1 Non-clinical interventions

How effective and cost effective are non-clinical interventions to reduce the rate of suicide?

Why this is important

Approximately 6,000 people take their own life each year in the UK. Many are not in contact with mental health services or GPs, so opportunities for clinical interventions are limited. Non-clinical interventions such as telephone or text helplines or volunteer-run face-to-face talking are important to support people with suicidal thoughts and keep them safe. There is increasing demand for non-clinical interventions but little evidence on the benefits. Research is needed to evaluate how effective they are.

Criterion	**Explanation**
Population	People in the community who are at risk of suicide
Intervention	Non-clinical interventions (for example, as provided by trained volunteers) delivered by telephone (via helpline) or face-to-face
Comparator	Usual care or no intervention
Outcomes	Primary outcomes to include suicide-related outcomes (Suicides, attempted suicides and suicidal ideation) Secondary outcomes, to include mental health (for example, self-rated depression), service use and costs
Study design	Study designs could include cluster RCTs or other types of evaluation with the purpose of ascertaining the effectiveness and cost-effectiveness of non-clinical interventions at reducing suicide rates (primary outcome). It will also be important to gain public and staff feedback as part of any study so a mixed methods approach to include qualitative elements may also be appropriate
Timeframe	Studies would require sufficient follow up time to capture changes in suicide rates (ideally 12 months)

2 Supporting people bereaved or affected by a suicide

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

Why this is important

The NHS does not provide a specialist bereavement service for people affected by suicide and many healthcare professionals, including GPs, do not know how to respond to this group. Some services have been developed locally to provide support. But because there is very little evidence on the benefits, local authorities are reluctant to commission such services. Research is needed to build an evidence base on these interventions. This can then be used as the basis for developing both statutory and voluntary services.

Criterion	**Explanation**
Population	People in the community who have been bereaved or affected by a suicide
Intervention	Specialist bereavement service (group and/or individual)
Comparator	Usual care or no intervention
Outcomes	Primary outcomes to include unresolved grief, isolation and mental health (for example, self-rated depression), Secondary outcomes to include service use and costs
Study design	Study designs could include cluster RCTs of a specialist bereavement service or other types of evaluation with the purpose of ascertaining the effectiveness of a specialist bereavement services at help with feelings of grief and loss. It will also be important to gain public and staff feedback as part of any study so a mixed methods approach to include qualitative elements may also be appropriate
Timeframe	Studies would require sufficient follow up time to capture changes in primary outcomes (ideally 6 months)

3 Prevention in custodial and detention settings

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

Why this is important

The number of people dying by suicide in custodial or other detention settings such as prisons, immigration detention centres, young offender institutions and police custody has increased over the past decade. But there is a lack of evidence on preventive interventions. More research is needed to evaluate the effectiveness of different interventions in a range of custodial settings.

Criterion	**Explanation**
Population	People in custodial or detention settings who are at risk of suicide
Intervention	Clinical or non-clinical interventions (for example, as provided by trained volunteers) delivered either in group or individual format
Comparator	Usual care or no intervention
Outcomes	Primary outcomes to include suicide-related outcomes (Suicides, attempted suicides and suicidal ideation) Secondary outcomes, to include mental health (for example, self-rated depression), service use and costs
Study design	Study designs could include cluster RCTs or other types of evaluation with the purpose of ascertaining the effectiveness and cost-effectiveness of clinical or non-clinical interventions at reducing suicide rates (primary outcome). It will also be important to gain public and staff feedback as part of any study so a mixed methods approach to include qualitative elements may also be appropriate
Timeframe	Studies would require sufficient follow up time to capture changes in suicide rates (ideally 12 months)

4 Training

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

Why this is important

The UK evidence base on the effectiveness of gatekeeper training is limited. There are few gatekeeper training programmes for people working with the public. Training for all gatekeepers is important because it may help to increase the number of people who seek help. But research is needed to evaluate how gatekeeper training can help people working with the public prevent suicide and reduce the stigma facing people with suicidal thoughts.

Criterion	**Explanation**
Population	People working with members of the public and in particular with people at high risk of suicide
Intervention	Gatekeeper training (to train people to identify the warning signs of a suicide crisis and how to respond)
Comparator	Usual care
Outcomes	Primary outcomes to include suicide-related outcomes (Suicides, attempted suicides and suicidal ideation) Secondary outcomes, to include mental health (for example, self-rated depression), service use and costs
Study design	Study designs could include cluster RCTs or other types of evaluation with the purpose of ascertaining the effectiveness and cost-effectiveness of clinical or non-clinical interventions at reducing suicide rates (primary outcome). It will also be important to gain public and staff feedback as part of any study so a mixed methods approach to include qualitative elements may also be appropriate
Timeframe	Studies would require sufficient follow up time to capture changes in suicide rates (ideally 12 months)

5 Suicide awareness campaigns

What is the effectiveness and cost effectiveness of targeted media campaigns in preventing suicide?

Why this is important

Suicide is preventable. What is the most appropriate form of public messaging on suicide is a key question because there can be a fine line between the helpful or potentially harmful messages. With high-profile national and local campaigns being rolled out, a universal approach to the awareness campaign may not have a direct positive impact. Research on the effectiveness of awareness campaigns on a targeted population is needed to further develop this evidence base.

Criterion	**Explanation**
Population	People in the community
Intervention	Media campaigns targeted at specific high-risk groups or high-frequency locations
Comparator	Usual care or no intervention
Outcomes	Primary outcomes to include suicide-related outcomes (Suicides, attempted suicides and suicidal ideation) Secondary outcomes, to include mental health (for example, self-rated depression), service use and costs
Study design	Study designs could include cluster RCTs or other types of evaluation with the purpose of ascertaining the effectiveness and cost-effectiveness of targeted media campaigns at reducing suicide rates (primary outcome). It will also be important to gain public and staff feedback as part of any study so a mixed methods approach to include qualitative elements may also be appropriate
Timeframe	Studies would require sufficient follow up time to capture changes in suicide rates (ideally 12 months)