in announcements which have a national impact (that anything around suicide would) can only be agreed nationally. The rail industry is well aware of research in this area and is currently looking to change its standard messaging.	Thank you for your comment. This was discussed with the committee and although there is no recognised best practice, what we do should be informed by evidence. Any future research in this area will therefore impact any future changes. We have amended the recommendation to reflect this as follows "1.3.2 Promote evidence-based best practice with rail, tram and underground train companies."
Network Rail	Full	7	18	Reference is made to Home Office Police. From the rail sectors point of view (and that of our colleagues on London Underground) we would recommend that the British Transport Police are referenced too. Their information about suicides on the rail network and potential clustering will be important to multi-agency partnerships	Thank you for your comment. The committee agree and have drafted the following recommendation "1.4.4 For community settings, also use rapid intelligence gathering (continuous and timely collection of data) to identify suspected suicides, emerging methods and potential suicide clusters. This intelligence could also be used to identify people who need support after such events (see recommendations 1.8.1 and 1.9.1). Collect this local data from a range of sources including: • police and transport police • prisons • immigration removal centres (IRCs) • coroners."
Network Rail	Full	12	9	In this section there is no reference to social media. Is the guidance assuming Media as captured within it means both print and social? In the rail industry we have specific guidance on how to deal with for example customers or third parties that tweet about suicides on the network. We would urge that the management of social media is not ignored in the guidelines	Thank you for your comment. The committee acknowledge this and have included a reference to the Samaritans' Media guidelines for reporting suicide in this section, which includes on how to report about social media. In addition, the committee acknowledged that the guideline (in the committee discussion section of the evidence review) recommendations should cover social media and were aware that different types of social media have their own steps to deal with suicide-related content.
Network Rail	Full	14	2	We would like the railway and underground rail system locations to be specifically referenced here given the accessibility of the networks	Thank you for your comment. We have added "railways" to Locations where suicide is more likely.

NHS England				Training: Need to target the correct staffing groups and the right staff need to be released for training. This isn't always achieved and most training seems to be over-presented by certain staff groups. Regime, understandably, needs to take priority but policies such as this will not be effective if this can't happen. Training: advise against: Mental Health First Aid is not the best package for prison setting. Conflating suicide training with self harm training. They are different things and quite often self-harmers state they do this in order to 'stay alive'.	Thank you for your comment. The guideline has recommendations on who should be offered training, individual organisations must then decide who will receive the training. The recommendations on training do not include specifics about what the training should include, however the partnerships should decide what the training should cover and they should oversee and evaluate the training.
NHS England				We welcome the recommendation to employers to provide training to their employees where they employ occupational groups with a higher risk of suicide. We think this is an important inclusion for staff safety and well-being. Thank you for the opportunity to comment	Thank you for your comment.
NHS England	Full	general	general	The Clinical Reference Group (CRG) welcomes this NICE Guidance. We are particularly pleased to see a focus on clusters of suicide and a strong focus on partnership working across services. However, we would like to highlight the non-inclusion of people within Secure Services as a potential high risk group. Whilst the risk of this group may be included in other NICE Guidance about secondary/tertiary care we consider that some specific mention might be appropriate in this documentation. We also would like a closer focus on some of the high risk areas in the prison system, for example the risk associated with the Imprisonment for Public Protection (IPP) Sentence and the impact that this has on hopelessness in prisoners. This has been particularly highlighted to CRG members by prisoners in focus groups when discussing factors influencing mental health in prison settings.	Thank you for your comment. Secure services are covered in all the recommendations relating to residential custodial and detention settings.
North West Boroughs Healthcare NHS Foundation Trust	Full	Omission	Omission	Strategies for reaching high risk groups usually 'under the radar' needs to be mentioned	Thank you for your comment. A review question on high-suicide risk groups was not prioritised at scoping. We will forward your comment to the surveillance team at NICE for future updates.
North West Boroughs Healthcare NHS Foundation Trust	Full	Omission	Omission	Mental health well-being and resilience needs to be highlighted as public health priority especially in children and adolescents	Thank you for your comment. This is outside of scope for this guideline.
North West Boroughs Healthcare NHS Foundation Trust	Full	4	8	Re: Including representative from: The list should include stakeholders in preventing suicide in adolescents and young adults including educational institutions	The committee agree and were mindful of the fact that different groups of people could be included in the wider network, depending on local circumstances and settings. As such the committee drafted a recommendation as follows "1.1.1 Set up a multi-agency partnership for suicide prevention. This could consist of a core group and a wider network of representatives." We have referenced Public Health England guidance at the start of the guideline provides further information on this.
North West Boroughs Healthcare NHS Foundation Trust	Full	4	21	Re: Each custodial or detention setting should set up a multi-agency 21 partnership that includes representatives from: The list should include secondary care providers who provide services to prisons	Thank you for your comment. The committee agree that secondary care providers are covered under "healthcare staff in custodial settings".
North West Boroughs Healthcare NHS Foundation Trust	Full	6	8	Re: Suicide prevention action plans Action plans should include suicide intervention and on-going clinical or support services- there is need for safe step down discharge pathways for people presenting to mental health services with self-harm/attempted suicide as they are	Thank you for your comment. Discharge pathways relates to specialist mental health services and therefore would be out of scope for this guideline. The representatives listed are included in the representatives listed in the multi-agency partnership.

				at highest risk amongst patients presenting to mental health services . Clinical commissioning groups, local authorities primary and secondary health care providers along with third sector organisations need to engage at the minimum , the list is not exhaustive.	
North West Boroughs Healthcare NHS Foundation Trust	Full	9	1	Re: Suicide prevention campaigns May be helpful to consider role of suicide prevention ambassadors within the respective work areas	Thank you for your comment. The recommendations on suicide campaign messages have been removed. The committee agreed that it was more appropriate for suicide prevention campaigns to run at a national level and focus on activities to raise awareness of suicide at a local level.
Northumberland Tyne & Wear NHS Foundation Trust	Full	General	General	The role of STPs is not mentioned	Thank you for your comment. The committee agree that STP's via the governance provided by health and wellbeing boards in the following recommendation "1.1.2 Ensure the partnership has clear governance and accountability structures. Include oversight from local health and care planning groups for example, health and wellbeing boards."
Northumberland Tyne & Wear NHS Foundation Trust	Full			Additional guidance on best practice on supporting people bereaved or affected by suicide would be helpful. For example, which agencies should be delivering support at which point in time. There might be a distinction between immediate “first aid” support and longer term interventions.	Thank you for your comment. We have now added a hyperlink to National Suicide Prevention Alliance in the recommendation on supporting people bereaved or affected by a suspected suicide. "1.8.2 Offer those who are bereaved or affected by a suspected suicide practical information expressed in a sensitive way, such as Public Health England's Help is at hand guide. (This also signposts to other services.) Ask them if they need more help and, if so, offer them tailored support.” "1.8.3 Consider: • providing support from trained peers who have been bereaved or affected by a suicide or suspected suicide • the impact on staff and residents in residential custodial and detention settings, and whether any adjustments are needed to working patterns or the regime."
Northumberland Tyne & Wear NHS Foundation Trust	Full	General	General	Emphasis should be placed throughout the document on the importance of multiagency communication and data sharing in relation to suicide prevention, particularly at times of transition including discharge/transfer, or where the provider is changing, as well as between integrated services eg In-reach mental health teams.	Thank you for your comment. The importance of multi-agency communication and data sharing is covered in recommendations 1.1, 1.2, 1.3 and 1.4.
Northumberland Tyne & Wear NHS Foundation Trust	Full	4	4	There should be consideration whether community multi-agency partnerships should be based on single local authority areas or cover multiple geographies. Some functions, such as audits and rapid intelligence gathering could more effective be resourced and delivered across larger areas and would ensure consistency of approach and better comparative learning. Targeting of high risk areas might be better undertaken on a more local level	Thank you for your comment. The committee agree and has added a new recommendation as follows "1.2.7 Consider collaborating with neighbouring local authorities to deliver a single strategy."
Northumberland Tyne & Wear NHS Foundation Trust	Full	4	9	While public health services are mentioned in multiagency partnerships, Public Health England is not specifically referred to but may have important skills to offer in data monitoring, analysis and benchmarking.	Thank you for your comment. We have provided a link to Public Health England's resource on 'Local suicide prevention planning: a practice resource' at the start of the recommendations.
Northumberland Tyne & Wear NHS Foundation Trust	Full	4	19	Where secondary mental health providers work into custodial settings, they should be included in the organisations multi-agency partnership.	Thank you for your comment. The committee agree that staff who reach into the prison to support mental health needs of prisoners are covered under "healthcare staff in custodial settings".
Northumberland Tyne & Wear NHS	Full	5	9	Suicide prevention strategy should include standards of training related to suicide prevention, and support mechanisms.	Thank you for your comment. We have added a new recommendation as follows "1.2.6 Oversee provision and delivery of training and evaluate effectiveness."

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Northumberland Tyne & Wear NHS Foundation Trust	Full	7	17	Rapid intelligence gathering would involve additional resource and cost and would be more effectively undertaken over larger geographies.	Thank you for your response. The committee have recommended that multi-agency partnerships should consider collaborating with neighbouring local authorities to develop a single strategy, which would include rapid intelligence gathering. As such, the process of rapid intelligence gathering would remain a local decision to feed into the strategy. However, we will pass this information to our resource impact team for their information.
Northumberland Tyne & Wear NHS Foundation Trust	Full	7	23	It may also be helpful to include specifics that should be recorded by Secure Children's Homes for young people detained under welfare orders, for example, risk profile, pattern of care placements and transition information to identify trends.	Thank you for your comment. The suggestion of "risk profile" is covered in the following recommendation that applies to both community and residential custodial or detention setting "1.4.2 Collect and analyse local data on suicide and self-harm. This could include data on: method, location, timing, details of individual and local circumstances, demographics, occupation and characteristics protected under the Equality Act (2010). Sources could include reports from: •the local ombudsman •the Parliamentary and Health Service Ombudsman •coroners •the Prison and Probation Ombudsman •the voluntary sector" We have added additional information for residential custodial and detention settings that includes pattern of care placements and transition information. The recommendation reads "1.4.3 For residential custodial and detention settings also collect data on sentencing or placement patterns, sentence type, offence, length of detention and transition periods (for example, early days or transition between estates or into the community) ."
Northumberland Tyne & Wear NHS Foundation Trust	Full	9	7	Should meet the target audiences NEEDS and preferences.	Thank you for your comment. The recommendations on suicide campaign messages have been removed. The committee agreed that it was more appropriate for suicide prevention campaigns to run at a national level and focus on activities to raise awareness of suicide at a local level. The following recommendation on local activities takes into account local needs and preferences " 1.5.3 Take into account socioeconomic deprivation, disability, physical and mental health status, and cultural, religious and social norms about suicide and help-seeking behaviour, particularly among groups at high suicide risk."
Northumberland Tyne & Wear NHS Foundation Trust	Full	11	14	It would be helpful in this section to include a recommendation that professionals who are likely to be involved in post-suicide investigations (PPO/Coroners/Serious Case Reviews etc) be provided with clear guidance/guidelines as to the process.	Thank you for your comment. The committee that many different groups of people may be affected but have not provided an exhaustive list.
Northumberland Tyne & Wear NHS	Full	17	20	Multiagency partnership with Secure Children's Homes should include residential care staff.	Thank you for your comment. The committee have included "healthcare staff in residential custodial and detention settings" and "staff in residential custodial and

Foundation Trust					detention settings" in the list of representatives in community and residential custodial and detention settings.
Nottinghamshire Healthcare NHS Foundation Trust	Full	4	18	Given the reference to educational institutions later in the document for example page 6 line 3 representatives from Universities should be included in multi-agency partnerships as they may have academic staff with relevant clinical and research experience in the area of suicide prevention. These links would be included in the map of stakeholders mentioned on page 5 line 13	The committee agree and were mindful of the fact that different groups of people could be included in the wider network, depending on local circumstances and settings. As such the committee drafted a recommendation as follows "1.1.1 Set up a multi-agency partnership for suicide prevention. This could consist of a core group and a wider network of representatives." We have referenced Public Health England guidance at the start of the guideline provides further information on this.
Nottinghamshire Healthcare NHS Foundation Trust	Full	5	5	Given the reference to educational institutions later in the document for example page 6 line 3 representatives from Universities should be included in multi-agency partnerships as they may have academic staff with relevant clinical and research experience in the area of suicide prevention. These links would be included in the map of stakeholders mentioned on page 5 line 13	Thank you for your comment. The committee agree and were mindful of the fact that different groups of people could be included in the wider network, depending on local circumstances and settings. As such the committee drafted a recommendation as follows "1.1.1Set up a multi-agency partnership for suicide prevention. This could consist of a core group and a wider network of representatives." We have referenced Public Health England guidance at the start of the guideline provides further information on this.

Nottinghamshire Healthcare NHS Foundation Trust	Full	5	17	It is suggested that local and national data on self-harm is also considered because of repeat self-harm being one of the strongest predictors of attempted/suicide particularly for young people under 25	Thank you for your comment. We have amended the following recommendation "1.4.2 Collect and analyse local data on suicide and self-harm."
Nottinghamshire Healthcare NHS Foundation Trust	Full	7	24	Should include data on mental health diagnosis as this is important data relevant to trends	Thank you for your comment. Mental health diagnosis is covered in the recommendation as part of "details of individual (and local) circumstances".

Nottinghamshire Healthcare NHS Foundation Trust	Full	8	9	Needs to acknowledge limitations with definition of suicide for example suicide may occur as accidental outcome of high risk behaviour rather than because of direct, expressed intent to end life	Thank you for your comment. The committee agreed that this guideline is concerned with suicide defined as the act of voluntarily and intentionally taking one's own life' whereas death by misadventure covers the accidental outcome of high-risk behaviour.
Nottinghamshire Healthcare NHS Foundation Trust	Full	9	9	Universities are mentioned here thus the need to refer to them in multi-agency partnerships throughout the guidance	Thank you for your comment. The recommendations on suicide campaign messages have been removed. The committee agreed that it was more appropriate for suicide prevention campaigns to run at a national level and focus on activities to raise awareness of suicide at a local level. The committee agree and were mindful of the fact that different groups of people could be included in the wider network of the multi-agency partnership, depending on local circumstances and settings. As such the committee drafted a recommendation as follows "1.1.1 Set up a multi-agency partnership for suicide prevention. This could consist of a core group and a wider network of representatives."
Nottinghamshire Healthcare NHS Foundation Trust	Full	10	13	Peer supporters are particularly important in custodial settings and are a group who need training in custodial settings. Our Trust has experience of evaluating peer support schemes and training peer supporters and would be willing submit experiences to the NICE shared learning database.	Thank you for your comment. We have forwarded your comment to the System Engagement team
Nottinghamshire Healthcare NHS Foundation Trust	Full	12	13	Sensitive language implies there is a standard form of language that is sensitive. Sensitive language will differ depending on for example cultural beliefs and norms. This should be acknowledged as using sensitive language will be perceived as quite challenging.	Thank you for your comment. The committee have amended this recommendation as follows “1.8.2 Offer those who are bereaved or affected by a suspected suicide practical information expressed in a sensitive way, such as Public Health England's Help is at hand guide. (This also signposts to other services.) Ask them if they need more help and, if so, offer them tailored support.”
Nottinghamshire Healthcare NHS Foundation Trust	Full	13	8	This list needs to include peer supporters in custody for example listeners	Thank you for your comment. Peer supporters are included in the following group "people in contact with the criminal justice system particularly those in prisons".
Nottinghamshire Healthcare NHS Foundation Trust	Full	13	21	Groups at high risk should include those with a history of self-harm because of the evidence linking self-harm with increased risk of suicide	Thank you for your comment. We added "people who self-harm" to groups at high suicide risk.
Nottinghamshire Healthcare NHS Foundation Trust	Full	23	14	Gender and cultural differences are also relevant here	Thank you for your comment. The committee have amended the recommendation as follows " 1.5.3 Take into account socioeconomic deprivation, disability, physical and mental health status, and cultural, religious and social norms about suicide and help-seeking behaviour, particularly among groups at high suicide risk."
Nottinghamshire Healthcare NHS Foundation Trust	Full	26	25	Peer supporters are particularly important in custodial settings for example listeners and or other peer supporters . Our Trust has experience of evaluating such peer support schemes and training peer supporters and would be willing to submit experiences to the NICE shared learning database.	Thank you for your comment. We have forwarded this to our System Engagement team.
Nottinghamshire Healthcare NHS Foundation Trust	Full	27	14	This could be challenging to implement. If partnerships can include training providers for example universities or third sector organisations in the multi-agency partnership from the outset this challenge is more likely to be overcome	Thank you for your response. We will pass this information to our resource impact team for their information.
Nottinghamshire Healthcare NHS Foundation Trust	Full	33	18	Our Trust has experience of supporting GPs and Practice Nurses to respond better to those who present with self-harm and would be willing to submit experiences to the NICE shared learning database. Our Trust has experiences of supporting those in custody to use self-help strategies for managing self-harm and awareness raising training for prison staff.	Thank you for your comment. We will pass this information to our local practice collection team. More information on local practice can be found here: https://www.nice.org.uk/about/what-we-do/into-practice/local-practice-case-studies.

Office of the Police & Crime Commissioner for South Yorkshire	Full	4	7	It is not clear whether the multi-agency partnership for suicide prevention in the community is accountable to any particular body – and if so, whom?	Thank you for your comment. We have added a new recommendation to address this omission "1.1.2 Ensure the partnership has clear governance and accountability structures. Include oversight from local health and care planning groups for example, health and wellbeing boards."
Office of the Police & Crime Commissioner for South Yorkshire	Full	4	21	In some circumstances, it may be more realistic for there to be multi-agency partnerships for suicide prevention in custodial or detention settings based on a cluster arrangement. For example, in South Yorkshire we have 4 prisons all located within the same local authority area, and some prisons during the course of their sentence may move between these establishments and so it would make sense that their activities and plans are well co-ordinated. (In the same way that it makes sense to co-ordinate partnership activity between custody and community). Whilst this not be the situation in all prisons, where it makes sense to do so – this option should be available within the spirit of the guideline.	Thank you for your comment. The committee acknowledge that multi-agency partnerships for suicide prevention in residential custodial or detention settings based on a cluster arrangement occur in some instances. However, they feel that the following recommendation under residential custodial and detention settings covers this "1.1.6 Link the partnership with other relevant multi agency partnerships in the community."
Office of the Police & Crime Commissioner for South Yorkshire	Full	5	5	Suggest consideration of criminal justice services, thinking specifically of the Police and Prison Escort and Custody Service - they may have valuable contribution in terms of any detention of prisoners within the Police Custody environment, in the court-based custody facilities, specifically at the point of sentence, and during transportation between Police Custody/ Court / Prison.	Thank you for your comment. We have added "escort custody services" to the list of representatives in the core group.
Office of the Police & Crime Commissioner for South Yorkshire	Full	5	17	Should the partnerships determine the collective outcomes that they are seeking to achieve through the suicide prevention strategies they develop? Should 'routinely collected data' be determined and agreed at the outset?	Thank you for your comment. The committee agree that the partnerships should be clear about their objectives and the following recommendations cover this "1.2.4 Review local and national data on suicide and self-harm to ensure the strategy is as effective as possible." "1.2.5 Assess whether initiatives successfully adopted elsewhere are appropriate locally or can be adapted to local needs, or whether previously successful initiatives can be reintroduced." " 1.2.6 Oversee provision and delivery of training and evaluate effectiveness" In addition, the partnerships are accountable to health planning groups and boards "1.1.1 Ensure the partnership has clear governance and accountability structures. This should include oversight from local health and care planning groups, for example health and wellbeing boards." The committee agree that 'routinely collected data' be determined and agreed at the outset and this is reflected in the following recommendation "1.2.4 Review local and national data on suicide and self-harm to ensure the strategy is as effective as possible."
Office of the Police & Crime Commissioner for South Yorkshire	Full	5	26	The multi-agency suicide prevention strategies in the community or in custodial/ detention settings should be required to specifically reference the other in order to ensure and demonstrate how they dovetail with each other within a local area. This will help ensure that the partnerships are cognisant of each other's plans and how they respectively manage that transition from custody to community, and vice versa, in order to achieve 1.1.14 (& recommendation 1.1.1).	Thank you for your comment. The committee consider that this is covered in the following recommendation " 1.1.6 Link the partnership with other partnerships including relevant multi-agency partnerships in the community."
Office of the Police & Crime Commissioner for South Yorkshire	Full	5	26	Should these suicide prevention strategies also take account of influencing local infrastructure planning decisions (public transport projects; high buildings; major roads/ highways; prison build & other custodial settings)?	Thank you for your comment. We have added the following recommendation "1.3.2 Work with planners who have responsibility for designing bridges, multi-storey car parks and other structures that could potentially pose a suicide risk."

Office of the Police & Crime Commissioner for South Yorkshire	Full	6	16	Should suicide prevention action plans take account of risks associated with new local infrastructure projects that may introduce new suicide risks, that that risks can be mitigated from the outset?	Thank you for your comment. We have added a new recommendation "1.3.2 Work with planners who have responsibility for designing bridges, multi-storey car parks and other structures that could potentially pose a suicide risk."
Office of the Police & Crime Commissioner for South Yorkshire	Full	7	11	Could also take account of any published learning from completed Serious Case Reviews or Domestic Homicide Reviews	Thank you for your comment. These examples are not included, however the list of sources is not an exhaustive list and the mentioned examples may be included, if appropriate the given situation.
Office of the Police & Crime Commissioner for South Yorkshire	Full	8	20	Take into account factors that may adversely impact mental well-being which could ultimately lead to suicidal episodes	Thank you for your comment. The committee agree with this and have drafted the following recommendation on suicide awareness and training " 1.7.4 Ensure suicide awareness and prevention training helps people to: •understand local suicide incidence and its impact, and know what support services are available •encourage others to talk openly about suicidal thoughts and to seek help (this includes providing details of where they can get this help) take into account socioeconomic deprivation, disability, physical and mental health status, and cultural, religious and social norms about suicide and help-seeking behaviour, particularly among groups at high suicide risk.”
Office of the Police & Crime Commissioner for South Yorkshire	Full	10	3	Should this reflect the opportunity to attempt suicide in the digital public space - social media, in particular?	Thank you for your comment. The committee consider that suicide in the digital public space is covered by the following recommendation which now includes providers of social media platforms. “1.10.2 For community settings, promote guidance on best practice for media reporting of suicide (including providers of social media platforms). Highlight the need to: •use sensitive language that is not stigmatising or in any other way distressing to people who have been affected •reduce speculative reporting •avoid presenting detail on methods.”
Office of the Police & Crime Commissioner for South Yorkshire	Full	11	2	Partnerships should take steps to evaluate the effectiveness of training delivered – otherwise, training may be delivered, but without evaluation of its effectiveness, may be unclear what difference it has made to suicide prevention; and what works.	Thank you for your comment. The committee have drafted the following recommendation to ensure partnerships evaluate the effectiveness of training "1.2.6 Oversee provision and delivery of training and evaluate effectiveness."
Office of the Police & Crime Commissioner for South Yorkshire	Full	11	16	Include those affected by attempted suicide/ near miss	Thank you for your comment. This section focuses on 'After a suspected suicide.' Therefore it would not be appropriate to include an attempted suicide in this recommendation.
Office of the Police & Crime Commissioner for South Yorkshire	Full	11	18	Include those affected by attempted suicide/ near miss	Thank you for your comment. This section focuses on 'After a suspected suicide.' Therefore it would not be appropriate to include an attempted suicide in this recommendation.
PAPYRUS (Prevention of Young Suicide)	Full	4	1	· PAPYRUS would like the whole issue of prescribing of antidepressants (currently in other NICE guidance on depression etc. to be made more explicit, even in cross-reference, somewhere in the current document.	Thank you for your comment. We have added hyperlinks of related guidance, including the NICE Depression guideline, under the following section of the guideline "Finding more information and resources"

				Also, perhaps it is not particularly clear to whom these and other recommendations throughout are being made.	We have amended recommendation headings and used subheadings in various recommendations to make it clear who the recommendations are for.
PAPYRUS (Prevention of Young Suicide)	Full	8	16/17	We must exercise extreme caution in guiding people about methods used locally. PAPRYUS is disappointed that this is not made clearer ion this section. There is a significant risk of simulation here if this is not spelled out properly.	Thank you for your comment. We have now removed this recommendation. We have also amended the recommendation in this section to include the Samaritans Media guidelines as an example of good practice for suicide awareness campaigns "1.5.4 Ensure the language and content of any awareness-raising materials is: • appropriate for the target group • sensitive and compliant with media reporting guidelines, such as the Samaritans' Media guidelines for the reporting of suicide."
PAPYRUS (Prevention of Young Suicide)	Full	8	14	Either cite a reference showing the evidence for the claim that “around 60 people may be affected by each death” OR or change this to something like “We should also make people aware of the impact of suicide. We can assume that a significant number of people may be affected by each suicide and significantly so; often, it is difficult to measure this with precision as relationships are not always known to researchers and people affected do not always declare their connections with the death or with the person who has died.”	Thank you for your comment. This recommendation has been removed and the following information has been incorporated into recommendation 1.5.1 "Consider local activities to: • raise community awareness of the scale and impact of suicide and self-harm"
PAPYRUS (Prevention of Young Suicide)	Full	9	1	This is a good summary and take a good practical approach.	Thank you for your comment.
PAPYRUS (Prevention of Young Suicide)	Full	11	6	PAPYRUS supports this whole section. Many of us have been bereaved b the suicide of a child or young person in our families and communities.	Thank you for your comment and support for this section of the guideline.
PAPYRUS (Prevention of Young Suicide)	Full	18	19	Good to see this section , especially the need for a named person in each local authority to lead on SP.	Thank you for this comment and support for this guideline.
Prison Reform Trust	Full	General	General	One of the ways to prevent suicide in custodial settings is to be mindful of who we send to prison in the first place. It must be made clear that prisons are not places of safety. In the year to September 2017 there were 77 self-inflicted deaths in custody. Prisoners have higher rates of suicide than the general population – ‘Suicides in male prisoners in England and Wales, 1978-2003’ by Fazel, Benning and Danesh found that the suicide rate in male prisoners was five times higher than in the community. We must clearly avoid people being sent to prison under the false notion that access to support will be beneficial to their wellbeing. Liaison and diversion services play an important role in identifying those who have mental health, learning disability, substance misuse or other vulnerabilities when they first come into contact with the criminal justice system. There is a role for community and custodial multi-agency partnerships recommended by this guidance to recognise the increase risk of suicide and self-harm that prison poses and promote sufficient awareness and consideration of this at all stages of a persons contact with the criminal justice system.	Thank you for your comment. Preventing people entering prisons is out of scope for this guideline. Liaison and diversions services are included in the core group of representatives of the multi-agency partnerships. The committee recognise this and drafted a section 1.5 in the guideline "Awareness raising by suicide prevention partnerships" which includes residential custodial and detention settings.
Prison Reform Trust	Full		Section 1.2	A suicide prevention strategy for custodial settings must consider the important role family and friends can play and ensure there are effective ways of responding to concerns and information that they share with prison staff. The Farmer review made the following recommendation to that effect: ‘As part of their Performance Agreement each prison should establish a clear, auditable and responsive ‘gateway’ communication system for families and	Thank you for your comment. We have included "people with personal experience of a suicide attempt, suicidal thoughts and feelings, or a suicide bereavement" in the core group of representatives for residential custodial or detention settings. This may include family and friends (both inside and outside prison).

				significant others: a dedicated phone line that is listened to and acted upon. · Families' concerns about mental and physical health should be systematically recorded and action taken. · Families (and significant others) should be properly informed about and able to request the opening of an Assessment, Care in Custody and Teamwork (ACCT) document: - If after completion of a risk-based assessment an ACCT document is opened they should be kept appropriately updated of any intervention/action arising from this. - If after completion of a risk-based assessment it is decided not to open an ACCT document, then the family member or other person who raised the matter should be written to detailing the reason for the decision.'	
Prison Reform Trust	Full	15-16	General	Factors that could be included when researching what interventions are effective and cost effective in reducing suicide rates in custodial settings should include access to family, access to meaningful activity/impact of being in a cell.	Thank you for your comment. We have not added this as these are factors outside of scope for this guideline.
Prison Reform Trust	Full	15-16	General	Additional research recommendation could include the impact of different sentence types on risk of suicide. As mentioned above, Prison Reform Trust highlighted the high rates of self harm for people serving IPP sentences. A closer look at the impacts of different sentence experiences, for example the uncertainty associated with indeterminate sentences, could be valuable in informing better ways of working with these groups, periods of particular high risk within a sentence. It could also be informative when sentencing people who are more likely to be at risk of suicide in prison.	Thank you for your comment. We have not added this as these are factors outside of scope for this guideline.
Prison Reform Trust	Full	4-5,	Section 1.1.3	The list of possible representatives to be included in multi-agency partnerships for suicide prevention in custodial settings should include family members. Arguably this already fits under 'people who have attempted or been affected by suicide' (page 5, line 5). However, family members should be more explicitly stated, both because of the value they can have in terms of support and prevention and because of the additional anxieties and barriers custody creates between them and their loved ones. Lord Farmer's review, which looked at the importance of family ties in prison recognised this value in the recommendation that 'the Ministry of Justice should make a fund available that governors can bid for to trial innovations that engage with families specifically in order to prevent suicide.'	Thank you for your comment. The committee have included family members in the bullet of "people with personal experience of a suicide attempt, suicidal thoughts and feelings, or a suicide bereavement"
Prison Reform Trust	Full	6	Section 1.3	The recommendation that multi-agency partnerships develop suicide prevention action plans needs more practical guidance about what should be included in the plan to distinguish it from the previous recommendation about strategy. PHE's Local suicide prevention planning: a practice resource goes into more detail about this in Chapter 4 (particularly sections 4.7.1) which would be useful to replicate here. These details would benefit from some distinct guidance for what to include in action plans for custodial settings.	Thank you for your comment. The committee have now restructured the sections of the guideline to make it clear who is involved in the partnership, what strategies the partnership should develop and actions the partnership should undertake. We have also referenced Public Health England guidance at the start of the guideline.
Prison Reform Trust	Full	7	1.4.3	We welcome the recommendation for custodial settings to collect data on sentence type, offence, length and transition periods to identify trends, though there is room to elaborate. In 2016 Prison Reform Trust highlighted the high rates of self harm for people serving Indeterminate Sentences for Public Protection (IPP) after analysis of the available data, and we would expect that this is taken into consideration by any prison holding IPP sentenced prisoners. Other characteristics may help to identify those that are more at risk of suicide in custodial settings. Prison Service Instruction (PSI) 17/2016 The Care and	Thank you for your comment. Transgender prisoners would fall under "people in contact with the criminal justice system, particularly those in prisons" in the groups at high suicide risk. The committee acknowledge that transgender prisoners are at a higher risk of suicide within the LBGT subgroup. This had been highlighted in the equality impact assessment form. Those with mental illness diagnosis would fall under "people in care of mental health services". Those with chronic conditions and/or those associated with pain

				Management of Transgender Offenders 'transgender prisoners be viewed as an 'at-risk' group in terms of suicide and self-harm'. PSI 64/2011 Management of prisoners at risk of harm to self, to others and from others (Safer Custody) recognises thatMental illness diagnosis such as depression, bipolar disorder, schizophrenia and physical illness, especially chronic conditions and/or those associated with pain and functional impairment are also risk factors. PSI 64/2011 also recognises periods of increased risk such as during early days in custody, following a transfer to a different prison or after a Parole Board hearing refusal. It would be worth referencing and linking to this document in the guidance. The draft is also lacking a gendered approach. Given the disproportionately high number of self-harm incidents amongst women prisoners (23% of all prison self-harm incidents despite representing just 5% of the prison population), higher levels of mental health conditions amongst women prisoners (65% of women in prison suffer from depression compared to 37% of men), and high prevalence of women prisoners having been victims of abuse, there is a need for gender specific and trauma informed responses.	and functional impairment out are of scope for this guideline. Periods of increased risk such as during early days in custody, following a transfer to a different prison or after a Parole Board hearing refusal are covered in the following "1.4.3 For residential custodial and detention settings should collect data on sentencing or placement patterns, sentence type, offence, length of detention and transition periods (for example, early days or transition between estates or into the community)." We have added further information in the committee discussion in relation to a gendered approach for the guideline as follows "The committee noted that gender is an important factor to consider for suicide prevention and it may also be helpful to consider gender with regards to safety in prisons. However the committee agreed that there is little evidence to guide gender specific approaches in relation to suicide prevention." In relation to prisons, the figures provided on self-harm, mental health conditions and abuse are out of scope for this guideline.
Prison Reform Trust	Full	11	1.8.1 – 1.8.4	Supporting and communicating with those that are bereaved or affected by suicide is a particular challenge in custodial settings given the physical barriers that lie between the person and their loved ones. Family Liaison Officers should be trained in ways to sensitively communicate information about suicide or suspected suicides to family members, and ensure support is in place for those who are bereaved or affected by suicide.	Thank you for your comment. The committee agree that family liaison officers should receive training and they are included in the drafted recommendations as follows " Ensure training is available for: • those in contact with people or groups at high suicide risk • people working at locations where suicide is more likely • gatekeepers • people who provide peer support in residential custodial and detention settings • people leading suicide prevention partnerships • people supporting those bereaved by suicide." "Provide generic and specialist training as needed for specialists and non-specialists."
Prison Reform Trust	Full	5 to 7	Section 1.2	This section would benefit from some distinct recommendations for custodial settings to make sure it is relevant. For example, the logic applied to working with transport companies to promote best practice when announcing delays due to a suspected suicide could easily be applied to communicating prison regime changes that might result from a suspected suicide.	Thank you for your comment. We have added in new recommendations specifically for residential custodial and detention settings as follows "1.2.9 Identify and manage risk factors and behaviours that make suicide more likely." "1.2.10 Consider collaborating with neighbouring residential custodial and detention organisations to deliver a single strategy. " These are to complement recommendations 1.2.1 to 1.2.6, which are for both settings.
Prison Reform Trust	Full	5 to 7	Section 1.2	Although prisons can and do look at good practice in other establishments to inform their own, it important to recognise that HMPPS play a role in assessing effective initiatives and disseminating information about this too. There are some strategic decisions that need to be made centrally – for example, we understand that in some prisons in-cell telephony and lower call charges are having positive impact on wellbeing and therefore reduce incidents of self-harm and suicide, and this is part of the rational for rolling this out across the estate.	Thank you for your comment. The committee recognised that HMPPS have a role to play in helping information dissemination and as such the committee drafted the following recommendations to complement the work of HMPPS. "1.2.10 Consider collaborating with neighbouring residential custodial and detention organisations to deliver a single strategy." "1.2.5 Assess whether initiatives successfully adopted elsewhere are appropriate locally or can be adapted to local needs, or whether previously successful initiatives can be reintroduced."

Prison Reform Trust	Full	5 to 9	1.5	Although the recommendations of this section broadly apply to custodial settings, it would be more relevant to include specific references to the types of support that are available in custodial settings such as listeners, Samaritans and Safer Custody teams. Most people in prison will be aware of the support offered by listeners and the Samaritans numbers are widely promoted next to PIN phones and by prison staff. However, we occasionally speak to people through our advice service who are unaware of the Safer Custody team in the prison and so have not accessed this support when they might have benefitted from it. The importance of raising awareness in prison is all the more apparent when you consider finding from the 2015 Ministry of Justice report into self-inflicted deaths in prison custody in England and Wales. Of the 1375 self-inflicted deaths in custody between 1996 and 2014 only 27% were on an ACCT at the time of their death. This shows that the ACCT system in prisons is a poor predictor of risk of suicide in prison. This might be explained in part by the fact that a high proportion of the prison population match the profile of someone at risk of suicide – in fact the draft guidance already recognises 'people in contact with the criminal justice system, particularly those in prisons' as a group with high suicide risk itself. Greater emphasis must therefore be put on raising awareness in prisons to reach those who have not been identified by the ACCT process and who may lack the information or confidence to seek support. As above, this awareness raising should also extend to families by making sure information about suicide prevention is available in visits centres and online.	Thank you for your comment. The committee agree and drafted the following recommendation to include reference to the support available in custodial settings "1.5.2 For residential custodial and detention settings, also consider raising awareness of: • the risk associated with 'early days' and transitions between estates or into the community • the value of peer support for example, The Listener Scheme • the need for institutional support, such as safer custody teams (see HM Prisons and Probation Service's Prison Service Instructions 2011Prison Service Instructions 64-2011)."
Prison Reform Trust	Full	11 to 12	1.8.5 – 1.8.8	Guidance about preventing suicide clusters could be made more relevant to custodial settings. For example, following a suicide or any death in custody it is important to identify as best possible those whose risk may have increased as a result and ensure additional support is in place. As per the description on page 14, this could include those with social relationships or those in close proximity such as any person sharing the cell or other living space. Consideration should be given to those who are already identified as presenting risk of suicide or self harm as that risk may have increased.	Thank you for your comment. The committee have drafted the following recommendations for residential custodial and detention settings "1.9.2 After a suspected suicide in residential custodial and detention settings, undertake a serious incident review as soon as possible in partnership with the health providers. Identify how: • to improve the suicide prevention action plan • to help identify emerging clusters • others have responded to clusters." "1.9.3 Develop a coordinated approach to reduce the risk of additional suicides. "
Prisons and Probation Ombudsman	Full	General	General	The PPO investigates deaths, from any cause, in prisons, secure training centres, secure children's homes, probation approved premises and immigration removal centres. Among the services the PPO investigates, self-inflicted deaths rose 34% in 2015-16 and then 11% in 2016-17. There is universal agreement that these rates were simply unacceptable. Although there was a welcome fall in 2017-18, self-inflicted deaths are still at historically high levels. We welcome NICE's efforts to tackle the issue with the foundation of suicide prevention partnerships. There has been no simple, single explanation for the increases we have seen: each self-inflicted death is the tragic culmination of an individual crisis for which there can be a myriad of triggers. But we consider that multi-agency partnerships for suicide prevention could offer a significant improvement on current practice and will help the efforts we have seen over the last 12 months to really bring down the number of self-inflicted deaths in custody. Every year the Prisons and Probation Ombudsman puts together a programme for our Learning Lessons bulletins and thematic reports. These identify lessons to	Thank you for your comment and support for the multi-agency partnerships. We will pass on the learning bulletins to the implementation team at NICE. The risk factors included in the recommendation is not intended to be an exhaustive list. The recommendation reads as follows "1.4.2 Collect and analyse local data on suicide and self-harm. This could include data on: method, location, timing, details of individual and local circumstances, demographics, occupation and characteristics protected under the Equality Act (2010). Sources could include reports from: • the local ombudsman • the Parliamentary and Health Service Ombudsman • coroners • the Prison and Probation Ombudsman • the voluntary sector. 1.4.3 For residential custodial and detention settings, also collect data on: • sentencing or placement patterns • sentence type

				be learned from collective analysis of our investigations. Our aim is to encourage a greater focus on learning in order to contribute to improvements in the services we investigate, potentially helping to prevent avoidable deaths and encouraging the resolution of issues that might otherwise lead to future complaints. These are available from our website (ppo.gov.uk/document/learning-lessons-reports). The following publications published within the last 5 years will inform this consultation: “Self-inflicted deaths among female prisoners” (November 2017) “Prisoner mental health” (January 2016) “Self-inflicted deaths of prisoners – 2013/14” (March 2015) “Self-inflicted deaths of prisoners on ACCT” (April 2014) “Risk factors in self-inflicted deaths in prison” (April 2014) Some of the common themes are listed below. Identifying, monitoring and acting on risk: Prisons should ensure vigilance in risk management, proactively identifying suicide and self-harm risk based on: established risk factors (see below); triggers particular to the individual; and their presentation to staff. Staff working in prison reception in particular need to be aware of the known risk factors for suicide and self-harm. Evidence of risk should be fully considered and balanced against the prisoner’s demeanour. Staff should record what factors they have considered and the reasons for decisions. Mental health referrals need to be made and acted on promptly. Care should be taken to ensure continuity of care from the community. Risk monitoring should involve relevant professionals from different disciplines and especially where prisoners are receiving routine or substantial input from their services. Beyond monitoring, prisons should take appropriate steps to reduce identified risks, including setting caremap actions that are detailed, specific, meaningful and time bound. Prisons should consider the risks associated with withdrawing privileges when prisoners are being monitored on the ACCT process. Role of mental health services: Prison mental health services should ensure that all cases are treated with an appropriate degree of urgency, and avoid delays with assessment and care. Prisons should ensure there is clarity around roles and responsibilities of custodial and mental health staff and otherwise ensure there is efficient and timely information sharing. Bureaucratic, cultural or other barriers to effective joint working between custodial and mental health staff should be addressed. Implementation of thesuicide and self-harm monitoring procedures (ACCT): Prisons should implement the ACCT process effectively, as intended by the Prison Service Instruction (PSI) and with appropriate management oversight. Prisoners on open ACCT documents must only be segregated in exceptional circumstances. Challenging and anti-social behaviour can be a sign of distress or mental ill-health; it should not be viewed in isolation as a disciplinary issue. Prison staff should be provided with regular refresher training on the ACCT process. Prisons should ensure caremap actions are appropriate for reducing risk and that progress in delivering the objectives of caremap actions is actively monitored, with progression through the ACCT process being dependent on this and with consistency of case manager where possible. Prisons should use enhanced case management to bring greater senior engagement, oversight and responsibility for keeping the most complex and challenging prisoners safe. Emergency response:	• offence • length of detention • transition periods (for example, 'early days' and transitions between estates or into the community)."

				Prisons should ensure all prisoners are accounted for during roll calls. Prisons should ensure all staff, including night shift staff, carry cut-down tools. Prisons should ensure that ambulances are despatched without delay in the event of medical emergency. Prisons should ensure that staff bring all relevant emergency equipment promptly to the scene of an emergency. Prisons should ensure staff are aware of recently issued guidance on when it is appropriate to attempt resuscitation. Our April 2014 publication identified seven risk factors (history of mental illness, history of self-harm in custody, substance misuse, new arrivals to custody, remand prisoners, indeterminate sentenced Prisoners (IPP prisoners), offence against family members) and found one or more of these factors occurred in 94% of the 361 self-inflicted deaths discussed in the report. The PPO has repeatedly found that too great an emphasis is often placed on staff perceptions of a prisoner's state of mind or what the prisoner says, with little or no thought to the other risk factors. Additional risk factors include: Being the victim of bullying (and bullying is often related to drug debts) Relationships breakdown Medication is changed, ended or otherwise disrupted Segregation or adjudication punishment.	
Prisons and Probation Ombudsman	Full	4	19	We support the requirement for every custodial or detention setting to set up a multi-agency partnership that includes: Healthcare staff Governors Staff Emergency services Voluntary and other third-sector organisations Probationary and transition services People who have attempted or been affected by suicide. Our comments on the broad proposal would be: 1) Is the document clear enough on definitions of "custodial or detention setting"? 2) Is there scope for increasing the role of prisoners in the partnership? 3) How does a prison's partnership engage with the local community's partnership? And the partnership of neighbouring custodial settings? Is the document clear enough on definitions of "custodial or detention setting"? As defined in ourTerms of Reference, the PPO investigates fatal incidents at the following: a) Prisons b) Young Offender Institutions (YOIs) c) Secure Training Centres (STCs) d) Secure Children's Homes (SCHs) (children can be placed in SCHs on custodial or welfare placements) e) Approved Premises (often known as probation hostels) f) Immigration removal centres, pre-departure accommodation, short-term holding facilities g) Court premises We will investigate fatal incidents of people who are temporarily absent from the establishment but still subject to detention (in hospital, for example). We also investigate fatal incidents under managed escort (including where a person in police custody is escorted to a court with the Prisoner Escort Custody Service). For immigration detainees, this includes escort anywhere in the UK and internationally. The Independent Office of Police Conduct (IOPC, formerly the IPCC) will investigate the following fatal incidents:	Thank you for your comment. 1) The guideline does not include a definition for this however we have added this to the section of the guideline 'Who is this for.' 2) The committee agree that the role of prisoners and their involvement is covered under "people with personal experience of a suicide attempt, suicidal thoughts and feelings, or a suicide bereavement, to be selected according to local protocols." 3) We have specified who the partnership should be engaging with in the following recommendation "1.1.6 Link the partnership with other partnerships including relevant multi-agency partnerships in the community." The committee have included recommendations for who should set up the multi-agency partnerships in the community and residential custodial and detention settings as follows "1.1.1 Local authorities should work with local organisations to: • Set up a multi-agency partnership for suicide prevention. This could consist of a core group and a wider network of representatives. • Identify clear leadership for the partnership. • Ensure the partnership has clear terms of reference, based on a shared understanding that suicide can be prevented. " " 1.1.4 Set up a multi-agency partnership for suicide prevention in residential custodial and detention settings. This could consist of a core group and a wider network of representatives. Ensure the partnership has: •clear leadership •clear terms of reference, based on a shared understanding that suicide can be prevented •clear governance and accountability structures."

				a) Deaths in police custody b) Deaths of individuals other than immigration detainees held in pre-departure accommodation, short-term holding facilities or managed immigration escort. NHS Trusts investigate deaths of patients detained in a hospital. The Royal Military Police have a role where there is a death in military detention. It would be helpful to state explicitly which of the settings listed above will be expected to set-up a multi-agency partnership for suicide prevention. Will this extend to Prisoner Escort Custody Service Teams working at courts? Police stations? Secure Children's Homes? Etc. Is there scope for increasing the role of prisoners in the partnership? Including prisoners and others in detention on the partnership would probably be covered by the requirement that they include "people who have attempted or been affected by suicide". But we think it would be helpful to be explicit that prisoners and others in detention should be included on the Partnership. How does a prison's partnership engage with the local community's partnership? And the partnership of neighbouring custodial settings? A prison's partnership will draw upon many key external professionals and agencies and the membership of a prison's partnership may include the same people who attend the community partnership. We think it would be helpful, however, to be more explicit about the read-across from the prison to the community. Perhaps a requirement that a prison partnership includes a representative from the local community partnership and that a community partnership includes a representative from any local prison partnership would be appropriate? On this point, a prison's partnership will necessarily focus on prisoners. If they were to be identified, the risks to the staff of a prison would be identified within the local community's Partnership. There may be value in being explicit about this to avoid a blindspot developing. Prisons are clustered by HMPPS into management structures. It is also the case that many prisons are geographically very close to each other. It might be helpful to consider how a prison's partnership will engage with the partnerships of similar prisons and/or nearby prisons and share knowledge, learning and information. It is important to remember that prisoners move across the estate. Each prison partnership will encounter prisoners with direct experience of the work of other partnerships.	
Prisons and Probation Ombudsman	Full	7	23	Please see our comments above on identifying risk factors. It would be helpful to include these additional factors here.	Thank you for your comment. The risk factors included in the recommendation is not intended to be an exhaustive list. The recommendation reads as follows "1.4.2 Collect and analyse local data on suicide and self-harm. This could include data on: method, location, timing, details of individual and local circumstances, demographics, occupation and characteristics protected under the Equality Act (2010). Sources could include reports from: •the local ombudsman •the Parliamentary and Health Service Ombudsman •coroners •the Prison and Probation Ombudsman

					•the voluntary sector” The additional risk factors mentioned all fall under the categories included in the above recommendation.
Prisons and Probation Ombudsman	Full	10	11	Please see our comments above on challenges we have identified in our investigations around emergency response in prisons. It would be useful to include, under “Training” or “After a suspected suicide”, a section on Partnerships’ engagement with their prison’s emergency response procedures.	Thank you for your comment. The committee have drafted the following recommendation which cover this situation "1.9.2 After a suspected suicide in residential custodial and detention settings, undertake a serious incident review as soon as possible in partnership with the health providers. Identify how: • to improve the suicide prevention action plan • to help identify emerging clusters • others have responded to clusters."
Public Health England	Full	15 - 16	General 23 - 4	Recommendations for Research needs to include: The link between near-lethal self-harm, previous self-harm in custody or in the community, and risk of suicide in custodial settings to support tailored intervention strategies for high risk individuals.	Thank you for your comment. All of our research recommendations include all population groups as we have not specified any subgroups, for example, by risk status.
Public Health England	Full	1	5	Need clarification as to whether guidance applies specifically to adult custodial settings only. Children and Young People’s Secure Estate (CYPSE) is not explicitly referenced nor excluded.	Thank you for your comment. We have added this to the section of the guideline 'Who is this for.'
Public Health England	Full	1	6	Suggest add ‘custodial staff’ to list of people affected by suicide in reference to ‘families and emergency responders’ as prison staff particularly have experienced trauma from working in response to deaths in custody.	Thank you for your comment. We have added this to the section of the guideline 'Who is this for.'
Public Health England	Full	1	17	In list of ‘Who is it for’ the guidance has listed: “Prison and custodial services, detention centres, community rehabilitation companies and the national probation service”- this list contains confusing non-specific references. The guidance needs to more explicitly include police custody and court cells Public Health England (PHE) suggest replacing this text with ‘people working in Prisons (public and contracted out), immigration removal centres (IRCs) and police custody suites.”	Thank you for your comment. We have added this to the landing page of the guideline, on the NICE website, in the section 'Who is this for.'
Public Health England	Full	4	17	We recommend Criminal Justice Services should be described more clearly. We suggest breaking down the description to: Police Custody Suites; Prisons; IRCs; Children and Young People custodial settings; Probation Services and Community Rehabilitation Companies.	Thank you for your comment. We have added this to the section of the guideline 'Who is this for.'
Public Health England	Full	4	18	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/585411/PHE_local_suicide_prevention_planning_practice_resource.pdf PHE recommend adding in education (including representation from local schools, Further Education and Higher Education Institutes) to reflect PHE’s Local Suicide Prevention Planning resource: PHE also recommend specifying appropriate representation from local Housing Associations and possibly including reference to representation from Job Centres as it is important to reflect debt/ financial difficulty/ housing crises as factors contributing to suicide risk. This is because suicide is a significant inequality issue as there is an association with poverty, deprivation and unemployment. Evidence from economic downturns shows an increase in suicide. The impact of the recession during 2008-2010 on suicide could account for 1000 excess deaths due to suicide during this time, based on expected trend. This research suggested a strong association with rising unemployment. Financial difficulties, debt and loss of home increase an individual’s risk of depression, suicide attempt and suicide. Further information is available in point 2.10	Thank you for your comment. The committee agree and were mindful of the fact that different groups of people (for example representatives from educational institutions, local Housing Associations and job centres) could be included in the wider network, depending on local circumstances and settings. As such the committee drafted a recommendation as follows "1.1.1 Set up a multi-agency partnership for suicide prevention. This could consist of a core group and a wider network of representatives." We have referenced Public Health England guidance at the start of the guideline provides further information on this.

				of PHE's submission to the Health Select Committee's Inquiry into suicide prevention:http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-and-social-care-committee/suicide-prevention/written/37695.pdf	
Public Health England	Full	4	24	The list of personnel recommended to be included in a custodial setting is incomplete and reads as it is only relevant to prisons – rather than making a separate list for each custodial setting we recommend that one list is provided with a caveat that relevant personnel should be identified. Therefore the list should also include: IRC healthcare IRC Directors Directors of Private prisons (rather than governors) Recreational, welfare and education staff Community Rehabilitation Services Services which support people when they leave a custodial setting which could include commissioners of mental health services and drugs and alcohol services; clinical commissioning groups (see comment 6 below)	Thank you for your comment. We have amended the recommendation as follows "1.1.5 Include representatives from the following in the partnership's core group: • governors or directors • healthcare staff in residential custodial and detention settings • staff in residential custodial and detention settings • pastoral support services • voluntary and other third-sector organisations • escort custody services • liaison and diversion services • emergency services • offender management and resettlement services • people with personal experience of a suicide attempt, suicidal thoughts and feelings, or a suicide bereavement, to be selected according to local protocols." The list of personnel suggested are covered by the representatives listed in the recommendation.
Public Health England	Full	5	06-Jan	PHE support the recommendation in the guidance of the need to link community, and custodial and detention setting groups to deal with the high level of suicide in the first two weeks after leaving prison. We would recommend the setting up of a multi-agency sub group to ensure there is support for people at risk when leaving prison. Ref:Suicide in recently released prisoners: a population-based cohort studyDaniel Pratt, Mary Piper, Louis Appleby, Roger Webb, Jenny Shaw Lancet2006; 368: 119–23	Thank you for your comment. We have added further information in the discussion section of the evidence review 1 Multi-agency partnerships.
Public Health England	Full	5	1.2 & 1.3	PHE support the need to set up Multi-agency partnerships for suicide prevention in custodial or detention settings and it needs to be clearly stated in the guidance that each prison should have a group, which also links back to the wider community multi-agency group. Each group should develop a clear strategy and action plan which is monitored and reviewed.	Thank you for your comment. The committee have acknowledged this and drafted the following recommendation " 1.1.4 Set up a multi-agency partnership for suicide prevention in residential custodial and detention settings. This could consist of a core group and a wider network of representatives. Ensure the partnership has: •clear leadership •clear terms of reference, based on a shared understanding that suicide can be prevented •clear governance and accountability structures." The strategy and action plan in relation to residential custodial and detention settings is covered in recommendations in section 1.2 and 1.3.
Public Health England	Full	5	4	Replace transition services (which don't exist as an entity) to: Services which support people when they leave a custodial setting which could include commissioners of mental health services and drugs and alcohol services; clinical commissioning groups.	Thank you for your comment. In response to your comment and other stakeholder comments, we have updated the term "probationary and transition services" to "offender management and resettlement services"
Public Health England	Full	5	5	The recommendation to include in membership of multi-agency partnership group 'people who have attempted or been affected by suicide' would be difficult to implement in prisons and especially IRCs. This is because people in prison who have recently (as in during that period of incarceration) attempted suicide are likely to be vulnerable and/or undergoing care. IRCs have a very rapid turnover of population. Therefore, getting a patient representative in either setting is problematic. So patient 'selection' for	Thank you for your comment. The committee acknowledge that involving this population group may have challenges, however the committee has drafted the recommendation to inform the discussion according to local arrangements "1.1.3 people with personal experience of a suicide attempt, suicidal thoughts and feelings, or a suicide bereavement, to be selected according to local protocols."

				participation would need to be carefully scrutinized but it may more appropriate to have User Voice (an established support network for ex-prisoners to engage in health services), identify and select an ex-prisoner to support this work rather than a serving prisoner. PHE recommend replacing “people who have attempted or been affected by suicide” with “patient representation to be defined according to local protocols”	
Public Health England	Full	5	8	Under suicide prevention strategies, PHE maintain that it would be helpful to make a specific reference to responsibility for governance and accountability for delivery of the action plan. Where should the plan sit for example, should progress be reported to the Health and Wellbeing Board?	Thank you for your comment. The committee have included the following recommendation "1.1.1 Ensure the partnership has clear governance and accountability structures. Include oversight from local health and care planning groups for example, health and wellbeing boards."
Public Health England	Full	5	8	PHE advocate including an overarching statement to clarify difference between a suicide prevention strategy and a suicide prevention action plan. Please see PHE’sresourcefor more information.	Thank you for your comment. The committee have now restructured the sections of the guideline to make it clear who is involved in the partnership, what strategies the partnership should develop and actions the partnership should undertake. We have referenced Public Health England guidance at the start of the guideline.
Public Health England	Full	5	8	We recommend that multi agency strategies make explicit reference that suicide is preventable; it is safe to talk about suicide, suicide is not inevitable, as already set out on page 4 line 7 of the guidance.	Thank you for your comment. We have added the following recommendation "1.2.1 Develop a multi-agency strategy based on the principles of the Department of Health and Social Care's suicide prevention strategy for England and other relevant strategies. It should emphasise that suicide is preventable, and it is safe to talk about it."
Public Health England	Full	5	11	PHE recommend replacing: “Make it clear who leads on suicide prevention” with “Identify clear leadership for the multi-agency partnership, strategy and action plan” as the suggestion to ‘make it clear who leads on suicide prevention’ contradicts the idea of collaborative approach where shared leadership is model of good practice. There are defined responsibilities for organisations like prisons and IRCs regarding deaths in custody for investigation and inspection purposes, but suicide prevention by definition is multi-agency.	Thank you for your comment. The committee have added the following recommendations "1.1.1 Identify clear leadership for the partnership" "1.2.2 Identify clear leadership for the multi-agency strategy" "1.3.1 Identify clear leadership for the action plan"
Public Health England	Full	6	4	PHE recommend that the list of local institutions explicitly include prisons and IRCs.	Thank you for your comment. We have not amended this recommendation, as this recommendation is for multi-agency partnerships in the community.
Public Health England	Full	6	12	PHE recommend changing the text to the following: ‘collect, analyse and interpret local data and insight’.	Thank you for your comment. This recommendation has been amended and the suggested wording is no longer appropriate. The new recommendation is as follows "1.3.1 Interpret data to determine local patterns of suicide and self-harm, particularly among groups at high suicide risk (see section 1.4). "
Public Health England	Full	6	16	PHE advocate a stage between collecting, analysing and interpreting data and insight and implementing the plan which is ‘to identify priority actions based on analysis of data and insight and informed by evidence’. Please see PHE’sresourcefor more information.	Thank you for your comment. The committee have drafted the following recommendation "1.3.1 Prioritise actions based on the joint strategic needs assessment and other local data to ensure the plan is tailored to local needs." There is also a reference to 'Public Health England's resource on Local suicide prevention planning: a practice resource' at the start of the recommendations.
Public Health England	Full	6	17	PHE recommend implement ‘actions’. Please see section three in PHE’sresourcefor more information and points three and four in PHE’s evidence to the inquiry on suicide prevention (http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-and-social-care-committee/suicide-prevention/written/37695.pdf).	Thank you for your comment. The committee have drafted to following recommendation to address this in section 1.3 Suicide prevention action plans "1.3.1 Develop and implement a plan for suicide prevention and for after a suspected suicide."
Public Health England	Full	7	17-20	PHE recommends that 1.4.2 should include reference to prisons and IRCs and recommends the following amendment:	Thank you for your comment. The committee agreed and drafted the following recommendation to include prisons and IRCs "1.4.4 For community settings, also use rapid intelligence gathering (continuous and timely collection of data) to identify suspected suicides, emerging methods

				Multi-agency partnerships in the community and in prescribed places of detention should consider continuous and timely collection of data…..	and potential suicide clusters. This intelligence could also be used to identify people who need support after such events (see recommendations 1.8.1 and 1.9.1). Collect this local data from a range of sources including: • police and transport police • prisons • immigration removal centres (IRCs) • coroners."
Public Health England	Full	7	7	'National Offender Management Service' was replaced by Her Majesty's Prison and Probation Service in April 2017. The text should be updated to reflect this.	Thank you for your comment. This has been amended as suggested.
Public Health England	Full	7	14	List of parameters of interest- Seasonality is not the only time-related characteristic of interest in custodial settings; time of day or night and whether weekday or weekend and where in custodial cycle or change in location are also relevant time metrics and we therefore recommend these metrics are also included. Ref: Prevention of Suicidal Behavior in Prisons, An Overview of Initiatives Based on a Systematic Review of Research on Near-Lethal Suicide Attempts Lisa Marzano, Keith Hawton, Adrienne Rivlin, E. Naomi Smith, Mary Piper, and Seena Fazel Crisis(2016), 37(5), 323–334	Thank you for your comment. Following your comment and committee discussion the committee have removed seasonality and added "timing" to this recommendation as follows "1.4.2 Collect and analyse local data on suicide and self-harm. This could include data on: method, location, timing, details of individual and local circumstances, demographics, occupation and characteristics protected under the Equality Act (2010). Sources could include reports from: •the local ombudsman •the Parliamentary and Health Service Ombudsman •coroners •the Prison and Probation Ombudsman •the voluntary sector." The other suggestions of data on "where in custodial cycle or change in location" would be collected under "location" and "details of individual and local circumstances"
Public Health England	Full	9	22-24	We recommend the text is edited as below: Comply with national guidance about reducing access to methods of suicide (for example, by implementing the safer cell standards in custodial settings, with all ligature points removed …. http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2011/06/QTLB-Safer-Cells-Issue-4.pdf	Thank you for your comment. The hyperlink to this document is now included as suggested.
Public Health England	Full	9	8	PHE recommend including displays at prominent locations, for example schools and general practices. Please see Appendix 2 in PHE's evidence to the Inquiry into suicide prevention:http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-and-social-care-committee/suicide-prevention/written/37695.pdf	Thank you for your comment. The recommendations on suicide campaign messages have been removed. The committee agreed that it was more appropriate for suicide prevention campaigns to run at a national level and focus on activities to raise awareness of suicide at a local level.
Public Health England	Full	9	10 to 11	Recommend this line is extended to include wings and landings, common areas, healthcare in prescribed places of detention as these are prominent areas in detained settings	Thank you for your comment. The recommendations on suicide campaign messages have been removed. The committee agreed that it was more appropriate for suicide prevention campaigns to run at a national level and focus on activities to raise awareness of suicide at a local level.
Public Health England	Full	10	1.7	In this section, PHE advocate the need to highlight the issue of co-morbidity of mental and physical health issues and a need to take a holistic view of an individual which will include warning signs/ risks which are often missed as 'treatment' singularly focussed; training must address this. Please see page 26 in PHE'sresourceand the following paper for more information:https://www.ncbi.nlm.nih.gov/pubmed/22393218	Thank you for your comment. The committee acknowledge this and have drafted the following recommendations to ensure that any training delivered is appropriate and is delivered to a high standard "1.2.6 Oversee provision and delivery of training and evaluate effectiveness."
Public Health England	Full	10	22	"Gatekeepers" should include reference to GPs, housing associations, job centre staff, those managing conversations re universal credit, hospital staff (to recognise co-morbidity issues).	Thank you for your comment. The committee drafted a definition for gatekeepers, which includes people in groups that have contact, because of their paid or voluntary work, with people at risk of suicide and therefore includes all the groups mentioned.

					It reads as follows "People in groups that have contact, because of their paid or voluntary work, with people at risk of suicide. People in these groups are may be trained to identify people at risk of suicide and refer them to treatment or supporting services as appropriate. They may include: health and social care practitioners, criminal justice and detention settings staff, police and emergency services, people who provide a paid or voluntary service for the public, faith leaders, railway and underground station staff and staff in educational institutions."
Public Health England	Full	11	1	The reference to peer support in prisons needs clarification to reflect the importance of informal peer support. Ref: Prevention of Suicidal Behavior in Prisons, An Overview of Initiatives Based on a Systematic Review of Research on Near-Lethal Suicide Attempts Lisa Marzano, Keith Hawton, Adrienne Rivlin, E. Naomi Smith, Mary Piper, and Seena Fazel Crisis(2016), 37(5), 323–334 Wesuggest amending text to “Ensure peer mentors are available in each prison and ensure receive appropriate training”.	Thank you for your comment. The committee have reworded the recommendation to incorporate this as follows "1.7.1 Ensure training is available for: • those in contact with people or groups at high suicide risk • people working at locations where suicide is more likely • gatekeepers • people who provide peer support in residential custodial and detention settings • people leading suicide prevention partnerships • people supporting those bereaved by suicide."
Public Health England	Full	11	9	We suggest replacing to the phrase ‘cell or prison mates’ with 'friendship and social contact groups in custodial settings'	Thank you for your comment. As per other stakeholder comments, this has been changed to "other prisoners and detainees"
Public Health England	Full	11	3 to 14	It is important that the impact of a suicide on the custodial or detained setting’s regime is considered. It may be necessary, for example, for people detained to change working patterns or stop work for a period of time. This may also be necessary for staff.	Thank you for your comment. The committee consider that this is part of the wider situation that should be taken account of and is reflected in the following recommendation "Provide ongoing support for those involved, including people directly bereaved or affected and those who are responding to the situation (see recommendation 1.8.)."
Public Health England	Full	13	14	PHE recommend including the following: Those in debt, homeless, carers, ‘living with and/or caring for those with mental illness’. For more information, please see the following:https://www.ncbi.nlm.nih.gov/pubmed/22393218and http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/2016-report.pdf	Thank you for your comment. We have not included the references as we did not prioritise a review question on groups at high suicide risk at scoping. However, we have included" people in care of mental health services" and "people with a physical illness".
Public Health England	Full	13	8,24	See previous reference to definition of ‘custodial settings’ (Comment 3)	Thank you for this comment. We have added this to the section of the guideline 'Who is this for'
Public Health England	Full	14	1	“Places where suicide is more likely” should include specific reference to prisons and IRCs	Thank you for your comment. The term has been changed to 'locations where suicide is more likely'. The committee have included specific reference to prisons and IRCs by drafting the following recommendation “1.6.2 Ensure local compliance with national guidance to reduce access to methods of suicide: • In custodial settings, for example, provide safer cells (see the Ministry of Justice's Quick-time learning bulletin: safer cells).”
Public Health England	Full	16	2	Research recommendations: We recommend the following amendment Factors may include staff to prisoner ratio, amount of time out of cell in purposeful activity; length of sentence, recent incarceration and movement between settings, violence, overcrowding and a rise in the prison population Add term detention settings when using term custodial settings	Thank you for your comment. This section has been revised to state the following "In residential custodial and detention settings, they agreed that extra support during particularly vulnerable times, such as 'early days', might reduce the risk of suicide. Peer support, along with measures such as the provision of 'safer cells', might also help to act as deterrents. But there is a lack of evidence and more research is needed to evaluate the effectiveness of different interventions in a range of custodial settings." The term residential custodial and detention settings are now used throughout.

				Add research into numbers of cells meeting safer cell standards.	We have added numbers of cells meeting safer cell standards as an outcome to the research recommendation.
Public Health England	Full	22	17 - 22	Most prescribed places of detention do not have multi-agency partnerships in place and there would be resource implications for this particularly in relation to data analysis	Thank you for your comment. We will pass this information to our resource impact team for their information.
Rethink Mental Illness	Full version	General		- Our services were clear that major issue in preventing suicide in prisons is a lack of staff. As well as having less time per prisoner, a lack of staff limits the number activities that can be run and supervised. Prisoners spend longer time in cells as a result. - This have as huge impact on levels and severity of depression and other mental health problems among inmates. A recent report by the Public Accounts Committee on mental health in prisons recognised this and called for extra staff to be recruited. - Another key recommendation from our services was that attempts to reduce suicide in prisons are targeted at prisoners on lengthier sentences, as they are most at risk. - Whilst initiatives such as safer cells are welcome and can contribute to suicide prevention, our services were clear that it is important to be realistic about the impact they can have, as they do not eliminate all options a prisoner has to end their life. Technological innovations exist that could see suicide prevention go further than safe cells. - New developments include technology that can detect unusual movements in a cell, or increased levels of carbon monoxide. These could help reduce suicide in prisons, but would come with significant cost implications for the prison estate. - Training on suicide prevention varies considerably between different prisons and members of prison staff. This problem has been exacerbated by cuts to budgets. In practice, many prison staff learn how to attempt to prevent suicide on the job. Increasing formal training meaningfully will require additional investment. - Our services also expressed concern about local authorities leading multi-agency plans on suicide prevention in prisons. These concerns centred on the fact that local authority staff lack expertise on how prisons operate. Their efforts to lead suicide prevention in them may not be well received as a result. - A 2017 National Audit Office report highlighted that self-harm and suicide rates have increased significantly since 2012, as well problems with data on prisoner health. Our services suggested one of the factors behind the increase is the spiralling use of different drugs in prisons, which must be factored into any prevention plan. - Tramadol, heroin and cannabis were the most commonly used drugs in previous years. Currently, psychoactive substances such as spice are the major issues, and these present different challenges. These psychoactive	Thank you for your comments. Staffing levels are out of scope for this guideline. The committee recognises that particular prisoners may be at higher risk of suicide and have drafted the following recommendation 1.4.4 “For residential custodial and detention settings, also collect data on: •sentencing or placement patterns • sentence type • offence • length of detention • transition periods (for example, 'early days' and transitions between estates or into the community).” The committee were mindful of these ongoing initiatives in terms of safer cells and have drafted the following recommendation “1.6.2 Ensure local compliance with national guidance to reduce access to methods of suicide: •In custodial settings, for example, provide safer cells (see the Ministry of Justice's Quick-time learning bulletin: safer cells).” The guideline also includes specific recommendations on training. The committee recognises that training can be costly however any recommendations on training are expected to be made available through existing continuous professional development programmes, so the costs for professionals and organisations could be minimised. This recommendation has now been amended as follows “1.1.1 Local authorities should work with local organisations to: •Set up a multi-agency partnership for suicide prevention. This could consist of a core group and a wider network of representatives. •Identify clear leadership for the partnership.

				substances are extremely volatile with a varying effects on each individual. They can frequently lead to psychosis and suicide attempts. Addressing the increased use of these drugs should be at the centre of local and national plans to prevent suicide in prisons.	•Ensure the partnership has clear terms of reference, based on a shared understanding that suicide can be prevented." Thank you for your comment. The committee recognise the use of drugs in prisons and have drafted the following recommendation for multi-agency partnerships in residential custodial and detention settings "1.9.2 After a suspected suicide in residential custodial and detention settings, undertake a serious incident review as soon as possible in partnership with the health providers. Identify how: • to improve the suicide prevention action plan • to help identify emerging clusters • others have responded to clusters."
				- On data, our services reported work to prevent suicides is frequently not recorded. Staff already have enormous amounts of administrative work to do and are overstretched generally, which limits the time they have available to record preventative activity. Suicide prevention work is also often regarded as business as usual among prison staff, so is often unreported. - Practical issues also prohibit the consistent recording of suicides that are prevented. Prison staff, healthcare staff and those that work in probation all use independent computer systems. A basic step for all suicide prevention activity is a degree of commonality between the technology used by these different teams.	Thank you for your comment. The committee did not consider that it was appropriate to specify data collection software, as the onus is on the multi-agency partnership to liaise with other similar partnerships, when considering collecting and sharing data.
				- Our prison services in the North East have been piloting a 'Pat Dog' service following a grant from the Ministry of Justice. The 'Pat Dog' scheme involves prisoners that are referred to the service being given access to a dog as part of an agreement with prison staff. - Prisoners become more open and honest about how they feel and any problems they have as a result spending time with a dog, which leads to them being given a more accurate and effective diagnosis and treatment. - Wellbeing scores are taken at the beginning at end of their participation and a significant improvement has been shown. It has also led to a reduction in self-harm among prisoners who take part, as they are told that if they self-harm they will be unable to access the dog. As a result, many participants have stopped self-harming. - Alongside access to a dog, prisoners are also able to take part in sessions where they encourage the dog to perform certain tricks and manoeuvres, which give a sense of achievement as well as a bond with the animal.	Thank you for your comment. This may be considered as a future update of the guideline, when this information is published.

				- A full evaluation is being conducted by the Centre for Mental Health and a report is expected to be published is June. The indicative findings from the project, involving 100 prisoners, are extremely encouragingly. - Once the findings of the evaluation are published, if the pilot is successful, additional funding to roll the scheme out should be considered as part of plans to reduce instances of suicide in the prisons estate.	
Royal College of General Practitioners	Full		General	With the investment of additional resources, high risk groups could be screened in primary care. Special attention should be given to vulnerable groups and they should be prioritised such as asylum seekers etc If screening is not an option then case finding could be?	Thank you for your comment. Screening and case-finding is outside of scope for this guideline.
Royal College of General Practitioners	Full		General	Suicide prevention- depression screening questions could be added into the Health Check offered at the age of 40 years and the new patient health check	Thank you for your comment. This is outside of scope for this guideline.
Royal College of General Practitioners	Full		General	Monitoring and reviewing of prescribing in primary care of opiates, benzodiazepines and psychotropic medication together. Safe prescribing- involve the pharmacist	Thank you for your comment. This is outside of scope for this guideline.
Royal College of General Practitioners	Full		General	Better working and communication with liaison psychiatry. Sharing safety plans and crisis plans	Thank you for your comment. We have included the following recommendations in the "Suicide prevention action plans" "1.3.1 Share experience and knowledge between stakeholders. Also share data, subject to local information sharing agreements." "1.3.1 Oversee local suicide prevention activities, including awareness raising and crisis planning."
Royal College of General Practitioners	Short			There should be more reference to relevant mental health NICE guidelines and integration with them. It is tremendously frustrating for GPs and other community services to have “Personality Disorder Services” that are rigid and poor at engaging those who cannot travel or have fears of meeting in groups or those with whom they are not familiar or feel ashamed of their thoughts. There is little interaction with Primary Care who carry the burden of suicide prevention and then feel guilty when suicide is completed. The psychiatric services could be more accessible to GPs needing help with such? Voluntary groups and services are tremendous but GPs could interact more with them too? Psychiatric services need to realise that not everyone who self harms has a “PD”. There was no reference to this problem in the Self Harm or Mental Health guidelines.	Thank you for your comment. We have cross-referenced other relevant NICE guidance in the guideline and the recommendations in the NICE care pathway will link to other recommendations, where appropriate. The committee have recommended that partnerships share data and have also recommended training for gatekeepers, of which primary care providers are included.
Royal College of General Practitioners	Full		1.1	Primary care should be part of a multiagency partnership group	Thank you for your comment. 'Primary care providers' is included as a representative in the multi-agency partnership.
Royal College of General Practitioners	Full		1.7	Training should be provided to all the multiagency partnership members and that would include clinical and non-clinical staff in primary care. Primary care involves a wider range of people than just general practice e.g. district nurses, school nurses etc	Thank you for your comment. The committee acknowledge this and recommend providing training to all gatekeepers, as per the following definition "People in groups that have contact, because of their paid or voluntary work, with people at risk of suicide. People in these groups are may be trained to identify people at risk of suicide and refer them to treatment or supporting services as appropriate. They may include: health and social care practitioners, criminal justice and detention settings staff, police and emergency services, people who provide a paid or voluntary service for the public, faith leaders, railway and underground station staff and staff in educational institutions."

Royal College of General Practitioners	Short	6	1.3.1	This omits the “elephant in the room.” Even reading NICE Self Harm and Mental Health Pathways it is omitted. Possibly because of changes to section 135 and 136 of the Mental Health Act 1983, mental health services are now mandating Police services to make initial assessments for people who phone in with suicidal thoughts. At least two police then arrive at that person’s home (or in a public place which is more understandable) and spend however long it takes making assessments, checking with their lead sergeant and then possibly taking the person to the nearest mental health unit for assessment. The police are the main preventers. The assessment used to be a CPN or GP’s role. When and why did this change? It is immensely demanding of police time and can add to the shame and vulnerability that a person with suicidal thoughts suffers. Many have suffered abuse in the past, and police attendance adds to their impression that it is “their fault”. Certainly the neighbours and community observing the arrival of police cars suspect a drug raid! In fact, some police are very good at assessment and much kinder than some health care staff who still make people who self-harm or burn themselves wait until the end of the queue. It should be mentioned if this is to continue that the Police have a forefront role?	Thank you for your comment. The committee were conscious that police play a role and have addressed this at several points throughout the guidance.
Royal College of General Practitioners	Short	13	17	This list should include those on the autism spectrum as recent evidence shows that suicide is the commonest cause of death in those with ASD and no learning difficulty. Hirvikoski,T et al (2015) Premature Mortality in autism spectrum disorder. The British Journal of Psychiatry, 207(5)	Thank you for your comment. The committee have added "people with autism" to the list of "high suicide risk" in the terms used in the guideline. However we have not included the references as we did not prioritise a review question on groups at high suicide risk oat scoping. We will pass your comment and references to the surveillance team at NICE.
Royal College of Nursing	General	General	General	The Royal College of Nursing (RCN) welcomes proposals to develop guidelines for preventing suicide in community and custodial settings. The RCN invited members who care for people with mental health problems and those in custodial settings to review the draft document on its behalf. The comments below reflect the views of our reviewers.	Thank you for your interest in this guideline.
Royal College of Nursing	General	General	General	Reactive measures such as barriers on bridges and nets in prisons are an important part of preventing suicide, but they are no replacement for properly staffed and funded mental health services. Poor mental health support in the community can lead to more people with mental health problems ending up in prison, where support is often even harder to come by. Inside, factors such as violence and substance abuse can make a bad situation worse, and a desperate shortage of mental health nurses means many of those in prison cannot get the care they need, either to improve their condition or prevent reoffending. The government must invest in the mental health workforce, particularly in prisons, and urgently address the chronic shortage of nurses.	Thank you for your comment. Mental health support in the community is outside of scope for this guideline. The committee has recommended that healthcare staff are representatives on multi-agency partnerships.
Royal College of Physicians	Full			This strategy is OK at the ‘macro’ level although is a long and repetitive read but what about the ‘micro’ level? Our Faculty represents health professionals (doctors and nurses) who attend people in police and other custody settings who are at risk of suicide. In such cases we emphasise the importance of taking a full medical history, conducting an appropriate physical and mental state examination	Thank you for your comment. The committee considered that this is part of routine care and does not require a recommendation.

				and, when time permits, taking into account information from medical record and collateral sources (such as family). This is not reflected in the document but no doubt because it is about the macro level and not the micro level but we recommend cross-reference to this, and other aspects of prevention of suicide, at the individual case level. We are also concerned that it should be clear which body takes lead responsibility for setting up the sort of groups envisaged.	The committee has now clarified who is responsible for setting up the partnerships "1.1.1 Local authorities should work with local organisations to: • Set up a multi-agency partnership for suicide prevention. This could consist of a core group and a wider network of representatives. • Identify clear leadership for the partnership. • Ensure the partnership has clear terms of reference, based on a shared understanding that suicide can be prevented. " " 1.1.4 Set up a multi-agency partnership for suicide prevention in residential custodial and detention settings. This could consist of a core group and a wider network of representatives. Ensure the partnership has: •clear leadership •clear terms of reference, based on a shared understanding that suicide can be prevented •clear governance and accountability structures."
Royal College of Physicians				Just a small point. I have no problem admitting that I have never been funded by the tobacco industry but surely there are other more relevant potential conflicts of interest. I might have shares in Dignitas (but I don't!). Just struck me as n odd question.	Thank you for your comment. We acknowledge this however this question is included on all NICE comment forms as the WHO classify the tobacco industry as respondents, not as stakeholders.
Royal College of Psychiatrists	Full	General	General	At 34 pages, this document is 2-3 times longer than ideal for a document designed for a multiplicity of agencies – and therefore often lay people – and for a document which explicitly does not include core aspects of suicide prevention, but rather refers to other national strategies.	Thank you for your comment. The guideline has been reduced to 28 pages by removing duplicated recommendations in the consultation version of the guideline.
Royal College of Psychiatrists	Full	General	General	The document is supposed to cover suicide prevention in the community and in custody, however, this is based on the premise that both settings have a significant amount in common in relation to suicide prevention. But it quickly becomes clear during the document, that this is not the case and too often it appears that the custody recommendations appear as an afterthought. Very few of the recommendations for community prevention would apply to custody and many specific areas in custody prevention are absent. One very specific difference is that there is an investigation into every death in custody by the Prisons and Probation Ombudsman (PPO). These reports make specific recommendations in relation to the death which the prison should address. This report also informs the subsequent Inquest. Therefore, every suicide in custody is examined in far greater detail that would be the case in the community and it is essential that the Governance processes in prisons take account of the recommendations to prevent future suicides.	Thank you for your comment. We have now added emphasis to the recommendations for residential custodial and detention settings. The committee acknowledge that every death should be investigated and have drafted the following recommendation " 1.9.2After a suspected suicide in residential custodial and detention settings, undertake a serious incident review as soon as possible in partnership with the health providers. Identify how: • to improve the suicide prevention action plan • to help identify emerging clusters • others have responded to clusters."
Royal College of Psychiatrists	Full	General	General	The guidance states it aims to look at "ways to identify and help people at risk", yet there is no reference at all to suicide attempts/self harm and how these people should be helped to prevent them from dying by suicide in the future.	Thank you for your comment. The committee recognise this and have recommended that data be collected on people who self-harm as this is a high risk group and should inform suicide prevention strategies.
Royal College of Psychiatrists	Full	General	General	Overall, this guideline provides little evidence-based practical help in preventing suicides either in the community or in custody. The areas missing include: The relationship between self harm and suicide Follow up following self harm Effective treatment of mental disorder in those at risk of suicide The use of Safety Plans to help those who present at risk of suicide Targeting high risk groups, including those with mental disorder and alcohol problems.	Thank you for your comment. The committee recognise this and have recommended that data be collected on people who self-harm as this is a high risk group and should inform suicide prevention strategies. Effective treatment of mental disorder in those at risk of suicide and the use of Safety Plans to help those who present at risk of suicide are outside the scope of this guideline. The committee has put a focus on targeting high-risk groups according to local need as in the following recommendation

					"1.3.1 Prioritise actions based on the joint strategic needs assessment and other local data to ensure the plan is tailored to local needs." Please also see NICE guideline “Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence” and Public Health England’s “Better care for people with co-occurring mental health, and alcohol and drug use conditions” for further information.
Royal College of Psychiatrists	Full	General	General	There is no reference to the WHO document from 2007 “Preventing suicide in jails and prisons” which includes very specific and evidence-based recommendations about preventing suicides in prisons.	Thank you for your comment. The committee were mindful of this document when considering the evidence and drafting recommendations for residential custodial and detentions settings and have added a reference
Royal College of Psychiatrists	Full	1		Although listing the agencies for who the document is intended, there is not simple, clear statement at this stage (or any other) as to why they should use this document in preference or in addition to others.	Thank you for your comment. NICE were commissioned to do this guideline to provide a single reference point for suicide prevention guidance in England.
Royal College of Psychiatrists	Full	4		‘Local authorities should … set up and lead a local multi-agency partnership on suicide prevention’ Why? There is no evidence presented that this costly proposal would have any prevention benefits. Although (page 15) the document points out that many people who complete suicide are not in contact with medical professionals – it is unlikely they are in contact with local authorities about this either. Accepted that, as the 1999 HM Chief Inspector of prisons asserted ‘Suicide is everyone’s concern’ – if we need new NICE guidance on multi-agency partnerships, then the nature of essential tasks not picked up by healthcare should be clearer.	Thank you for your comment. The committee noted the lack of evidence for multi-agency partnerships, but also noted that more than 95% of local authorities already have suicide prevention partnerships in place as per the 2012 national suicide prevention strategy. The committee’s own experience supports the use of local partnerships in general and that these groups are set up to carry out actions for which there is evidence. The committee has considered this comment amongst others and has amended the recommendation as follows to make it clear that clear leadership is needed but this guideline is not in a position to determine who that should be. "1.1.1 Local authorities should work with local organisations to: • Set up a multi-agency partnership for suicide prevention. This could consist of a core group and a wider network of representatives. • Identify clear leadership for the partnership. • Ensure the partnership has clear terms of reference, based on a shared understanding that suicide can be prevented."
Royal College of Psychiatrists	Full	4		There isn’t any clear evidence to support the recommendation that, insofar as such partnerships would be useful, they should be led by a local authority. This may be related to the lack of clarity on tasks needed – for example, working with transport companies would seem an important task, but are local authorities best placed to take this on? What is the evidence for local authority expertise in managing suicide prevention in any other of its aspects? Although it is true that some suicides may not be related to mental ill-health, many are and people with mental disorders are at very high risk of suicide related behaviours as well as completed suicide. Mental health service providers have extensive expertise in assessing and managing risk of suicide. If multiagency partnerships can be shown to be of value, the case can be made that mental health services should have the lead.	Thank you for your comment. The committee noted the lack of evidence for multi-agency partnerships, but also noted that more than 95% of local authorities already have suicide prevention partnerships in place as per the 2012 national suicide prevention strategy. Examples of such strategies that may be addressed at a local level include preparing contingency plans to respond to a suicide in the community or collaborating with neighbouring residential custodial and detention organisations to deliver a single strategy. The committee has considered this comment amongst others and has amended the recommendation as follows to make it clear that clear leadership is needed but this guideline is not is a position to determine who that should be. "1.1.1 Local authorities should work with local organisations to: • Set up a multi-agency partnership for suicide prevention. This could consist of a core group and a wider network of representatives. • Identify clear leadership for the partnership.

					• Ensure the partnership has clear terms of reference, based on a shared understanding that suicide can be prevented."
Royal College of Psychiatrists	Full	5		Collection, analysis and interpretation of local patterns of attempted suicide and suicide. There is little indication that the document authors understand the research skills needed to accomplish this sort of thing, but, further part of the reason that we may be short of local data is that while all risks are just evidence based estimates, estimates based on rare events are particularly likely to be flawed. The locality would have to be of sufficient size and have sufficient numbers of suicide events for anything approaching useful data. This sounds like the precursor to a substantial, costly and potentially misleading bureaucracy. What is the evidence that the National Confidential Inquiry into Suicide and Homicide does not already provide good enough data? Insofar as there are gaps, would it not be better to fund into extending this expertise rather than setting up new systems? Much of his comment applies to section 1.4 too. In addition, are the writers aware that data are collected on deaths in prison and probation and reviewed by the Prisons and Probation Obudsman? And the Prison Inspectorate regularly complements this with unannounced visits to prisons and with thematic reports? We already have much of the data called for. Here we do not need new systems for data gathering, we need scarce resources spent on restoring prison staffing levels and experience and, especially in this context as well as for many other aspects of safety, getting on top of the extensive drugs problem I prisons.	Thank you for your comment. The committee agree that data collection should not be an end in itself and the issue of small numbers of deaths in individual areas makes measurement challenging. We agree that local areas should look at routinely collected data (for example local profiles, Public Health England sources) and we include examples in the guideline. There is still a role for local data collection particularly when focussed on locally specific issues. The National Confidential Inquiry into Suicide and Homicide (NCISH) does collect basic general population data but the main focus is information on patient's suicide which is outside the scope of the guideline. However we also now include a cross reference to the NCISH work in the context section. In relation to prison services, the committee agree that that multi-agency partnerships should use existing national data that is available and collect further data required locally to allow for rapid evidence assessment.
Royal College of Psychiatrists	Full	5	8	In the section on suicide prevention strategies, there is nothing about what has been learned from previous national strategies, both in this country and internationally and if anything has been shown to be effective. It does note that in the explanation about how they arrived at this recommendation, it says "evidence is limited". This is surely the key to this work.	Thank you for your comment. The committee have added further information to the following recommendation "1.2.5 Assess whether initiatives successfully adopted elsewhere are appropriate locally or can be adapted to local needs, or whether previously successful initiatives can be reintroduced."
Royal College of Psychiatrists	Full	7	1	We would support the collection of local data in order to understand any local factors which appear to increase the risk of suicide. But, the statement that this data should then inform the local action plan, is easily stated, but perhaps much harder to achieve. Examples where this has been successful would be helpful.	Thank you for your comment. We have added a link to 'Public Health England's resource on Local suicide prevention planning: a practice resource' at the start of the recommendations for further information and exemplars.
Royal College of Psychiatrists	Full	7	23	The recommendation that data on "sentence type, offence, length and transition periods", will help to reduce suicides in a specific prison is difficult to understand, especially as there is no evidence quoted to support this.	Thank you for your comment. The committee agreed that collection and analysing of data will help to inform the action plans and future amendments.
Royal College of Psychiatrists	Full	8	2	The sections on suicide awareness raising and suicide prevention campaigns makes no specific recommendations which would apply to people presenting to primary care/ A&E with increased risk of suicide. There is little that is specific to custody, except where it seems they have been added as an afterthought and few of the community ones would apply to a custodial setting.	Thank you for your comment. The section on media campaigns has been removed and the committee have included people working in primary care and A&E among those who should be offered training. The committee agree and have placed more emphasis on recommendations for residential custodial and detention settings.
Royal College of Psychiatrists	Full	9	34	We support the highlighting of painkiller prescriptions as an increasingly recognised contributor to suicide	Thank you for your comment.
Royal College of Psychiatrists	Full	10	12	The recommendation "Ensure suicide awareness and prevention training is provided for people who work with high-risk groups" is not followed or supported by saying who these people are, how they are identified and how training can be delivered. In relation to custody, there is no reference to the effectiveness of the prison	Thank you for your comment. The committee have stated the people in high risk groups and have identified people who should be offered training. They may include: health and social care practitioners, criminal justice and detention settings staff, police and emergency services, people who provide a paid or voluntary service for the public, faith leaders, railway and underground station staff and staff in educational institutions. In relation to ACCT, the committee have included the following recommendation "1.3.3 Assess suicide and self-harm prevention procedures (for example, HM Prison and Probation Service's Assessment Care in Custody and Teamwork and

				system of suicide prevention (ACCT), the need for mental health awareness training for prison officers, Listeners etc. and how to achieve this.	Assessment care-planning system, and Home Office's Assessment Care in Detention and Teamwork case management systems). Act on the findings."
Royal College of Psychiatrists	Full	13		It is good that the document recognises that anyone in contact with someone else's completed suicide is likely to be traumatised by it and need help. The (admittedly sparse) evidence base suggests, however, that while such people, including prisoners, may be at some increased risk of suicide related behaviours in relation to family members, the greater risk otherwise may be among those people who are associating with someone who has survived a serious suicide attempt (e.g. see Hales et al,Journal of Adolescence 26 (2003) 667–685).	Thank you for your comment. We have the following text included in the terms used in t guideline for those at high suicide risk "family and friends of those who have died by suicide" Thank you for providing the reference. However we have not included the reference as we did not have a review question on groups at risk of suicide. We will pass your comment and reference to the surveillance team at NICE.
Royal College of Psychiatrists	Full	13	18	While focus is put on young and middle aged men, it's worth noting that the statistics used by the ONS discounted the fact that overall and in men, the highest rates of suicide were in the elderly above the age of 70 and 85 in males, due to low numbers. The interpretation of this data is baffling considering that leaving the UK aside, the evidence worldwide provided by the World health organisation and in countries with larger populations such as the USA, categorically states and has for years that "With regards to age, suicide rates are highest in persons aged 70 years or over for both men and women in almost all regions of the world" (WHO 2015). In the USA, the highest suicide rates in 2015 were in those aged 65 – 84, followed by those aged over 85 years and then those aged 25 -44. With this evidenced based trend, it's hard to understand how the ONS can discount suicide rates in Wales of over 85's that is one and a half times higher than the highest other category, or the rate above 85 and 90 years of age in England that is higher than any other category. If the ONS statistics are grouped to reflect occupational/life stages and transitions, the rates would look like this: Adults Aged 65 years and above = 84.3 per 100,000 Adults of retirement age from 60 years and above 98.7 Younger working adults of age 20 - 39 = 70.4 Mature working adults of age 40 - 59 = 89.	Thank you for your comment. The committee agreed to focus on "young and middle-aged men" as the example of a population group at high suicide risk. By adding various different age groups, there is the risk of distracting the attention away from any single particular age grouping.
Royal College of Psychiatrists	Full	15		Specialist bereavement services for people affected by a suicide seem like a good idea – but if they are to be set up, they will also need to be described from the best evidence base currently available, and then to be research-evaluated.	Thank you for your comment.
Royal College of Psychiatrists	Full	16	3	We know already that the cuts in prison officer staffing since around 2012 have paralleled unprecedented rises in all cause mortality, self-harm and violence to others in prisons. Research should not be used as a way of procrastinating on restoring safe staffing numbers and competencies.	Thank you for your comment.
Royal College of Psychiatrists	Full	16	6	The concept of 'gatekeeper training' is bureaucracy speak and not helpful. Insofar as this is not covered in the other NICE documents on suicide prevention, we need to know who needs training for what – furthermore effectiveness of training can only be evaluated on that basis.	Thank you for your comment. We have included a definition for gatekeepers in our 'terms used in the guideline' section. It is up to individual services or organisations to decide how needs training and the NICE guideline is not in a position to do this.
Royal College of Psychiatrists	Full	16	26	Given the recognition of prescribed painkillers in suicide, the Faculty of Liaison Psychiatry recommends an additional high risk group on 'people with long term physical health conditions, especially chronic pain'. Ideally this would be broken into two groups – long term physical health conditions, and chronic pain. A few references to the link of suicide and physical health are Psychological medicine (2015) 45(3):495-504. Risk of suicide and suicide attempts associated with physical disorders: a population-based, balancing score-matched analysis. J. M. Bolton, R. Walld, D. Chateau, G. Finlayson.Medicine (1994) 73(6):281-298. Suicide as an outcome for medical disorders. E.C Harris & B.M.Barraclough.	Thank you for your comment. We have included people with physical illness in the groups at high suicide risk. We have not differentiated between the subgroups suggested as we did not have a review question on groups at risk of suicide. We will pass your comment and references to the surveillance team at NICE.

Royal Pharmaceutical Society	Short version	8	10	This is the first time that suicide is explicitly stated that it is preventable in the guideline. It would be helpful to state this at the outset of the guidance.	Thank you for your comment. The following recommendation includes a bullet point stating that suicide is preventable "1.1.1 Ensure the partnership has clear terms of reference, based on a shared understanding that suicide can be prevented."
Royal Pharmaceutical Society	Short version	9	22,23,24	It would be helpful to include more explicit link to what national guidelines NICE is referring to. See comment below but also NHS England has recently released guidance on items which should not be routinely prescribed in primary care. Substances included in this (e.g. Co-proxamol and Dosulepin [A NICE “do not do”] are implicated in overdose death data from the ONS)	Thank you for your comment. The recommendation has now been amended as follows and includes a link to the relevant documents "1.6.2 Ensure local compliance with national guidance to reduce access to methods of suicide: • In custodial settings, for example, provide safer cells (see the Ministry of Justice's Quick-time learning bulletin: safer cells). • In the community, for example, restrict access to painkillers (see NHS England's Items which should not be routinely prescribed in primary care: guidance for CCGs, Medicines and Healthcare products Regulatory Agency's Best practice guidance on the sale of medicines for pain relief and Faculty of Pain Medicine's Opioids Aware).”
Royal Pharmaceutical Society	Short version	9	22,23,24	Evidence review 6 highlights the success of restricting paracetamol and highlights two ways of tackling this “medication management could 302 prevent self-poisoning by reduced package size of paracetamol at a population level and/or 303 monitoring repeat prescriptions at an individual level.” Does the committee think it would be appropriate for the NHS to monitor this in a systematic manner?	Thank you for your comment. The committee consider this to be an important issue and have drafted the following recommendation "1.6.2 Ensure local compliance with national guidance to reduce access to methods of suicide: • In custodial settings, for example, provide safer cells (see the Ministry of Justice's Quick-time learning bulletin: safer cells). • In the community, for example, restrict access to painkillers (see NHS England's Items which should not be routinely prescribed in primary care: guidance for CCGs, Medicines and Healthcare products Regulatory Agency's Best practice guidance on the sale of medicines for pain relief and Faculty of Pain Medicine's Opioids Aware).”
Royal Pharmaceutical Society	Short version	9	22,23,24	It may be helpful to highlight that particular professions in healthcare services may have routine access to means i.e. medicines as one of the main target groups of NICE guidelines are healthcare professionals. Recommendation 1.7.2 does refer to “occupational groups with high risk of suicide”. It is covered on page 14 but an example here might be assist readers.	Thank you for your comment. These professions are included in the following recommendation "1.6.3 Reduce the opportunity for suicide in locations where suicide is more likely for example, by erecting physical barriers." The definition for 'locations where suicide is more likely' in the terms used in this guideline section includes the settings in which such professionals would work. The committee also noted in the discussion section for the evidence review that there was a gap in the evidence on restriction of access to means in settings where specific occupational groups have access to means for suicide such as doctors, nurses, veterinary workers, and farmers.
Royal Pharmaceutical Society	Short version	9	22,23,24	NICE CG16 Recommendations 1.2.1.12 – 1.2.14 have recommendations on reducing access to means, Service users at risk of self-poisoning in primary care. Could the committee consider referencing this in relation to suicides where the means has been obtained from healthcare services?	Thank you for your comment. This guidance is referenced in 'Finding more information and resources' section of the guideline.
Royal Pharmaceutical Society	Short version	10	12	Certain groups such as healthcare professionals have access to powerful medications as means. It might be helpful to give as examples in the main body of recommendation although it is covered on page 14	Thank you for your comment. These professions are included in the following recommendation "1.6.3 Reduce the opportunity for suicide in locations where suicide is more likely for example, by erecting physical barriers." The definition for 'locations where suicide is more likely' in the terms used in this guideline section includes the settings in which such professionals would work. The committee also noted in the discussion section for the evidence review that there was a gap in the evidence on restriction of access to means in settings

					where specific occupational groups have access to means for suicide such as doctors, nurses, veterinary workers, and farmers.
Samaritans	Evidence Review 8			The following literature review on Suicide Prevention Media Campaigns (Pirkis et al, 2017) should be considered for inclusion in the evidence base: https://www.tandfonline.com/doi/abs/10.1080/10410236.2017.1405484?journalCode=hhth20	Thank you for your comment. This paper was published after our search date and therefore was not included in the evidence review. The recommendations on suicide campaign messages have been removed. The committee agreed that it was more appropriate for suicide prevention campaigns to run at a national level and focus on activities to raise awareness of suicide at a local level.
Samaritans	Evidence reviews – research recommendations	General	General	We are concerned that the research recommendations state under the "timeframe" section that "studies would require sufficient follow up time to capture changes in suicide rates (ideally 12 months)". Three-year rolling averages are typically used for the monitoring of suicide rates by researchers and government agencies in order to identify trends in rates and avoid drawing conclusions from individual year on year fluctuations. A longer timeframe is therefore likely to be required in order to accurately capture changes in suicide rates. Any assessment within a 12-month timeframe would need to look more closely at measures based on the "secondary outcomes" identified by the research recommendations such as service uptake or changes in knowledge/attitude of practitioners.	Thank you for your comment. We have now removed "ideally 12 months" from research recommendations.
Samaritans	Draft guideline	5	Sep-26	This section could be made clearer by breaking it into separate sections. It currently combines a) how to develop a strategy (e.g. engage stakeholders, map stakeholders and activities – lines 12-13), b) what the partnership should do after a strategy has been produced (e.g. oversee local suicide prevention activities – lines 14-16) and c) what a strategy should include (e.g. work with transport companies and the media – lines 21-26).	Thank you for your comment. The committee have now revised this section to make it clearer.
Samaritans	Draft guideline	5	11	We support the emphasis in the draft guidelines on clarity of leadership over local multi-agency partnerships. Evidence heard by the APPG for Suicide and Self-harm Prevention inquiry into local suicide prevention plans indicated that local leadership was crucial in ensuring the long-term survival of multi-agency partnerships. In addition to clear leadership of the group itself, buy-in from senior management of the local authority, CCGs and other relevant agencies is also valuable. This should include oversight from local Health and Wellbeing Boards which can help to build local cross-agency engagement in local suicide prevention work at a senior level as well as serving as a useful scrutiny function. The guideline should recommend that local multi-agency partnerships receive oversight from local Health & Wellbeing Boards.	Thank you for your comment. We have amended the following recommendation in the Suicide prevention partnerships section to reflect oversight from local Health and Wellbeing Boards as follows "1.1.2 Ensure the partnership has clear governance and accountability structures. Include oversight from local health and care planning groups for example, health and wellbeing boards."
Samaritans	Draft guideline	6	15 - 16	The guideline should point out that care should be taken when sharing information about suicide methods as such details can be potentially harmful to people who are vulnerable to suicide. While it is appropriate to share such information confidentially with stakeholders where it adds value to local suicide prevention work, unnecessary sharing or placing of information on suicide methods in the public domain should be avoided.	Thank you for your comment. We have amended the recommendation as follows "1.3.1 Share experience and knowledge between stakeholders. Also share data, subject to local information sharing agreements."
Samaritans	Draft guideline	8	16 - 17	It is not clear why there is a need to "take into account local trends, locations and methods" in the context of a general suicide awareness raising initiative and what purpose this would serve. As already mentioned in comment 7, the highlighting of suicide methods to the general public can be potentially harmful to people who are vulnerable to suicide.	Thank you for your comment. The committee agree with this comment and have now amended the recommendations in this section and included the Samaritans Media guidelines as an example "1.5.4 Ensure the language and content of any awareness-raising materials is: • appropriate for the target group • sensitive and compliant with media reporting guidelines, such as the Samaritans' Media guidelines for the reporting of suicide."

Samaritans	Draft guideline & Evidence review 8	8	13 - 14	Recommendation 1.5.2 – gives example that ’60 people may be affected by a suicide’. This research suggests that 135 people are exposed to a suicide (i.e. knew the person). · Cerel, J., Brown, M., Maple, M., Singleton, M., Van de Venne, J., Moore, M., Flaherty, C. (2018) How Many People Are Exposed to Suicide? Not Six. Suicide and Life-Threatening Behavior,https://doi.org/10.1111/sltb.12450 This research should be considered for addition to the guideline’s evidence base.	Thank you for your comment. This recommendation has been removed and the following information has been incorporated into recommendation 1.5.1 "Consider local activities to: • raise community awareness of the scale and impact of suicide and self-harm"
Samaritans	Draft guideline	8	5 TO 6	In addition to using sensitive language, general suicide awareness raising campaigns should ensure they don’t highlight methods of suicide which could be potentially harmful to people who are vulnerable to suicide. Campaigns should follow the general principles set out the Samaritans Media Guidelines, for example by being careful not to normalise, glorify or sensationalise suicide or self-harm. As mentioned in comment 4 above, a focus on stories of hope and recovery can be beneficial.	Thank you for your comment. The committee agree with this comment and have now amended the recommendations in this section and included the Samaritans Media guidelines as an example as follows "1.5.4 Ensure the language and content of any awareness-raising materials is: • appropriate for the target group • sensitive and compliant with media reporting guidelines, such as the Samaritans' Media guidelines for the reporting of suicide."
Samaritans	Draft guideline	9	13 - 14	This sentence is slightly unclear. Perhaps this should say “existing national suicide prevention campaigns” rather than “existing national suicide prevention programmes” if it relates specifically to campaigning activity? Also, the guideline could recommend that those developing new campaign initiatives join/get in touch with the National Suicide Prevention Alliance (NSPA) as many of its members are already involving in campaigning work in this area. This could help to improve coordination of campaigning activity and prevent unnecessary duplication of work.	Thank you for your comment. The recommendations on suicide campaign messages have been removed. The committee agreed that it was more appropriate for suicide prevention campaigns to run at a national level and focus on activities to raise awareness of suicide at a local level.
Samaritans	Draft guideline	9	2 – 12	This section could add that the campaign messages should be monitored and evaluated so that changes can be made during the campaign if necessary. Campaigns should also be evaluated at the end of the campaign period based on clear outcomes that it was intended to achieve at the outset (e.g. behaviour change, increased access to services, etc rather than just raised awareness). Future campaigns can then be developed or repeatedly based on evidence of effectiveness. There is no mention of the use of social media in this section, the committee should consider including this.	Thank you for your comment. The recommendations on suicide campaign messages have been removed. The committee agreed that it was more appropriate for suicide prevention campaigns to run at a national level and focus on activities to raise awareness of suicide at a local level. In the committee discussion of the evidence review "the committee noted the emergence of social media in awareness campaigns but no evidence was identified in the review."
Samaritans	Draft guideline & Evidence review 3	11	19 - 24	The following research found that historical clusters predict 36% of subsequent clusters and highlights the need for other strategies to detect emerging clusters, for example up-to-date data. This supports recommendation 1.8.5 to ‘Use information from the action plan and rapid intelligence gathering to identify potential clusters’. · Too, L. S., Pirkis, J., Milner, A., Robinson, J., & Spittal, M. (2018) Clusters of Suicidal Events Among Young People: Do Clusters from One Time Period Predict Later Clusters? Suicide and Life-Threatening Behavior, https://DOI: 10.1111/sltb.12460 This research should be considered for addition to the guideline’s evidence base.	Thank you for your comment. This research was published after the time period within the searches were undertaken. The recommendation will not change following this research however we have included the following information into the discussion section of evidence review 3 on suicide clusters "In addition, it has been found that historical clusters predict 36% of subsequent clusters and highlights the need for other strategies to detect emerging clusters, for example up-to-date data (Too L et al 2018)" We will also forward it to the surveillance team for consideration for future updates.
Samaritans	Draft guideline	11	15 - 18	We agree with the need to provide support to people bereaved by suicide but think that this section could be stronger and should recommend that support is proactively offered to people bereaved by suicide rather than just considered. Also, when providing support services to people bereaved by suicide the guidance provided by Public Health England in partnership with the National Suicide Prevention Alliance should be followed:http://www.nspa.org.uk/home/our-work/joint-work/support-after-a-suicide-providing-local-services/	Thank you for your comment. We have amended the following recommendation " 1.8.2 Offer those who are bereaved or affected by a suspected suicide practical information expressed in a sensitive way, such as Public Health England's Help is at hand guide. (This also signposts to other services.) Ask them if they need more help and, if so, offer them tailored support.”

Samaritans	Draft guideline	11	3	This section could benefit by adding some details on the importance of "postvention" initiatives, particularly in settings that involve young people such as schools and colleges. Services like the Samaritans 'Step by Step' programme provides advice and support to school leadership teams to ensure that schools can develop a postvention plan which they can activate in the event of a suicide taking place within the school community. Further details are available at:https://www.samaritans.org/your-community/samaritans-education/step-step	Thank you for your comment. We have included hyperlinks to the Help is at Hand guide and National Suicide Prevention Alliance resources on Support after a suicide-providing local services as examples of support that can be provided.
Samaritans	Draft guideline	14	1 – 5	In addition to the Public Health England resources, the guideline could also refer to the Samaritans partnership programme with Network Rail and the wider rail industry to prevent suicide on the rail network. Network Rail and Samaritans work with local multi-agency partnerships in many local authority areas where there are key rail stations. Further information about this work is available at:https://www.samaritans.org/for-business/rail-industry-suicide-prevention-programme	Thank you for your comment. We have added "railways" to locations where suicide is more likely. This list provides examples of locations where suicide is more likely. The reference provided is specific for railways and does not provide a list of locations where suicide is more likely, therefore it would not be relevant to reference.
Samaritans	Draft guideline	5 12	23 - 26 10 – 28	In recommending that the local multi-agency partnership should develop a clear plan for liaising with the media, it would also be useful to point out that consulting with Samaritans over any specific concerns regarding local media reporting of suicide can often be beneficial. With over 20 years of experience in this field, Samaritans is recognised as the leading expert in the UK on media guidelines work for suicide prevention. We are disappointed that our expert testimony was not sought in the development of this guideline. In addition to the Samaritans Media Guidelines referred to in lines 23-24, Samaritans also provides a media advisory service, providing training to various media outlets (45 sessions were delivered in 2017), monitoring over 6,000 news articles per year locally, regionally and nationally, following up articles of concern with editors, and providing advice and training to broadcasters and producers. Samaritans is happy to work with and advise local multi-agency partnerships when there are concerns about local media reporting. The draft guideline should refer to the advisory role that Samaritans can provide in supporting local agencies to deal with specific cases of local reporting that is causing concern, and anticipated concerns with upcoming cases. We are concerned that the recommendation to local partnerships to encourage training for journalists (page 12, lines 11-12) could be misinterpreted as guidance that they should be providing training themselves. This is a specialised area and should only be carried out by experts. It could also risk confusing/duplicating existing arrangements as training is already being provided nationally, for example through the large publishing houses (e.g. Samaritans is providing ongoing training for Johnston Press and Trinity Mirror groups). It would be a better use of expertise and resource to encourage multi-agency partnerships to focus on the messaging that they will provide media in the event of a suicide. Samaritans has previously worked with local multi-agency partnerships to agree messaging across emergency responders, health services, local authority and local voluntary agencies, in the event of a suicide at a high frequency location in the area. Therefore the recommendation for following national guidelines when engaging with the media to report suicides (page 12, line 15) should apply to all stakeholders, not just those in custodial and detention settings.	Thank you for your comment. We have moved this recommendation to the "Suicide prevention action plans" section of the guideline and referenced the Samaritans Media guidelines in the recommendation as follows "1.3.2 Build relationships with the media (including social media, broadcasting and newspapers) to promote best practice when reporting suicides or suspected suicides. (See section 1.10)" We have removed the recommendation regarding encouraging training for journalists. We have added a new recommendation for community and settings that promotes guidance on best practice for media reporting of suicide "1.10.2 For community settings, promote guidance on best practice for media reporting of suicide (including social media). Include the need to: • use sensitive language that is not stigmatising or in any other way distressing to people who have been affected • reduce speculative reporting • avoid presenting detail on methods. See: the World Health Organization's Preventing suicide: a resource for media professionals; the Samaritans' Media guidelines for reporting suicide; OFCOM's Broadcasting code and the Independent Press Standards Organisation (IPSO)." The committee have amended the following recommendation to remove "the effect of" and have added an additional statement to take advice from the Samaritans' media team **"**1.10.4 Monitor media coverage of suspected suicides locally. If necessary, provide feedback to the journalist or editor in relation to their reporting (see 'Media guidelines for reporting suicide')."

				Local organisations have an important role to play in providing local and regional media with positive stories of hope and recovery. Research shows that these helpful stories can support suicide prevention efforts. Examples include positive case studies demonstrating the value of seeking help to aid recovery from a suicidal crisis, and highlighting valuable support services within local communities. This should be included in the guidance. https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/role-of-media-reports-in-completed-and-prevented-suicide-werther-v-papageno-effects/DFF62CAE7A44147EE9CAB4DFB50B49F0 In lines 26-28, we recommend removing “providing feedback to the reporter on the effect of their reporting”. This could lead to multiple contacts with journalists around reporting that is not actually based on evidence of risk. We recommend changing this to “and, if there are concerns, contact Samaritans’ media advisory service who can provide support and advice and can follow up with any publications that are reporting irresponsibly.” In addition, it would be helpful to include “If local partnerships are concerned about an upcoming inquest where there was problematic reporting of the death, there is a potential cluster situation, or a new/emerging suicide method, partnerships are advised to contact Samaritans media advisory service who regularly provide confidential briefings to media and support to coroners in this area.” Samaritans can, if required, provide detailed evidence to the committee on how our media advisory service and guidance has influenced the significant improvement in news reporting of suicide over the last decade.	
Samaritans	Draft guideline	28	21-22	It is important to recognise that all key staff across various agencies are aware of the risks of putting potentially harmful information about suicide incidents into the public domain, including via social media, as this could be read by vulnerable individuals or quoted and further disseminated by media outlets.	Thank you for your comment. This is acknowledged in the following recommendation "1.10.2 For community settings, promote guidance on best practice for media reporting of suicide (including social media). Include the need to: • use sensitive language that is not stigmatising or in any other way distressing to people who have been affected • reduce speculative reporting • avoid presenting detail on methods. See: the World Health Organization's Preventing suicide: a resource for media professionals; the Samaritans' Media guidelines for reporting suicide; OFCOM's Broadcasting code and the Independent Press Standards Organisation (IPSO)."
Samaritans	Draft guideline	28	21-22	It is important to recognise that all key staff across various agencies are aware of the risks of putting potentially harmful information about suicide incidents into the public domain, including via social media, as this could be read by vulnerable individuals or quoted and further disseminated by media outlets.	Thank you for your comment. This is acknowledged in the following recommendation "1.10.2 For community settings, promote guidance on best practice for media reporting of suicide (including social media). Include the need to: • use sensitive language that is not stigmatising or in any other way distressing to people who have been affected • reduce speculative reporting • avoid presenting detail on methods. See: the World Health Organization's Preventing suicide: a resource for media professionals; the Samaritans' Media guidelines for reporting suicide; OFCOM's Broadcasting code and the Independent Press Standards Organisation (IPSO)."
Samaritans	Draft guideline	8 (and 24)	2	Section 1.5 concerns general suicide awareness raising which we welcome but we also feel that this misses an opportunity to raise awareness about self-harm to encourage help seeking behaviour.	Thank you for your comment. The committee agree and the recommendation in this section now includes "suicide and self-harm".

			(and 16 - 18)	The Department of Health's Third progress report of the national suicide prevention strategy, published in 2017, expanded the strategy to include self-harm prevention as an additional area for action in its own right as self-harm is a key indicator of suicide risk.https://www.gov.uk/government/publications/suicide-prevention-third-annual-report Although we recognise that self-harm is covered separately by NICE Guidelines CG16 and CG133, these largely address the treatment of people have already come into contact with services. The Department of Health stated in 2016 that there are at least 200,000 general hospital presentation for self-harm per year but that "this represents only a small proportion of self-harming in the community". Since so many people who self-harm do not seek medical help, attention must be given to how to reach this group in order to encourage help seeking. Samaritans believes more needs to be done break down the stigma associated with self-harm, to raise awareness throughout local communities about self-harm and the support that is available. According to the draft guideline the committee agreed that "awareness-raising activities and messages, tailored to people's needs and circumstances, can get rid of common misconceptions surrounding suicide and let people know where they can go for help." On that basis we feel that the same principle could also be applied to awareness-raising activities around self-harm to increase the number of people seeking help from services. The draft guideline's section on awareness raising should include self-harm as well as suicide.	
South West London and St. George's Mental Health Trust	Short Version	4	19	We are concerned that this recommendation does not include forensic healthcare settings. Suicide also happens in high secure, medium secure and low secure healthcare settings. There needs to be shared learning across these settings with prison and detention settings.	Thank you for your comment. The committee considered forensic healthcare settings are part of secondary care and therefore outside of scope for this guideline.
Suicide Bereaved Network	Draft Feb '18	11	15,16	We recognise the value of providing peer support by trained people for those bereaved by suicide, but currently there are problems with its accessibility and availability. Peer support can take the form of 'open' or 'closed' support groups, telephone helplines, online forums or one-to-one befriending. We need more research into the dynamics and challenges of these different types of peer support. Furthermore, we need to develop robust standards, including methods of assessment and evaluation, to ensure that those bereaved by suicide receive the best possible support.	Thank you for your comment. The committee agree that it is covered in the following recommendation " 1.8.2 Offer those who are bereaved or affected by a suspected suicide practical information expressed in a sensitive way, such as Public Health England's Help is at hand guide. (This also signposts to other services.) Ask them if they need more help and, if so, offer them tailored support."
Suicide Bereaved Network	Draft	11	17,18	We recognise that people bereaved by suicide may need ongoing support, but that their needs will change with time. It may be necessary to develop different levels of support for the different stages of bereavement.	Thank you for your comment. The committee have reworded the following recommendation to cover this " 1.8.2 Offer those who are bereaved or affected by a suspected suicide practical information expressed in a sensitive way, such as Public Health England's Help is at hand guide. (This also signposts to other services.) Ask them if they need more help and, if so, offer them tailored support."
The National LGB&T Partnership	Equality Impact Assessment	2	general	It is positive that the Impact Assessment recognises that LGBT young people experience social isolation, however this should not be restricted to only young people. It is welcome that the guidance and impact assessment refers to LGBT people as a high-risk group. However, we believe specific recommendations on	Thank you for your comment. We have removed "young" from the Equality Impact Assessment form. We have also included this group in the list of those at "high suicide risk" and used this term throughout the guideline.

				equality issues should be mentioned in the guidance to ensure such communities' needs are addressed.	
The National LGB&T Partnership	Full	4	14	Representatives should be sought specifically from voluntary and third-sector organisations who work with communities that share protected characteristics, especially high-risk groups, such as LGBT people.	Thank you for your comment. We have amended the recommendation as follows "1.1.3 voluntary and other third-sector organisations, including those used by people in high-risk groups"
The National LGB&T Partnership	Full	5	9	Multi-agency partnerships should develop suicide prevention strategies for high-risk groups, for example LGBT communities, which should cover a range of settings, including schools, workplaces, housing and support settings.	Thank you for your comment. The committee agree and developed the following recommendation to ensure that high-risk groups are at the forefront of suicide prevention activities "1.3.1 Prioritise actions based on the joint strategic needs assessment and other local data to ensure the plan is tailored to local needs."
The National LGB&T Partnership	Full	5	23	Specific media campaigns may be necessary to reach communities that share protected characteristics, especially high-risk groups, such as LGBT people.	Thank you for your comment. The committee agree with this comment however after discussion the committee removed the recommendation section on campaigns as they decided that guidance on this area is more appropriate to come from a national level. Recommendations on groups at "high suicide risk" including LGBT, are included in the awareness section of the guideline.
The National LGB&T Partnership	Full	6	12	Action Plans should be based on data that is analysed across protected characteristics to identify trends, especially for high-risk groups, e.g. LGBT communities. The suggestion to do so on line 14 page 7 may not be seen as routine.	Thank you for your comment. We have amended the recommendation as follows to include groups at high suicide risk "1.3.1 Interpret data to determine local patterns of suicide and self-harm, particularly among groups at high suicide risk (see section 1.4). " "High suicide risk" is defined in the "terms used in our guideline" section.
The National LGB&T Partnership	Full	8	18	Awareness training should also include training on equality issues especially since people with protected characteristics, e.g. LGBT people, can be at higher risk.	Thank you for your comment. The committee have drafted the following recommendation to cover this "1.7.2 Offer training to organisations employing, working with or representing groups at high suicide risk."
The National LGB&T Partnership	Full	9	5	People in crisis should also be encouraged to use support groups that work with specific equality groups, which may be local.	Thank you for your comment. The recommendations on suicide campaign messages have been removed. The committee agreed that it was more appropriate for suicide prevention campaigns to run at a national level and focus on activities to raise awareness of suicide at a local level.
The National LGB&T Partnership	Full	9	8	Campaigns should also be prominent in housing and support locations, as well as LGBT commercial venues.	Thank you for your comment. The recommendations on suicide campaign messages have been removed. The committee agreed that it was more appropriate for suicide prevention campaigns to run at a national level and focus on activities to raise awareness of suicide at a local level.
The National LGB&T Partnership	Full	11	8	Community advocates may also be affected, these should be mentioned specifically because some may assume they are not professionals.	Thank you for your comment. The committee that many different groups of people may be affected but have not provided an exhaustive list.
The National LGB&T Partnership	Full	17	13	Representatives should be sought specifically from voluntary and third-sector organisations who work with communities that share protected characteristics, especially high-risk groups, such as LGBT people.	Thank you for your comment. The committee acknowledge that there are a range of voluntary and third-sector organisations, including those who work with communities that share protected characteristics, and these organisations should be considered under the umbrella term "voluntary and third-sector organisations."
The National LGB&T Partnership	Full	19	9	Specific media campaigns may be necessary to reach communities that share protected characteristics, especially high-risk groups, such as LGBT people.	Thank you for your comment. The committee agree with this, however after discussion the committee removed the recommendation section on campaigns as they decided that guidance on this area is more appropriate to come from a national level. Recommendations on groups at "high suicide risk" including LBGT, are included in the awareness section of the guideline.

The National LGB&T Partnership	Full	20	8	Action Plans should be based on data that is analysed across protected characteristics to identify trends, especially for high-risk groups, e.g. LGBT communities. The suggestion to do so on line 22 page 21 may not be seen as routine.	Thank you for your comment. We have amended the recommendation as follows to include groups at high suicide risk "1.3.1 Interpret data to determine local patterns of suicide and self-harm, particularly among groups at high suicide risk (see section 1.4)" In addition, "High suicide risk" is defined in the "terms used in our guideline" section.
The National LGB&T Partnership	Full	23	14	Awareness training should also include training on equality issues especially since people with protected characteristics, e.g. LGBT people, can be at higher risk.	Thank you for your comment. The committee have amended the recommendation as follows "Take into account socioeconomic deprivation, mental health status cultural, religious, and social norms about suicide and help-seeking behaviour particularly those in groups at high suicide risk".
University of Exeter	Draft guideline	1	5	It may be useful to provide a definition of “community and custodial settings.”	Thank you for your comment. We have added this to the section of the guideline 'Who is this for.'
University of Exeter	Evidence Review 2	4	D.2.2	Should read: Owens et al, 2014	Thank you for your comment. We have now amended this reference.
University of Exeter	Draft guideline	5	10	A primary goal of a local strategy is to set out how the national suicide prevention strategy will be delivered locally. This should be included in the bulleted list.	Thank you for your comment. We have added the following recommendation to ensure consistency between local and national strategies. "1.2.4 Review local and national data on suicide and self-harm to ensure the strategy is as effective as possible."
University of Exeter	Draft guideline	5	21	“Work with transport companies to…” - This is too specific an action to be included under strategy.	Thank you for your comment. We have moved this to the action plan section and it is included in the bullet point as follows "1.3.2 Promote evidence-based best practice with rail, tram and underground train companies."
University of Exeter	Draft guideline	5	21	We do not know what “best practice” with regard to announcing delays on the transport network is. There is no currently no evidence base; opinion and practice on the railway network is constantly changing.	Thank you for your comment. This was discussed with the committee and although there is no recognised best practice, what we do should be informed by evidence. The committee are aware of ongoing research conducted by Network Rail and best practice will be informed by this. We have amended the recommendation to reflect this as follows "1.3.2 Promote evidence-based best practice with rail, tram and underground train companies."
University of Exeter	Draft guideline	6	Dec-13	This item is misplaced. Collection and analysis of data is not part of an action plan. It is a separate exercise (see 1.4) that should precede and underpin the development of an action plan. The plan itself should set out precisely what actions will be taken, based on identified local priorities and needs.	Thank you for your comment. This has been removed and moved to section 1.4 Gathering and analysing suicide-related information.
University of Exeter	Draft guideline	6	18 and 21	The term ‘audit’ is misused here, resulting in tautology. Audit signifies the collection and analysis of data.	Thank you for your comment. This recommendation has now been amended as follows "1.3.1 Review the action plan at a time agreed at the outset by the multiagency partnership"
University of Exeter	Draft guideline	7	1	Section 1.4 should precede 1.3 so that collection and analysis of data and other intelligence can inform the development of the action plan.	Thank you for your comment. The committee agreed to keep the current format of the guideline as the collection and analysis of the data (section 1.4) can be used to revise and update the action plans (section 1.3).
University of Exeter	Draft guideline	7	9	This is the correct use of the term audit.	Thank you for your comment.
University of Exeter	Draft guideline	9	1	Are these recommendations for local multi-agency partnerships? If so, I would question the appropriateness of encouraging local groups to design and mount their own campaigns, especially in view of the caution given on p. 16, line 18 that “there can be a fine line between helpful or potentially harmful messages.” This	Thank you for your comment. The committee have amended the section heading for clarity, as follows "1.5 Awareness raising by suicide prevention partnerships"

				may be best left to those with knowledge of the best available research evidence and health communication specialists.	
University of Exeter	Draft guideline	9	3	They should be developed and tested with the help of people from the target audience, recognising that there are a number of different target audiences, who may require different kinds of advice/messages. These include: people who are feeling suicidal; concerned family members and friends, and those who may encounter suicidal individuals in the course of their work or daily activities, such as commuting (i.e. concerned strangers).	Thank you for your comment. The recommendations on suicide campaign messages have been removed. The committee agreed that it was more appropriate for suicide prevention campaigns to run at a national level and focus on activities to raise awareness of suicide at a local level. We acknowledge that there are a number of different target audiences and therefore we have added distinct recommendations for the residential custodial and detentions multi-agency partnership and included the following recommendation **“**1.7.4 Ensure suicide awareness and prevention training helps people to: •understand local suicide incidence and its impact, and know what support services are available •encourage others to talk openly about suicidal thoughts and to seek help (this includes providing details of where they can get this help) take into account socioeconomic deprivation, disability, physical and mental health status, and cultural, religious and social norms about suicide and help-seeking behaviour, particularly among groups at high suicide risk.”
University of Exeter	Draft guideline	9	2 to 3	The first requirement for suicide prevention campaign messages is that they are evidence-based, as far as possible. This includes evidence from qualitative research.	Thank you for your comment. The recommendations on suicide campaign messages have been removed. The committee agreed that it was more appropriate for suicide prevention campaigns to run at a national level and focus on activities to raise awareness of suicide at a local level.
University of Exeter	Draft guideline	9	14	Hyperlink to the committee’s discussion is missing	Thank you for your comment. We have amended this as suggested and hyperlinked to the rationale and impact section
University of Exeter	Draft guideline	10	2	See comment above. The relevant reference here is Public Health England’s Preventing suicides in public places: A practice resource (not Local suicide prevention plans)	Thank you for your comment. This reference has been amended as suggested.
University of Exeter	Draft guideline	10	1, 4 and 13	The term ‘places where suicide is more likely’ is not a recognised term and is confusing. It potentially encompasses: a) public sites that may be used for suicide, e.g. bridges and high buildings (see Public Health England’s Preventing suicides in public places: A practice resource); b) residential settings housing high-risk populations, e.g. custodial settings; c) occupational settings that offer access to means of suicide to specific occupational groups, e.g. medical professionals, vets and agricultural workers (see p. 14, line 3-4). These are distinct types of place, requiring different approaches, and should not be muddled. If the issue here is public sites that may be used for suicide then that term should be used, as per the PHE guidance. Consistent use of terminology is important to aid clarity.	Thank you for your comment. The committee have changed this to 'locations where suicide is more likely.' The committee have drafted recommendations for different settings, for example, use of safer cells in residential custodial and detention settings.
University of Exeter	Draft guideline	5 to 7	general	Sections 1.2, 1.3 and 1.4 are muddled. No clear distinction is made between strategy, action plan and data gathering in terms of their core functions. These should be more clearly differentiated and any duplication of content avoided.	Thank you for your comment. The committee have now restructured the sections of the guideline to make it clear who is involved in the partnership, what strategies the partnership should develop and actions the partnership should undertake.
University of Exeter	Draft guideline	14	1 to 5	See comment above. This should deal with public sites that may be used for suicide. Other types of setting (e.g. residential and occupational) requiring different approaches should be dealt with elsewhere.	Thank you for your comment. This has been changed to 'locations where suicide is more likely'. It is implicit that the definition is for public places and this is reinforced by the cross referral to Public Health England practice resource ‘Preventing suicides in public places’ For this guideline, the committee are unable to make recommendations orresidential settings as they cannot legislate what happens in a person’s home . The committee have drafted various recommendations for residential custodial

					and detention settings as well as the following recommendation for occupational locations "1.5.6 Consider encouraging employers to develop policies to raise suicide awareness and provide support after a suspected suicide. For example, see Public Health England and Business in the Community's toolkits."
University of Exeter	Draft guideline	14	7	Suggested clarification: "The process of collecting information in real time, as opposed to retrospectively, in order to inform timely response."	Thank you for your comment. This term has been removed from the terms used in this guideline section and incorporated into the recommendation as follows "rapid intelligence gathering (continuous and timely collection of data)"
University of Exeter	Draft guideline	15	2 to 3	This question is based on a limited and arguably unrealistic view of outcomes. It is highly unlikely that any single intervention will be shown to reduce the rate of suicide. It may be more appropriate to encourage realist approaches that focus on understanding mechanisms of action and pose the question: What works for whom, how and in what contexts?	Thank you for your comment. This has been amended as follows "How effective and cost effective are non-clinical interventions to reduce suicidal behaviours?" Please note that there is further detail in terms of PICO in evidence review 4.
University of Exeter	Draft guideline	15	4 to 11	The committee should also consider interventions designed to support concerned family members and friends.	Thank you for your comment. The committee have included the following text in the rationale and impact section for section 1.7 "The committee agreed that it may be effective to train a range of people involved with both the public ". Please note that this section 'Why this is important' has been removed.
University of Exeter	Draft guideline	22	10	Should read: "… overcome the shortcomings of each type of data."	Thank you for your comment. We have amended as suggested.
University of Exeter	Evidence Review 2	24	ER2	Owens et al 2009is the wrong reference. This should read Owens et al 2014 and give the full reference as follows: Owens C, Roberts S and Taylor J, 2014. Utility of local suicide data for informing local and national suicide prevention strategies. Public Health128(5):424-9.	Thank you for your comment. This has been amended as suggested.
University of Exeter	Draft guideline	25	16	Should read: "… methods often used and public sites that may be used for suicide" (see comment above).	Thank you for your comment. This has now been changed to "locations where suicide is more likely"
University of Exeter	Draft guideline	25	26	Should read: "… because they can sometimes give people time to stop and think…"	Thank you for your comment. This has been amended as suggested.
University of Exeter	Draft guideline	26	13	Should read: "… at public sites that may be used for suicide" (see comment above).	Thank you for your comment. This has been change to 'locations where suicide is more likely'
Washington Mind	Full	25	27	We are concerned that this recommendation may imply that 'staff' be present on road traffic bridges and cliff tops	Thank you for your comment. The committee agreed that interventions involving surveillance such as the installation of CCTV and the presence of staff at location where suicide is more likely, led to a reduction in the number of suicides. The committee suggested that such benefit was likely to be associated with increased vigilance at these locations and highlighted that an improvement in vigilance, of particular suicidal methods and locations would be crucial when preventing suicides. It should be noted that this is classed as a 'weak' recommendation as it is a consensus based recommendation.
Washington Mind	Full	26	12	Washington Mind provide a community approach training programme that enables our community to become 'gatekeepers' and would be willing to share our information with NICE. The training is offered to businesses, organisations, services and the general population. This training views the home, where the majority of suicides take place as a community setting.	Thank you for your comment. We have forwarded this to our System Engagement team.

**None of the stakeholders who comments on this clinical guideline have declared any links to the tobacco industry.*