Isle of Wight Suicide Awareness and Prevention Strategy 2014–2019

No Health Without Mental Health

It's everyone's business

My life a full life

NHS
Isle of Wight
Clinical Commissioning Group

Hampshire Constabulary

Isle of Wight Council

Isle of Wight NHS
NHS Trust

Contents

Foreword

On the Isle of Wight, when we lose a life to suicide, the pain and anguish felt by the families, friends and communities has a devastating effect. Suicide prevention is an important priority for the Island and we would like to share our appreciation to the bereaved families who have contributed to the development of this strategy.

There has been a lot of excellent work on the Island that has been designed to protect and support vulnerable individuals; the Self-harm Liaison Team, project Serenity, the NHS 111 Hub team, Samaritans, Mental Health First Aid Training are to name a few. However despite our best efforts the Emergency hospital admissions for self-harm (2011–12) was significantly worse than for England (312 per 100,000 compared to average for England of 207 per 100,000) and the number of open verdicts or suicides in 2011 was 13. Whilst this number appears relatively small compared to other regions, in relation to our population it is above average in England.

Whilst it is difficult to quantify the number of lives saved through our combined efforts, we do need to continue to evaluate the impact of the services and the positive outcomes achieved. In our changing environment it is important to think innovatively about how we can do things differently to reduce the number of suicides on the island.

Early intervention for positive mental health, improved access to recovery based services and reduced stigma and discrimination are undoubtedly part of the long term answers in particular for some of the groups in our communities that are at higher risk of suicide such as the unemployed, those with an existing mental illness, older people and people in contact with the criminal justice system.

There is no doubt that we face a difficult challenge to reduce the suicide rates across the Isle of Wight. It is therefore vital that we continue to work together to reduce the incidents of suicide and self-harm in our local communities. The health service alone cannot reduce all the associated causal factors and as highlighted in this strategy, it is action across government and all sectors that will improve the mental health and well-being on the Island and reduce the impact of risk factors and the number of lives lost to suicide.

The Health and Well-Being Board has agreed that all organisations on the Island should play a proactive role in delivering actions that raise the awareness of the risks of suicide and support and contribute to the work towards its prevention. It is important that we work in partnership across the voluntary, public and private sectors in order to make the greatest impact.

I would like to thank the many contributors to this strategy and their ongoing commitment to turn this strategy into actions that will help in reducing the number of suicides and increase the support for those bereaved or affected by suicide on the Isle of Wight.

Cllr Phil Jordan,
Executive Member for Public Protection
Isle of Wight Council

Dr John Rivers,
IoW CCG Executive Chair & Clinical Lead

Executive summary

The aim of this strategy and action plan is to provide a framework to:

- Improve the management of suicide prevention on the Isle of Wight.
- Focus local suicide prevention activity ensuring it is joined up, relevant, evidence based and sustained.

Suicide is a complex interplay between various risk factors and protective factors.

The two leading objectives for this strategy and action plan are to:

- **Reduce the suicide rate in the general population on the Isle of Wight.**
- **Increase support for those bereaved or affected by suicide.**

This strategy and action plan sits under the No Health Without Mental Health Strategy.

Recommendations for this strategy and action plan include the formation of a Suicide Prevention Group who will have responsibility to the Health and Well-being Board.

In England one person dies every 2 hours as a result of taking their own life. In 2010 4,215 people took their own life[1].

National and local data show that men are 3 times more likely to take their own lives than women. Men aged 35–49 are the group with the highest suicide rate.

On the Isle of Wight the indirectly standardised mortality rate for suicide and undermined injury 2010/11 is not significantly different to that for the average in England (a local value of 157 compared with 100. England best is 29)[2].

An audit by Public Health into suicides and open verdicts 2008–2011 found that:

- **In contrast to national suicide rates, which are increasing, on the Isle of Wight numbers fell from 18.8 per 100,000 in 2008 to 9.42 per 100,000 in 2011.**
- **77% of people who completed suicide were male and 23% female.**
- **The predominant age group for people who took their own lives was 45–59.**
- **The predominant method used was hanging.**

- **25% of people that had completed suicide had attempted suicide in the past.**

A study into the deaths of mental health service users on the Isle of Wight between January 2006 and December 2008[3] identified 51 Isle of Wight residents who chose to take their own lives, 68.6% of whom were local mental health service users (35 individuals, 10 women and 25 men).

Self-harm increases the likelihood that a person will eventually die by suicide by between 50 and 100 fold above the rest of the population in a 12-month period[4].

In England and Wales there are at least 200,000 general hospital presentations for self-harm (intentional self-poisoning or self-injury) per year[5].

On the Isle of Wight[6]:

- **Emergency hospital admissions for self-harm (2011–12) are significantly worse than for England (310 per 100,000 compared to the average for England of 207 per 100,000).**
- **Admissions caused by unintentional and deliberate injuries for under 18s (2009–10) are significantly worse than England (143 per 100,000 compared to 123 per 100,000).**
- **The indirectly standardised mortality rate for suicide and undetermined injury (2010–11) is not significantly different to England[7].**

Consultation

The development of this strategy and action plan was support by a 2-month consultation that consisted of:

- A workshop attended by 97 people.
- A questionnaire completed by 25 people.
- Conversations between the author and key strategic people.

Data collected by the Isle of Wight ambulance service shows a significant peak in paramedic responses to female deliberate self-harm between the ages of 16–20 and 41–45.

People at all stages within the criminal justice system, including people on remand and recently discharged from custody, are at high risk of suicide[8]. The three-year average annual rate of self-inflicted deaths by prisoners in England was 69 deaths per 100,000 prisoners in 2009–11[9].

Data collated by the Isle of Wight ambulance service indicates that between October 2010 and July 2013 paramedics attended 27 incidents of deliberate self-harm and 17 attempted suicides (as reported by paramedics at the time of the situation) at HMP Isle of Wight.

The consultation identified:

- A number of services that are working really well (IAPT, Mental Health First Aid, the Samaritans, Operation Serenity).
- The need to increase professional networking and information sharing.
- The need to provide training for teachers so that they can identify children at risk and refer appropriately.
- Support for schools to develop well-being and resilience workshops for students.
- A qualified mental health professional to provide support, risk assessment and training to the Hub.
- The need to provide more support for families and friends affected by suicide including professional bereavement counselling and a peer support group.
- The need to develop a web-based resource providing support and information on services and resources available and self-help.

1. Introduction

There are multiple factors and multiple different pathways that lead to suicidal behaviours. Generally, suicide is a multi-determined event. Not the consequence of a single issue but the combination of several issues in a person's life[10].

Suicide does not have one cause – many factors combine to produce an individual tragedy. Prevention too must be broad – communities, families and front-line services all have a vital role.

Professor Louis Appleby (Chair of the National Suicide Prevention Strategy Advisory Group).

Risk factors for suicide include mental and physical illness, alcohol or drug abuse, chronic illness, acute emotional distress, violence, a sudden and major change in an individual's life such as loss of employment, separation from a partner, or other adverse events, or in many cases, a combination of these factors[11].

Attached in Appendix One are the socio-demographic and personal factors that contribute directly, or influence a person's susceptibility to suicide as described by the Royal College of Psychiatrists[12].

Protective factors that reduce a person's vulnerability to suicidal behaviours include[13]:

- Strong connections to family and community support.
- Skills in problem solving, conflict resolution, and non-violent handling of disputes.
- Personal, social, cultural and religious beliefs that discourage suicide and support self-preservation.
- Restricted access to means of suicide.
- Seeking help and easy access to quality care for mental and physical illness.

Attached in Appendix Two is a précis of the results found by the Scottish Government in their literature review to identify the protective factors that reduce an individual's susceptibility to suicide[14].

As well as the immeasurable cost of self-harm and suicide to individuals, families, loved ones, frontline service staff, agencies that provide care and communities, there are also economic costs. On a national level the direct cost of self-harm to the NHS has been estimated at £5.1 million a year from self-poisoning and tricyclic antidepressants alone[15].

The government in Northern Ireland in 2004 estimated that the total cost per suicide, including economic and intangible costs, was £1.4 million[16].

The aim of this strategy is to provide a framework to:

- Improve the management of suicide prevention on the Isle of Wight.
- Focus local suicide prevention activity ensuring it is joined up, relevant, evidence based and sustained.

In September 2012 the coalition Government published a national strategy 'Preventing Suicide in England'. We have developed the two leading objectives identified in the national strategy to support our local strategy and action plan:

- Reduce the suicide rate in the general population on the Isle of Wight.
- Increase support for those bereaved or affected by suicide.

The national strategy also identifies six key areas for action:

1. Reduce the risk of suicide in key high-risk groups.
2. Tailor approaches to improve mental health in specific groups.
3. Reduce access to the means of suicide.
4. Provide better information and support to those bereaved or affected by suicide.
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour.
6. Support research, data collection and monitoring.

This strategy uses the framework of the six key areas for action to build a locally relevant action plan which incorporates recommendations from national policy, and local evidence and priorities to provide a framework of recommendations for reducing the number of suicides and providing better support from people bereaved or affected by suicide.

From April 2013, local authorities took on significant new public health functions including responsibility for coordinating and implementing work on suicide prevention. Directors for Public Health became the strategic leaders for public health and health inequalities in local communities, working in partnership with the local NHS and across public, private and voluntary sectors. Local statutory health and well-being boards were established to support this collaborative working[17].

This paper forms the Isle of Wight Suicide Prevention Strategy and is part of the No Health Without Mental Health Strategy. Recommendations for this strategy include the formation of a Suicide Prevention Group. This group would include representatives from stakeholder organisations on the island including; IoW CCG, IW NHS Trust, IW Local Authority, Education, Police, Ambulance, voluntary organisations who will have responsibility to report the development and delivery of the strategy and action plan to The My Life A Full Life Mental Health Partnership Development Group.

2. Policy context

2.1 Outcomes frameworks

Outcomes Frameworks provide a vision of what we want to achieve and a mechanism for measuring outcomes linked to that vision. There are three outcomes frameworks that support the work of the NHS, Public Health and Adult Social Care. Each identifies outcomes relevant to reducing the number of suicides, these outcomes is outlined in Appendix Three.

2.2 National policies

There are a number of national policies that inform this strategy. As well as supporting the objectives of the coalition Government's national strategy Preventing Suicide in England (2012) the key report and key policies that underpin this strategy are:

- The Future of Local Suicide Prevention Plans in England: Report by the All Party Parliamentary Group on Suicide and Self-Harm Prevention (2013).
- No Health Without Mental Health: a cross-government mental health outcomes strategy for people of all ages (2011).

Further detail about these reports can be found in Appendix Four.

3. Local context

The Isle of Wight has a population of 138,265[18]. The largest group of residents are aged 60 to 64 (8.1% of the population), and almost a quarter of residents (24.1%) are aged 65 and over. This is very high compared with the England average (16.6%)[19].

The Island is predominantly rural with 16% of the population living in rural areas. They face significant difficulties in accessing facilities, which present challenges for service delivery[20].

In rankings of deprivation for all 327 English district and unity authorities the Isle of Wight is ranked 114 in the scale of employment deprivation and 116 in the scale of income deprivation (rank one being the most deprived)[21].

There are a number of projects being delivered on the island that are improving the health and well-being of vulnerable groups on the Island through integrated working across agencies. Some of these projects are highlighted in Appendix Five.

3.1 Suicide data

In England one person dies every 2 hours as a result of taking their own life. In 2010 4,215 people took their own life nationally[22].

On the Isle of Wight the directly standardised mortality rate for suicide for the Island between 2009–2011 is 11.8 per 100,000 which is statistically significantly higher than the England rate of 7.9 per 100,000 as highlighted in Table 1.

It is to be noted that during this time period of 2009–2011 nationally numbers were rising each year where as on the Isle of Wight numbers fell from 18.8 per 100,000 in 2008 to 9.42 per 100,000 in 2011.

Table 1: Directly standardised suicide rate per 100,000 (2009–2011)

Three-year average

Source: ONS

4.10 – Suicide rate (provisional) 2009 - 11 — Directly standardised rate – per 100,000

Area	Value	95% Lower CI	95% Upper CI
England	7.9	7.7	8.0
Isle of Wight	11.8	8.5	15.9
Brighton and Hove	11.1	9.0	13.6
East Sussex CC	10.4	8.8	12.2
Southampton	9.7	7.5	12.4
Portsmouth	8.6	6.4	11.2
Surrey CC	8.1	7.2	9.1
Hampshire CC	8.1	7.2	9.0
Bracknell Forest	8.0	5.3	11.5
Oxfordshire CC	7.8	6.6	9.1
Buckinghamshire CC	7.6	6.3	9.2
Kent CC	7.4	6.6	8.3
Milton Keynes	7.0	5.2	9.2
West Berkshire	7.0	4.8	9.9
Slough	7.0	4.5	10.2
West Sussex CC	6.4	5.4	7.5
Medway	5.9	4.3	7.9
Reading	5.9	3.8	8.6
Windsor and Maidenhead	5.8	3.7	8.6
Wokingham	5.3	3.3	7.9

Source: EMPHO (based on ONS source data)

An audit by the Isle of Wight Council into suicides and open verdicts on the Isle of Wight 2008–2011 showed 77% of people who chose to take their own lives were male and 23% were female. This is line with national trends.

The audit found that the predominant age group for people who chose to take their own lives was 45–59 as depicted in Table 2 in Appendix Six. This is older than the national distribution where the age groups 35–49 has higher rate of suicide.

The predominant method used was hanging (Table 3 in Appendix Six) and 25% of people that had completed suicide had previously attempted suicide in the past.

Between 2008 to 2011 56% of people who chose to take their own lives on the Isle of Wight were employed, 16% were retired and 28% were unemployed or in education[23].

4. Consultation

The development of this strategy was support by a 2-month consultation that consisted of:

- A workshop attended by 97 people.
- A questionnaire completed by 25 people.
- Conversations between the consultant and key strategic people.

A full write up of the workshop can be found in Appendix Seven.

5. Priority areas

The Preventing Suicide in England strategy (2012) identifies 6 key areas for action. We have used these key areas as a framework for this strategy:

5.1 Priority area 1: Reduce the risk of suicide in key high-risk groups

Some groups of people are known to be at higher risk of suicide than the general population. On the Island, these groups have been identified as:

- Young and middle aged men;
- People in the care of mental health services, including inpatients;
- People with a history of self-harm;
- People in contact with the criminal justice system;
- Employment;
- Older people.

5.1.1 Young and middle aged men

Men are three times as likely to take their own lives as females. Most suicides are among men aged under 50. Men aged 35–49 are now the group with the highest suicide rate[24] in the UK as highlighted in Table 4 Appendix Six. However on the Isle of Wight the predominate age group for men and women is 46–55.

5.1.2 People in care of mental health services, including inpatients

One in four people who die by suicide in the UK were in contact with mental health services in the 12 months before the suicide, it is generally acknowledged that most had a diagnosis of a mental disorder at the time of their death[25].

In 2009 there were 1,078 suicides by people in England who were in contact with mental health services in the year prior to death[26].

Between 1997/98 and 2007/8 the number of inpatient suicides in England has nearly halved (47.6%)[27]. It is believed that the removal of non-collapsible fittings has contributed to this reduction[28].

A study into the deaths of people using mental health services on the Isle of Wight between January 2006 and December 2008[29] identified 51 Isle of Wight residents who chose to take their own lives, 68.6% of whom were local mental health service users (35 individuals, 10 of whom were women and 25 of whom were men).

The study concluded that people with mental health problems are at greater risk of suicide. More than two-thirds of people who chose to take their own lives had a severe depressive episode at the time of the act of suicide, however this is not always recognised[28].

The Isle of Wight NHS Trust analysed the number unexpected deaths by people known to mental health and substance misuse services from 1st January 2009 to 1st January 2013. Over a 3-year period they identified 19 mental health service users who chose to take their own life. This is a reduction in numbers from the previous study (6.3 per year compared to 11.6).

The means of suicide identified in the later study is predominantly poisoning for both male and females. For males the peak age range is between 36 and 55 and for females it is between 46 and 55.

5.1.3 People with a history of self-harm

A history of self-harm behaviour is a risk factor for suicide. A survey of young people aged 15–16 years estimated that more than 10% of girls and more than 3% of boys had self-harmed in the previous year. For all age groups, annual prevalence is approximately 0.5%.

At least half of people who take their own life have a history of self-harm, and one in four have been treated in hospital for self-harm in the preceding year[30].

In England and Wales there are at least 200,000 general hospital presentations for self-harm (intentional self-poisoning or self-injury) per year[31].

On the Isle of Wight[32] emergency hospital admissions for self-harm (2011–12) are significantly higher than for England (312 per 100,000 compared to average for England of 207 per 100,000). Admissions caused by unintentional and deliberate injuries for under 18s (2009–10) are significantly higher than England (143 per 100,000 compared to 123 per 100,000).

5.1.4 People in contact with the criminal justice system

People at all stages within the criminal justice system, including people on remand and recently discharged from custody, are at high risk of suicide[33]. The three-year average annual rate of self-inflicted deaths by prisoners in England was 69 deaths per 100,000 prisoners in 2009–11[34].

Someone who is received into a prison who is drug dependent is twice as likely to complete suicide in the first week of imprisonment as a non-dependent prisoner[35].

During the first 12 months after release there is a 3–10 fold greater risk of suicide than in the general population. A fifth of all suicides following release from prison occur in the first 28 days[36].

During 2012 there were 23,158 recorded self-harm incidents (a fall of 6% on the previous 12 months). The rate of male self-harm has risen to 201 incidents per 1,000 prisoners in 2012 compared with 194 in 2011. The rate of self-harm for females was 264 incidents per 1,000 prisoners in 2012, down from 377 in 2009[37].

HMP Isle of Wight consists of two sites, Albany and Parkhurst (a third, Camp Hill having closed in March 2013). Both are adult (over 21 years of age) male Category B sites holding sentenced prisoners from across England and Wales and with a combined operational capacity of 1139. The Albany site also includes a remand unit serving the Isle of Wight courts. Offenders in custody originating from the Isle of Wight will be held in prisons elsewhere in the country dependent on their age, gender, security category, sentence planning and resettlement needs.

Data collated by the Isle of Wight ambulance service indicates that between October 2010 and July 2013 paramedics attended 27 incidents of deliberate self-harm and 17 attempted suicides (as reported by paramedics at the time of the situation) at HMP Isle of Wight.

5.1.5 Employment

The national strategy identifies doctors, nurses, veterinary workers, farmers and agricultural workers as being occupations that are at high-risk of suicide. However, more recent research suggests that in 2000 occupations with the highest rates of suicide are now largely manual, including coal miners, builders, window cleaners, plasterers and refuse collectors[38].

National research and local research identify a strong link between people who are economically inactive and suicide.

5.1.6 Older people

The Isle of Wight has 24.1% of the population aged 65 and over. This is very high compared with the England average 16.6%[39]. Due to the high proportion of elderly people on the Island, the Island has one of the highest prevalences of dementia in the UK[40].

The rate of suicides in older people is the one age group where we have not seen a decline. The risk of depression increases with age, it is estimated that 40% of those over 85 are affected[41]. Depression is also associated with increased mortality and risk of physical illness.

A diagnosis of depression in those over 65 increased subsequent mortality by 70%[42].

Nationally, the number of people over the age of 74 with depression is projected to increase by 80% by 2026[43]. Therefore, there is likely to be a significant increase in the number of older people presenting with self-harm and suicidal behaviour[44].

Older adults presenting in hospital with self-harm are an extremely high-risk group for subsequent suicide, particularly men aged 75 years and over[45].

5.2 Priority area 2: Tailor approaches to improve mental health in specific groups

As well as targeting high-risk groups we can reduce suicide by improving the mental health of the population as a whole. But for this to work, we need to ensure that we include tailored measures for groups with particular vulnerabilities or problems to ensure they get the right support at the right time.

Groups that are identified nationally include:

5.2.1 Survivors of abuse or violence

The proportion of the population that are survivors of abuse or violence is unknown.

5.2.2 Veterans

It is estimated that 11.2% of the Islands over 16 population is a veteran[46].

5.2.3 People living with long-term physical health conditions

On the Island it is estimated that 20.1% of the population lives with a long term illness compared to the National average of 16.9%.

5.2.4 People with untreated depression

Nationally 19% of the over 16 population is estimated to have mild mental illness[47], with the prevalence being markedly higher at 27% in divorced or separated people, single people had a prevalence of 20% and those married or in a civil partnership were less at risk at 16% of the population.

9.1% of the population are diagnosed with depression on the Isle of Wight.

5.2.5 Economic circumstances

The national suicide prevention strategy states that there are direct links between mental ill health and social factors such as unemployment and debt. Both are risk factors for suicide.

People who are unemployed are two to three times more likely to die by suicide than people in employment[48], with unemployed men particularly at risk[49].

4.4% of the Islands economically active aged 16–74 are unemployed on the Isle of Wight.

5.2.6 People who misuse drugs or alcohol

31.4% of people aged over 16 on the Isle of Wight are estimated to drink alcohol above the daily recommended limits[50]. In 2010 there was estimated to be 697 opiate and/or crack users on the Isle of Wight[51]. The increasing use of legal highs has been recorded as resulting in people experiencing severe psychotic incidents and increases their risk of suicide.

5.2.7 Lesbian, gay, bisexual and transgender people

The percentage of the population on the Isle of Wight that are gay or lesbian, taken from the Integrated Household Survey in 2012, is estimated at 1.1% and 0.4% of the population are recorded as bisexual.

5.2.8 Black, Asian and minority ethnic groups and asylum seekers

2.68% of the Islands population are Black, Asian or a minority ethnic group[50].

5.2.9 Children and Young People

There are very few suicides in young people nationally however it is an important issue due to the vulnerability of young people, recent research by the NUS suggest that 13 per cent of students have suicidal thoughts[52].

Particularly high risk groups are looked after children, care leavers and children and young people in the Youth Justice System. On the Isle of Wight 0.6% of 0–17 year olds are looked after[53] and 0.2% subject to a child protection plan[54]. 9.1% of the population are aged 10–17 years of age of which 0.9% received their first reprimand, warning or conviction in 2011/12[55].

It is the long term impact of vulnerability which can increase the risk of someone having suicidal thoughts. Figure 1 illustrates the possible pathways through which factors acting from before birth up to the suicide might influence an individual's decision to attempt suicide and the outcome of such a decision.

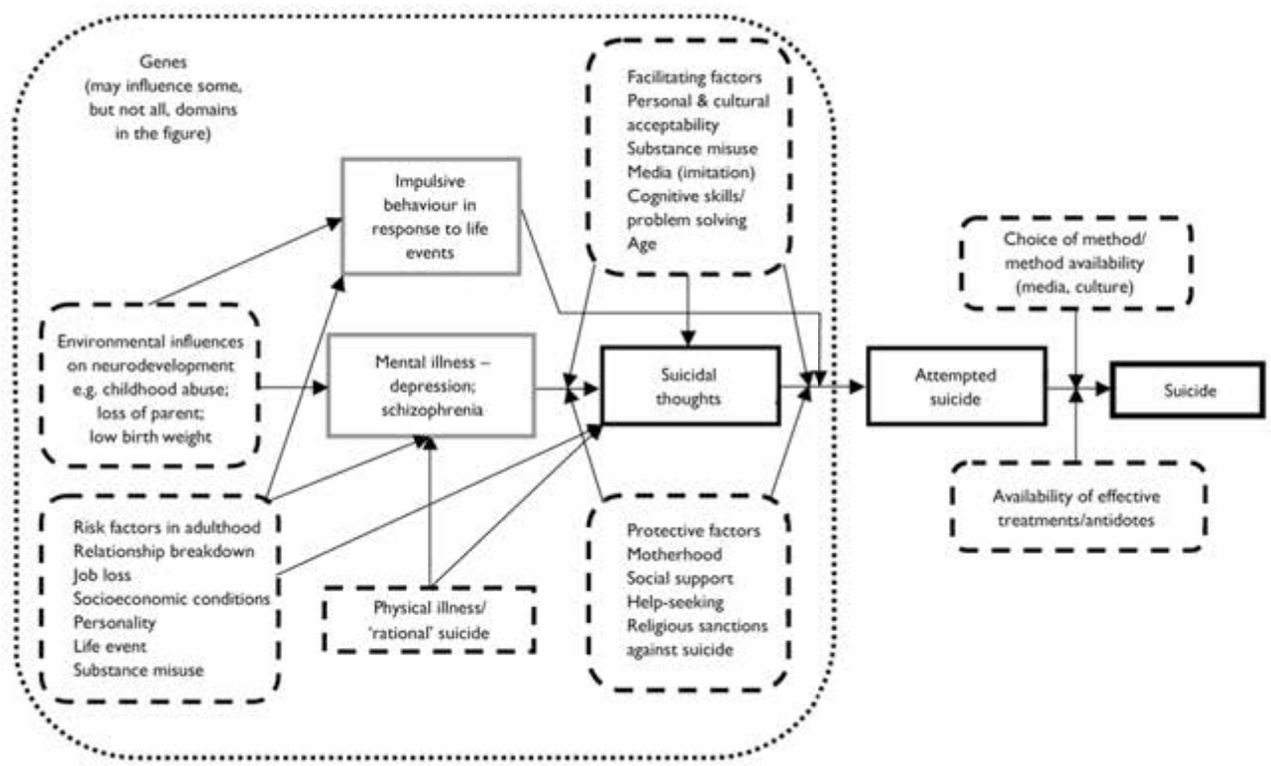


Figure 1: Life course influences on suicide[56]

5.3 Priority area 3: Reduce access to means of suicide

There is general agreement that it is possible to interrupt the suicidal process by making it difficult for people to obtain the means by which to kill themselves. Restricting access to means of suicide is recognised as having the potential to save lives[57].

The most common method of suicide for men is hanging, strangulation and suffocation (56% of all suicides for men). Along with drug related poisoning, this is also a common method amongst women (35% hanging, strangulation and suffocation, 36% drug related poisoning)[58].

Inpatient suicides have fallen by more than a half since the removal of non-collapsible fittings[59].

5.4 Priority area 4: Provide better information and support to those bereaved or affected by suicide

People who are bereaved by a suicide are at increased risk of mental health and emotional problems and may be at higher risk of suicide themselves[60].

The three key actions identified in the national strategy, needed to provide better information and support to those bereaved or affected by suicide are:

- Provide support that is effective and timely;
- Have in place effective local responses to the aftermath of a suicide; and
- Provide information and support for families, friends and colleagues who are concerned about someone who may be at risk of suicide.

One of the strongest themes to emerge from the local consultation for this strategy was the need to increase support to people bereaved or affected by suicide.

5.5 Priority area 5: Support the media in delivering sensitive approaches to suicide and suicidal behaviour

One in five schoolchildren with a history of self-harming questioned by researches said that they learnt about it after seeing or reading something on-line, second only to hearing about it from friends[61].

Over 60 research articles have looked at the issue of media reporting of suicide and found that it can lead to imitative behaviour[62]. In their media guidelines for reporting suicide and self-harm (2008) the Samaritans cite that incidents of self-poisoning increased by 17% in the week following the broadcast of an episode of a popular TV drama containing a storyline about a deliberate self-poisoning.

The media also has an important role in suicide prevention, both in terms of awareness raising and sensitive reporting of suicides. The guidelines advise avoiding the reporting of explicit details of suicide and labelling places as suicide hotspots and encourage the media to promote an understanding of the complexity of suicide.

5.6 Priority area 6: Support research, data collection and monitoring

Local audits on the Coroner's reports and SIRI at the Isle of Wight NHS Trust have informed this strategy, as has data from the ambulance service. Work is also being done regionally to benchmark data and share learnings. We need to continue to collect data in a robust way to support the development of the plan.

6. Action plan

The 6 areas for action have been split into two action plans that will aim to:

- Reduce the suicide rate in the general population on the Isle of Wight.
- Increase support for those bereaved or affected by suicide.

Each stakeholder organisation has been invited to review the consultation feedback and share the actions they aim to deliver between 2014 – 2016 that will help us, as an Island, deliver these aims. This action plan can be found in Appendix Ten and so far include the actions from the Isle of Wight Clinical Commissioning Group, Isle of Wight Council, Isle of Wight NHS Trust, Public Health, Youth Offending Team, Job Centre Plus, Offender Management, Police, Isle of Wight Fire and Rescue Service and HM Prison Isle of Wight.

The action plans will be reviewed and updated annually by the Suicide Awareness and Prevention Steering Group during the five year strategy.

To reduce the suicide rate in the general population on the Island.

We will:

- Continue to develop and implement an action plan that delivers the objectives of this strategy and monitors its progress.
- Report on the implementation of this strategy to the My Life a Full Life Mental Health Partnership Development Board.
- Ensure people are aware of the resources, self-management and support services available through a central directory of service.
- Vulnerable groups are identified and are given the correct support quickly e.g. those known to the criminal justice system or people calling NHS 111.
- Support voluntary and third sector organisations in collaborating to form a Mental Health Alliance and to develop local services for people with mental health problems.
- People are involved in the development and feedback of services through engagement events and service user and carer forums.

- Public Health will be using evidenced based approaches to build and strengthen communities, families and individuals and improve mental health well-being and resilience.
- Increase the access to psychological therapies (IAPT).
- Develop a multi-agency case review group to reflect on incidents, monitor patterns and dispel learnings.
- Deliver an annual audit of suicide and open verdicts to inform the Joint Strategic Needs Assessment and help with future planning and commissioning.
- Improve responses to mental health crisis calls through police and mental health practitioners responding to calls together during peak times (Serenity).
- Explore best practice in ensuring people admitted to hospital are assessed and supported appropriately if they have mental health problems.
- Isle of Wight Council, CCG and Police will promote good mental health of their staff and promote awareness and self-management programmes.
- Strengthening communication and relationships between multi-agency partnerships.
- Support the media in appropriate reporting of suicide through workshops and encourage appropriate signposting to national and local services for those affected by the reporting.

How we will support the bereaved better?

We will:

- Improve access to information and services about support to the bereaved.
- Scope how to identify those recently bereaved by suicide and offer appropriate support.
- Training for police officers about mental health and how it drives choice and behaviour in offending.

7. Governance

The report by the All Party Parliamentary Group on Suicide and Self-Harm Prevention (2013)[63] recommended that each local authority develop a Suicide Prevention Strategy, and forms a Suicide Prevention Group to oversee the strategy. This paper forms the Suicide Prevention Strategy with an action plan given below.

A multi agency Suicide Awareness and Prevention Steering Group has been developed that meets bimonthly to oversee the delivery of this strategy and reports to the My Life A Full Life Mental Health Partnership Development Group.

The all-party group also recommends that suicide and self-harm are addressed in the Joint Strategic Needs Assessment (JSNA) beyond being a measure, and suggests that local health and well-being strategies include specific measures to support people bereaved by suicide and to address self-harm prevention.

Recommendations are made to include these measures in refreshes in the Isle of Wight JSNA, Health and Well-being Strategy and the CCG Commissioning Strategy.

Regional work sharing best practice and benchmarking data is being led by NHS South of England. Their report with an action plan is due in the autumn of 2013. Their action plan should be integrated with this plan and form part of the work plan for the Suicide Awareness and Prevention Group

8. Resources

8.1 Media guidelines

Media guidelines for reporting suicide and self-harm (2008) Samaritans. Available from www.samaritans.org

The Editors' Codebook (2009) available from www.editorscode.org.uk reporting suicide pp48–51

8.2 Help lines and information aimed at individuals

Campaign Against Living Miserably CALM www.thecalmzone.net

Health Talk on Line www.Healthtalkonline.org

Help is at hand (aimed at people bereaved by suicide) http://www.nhs.uk/Livewell/Suicide/Documents/Help%20is%20at%20Hand.pdf

PAPYRUS Prevention of Young Suicide www.papyrus-uk.org

The Samaritans www.samaritans.org

Survivors of Bereavement by Suicide www.uk-sobs.org.uk

Rural Stress Helpline http://www.ruralstresshelpline.co.uk

Winston's Wish a charity for bereaved children www.winstonswish.org.uk

Mindfull. Mentoring, counselling and self-help for young people www.mindfull.org

8.3 Service development

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Safer mental health services: a toolkit (2012).

The Mental Health Network NHS Confederation in partnership with the National Patient Safety Agency have a range of suicide prevention toolkits available to download from www.nhsconfed.org/mhn including:

- Community and emergency healthcare (2011).
- Ambulance services (2011).
- Community mental health services (2011).
- General practice (2011).
- Emergency departments (2012).

NICE Clinical Guidelines available on:

- Self harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care (Clinical Guideline 16. 2004).
- Self Harm: Longer-term management (Clinical Guideline 133. 2011).
- Self harm: draft quality standards (2013).

A framework to assess the quality of risk assessment. Quality of Risk assessment Prior to Suicide and Homicide: A Pilot Study (June 2013). The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Centre for Mental Health and Risk, University of Manchester http://www.bbmh.manchester.ac.uk/cmhr

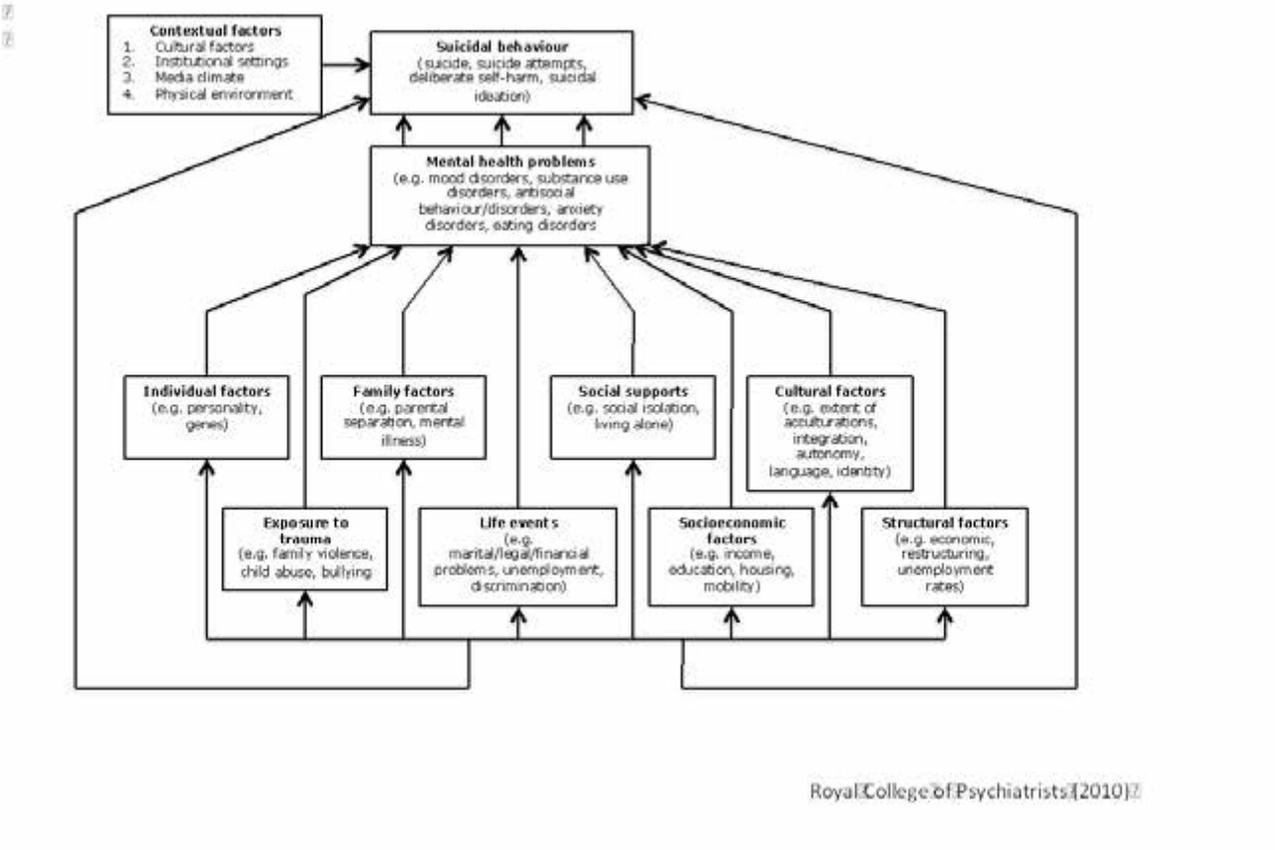
Campaign to End Loneliness and Isolation: A toolkit for Health and Well-being Boards http://www.campaigntoendloneliness.org.uk/toolkit/

National CAMHS Workforce Programme. Self-harm in children and young people handbook (2011) http://www.chimat.org.uk/resource/item.aspx?RID=105602

CSIP Guidance on action to be taken at suicide hotspots (2006) http://www.nmhdu.org.uk/silo/files/guidance-on-action-to-be-taken-at-suicide-hotspots.pdf

Protective Behaviours: A Toolkit for Keeping Children and Young People Safe. Available from www.safety-net.org.uk

Appendix One: Pathways to suicidal behaviour



Royal College of Psychiatrists (2010)

Appendix Two: Protective factors

Introduction

In 2008 the Scottish Government commissioned a review of the literature on risk and protective factors for suicide and suicidal behaviour[lxiv]. The full review is available from http://www.scotland.gov.uk/Resource/Doc/251539/0073687.pdf. Below is a synopsis of the protective factors identified through the systematic review and primary study evidence. Protective factors are defined as societal or psychosocial conditions or individual behaviours that lessen the likelihood that an individual will engage in suicidal behaviour.

Coping skills

Problem-solving skills may be protective against suicidal behaviour among those who have attempted suicide. There is conflicting evidence on the interplay between the suicide risk factor of hopeless and problem-solving-based coping skills. One study shows that problem- solving coping may mediate against hopelessness among adults who have attempted suicide while another demonstrates that hopelessness can mediate against the protective effect of problem-solving-based coping.

A number of coping skills requiring an element of self agency appear to be protective against suicidal behaviour particularly among adolescents, including self-control and self-efficacy, instrumentality, social adjustment skills, positive future thinking and sublimation. Being in control of emotions, thoughts and behaviour can mediate against suicide risk associated with sexual abuse among adolescents.

Reasons for living

High levels of reasons for living, future orientation and optimism protect against suicide attempt among those with depression. Hopefulness is protective against suicide among African-American women exposed to poverty and domestic violence. There is some evidence that those who have previously attempted suicide can develop positive coping strategies to protect themselves against future suicidal behaviour. Resilience factors are better predictors of suicidal behaviour than the amount of exposure to stressful life events.

Physical activity and health

There is some evidence that an attitude towards sport as a healthy activity and participation in sporting activity is protective against suicidal behaviour among adolescents. A perception of positive health may be protective against suicide among females who have experienced sexual abuse.

Family connectedness

Good relationships with parents mitigate against suicide risk, especially in adolescents and including those who have been sexually abused. Positive family relationships also provide a protective effect for adolescents including those with learning disabilities. Further evidence suggests that positive maternal coping strategies can have a protective effect on female adolescents. Having children living at home is protective against suicide for women; however, another study indicates that this protective effect may not exist among women who are HIV-positive.

Marriage is a protective factor against suicide (although more so for white females than black females in the USA). There is also evidence that marriage has a protective buffering effect against socio-economic inequalities related to suicide, particularly for men. It is important to consider other confounding variables including the finding that married men were less likely than non-married men to have problems with drugs, sex, gambling and having used or currently using psychiatric medicine.

Supportive schools

Supportive school environments, including access to healthcare professionals, are important protective factors among adolescents including those who have experienced sexual abuse, those with learning disabilities and those who identify as lesbian, gay, bisexual or transgendered.

Social support

Social support in general is protective against suicide among a range of population groups, including black Americans and women who have experienced domestic abuse.

Religious participation

There is a wide range of evidence to suggest that religious participation may be a protective factor against suicidal behaviour. However, the protective effect of religious participation can vary according to the level of secularisation within a country or community and social and cultural integration. Moral sanctions against suicide promoted by members of a religious community may have wider protective effect on the non-religious members of a community where the religious members are in the majority. Religious observance does not confer equal protection on individuals. Other factors, such as the observance of traditional cultural rituals, may have a stronger protective effect. The manner in which individuals relate to their God (in terms of religious coping style or private versus public expressions of religiosity) may further highlight different levels of protective factors within a single religious community.

Employment

There is some evidence that employment, especially full-time, has a protective effect against suicide. However, employment was not found to be protective among women who were HIV-positive.

Exposure to suicidal behaviour

One study found that exposure to accounts of suicidal behaviour in the media and, to a lesser extent, exposure to the suicidal behaviour of friends or acquaintances may be protective against nearly lethal suicide attempts. However, it is important to note that there is also a body of evidence of the suicide risks associated with media reporting.

Social values

Traditional social values may have a protective effect against suicidal behaviour among adolescent girls, while individualistic values may have a protective effect among adolescent boys.

Health treatment

Access to treatment by a health professional may be protective against repeat suicide attempts.

Appendix Three: Outcomes frameworks

The Public Health Outcomes Framework for England 2013–2016 identifies four key indicators relevant to this plan: social connectedness (domain 1), hospital admissions as a result of self-harm (domain 2), excess under 75 mortality in adults with serious mental illness and suicide (domain 4).

The NHS Outcomes Framework 2013–14 identifies 2 key improvement areas relevant to this plan: reducing premature death in people with serious mental illness (1.5) and improving outcomes from planned treatments – psychological therapies (3.1).

The Adult Social Care Outcomes Framework 2013–14 shares the Public Health Outcomes Framework indicator of social connectedness: proportion of people who use services and their carers, who reported that they have as much social contact as they would like (domain 1).

Both the Adult Social Care and NHS outcomes frameworks contain safeguarding domains that are relevant to work on suicide prevention (Adult Social Care domain 4 and NHS Domain 5).

Appendix Four: National policies

The Future of Local Suicide Prevention Plans in England: Report by the All Party Parliamentary Group on Suicide and Self-Harm Prevention (2013). This report identifies 23 recommendations for the government, local authorities, health services and other agencies to help ensure that the objectives of the national suicide prevention strategy are translated into tangible activates that have an impact at a local level, reducing the risk of suicide in local communities. These recommendations include:

Department of Health

i. Requiring all local authority areas to develop a suicide prevention plan led by the director of public health or senior member of the public health team and establish a suicide prevention group. Local suicide prevention plans should include provision for self-harm prevention and those bereaved by suicide.

Health and Well-being Boards

ii. Ensure that suicide and self-harm are addressed in the Joint Strategic Needs Assessment beyond being a measure.

iii. Ensure that the local suicide prevention plan is written into the local health and well-being strategy and includes provision for bereaved families.

iv. Ensure that specific measures to a) support people bereaved by suicide, and b) to address self-harm prevention, are written into in local health and well-being strategy.

v. Facilitate regular communication with local suicide prevention group.

vi. In areas where there is no plan or group, develop both as a priority. Using the model of Choose Life Coordinators in Scotland, designate a senior member of the public health team to undertake this.

No Health Without Mental Health: a cross-government mental health outcomes strategy for people of all ages (2011). This strategy identifies six mental health objectives. All the objectives are relevant to suicide prevention work but most particularly:

- Objective One: more people will have good mental health. This includes the aim of reducing the national suicide rate.
- Objective Two: More people with mental health problems will recover.
- Objective Five: Fewer people will suffer avoidable harm.

The Bradley Report (2009) highlights the needs of people with mental health and learning difficulties in the Criminal Justice System. Evidence suggests that there are more people with mental health problems in prison than ever before and there is growing consensus that prison may not always be the right environment for those with severe mental illness. Custody can exacerbate mental health problems, heighten vulnerability and increase the risk of self-harm and suicide. The report encourages early identification and assessment of those in the system with mental health problems and better information sharing to help inform charging, prosecution and sentencing decisions. The longer term aim is to increase the number of offenders treated in the community and those who must be in prison receive targeted and effective treatment and care while they are there.

Appendix Five: Local systems and data

The Isle of Wight Clinical Commissioning Group commissioned the Isle of Wight NHS Trust in 2012/2013 to pilot integrating mental health into the emergency 111 Hub that coordinates all emergency, urgent and unscheduled care for the Island. This was designed to streamline the approach for patients requiring mental health advice, support and assessment.

This service is now exploring using a clinical decision support system for mental-health risk screening, assessment, and management, which can also be developed to link to other agency systems (i.e. police, ambulance, Community Mental Health Services, Housing etc) This could enable for a singular risk assessment and the sharing of risk data of vulnerable people. This will provide a coordinated approach to ensure the right intervention and support from multiple agencies is initiated to maximise the health and well being outcomes achieved for the individual.

My Life, a Full Life is a programme of work to integrate care and support for people living with long term conditions on the Isle of Wight. This is a new and rapidly developing programme that is incorporating mental health as a key part of their work.

Three projects have been identified through this programme:

1. Self management and self care.
2. Crisis response and reablement.
3. Locality working.

Operation Serenity is a local initiative that aims to improve responses to mental health crisis calls, where vulnerable people may need specialist support or where there are concerns for their safety. On average the Island police receive 79 mental health crisis calls a month. The initiative involves a police officer and a qualified mental health practitioner responding to calls.

In the first six months the team responded to 112 incidents and demonstrated a more consistent and improved approach to risk taking minimising the need to use Section 136.

The Health Trainer service and 10 additional *Mental Health First Aid* instructors have been commissioned to deliver *Mental Health First Aid* training to communities on the Island. 500 people from a wide range of non-mental health backgrounds who work with both adults and young people have already received Mental Health First Aid training.

Appendix Six: Tables

Table 2: Ages of people who chose to take their own life on the IOW 2008-2011

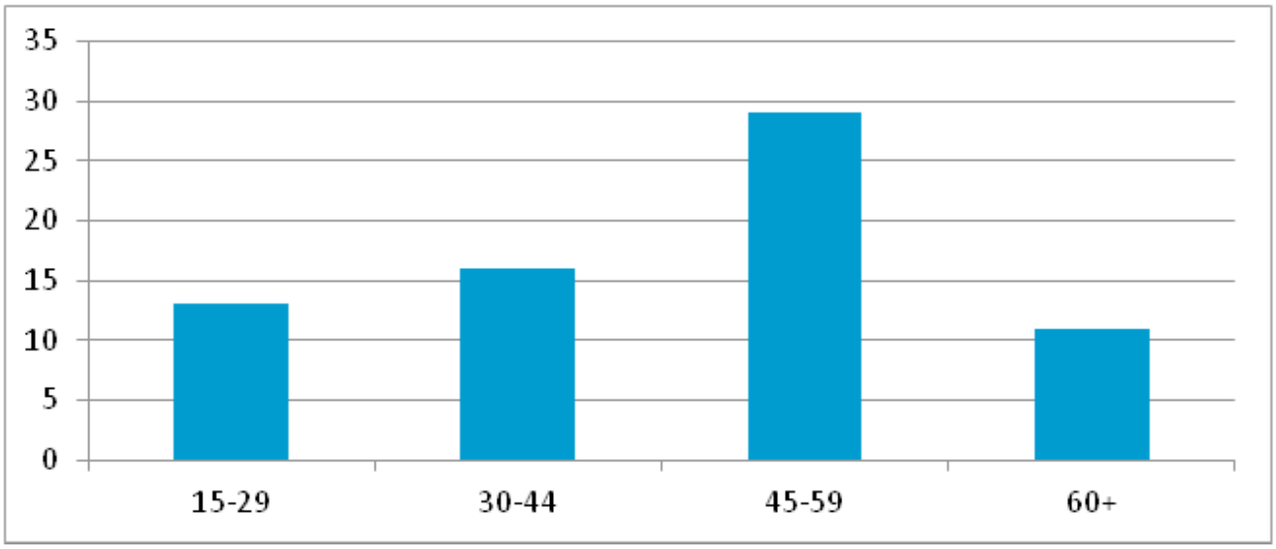


Table 3: Methods used in 2008–2011

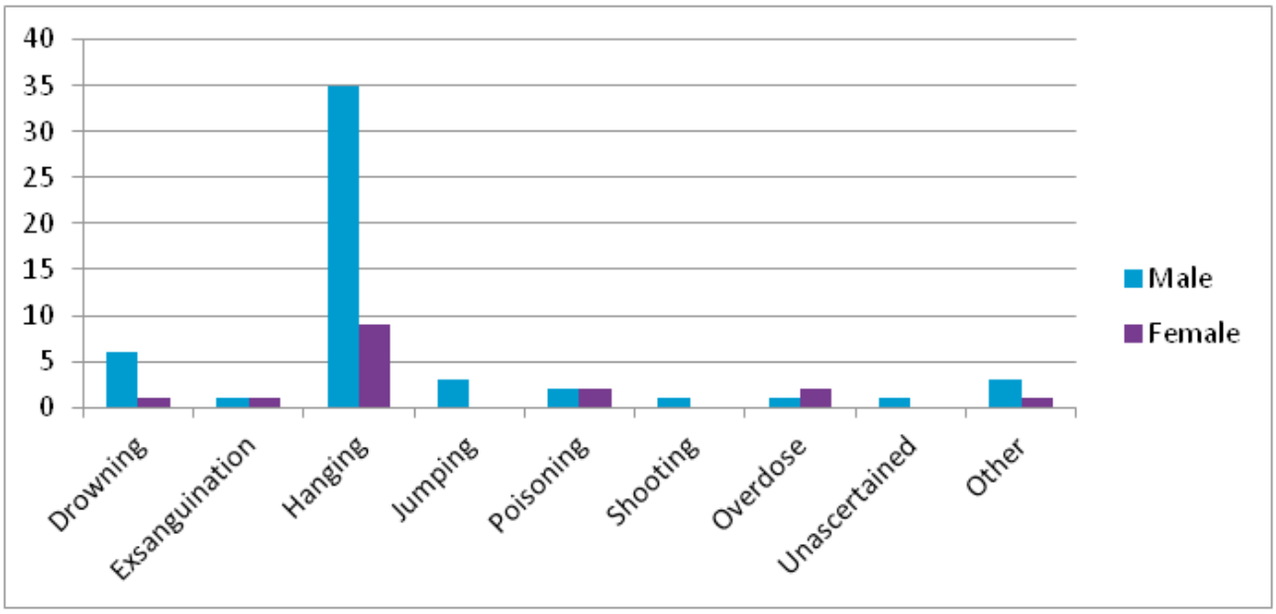
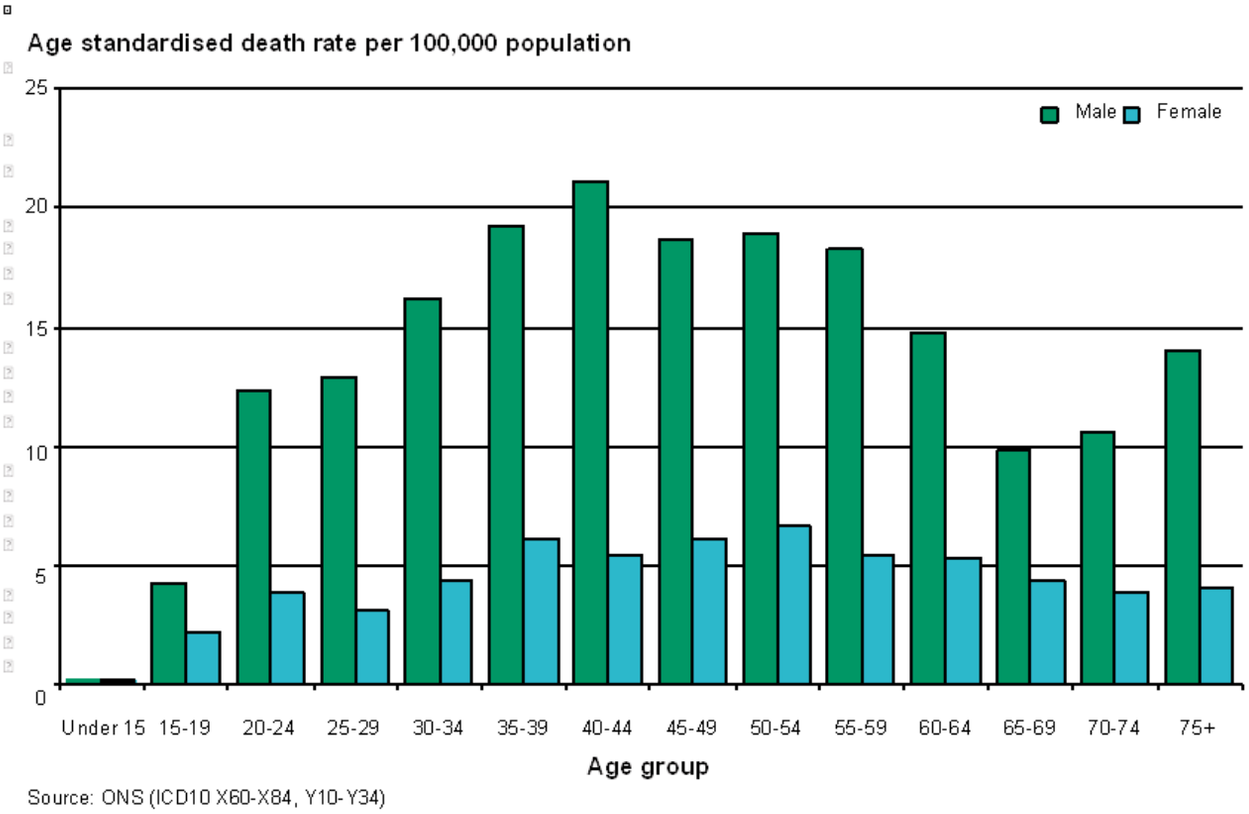


Table 4: Death rates from Intentional Self-harm and Injury of Undetermined Intent by five-year age band and sex, England 2010



Source: ONS (ICD10 X60-X84, Y10-Y34)

Appendix Seven: Engagement report

Isle of Wight Suicide Prevention Strategy
Workshop Write-Up

On the 26th of June 2013, 97 people attended a workshop designed to support the development of a suicide prevention strategy for the Isle of Wight. This is a write-up of the event.

Presentations

We began with presentations from Dr Sarah Bromley from the Clinical Commissioning Group and David Crawley from the IoW Samaritans.

Sarah began by warning us not to become too focused on the statistical significance of the number of people who choose to take their own life on the Isle of Wight. Every death is a tragedy to the individual, to their family and friends, to their colleagues, the community and to the frontline services that provide support.

She told us that the 2 key objectives of the strategy were:

1. To reduce the number of people who choose to take their own life on the Isle of Wight.
2. To provide better support for those bereaved or affected by suicide.

The national suicide prevention strategy identifies 6 key areas for action. Our strategy will also focus on those key areas and they will be used to provide the structure to the group work.

David spoke about the important work of the Samaritans on the IoW. They are open 45 hours a week, and last year took just under 10,000 contacts. David spoke about the importance of focusing on support for middle-aged men who often become very isolated after the break-up of relationships. The Samaritans are now taking contact by SMS text message.

First Group Work

Our first group work was to focus on three questions:

1. What is going really well?
2. What particular challenges are we facing?
3. What needs to happen to overcome those challenges?

What is going really well?

Participants were invited to write on a post-it-note something that they thought was working really well on the Island. This was then discussed within the group. A write up of the post-it-notes is given as a Wordle™, attached as Appendix One.

The most frequently cited examples of what is working really well were professional networking and information sharing, IAPT (talking therapies), Mental Health First Aid Training, the Samaritans, The Hub (triaging of 999 and 111 calls), and Serenity.

Operation Serenity is a joint working initiative between the police and mental health professionals providing a joint response to crisis calls.

Other examples of what are working well included support given to:

- Members of the lesbian, gay, bisexual and transgendered communities: OLGA and Youth pride.
- Young people: the YMCA bereavement and counselling services, the Children and Adolescent Mental Health Service, Papyrus, pastoral support given in schools, Check it Out health advice, and the IOW Youth Trust.
- People experiencing problems with drug and alcohol: Cranstoun, Get Sorted, and the island drug and alcohol service.
- People who self-harm: I Wish group and the self-harm liaison team.
- Adults with mental health problems: Home treatment/crisis team, Quay House, the community mental health teams, Treasure Your Mental Health campaign, the DBT service AESOP and Sevenacres.
- People bereaved: Survivors of Bereavement by Suicide (SOBS), The Compassionate Friends, Winston's Wish (charity for bereaved children) and the adult bereavement service.

The police, front line services, GPs, third sector agencies, Frontline debt and benefit help and the community spirit were also given as examples of what is working really well.

What particular challenges are we facing?

The full write-up of group work is included as Appendix Two. Amongst the themes that emerged were:

Workforce

People spoke about the need for clinical supervision and emotional support for staff. Training on mental health awareness, risk assessment, confidentiality and benefits. And specific training for teachers so that they can identify children at risk and refer appropriately.

Service Development

Comments were made about:

- Fragmented, risk-averse services that are age exclusive.
- An appropriate place of safety not always being available in a crisis.
- GPs and IAPT services being unable to assess suicidal patients who are not severely mentally unwell.
- The need to provide support to people with learning disabilities who experience suicidal ideation.
- The need to provide sustainable support to the third sector.
- The challenges of implementing payment by results.

More Support

The strongest theme that emerged from the workshop feedback was the need to provide more bereavement support to people left behind. Another theme was the challenge of loneliness especially amongst older people.

Pathways/Partnership Working

Feedback was given about the challenge of people bouncing around the system, poor communication between services and professionals, accessing services before you reach crisis point and the lack of joined up IT systems.

Small Community

People spoke about the challenges of living in a small community. Everyone knowing your business, lack of public transport in rural areas, high cost of travel and the lack of employment opportunities.

Dependency/Low Aspirations

Comments were made about low aspirations of young people, the lack of role models, apathy and a culture of dependence.

Communication

Strong feelings were expressed about the risk of social networking sites, people not knowing what services were available and the difficulty in engaging people.

Economic Climate

Reflecting on the economic climate people spoke about the challenge of managing cuts to local authority and mental health budgets, and changes to the benefits system and how that impacts on people.

What needs to happen to overcome those challenges?

A full write-up of this group work is included as Appendix Three. Solutions that emerged included:

Pathways/Partnership Working

People spoke about the sharing of care pathways and risk information across services including the third sector; greater multi-agency communication; integrated IT; and training and protocols on confidentiality, information sharing and risk.

Service Development

Comment was made about the needs for:

- An appropriate place of safety.
- A focus on early intervention.
- Better use of technology.
- Providing the Serenity service 24/7.

More Support

Participants identified the need for credit card size information on what early warning signs to look out for, greater community understanding, family support and help with benefits, and employer education.

Workforce

Some specific recommendations were made such as trained staff to risk manage on the Hub, having a workforce that is psychologically literate, offering evidence based treatments, and best practice care of staff.

Economic Climate

Overcoming funding issues and working smarter within the same restrictions were identified as possible solutions.

Communication

Suggestions were made about engaging with the media about the reporting of suicide and using the media more to publicise services and address stigma.

Focusing on Six Key Areas

Participants were invited to join a group working on one of the six key areas identified by the national strategy. Each group identified actions that are needed to address issues identified in that key area. Everyone was then invited to move around the groups and vote on the identified actions. The full list of actions is below.

There were a number of themes that emerged. There was overwhelming support for the development of a web-based resource for members of the public and professionals to access information and advice. The need to increase access to Mental Health First Aid training was identified, targeting care workers, members of the public and employers. A number of groups identified the need to increase access to bereavement counselling and support for carers and families and to support the setting up of a support group for people bereaved by suicide. The sharing of evidence-based interventions for all services to raise standards received popular support, and the need to support schools to deliver workshops on death and loss was identified.

Key area 1: Reduce the risk of suicide in high-risk groups		Number of votes
1	Better quality care planning/Access to the supports described in the care plan.	4
2	Face-to-face support needed or awareness of where to access.	4
3	Advertisement of services so people know where to go.	6
4	Find/provide safe place for young people.	0
5	Reduce stigma/greater awareness campaigns.	5
6	Education in schools.	2
7	Education for public/employers.	4
8	More Mental Health First Aid.	10
9	Early intervention – talk to someone.	11
10	Help-line for mental health/e-mental health (SMS access/www access).	3
11	Services need to ensure timely and on going support and follow up if I am stable (CMHS) not wait until it's too late.	11
12	Mental health training needed for 111 call handlers.	11

13	GP awareness training needed.	8
14	Fast track to services if deemed high risk.	5
15	Wellness supports to those not known to services.	3
16	Better listening services to include listening to carers.	18
17	Volunteer work for people at risk of suicide to promote self-esteem.	8
18	Better access to alcohol treatment.	9
19	Reduce access to alcohol for young people.	2
20	Sharing information across services for those identified as high risk (joined up care package).	13
21	Reduce isolation (physical, economical, cultural).	13
22	More clarity on how to access mental health services.	13
23	Website including directory of services.	9
24	An alternative to GPs as first point of access.	13
25	Buddy scheme to help people access services.	3
26	Awareness raising with employers of benefits of good mental health in the workplace.	7
27	'Stress' services not mental health services to reduce stigma.	11
Key Area 2: Tailor approaches to improve mental health in specific groups		**Number of votes**
28	Well-being (holistic approach not just mental health).	10
29	Not in "community".	1
30	Importance of anonymity.	2
31	Posters in cafes and hairdressers to normalise mental health.	2
32	Investment in the future – healthy living in schools.	2
33	Street pastors and school pastors very effective.	3
34	Community activities.	4
35	Approaching cultural barriers.	2
36	Importance of approaching those who are housebound.	8
37	Particular training for those who are District Nurses and members of the Ambulance Service.	8
38	Raising awareness of existing services.	20
39	More funding for Mental Health First Aid.	21
Key Area 3: Reduce access to the means of suicide		**Number of votes**
40	Mental Health First Aid training for the broader community – enabling others to take responsibility for the health of those around them.	31
41	Access to information and who to contact for help at lots of locations.	26
42	Risk register of those at risk of suicide.	3
43	Access to services in a more anonymous way – e.g. internet.	3
44	Register of what is available.	19
45	Open up referral routes to more agencies.	6
Key Area 4: Provide better information and support to those bereaved or affected by suicide		**Number of votes**
46	Smaller agencies/third sector to have designated contacts to signpost and support.	10
47	Clear pathway for those bereaved. Website. Input from those affected. Local documentation and information.	8
48	PHSE days within schools – workshops on death and loss.	22
49	Improved counselling for bereavement. No deadline (i.e. 6 sessions).	10
50	Self help group for survivors of suicide.	13
51	Centralised website for professionals and general public. Including what services do what and how to refer.	26
52	Reduce waiting list times and give at least one/two sessions informing client about 'normal grief responses' and 'what grief can look like'.	15
53	Self help initiatives/support group.	8
54	Training and development of professionals and rigorous supervision and professional proactive support.	16
55	Support for families/individuals living with suicidal individuals (para suicidal).	41

Key Area 5: Support the media in delivering sensitive approaches to suicide and suicidal behaviour		**Number of votes**
56	Centre for information that either public or professionals can use to obtain the most appropriate area to get help.	25
57	Better training for journalists with regards to reporting of either suicide or mental health issues/ events.	14
58	Raise the profile of Samaritans on the internet/website/Facebook pages and on reporting.	9
Key Area 6: Support research, data collection and monitoring		**Number of votes**
59	Send message to government for a national advertising campaign.	8
60	Target middle aged men going for health checks.	8
61	Change definition of untoward deaths so that we can understand what happened better.	6
62	Share evidence based interventions for all services to raise standards.	26

What Particular Challenges Are We Facing?

Workforce	Service Development
• Lack of clinical supervision. • Care of workers. • Capacity of mental health service – e.g. health professional being asked to determine how high suicide risk. • Dismissive attitudes to adolescent expressions of suicidal ideation. • To be able to train an appropriately qualified and accredited workforce whose clinical skills and outcomes are monitored. • Training is required in emergency (A&E) issues with confidentiality. • Need for supervision for professionals encountering issues. • Training, lack of awareness. • Pressure on support service staff to sort problems = stress and distress. • Lack of information about benefits. • Mental health professionals are too few, too busy to listen and show not enough interest. When required the say they have a more important call to make even after concerns are put over. • Support for teachers and training so they can identify children at risk and refer appropriately. • Lack of support for staff who have witness something – early proactive support. How do we create a culture where this is normal? • A Hub – share resources for proactive support for staff that is neutral. • Shortage of trained clinicians and psychologists. • Stigmatising attitudes from health professionals in A&E and police. • Clinical supervision for helping professionals (have high suicide rate).	• Implementing payment by results. • Patient engagement in developing services – balancing this with what we know to be evidenced based treatment and professional expertise. • How to implement up to date treatments whilst maintaining KPIs. • SOBS not on the Island. • Third sector support to be sustainable on the Island. • Alternatives for young people. • Criteria to access service – too young or too old. • Organisations being risk averse. • Fragmentation of services – not knowing what is out there. • Services finish at midnight. • Food at Seven acres is poor. • Adult services lacking in talking therapies. • You are treated as sub-human and a criminal in Sevenacres. Patronising. Its all about medication. • Medication isn't managed properly. • Quicker access to therapies. • Not always a place of safety in a crisis. • GP to be proactive approach and referral. • The mental health services – outreach particularly linking with schools. • GPs and IAPT services unable to assess suicidal patients who are not so ill. • 1 to 1 talking therapy whilst suicidal at their own home. • Providing support to clients with learning disability who experience/express suicidal ideation. • Accessing Sevenacres in a crisis. • No known suicide hotspots for overt interventions. • Premises to see patients in – need local to the patient and non-medical or in primary care.
More Support	**Pathways/Partnership Working**
• Supporting those left behind. • Support isn't there for clients when it is getting more serious/challenging. • Listen to person and or carer with empathy. • Support for carers. Who do they talk to? Someone who is completely neutral. • Support offered to individuals not family. • Loneliness especially among elderly. • Support for the bereaved. • Direction for concerned friends and families. • Direction for sufferers/despondent people. • Help offered when discharged – what happens then? • Personal aftercare support required to rebuild your life. • No support for those bereaved by suicide. • More support from all involved. Less people involved the better. • Loved ones committing suicide – not enough bereavement support. • Loneliness – no close friends groups. Not a supportive family network. • Employers not understanding the issues and how to help. • How do you protect people from themselves?	• Comprehensive assessment ➡ Right worker. • Communication between professionals. • Not listening – bouncing people around systems. • Accessing the right services at the right time before it reaches crisis point. • To get appropriate patients to the appropriate services in a timely manner. • Lack of joined up working. • Don't know where to go or what to do. • Lack of joined up services and integrated IT systems leading to people falling through the net. • Coordination of care. • All services to work together instead of passing the buck. • Chaotic, difficult to engage clients. • Multi agency working compromised by confidentiality and data protection. • Communication between/amongst agencies. • Lack of communication. Risks are not flagged. • Poor IT between departments, health, GP, social services.

Small Community	Dependency/Low Aspirations
• Small communities. Those that are private people find it difficult to ask for help (everyone knowing your business). • Rural environment leading to transport issues – no buses in isolated areas reducing access to services. • Lack of employment opportunities. • Cost of travel.	• Low aspirations of young people. • Young people pessimistic about their future opportunities. • People to aspire to. Good role models from local groups. • Apathy/lacking engagement. • Culture of dependence. • Poor education standards. • Parental apathy – lack/loss of aspiration vs parental pressure = stress.
Communication	**Economic Climate**
• Access to information. • Some services people don't know about. • Caldicott2 is getting in the way of communication. • Lack of information about what is available. • How to engage with and improve communication with stakeholders. • Hard to reach – silent sufferers. • Gap of awareness/reaching those that are not known to services. • Facebook etc, breeds feelings of discontent and isolation. • Facebook type communication picking up on ideation. • Modern technology. • Media focus on bad news.	• Services overwhelmed. • Cuts to mental health budget. • Cuts to local authority budgets. • Mental health practitioners have far too many clients on their caseloads and don't help because they can't. • Waiting time. • LGBT community newsletter cut of funding. • Economic climate – benefits, job loss. • Money cuts – changes to benefits system.

What Needs to Happen to Overcome Those Challenges?

Pathways/Partnership Working	Service Development
• Control point of contact and dissemination of information. • Integrated services and IT. • Develop a 'care pathway' and appropriate training to deal with suicidal ideation. • Sharing of care pathways across services/third sector. • Training and protocols re confidentiality and information sharing. • Talking to other professionals. • Greater multi agency communication. • Educating people in regards of suicide/risk concerns. • Standardised audit scoring tool to look at risk. • More information on referrals. • Faster referrals to therapy services. • More qualitative data. • At risk register for adults. • Effective multi agency working. • Improved communication across services sharing risk. • Local leadership from council.	• Don't call it mental health – just health. • Services to help earlier – earlier prevention. • No early discharge of patients. • Alternative resources needed such as CBT, counsellors. • Access to night services. • Serenity 24/7 service. • Empathy/understanding from crisis teams. • More resources at early intervention – less expense later on. • Need to bring on board modern technology in treatment – e.g. CBT on-line and instant messaging. • Fast track back into services. • Appropriate place of safety. • Encouraging more voluntary/third sector organisations. • More specialist mental health care for children/adolescents e.g. hospital beds. • Identify suicide hotspots.
More Support	**Workforce**
• Credit card size information for relatives and friends on what to look, unusual behaviours to look out for, recognising the signs. • More community groups to help people understand. • Family support and help with benefits. • Employer education.	• Staff training in benefits. • Have a workforce that is psychologically literate and offer evidence based treatments through a variety of modalities. • Training in risk assessment and risk management. • Ensure service providers appropriately. • Trained to assess for appropriate intervention. • Care of staff – best practice. • Trained staff to risk manage where calls should be directed on the Hub.
Economic Climate	**Communication**
• Overcome funding issues. • Working smarter within same restrictions. • Don't cut essential budgets. • Reinstate LGBT newsletter as very important for connecting vulnerable group.	• Talk about suicide more – get rid of the stigma. • Communicate messages of where and how to get help/ support. • Publicise agencies who can offer support especially for self-referral. • Hub and Council better informed of services. • Use media more – radio, the Beacon. • Engage with local media re reporting suicide sensitively. • Samaritans to be advertised more so they get more volunteers. • Faith in the system for users of the services.

Appendix Eight: Twelve points to a safer service

This checklist from the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCI) is based on recommendations from a national study of patient suicides and provides key guidance for mental health services. A recent research study suggests that these service changes (particularly 24 hour crisis teams, policies for people with drug and alcohol problems, and reviews after suicide) were associated with a reduction in the rate of suicide in implementing NHS Trusts.[65]

This is intended as a checklist for local services:

1. Staff training in the management of risk – both suicide and violence – every 3 years.
2. All patients with severe mental illness and a history of self-harm or violence to receive the most intensive level of care.
3. Individual care plans to specify action to be taken if patient is non-compliant or fails to attend.
4. Prompt access to services for people in crisis and for their families.
5. Assertive outreach teams to prevent loss of contact with vulnerable and high-risk patients.
6. Atypical anti-psychotic medication to be available for all patients with severe mental illness who are non-compliant with "typical" drugs because of side-effects.
7. Strategy for dual diagnosis covering training on the management of substance misuse, joint working with substance misuse services, and staff with specific responsibility to develop the local service.
8. In-patient wards to remove or cover all likely ligature points, including all non-collapsible curtain rails.
9. Follow-up within 7 days of discharge from hospital for everyone with severe mental illness or a history of self-harm in the previous 3 months.
10. Patients with a history of self-harm in the last 3 months to receive supplies of medication covering no more than 2 weeks.
11. Local arrangements for information-sharing with criminal justice agencies.
12. Policy ensuring post-incident multidisciplinary case review and information to be given to families of involved patients.

Appendix Nine: Consultation Closure Report

1. Introduction

The CCG, Public Health, Isle of Wight Council, NHS Trust, Police and third sector organisations have come together to produce the Isle of Wight Suicide Awareness and Prevention Strategy. It is essential that the views and health needs of the Island population and stakeholder organisations are reflected in the strategy and therefore there have been a number of consultations over a twelve month period to develop this strategy.

The consultation has been in two phases:

- Phase 1: Engagement to inform the strategy
- Phase 2: Consulting on the draft strategy

This paper is to summarise the consultation activity that took place to inform this strategy.

2. Phase 1: Engagement to inform the strategy

Phase one was from 15th May 2013 – 30th August 2013

During this phase delegates were asked:

- What is working well?
- What challenges do we face?
- How can we overcome these challenges?

The engagement involved publicising the engagement event, the survey monkey and that there was an opportunity to meet or speak with the project team. The activities included:

2.1 Awareness Raising:

- Isle of Wight radio did a number of broadcasts about the engagement during the news
- Article in the County Press: 31st May 2013
- Article on the County Press website: 22nd June 2013
- Article on Isle of Wight Mail

- Online article in On the Wight 30th May 2013
- Advertised on Isle of Wight Healthwatch website
- Emails circulated to network
- Press release sent out to all media and stakeholder organisations

2.2 Workshops and Interviews:

- Attended a number of groups, forums and boards
- A number of interviews with colleagues from stakeholder organisations
- A number of face to face workshops with groups this included: People Matter, Mental Health Sub Group, Service users and families Bereaved by Suicide

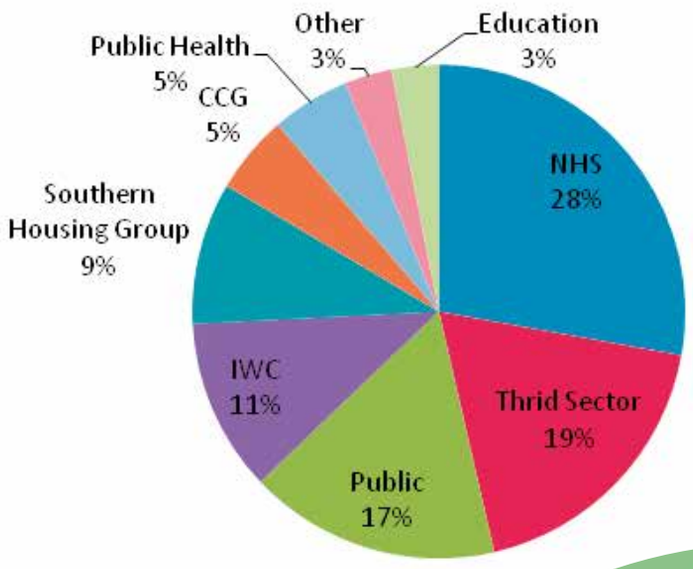
2.3 Online:

- A survey monkey was completed by 25 people
- Press releases were hosted on IW CCG, IW Trust and Healthwatch websites
- A email address was set up for correspondence

2.4 Engagement event:

The engagement event was attended by 97 people on 26th June 2013: A full Engagement report can be found in Appendix Seven of the strategy.

Table 1: A breakdown of which organisations the attendees represented at the engagement event.



Some of the solutions that were identified by the group during the consultation were:

Pathways/Partnership Working

People spoke about the sharing of care pathways and risk information across services including the third sector; greater multi-agency communication; integrated IT; and training and protocols on confidentiality, information sharing and risk.

Service Development

Comment was made about the needs for:

- An appropriate place of safety
- A focus on early intervention
- Better use of technology
- Providing the Serenity service 24/7

More Support

Participants identified the need for credit card size information on what early warning signs to look out for, greater community understanding, family support and help with benefits, and employer education.

Workforce

Some specific recommendations were made such as trained staff to risk manage on the Hub, having a workforce that is psychologically literate, offering evidence based treatments, and best practice care of staff.

Economic Climate

Overcoming funding issues and working smarter within the same restrictions were identified as possible solutions.

Communication

Suggestions were made about engaging with the media about the reporting of suicide and using the media more to publicise services and address stigma.

3. Phase 2: Consultation for the Draft Strategy

Phase two of the consultation was to obtain people's feedback and comments on the draft strategy. The consultation was from 20th May 2014 – 15th July 2014. During the engagement in Phase 1 it was highlighted that the stakeholder organisations should come together to develop a Steering Group to monitor the delivery of the strategy action plan. This group also reviewed Phase 2 of the consultation for the draft strategy.

The consultation involved a number of elements:

3.1 Awareness raising:

- A joint press release from the stakeholder organisations to all media agencies which included:
    - Article on the County Press 4th June 2014
    - NHS E-Bulletin
    - Online Article on Isle of Wight Radio Website 7th July 2014
    - Ventnor Town Council news Letter 23rd May 2014
- Emailed Existing networks the press release and draft strategy
- Circulated to all those involved in the Phase 1 of the engagement
- Circulated to all stakeholder organisations and staff including, GP practices, NHS Staff, Social Care, Public Health, Police, third sector organisations
- Hosted on CCG and NHS Trust website

3.2 Workshops and interviews:

The strategy was taken to a number of Boards, forums and groups which included:

- NHS Trust
- IW Council
- Voluntary Service Forum – 10th June
- Mental Health Sub Group
- Children's Trust Board
- Trust's Lesbian, Gay, Bisexual and Transgender patients and staff network

3.3 Online:

- An email address was used for correspondence
- The draft strategy was hosted online on the IOW CCG, IW Trust and Healthwatch website

4. Summary of comments

The Suicide Awareness and Prevention Steering Group received seven comments; four were from members of the public, one from the Trust's Lesbian, Gay, Bisexual and Transgender patients and staff network, one from a Public Health Colleague from another Island and one was from a media organisation.

The comments and feedback are included in Table 1.

The Suicide Awareness and Prevention Steering Group were happy to hear during the public consultation that the overall strategic direction was endorsed. Whilst the written response rate was low, respondents agreed with the strategic priorities and the action plan to address this with additional comments on how to achieve these priorities which are captured below.

Table 1. Comments from Consultation

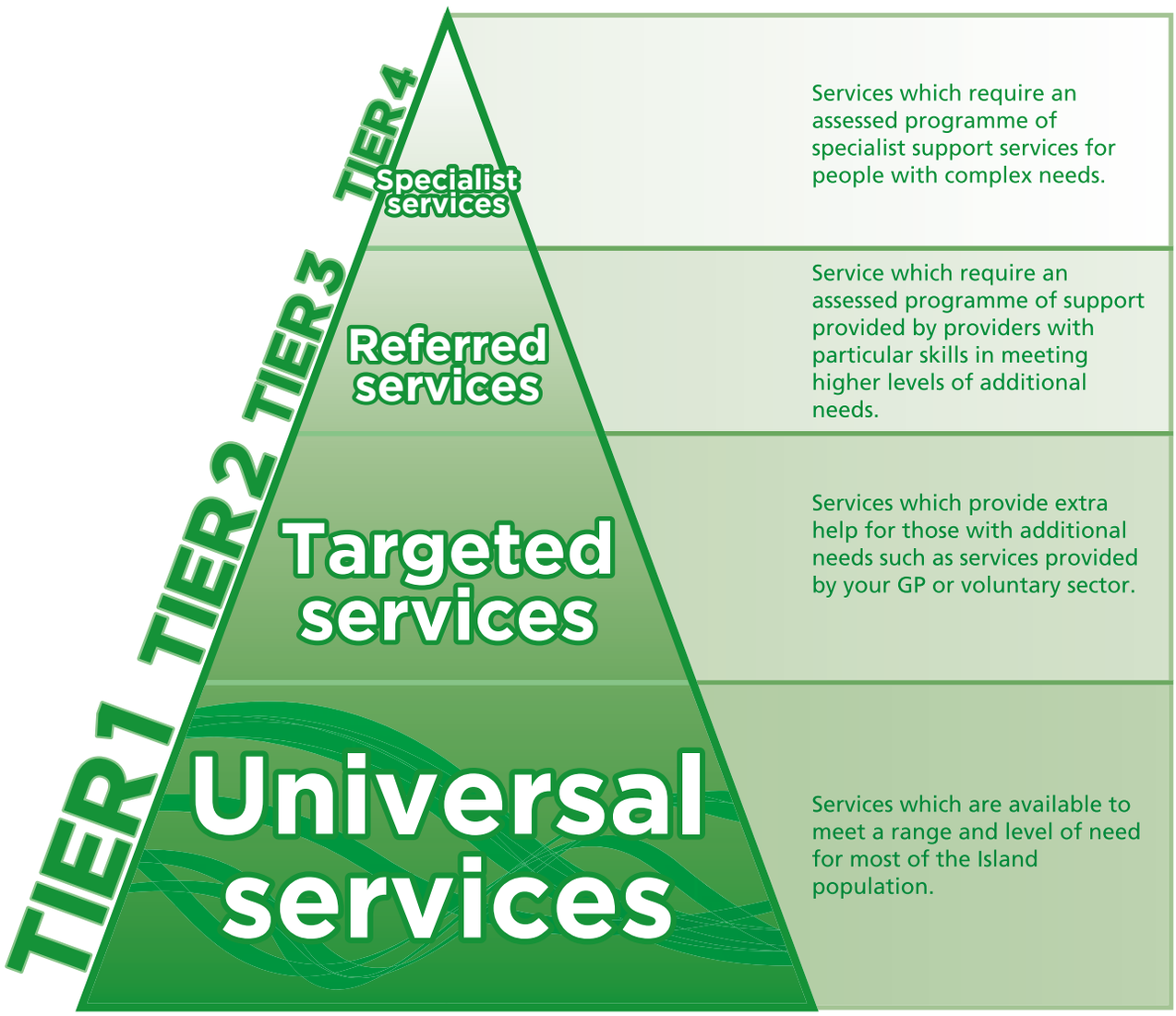
Number	Comment
1	I read Dr John Rivers account in the County Press, perhaps the NHS should provide more Mental Health staff in the community on the island, churches may be able to help for consultation with people that do get very depressed, I am a member of the Ryde Methodist Church and the Minister did try and get someone to help but they did not turn up and there are people that needs help with the Open Arms Meetings.
2	Befriending is another way of helping people to help relieve stress.
3	I have just spent the best part of this afternoon reading your strategy for suicide prevention. Excellent document with obvious contributions from lots of people who know what they are doing. I have one tiny comment that may be of use at some stage… that is the power of animals in reducing depression. Voluntary work with RSPCA, or the Donkey sanctuary, could raise self-esteem in the young. With the lonely elderly can really give them a reason to get up in the morning and have a warm living being to look after and cuddle up to. For those too frail to take a dog for walk, cats would be fine… Not sure if there has been any research into this. But I will never forget a sick child at a feeding centre in Angola, TB, possibly HIV, anorexic, lost his parents, almost catatonic with depression, totally non-communicative. We took him to a colleagues house where she kept rabbits. First time ever he showed interest. He came regularly for "rabbit therapy". Recovered enough to leave hospital and go to an orphanage. If you ever decide to do any research of this kind I would love to be involved! Thanks for reading this.
4	I am looking for funding to take the ASSIST 5 day course to become a trainer in "how to participate in suicide intervention".
5	Thanks so much for sharing this. I've read a lot of these strategies and following a quick scan of yours it looks by far the best I've read.
6	Myself and a couple of other ladies came up with an idea quite a while ago regarding setting up a suicide support group on the island, our idea was to set up a page on Facebook, website and drop in centre (at riverside centre) for people who are suffering detrimental feelings, families or friends who are looking for support as their loved ones are contemplating or committed suicide, we would provide signposting to available resources and support.
7	1. Section 6 – deliberate/unintended injuries – explain what this means? 2. Page 12 – refers to 'standardised mortality rate' – what is this? 3. Page 15, section 13 – Table 1 does not explain which hospitals we have compared ourselves against and why? 4. Why does the strategy work on 2011 data which is surely out of date? When is the next lot of data being published?
8	Reduce the suicide rate in the general population on the Isle of Wight: I have serious concerns about how this can be achieved, as it seems that many of the factors contributing to suicide are entirely outside the control of the NHS. There is high unemployment (and I'd guess that's particularly so among the younger generation), relatively poor rates of pay, and limited prospects on the island. With an increasingly ageing population, the proportion of wage earners to pensioners continues to fall, which does nothing to improve the situation. The island needs to make it's position known to central government, to obtain monetary assistance to redress the balance, and to ease (in particular) the financial difficulties experienced by individuals which leads them to consider suicide in the first place. As I've already said, prevention is better than cure and, in this instance, I feel that we need to look beyond the NHS.

Appendix Ten: Action plan

The 6 areas for action have been split into two action plans that will aim to:

- Reduce the suicide rate in the general population on the Isle of Wight.
- Increase support for those bereaved or affected by suicide.

Action plan 1 is split into 4 tiers:



This action plan has been populated by some organisations on the Isle of Wight. All are invited to contribute to this action plan to ensure the islands activities are captured, learning is shared and enable the facilitation of integrated working where possible.

6.1 Action plan 1: Reduce the suicide rate in the general population on the Isle of Wight

Tier 1: Universal services		
OUTCOME	**ACTION**	**TIMESCALE & LEAD**
Individuals and their families have access to information and are aware of the services available to them.	• Scope the information available and how people access this information. • Signposting: Develop a directory providing information and advice on services, self-help and available resources for professionals and service users. • Scope the development of the mental health alliance to provide coordinated and collaborative activity of the voluntary sector to support at risk groups.	Suicide Awareness and Prevention Working Group My Life A Full Life Head of MH & LD Commissioning, CCG 2014–2016
People are informed appropriately by the media and feel that the information is respectful to the needs of those affected.	• Media awareness day for Suicide Prevention on the Isle of Wight. • Responsible reporting by local media to reduce the risk of additional suicides - National Guidelines are followed by local media - Guidance and advice on responsible reporting of incidents by local media organisations. • Working with local media agencies to support the signposting of national helplines and locals services for people that are affected by articles.	Head of MH & LD Commissioning, CCG & Public Health Development Commissioner December 2014 Head of MH & LD Commissioning, CCG & Public Health Development Commissioner Head of MH & LD Commissioning, CCG & Public Health Development Commissioner 2014–2016
Employers recognise when staff are emotionally vulnerable and know how to support them to recover.	• Employers of large organisations on the island are engaged in supporting staff with their emotional well-being: e.g. support to staff during redundancy, HR policies and procedures internally to recognise vulnerable staff at risk of self-harm and sign post and support appropriately. • Improve the mental health and well-being of the Police Force – MILO: is a mental health liaison service within the police to identify and support police officers with anxiety and mental health risks.	Chamber of Commerce M.I.L.O – Mental Illness Liaison Officer, Police
People are involved in the development and feedback of services.	• Development of Mental Health Service Users and carers forum with the Service User & Carer Link Co-ordinator.	Head of MH, LD and Community Partnerships, IW NHS Trust

Fewer people will experience stigma and discrimination Public understanding of mental health will improve and as a result, negative attitudes and behaviours to people with mental health problems will reduce and families and communities will be more confident and resilient	• Improved mental well-being and build resilience by working through the Healthy Communities Partnership Group action plan to build and strengthen communities, families and individuals using evidence based ABCD (Asset Based Community Development) approaches. 'A health asset is any factor or resource which enhances the ability of individuals, communities and populations to maintain and sustain health and well-being. These assets can operate at the level of the individual, family or community as protective and promoting factors to buffer against life's stresses'. • Through participatory leadership Public health will co-ordinate, facilitate and monitor outcomes of the Health Communities Group reporting directly to the Health and Well-being Board.	Public Health Development Commissioner Ongoing
	• As part of the Public Health strategic vision linking to the IW five year integrated health and social care plan develop a holistic family focused platform. It is envisaged that these principles will lead to new kinds of community based working; they could also be used to refocus many existing council and health service programmes. • Implement Local Area Coordination enablement approach to empower vulnerable people to improve mental, physical and social well-being through using personal and community assets to develop non-service solutions.	Public Health Development Commissioner 2014–2016
More people with mental health problems will have good physical health. Fewer people with mental health problems will die prematurely and more people with physical ill health will have better mental health.	• Improve the physical health of people with mental illness diagnosis. Evidence shows that people with mental health diagnosis have higher levels of alcohol misuse, smoking and obesity than the population as a whole. • Through the Public Health business plan implement a review of currently commissioned health improvement programmes with the intention to re-commission in a holistic family centred integrated service that is incentivised to target health inequalities and outcomes for people with mental health conditions.	2014–2016
Improved mental well-being of children and young people linking to The Children and Young People emotional health and well-being strategy.	• Through the Public Health business plan implement a review of currently and soon to be commissioned services for school nursing and health visiting to focus on a holistic family centred approach to improving mental well-being.	Public Health Development Commissioner 2014–2016

Prisoners who pose a risk to themselves, to others and/or from others are identified and supported.	The National Offender Management Service (NOMS) strategy for the management of prisoners at risk of harm to themselves is set out comprehensively in Prison Service Instruction 64/2011. Key outputs of this strategy are that: • Prisoners who pose a risk to themselves, to others and/or from others are identified. • Staff, prisoners and visitors are aware of the risk identification, assessment and management procedures. • Prisoners are assessed for risk. • Prisoners at risk or posing a risk are involved in the assessment and management processes where safe to do so. • Prisoners at risk or posing a risk are managed according to the level and type of risk they pose, up to and including constant supervision. • Prisoners have access to identified peer support schemes in relation to managing the risk of harm to self. • Positive staff/prisoner engagement is supported and maintained. • At risk prisoners are encouraged to engage positively with the prison regime and interventions to contribute to the reduction of risk. • Serious incidents of self-harm or violence are investigated at an appropriate level. • Learning from deaths in custody and incidents of self-harm or violence is identified, disseminated and acted upon.	Offender Management Service

Tier 2: Targeted services		
OUTCOME	**ACTION**	**TIMESCALE & LEAD**
High risk individuals are identified and given the correct support quickly.	• NHS 111 call handlers use a mental health risk screening tool. • Informal education programmes developed that aim to support young people in coping with feeling bad - Schools: Support given to schools and colleges to develop workshops on mental well-being and resilience.	NHS Trust/NHS England Public Health / Education
People have a choice of services that meet their needs.	• E – mental health solutions are piloted e.g. Helios, PsychologyOnline.	Head of MH, LD and Community Partnerships, IW NHS Trust September 2014
Prisoners at risk or posing a risk are engaged positively in their assessment, management and recovery where safe to do so.	The National Offender Management Service (NOMS) strategy for the management of prisoners at risk of harm to themselves is set out comprehensively in Prison Service Instruction 64/2011. Key outputs of this strategy are that: • Information is identified, recorded and shared with stakeholders. • Contracts/Service Level Agreements (SLAs) with third party providers reflect the need for multi-disciplinary working in relation to at risk prisoners. • Following a death in custody, near death, act of self-harm or violence towards others, all relevant stakeholders are informed. Where appropriate, their work is facilitated (if applicable) and a record of contact is maintained.	Offender Management Service

Tier 3: 3 Referred services		
OUTCOME	**ACTION**	**TIMESCALE & LEAD**
Information relating to suicide is collected and analysed which will inform agencies in the prevention of suicide.	• Access to the means of suicide is reduced where possible – Incidents on the Island to be mapped to determine if there is a pattern between suicide attempts and location. • Annual audit of suicide and open verdicts and this would feed into the JSNA. • Development of multi-agency case review group that would meet bi annually to reflect on incidents and monitor patterns and dispel learnings.	Serenity Force Mental Health Response & Diversion Partnership March 2015 Head of Commission Support Health and Social Care Head of Commissioning MH & LD April 2015
Vulnerable individuals who are at risk of self-harm are identified and supported appropriately.	• Risk assessment [inset text] • All patients are risk assessed • Individuals of all ages who have self harmed receive the right support at the right time – Self-harm liaison team support older people. • Inpatient unit procedure [insert text]	Self Harm Liaison Team, Head of MH & LD Community Partnerships, IW NHS Trust Ongoing
Prisoners affected by incidents of self-harm, violence or a death in custody are identified, risk assessed, managed and supported where appropriate.	The National Offender Management Service (NOMS) strategy for the management of prisoners at risk of harm to themselves is set out comprehensively in Prison Service Instruction 64/2011. Key outputs of this strategy are that: • Information is identified, recorded and shared with stakeholders. • Contracts/Service Level Agreements (SLAs) with third party providers reflect the need for multi-disciplinary working in relation to at risk prisoners. • Following a death in custody, near death, act of self-harm or violence towards others, all relevant stakeholders are informed. Where appropriate, their work is facilitated (if applicable) and a record of contact is maintained.	Offender Management Service
Young people known to YOT and their families have access to information and are made aware of the support services available to them.	• Review YOT Induction Pack to include directory of local services which can be accessed independent of YOT advice/process. • Ensure literature/leaflets etc are accessible to service users in a variety of formats and locations. • Signposting and exit strategies are offered to ensure ongoing intervention once YOT involvement closes.	IOW YOT Operational Team Manager March 2015
Young people in the community and subject to YOT supervision are properly assessed, referred and supported where risk of harm to self is evidenced.	• All young people known to YOT will be subject to comprehensive initial assessment (via Asset or Assetplus) and regular review in line with National Standards for Youth Justice 2013 and the IOW YOT Vulnerability Assessment and Management Policy.	IOW YOT Operational Team Manager March 2015
	• Care pathways will be established to ensure effective partnership working and timely access to services.	IOW YOT Management Board March 2015
Frontline YOT staff are trained and feel confident in working with young people who are known to the youth justice and experiencing mental health difficulties.	• All frontline staff to attend and complete Mental Health First Aid training (and, where possible, Youth Mental Health First Aid).	IOW YOT Operational Team Manager March 2015

All YOT staff are aware of support services available to them, and effectively supported in managing their own mental health.	• Regular supervision and support provided in line with IOW YOT policy. • Promotion of positive strategies to encourage good mental health (including awareness of triggers and strategies) via Team Meetings, training etc. • Information made available regarding support services specifically for staff, and the general population on the IOW.	Hampshire and IOW YOTs Head of Service and IOW YOT Operational Team Manager March 2015

Tier 4: Specialist services		
OUTCOME	**ACTION**	**TIMESCALE & LEAD**
People who are vulnerable that enter the acute hospital are assessed and supported appropriately.	• Scope A&E Rapid Assessment Interface and Discharge – A 24 hour, seven day a week, integrated mental health liaison service which would identify patients at risk of suicide following a risk assessment in A&E.	Head of MH & LD Commissioning Manager March 2016
People leaving inpatient units are supported.	• All patients are to be followed up within seven days of being discharged from Sevenacres.	Head of MH, LD and Community Partnerships, IW NHS Trust Ongoing
When people are in crisis they are supported appropriately by the emergency services to minimise risk.	• Serenity Pilot – a scheme to improve responses to mental health crisis calls by the Police and Adult Mental Health Services, where vulnerable people may need specialist support or there are concerns for their safety.	Police/ NHS Trust/ CCG
Young people in custody are properly assessed, placed and supported whilst serving their custodial sentence, where risk of harm to self is evidenced.	• Completion of comprehensive assessment (via Asset/Asset Plus) prior to sentence during completion of all Pre-Sentence Reports. • Provision of accurate and timely information through submission of Placement Information Forms (PIFs) and Post Court Assessments (PCAs) to the YJB Placements Team. • Effective liaison with healthcare providers in the secure estate, including identification of in reach/out reach service, requests for placement transfer (where required) and resettlement planning.	IOW YOT Operational Team Manager March 2015

6.2 Action plan 2: Supporting the bereaved

OUTCOME	ACTION	TIMESCALE & LEAD
The bereaved receive high quality targeted support.	• Improved access to information about support. ○ Information is distributed by: ■ Bereavement officers ■ Coroners court ■ Bereavement Officers in St. Mary's ■ Funeral directors ■ Statutory and voluntary organisation ■ Police officers who are delivering death messages ■ GP practice	Suicide Awareness and Prevention Steering Group
	○ All Strategy documentation and information distributed needs to be available in different formats, languages and reasonable adjustments made for LD.	LDPG
	• Understanding by practitioners of the services available. ○ Develop a directory of services including the criteria for accessing services.	My Life a Full Life
	• Improved access to services. ○ Scope how to identify those bereaved by a suicide. ○ Scope how to provide them with appropriate information, access for bereavement support.	Suicide Awareness and Prevention Steering Group
	• Schools are supported following a suicide of a pupil or staff member. ○ Post vention service support in the schools – appropriate support is in place.	Commissioned services from statutory and voluntary organisations
	The National Offender Management Service (NOMS) strategy for the management of prisoners at risk of harm to themselves is set out comprehensively in Prison Service Instruction 64/2011. Key outputs of this strategy are that: • Prisoners affected by incidents of self-harm, violence or a death in custody are identified, risk assessed, managed and supported where appropriate. • Staff and visitors who are immediately affected by incidents of self harm, violence or a death in custody are identified and supported. • Following a death or near death in custody, or for terminally ill prisoners, initial and on-going liaison takes place between the prisoner's nominated next of kin and the prison.	Offender Management Service
People who are suspects of offences are identified who have been bereaved by suicide.	• Training for police offices about mental health and how it drives choice and behaviour in offending. ○ Train police offices to identify bereavement in the investigation as a cause of behaviour.	Serenity Force Mental Health Response & Diversion Partnership
Young people known to YOT and their families have access to information and are made aware of bereavement support services available.	• Review YOT Induction Pack to include directory of local services which can be accessed independent of YOT advice/process. • Ensure literature/leaflets etc are accessible to service users in a variety of formats and locations.	IOW YOT Operational Team Manager March 2015
All staff are aware of bereavement support services available to them, and effectively supported during periods of bereavement.	• Information made available regarding bereavement support services. • Application of the IOWC Special Leave policy where applicable.	IOW YOT Operational Team Manager March 2015

References

[1] *Preventing Suicide in England: A Cross-government outcomes strategy to save lives* HMG/DH 2012

[2] *Isle of Wight Community Mental Health Profiles 2013* Public Health Observatory

[3] Shahpesandy, H., van Heeswijk, A., (2012). Suicide on the Isle of Wight: A Case-study of 53 Suicides among Mental Health Service Users Between 2006 and 2008. Ir J Psych Med 29(2) 80 – 84

[4] Taken from Self-harm: Longer-term management NICE Clinical guidelines 133. November 2011 p3

[5] *Multicentre Study of Self-harm in England* (Universities of Oxford and Manchester) DH

[6] *Isle of Wight Community Mental Health Profile* 2013 Public Health Observatory

[7] Statistical significance cannot be determined because of the low numbers involved.

[8] *Preventing Suicide in England: A Cross-government outcomes strategy to save lives* HMG/DH 2012 p18

[9] *Preventing Suicide in England: A Cross-government outcomes strategy to save lives* HMG/DH 2012 p18

[10] *Self-harm, suicide and risk: helping people who self-harm* (2010) Royal College of Psychiatrists

[11] *Public Health Action for the Prevention of Suicide: A Framework* (2012) World Health Organisation

[12] *Self-harm, suicide and risk: helping people who self-harm* (2010) Royal College of Psychiatrists

[13] *Public Health Action for the Prevention of Suicide: A Framework* (2012) World Health Organisation

[14] *Risk and Protective Factors for Suicide and Suicidal Behaviour: A Literature Review* (2008) Scottish Government Social Research

[15] National collaborating Centre for Mental Health, 2004: pp25 – 26 cited in *Self-harm, suicide and risk: helping people who self-harm* (2010) Royal College of Psychiatrists

[16] ibid

[17] *Healthy Lives, Health People: Our Strategy for Public Health in England*. 2010 HM Government

[18] 2011 Census. ONS

[19] IOW JSNA 2011 - 12

[20] ibid

[21] Indices of Deprivation 2010 – Isle of Wight LIP Summary

[22] *Preventing Suicide in England: A Cross-government outcomes strategy to save lives* HMG/DH 2012

[23] Audit of Suicides and Open Verdicts taking place on the Isle of Wight between 2008 to 201, Isle of Wight Public Health, 2013

[24] *Preventing Suicide in England: A Cross-Government Outcomes Strategy to Save Lives* HMG/DH 2012 p13

[25] Bertolote, J. M., Fleischmann, A., (2002) Suicide and psychiatric diagnosis: a worldwide perspective. *World Psychiatry*, 1, 181–185. Cited in *Self-harm, suicide and risk: helping people who self-harm* (2010) Royal College of Psychiatrists

[26] Statistical Update on Suicide. September 2012 DH

[27] Kapur, N., et al (2012) Suicide in psychiatric in-patients in England *Psychological Medicine* quoted by *Centre for Mental Health and Risk*

[28] *Preventing Suicide in England: A Cross-Government Outcomes Strategy to Save Lives* HMG/DH 2012

[29] Shahpesandy, H., van Heeswijk, A., (2012). Suicide on the Isle of Wight: A Case-study of 53 Suicides among Mental Health Service Users Between 2006 and 2008. Ir J Psych Med 29(2) 80 - 84

[30] Runeson, B., Tidemalm, D., Ddahlin, M., et al. (2010) Method of attempted suicide as predictor of subsequent successful suicide: national long term cohort study. *British Medical Journal* 341 cited in *Preventing Suicide in England: A Cross-Government Outcomes Strategy to Save Lives* HMG/DH 2012 p16

[31] *Multicentre Study of Self-harm in England* (Universities of Oxford and Manchester) DH

[32] *Isle of Wight Community Mental Health Profile* 2013 Public Health Observatory

[33] *Preventing Suicide in England: A Cross-government outcomes strategy to save lives* HMG/DH 2012 p18

[34] *Preventing Suicide in England: A Cross-government outcomes strategy to save lives* HMG/DH 2012 p18

[35] The Patel Report: Prison Drug Treatment Strategy Review (2010) p19

[36] The Patel Report ibid p211

[37] *Safety in Custody Statistics England and Wales Update to December 2012* Ministry of Justice Statistics Bulletin 25 April 2013

[38] Roberts, S.E., Jaremin, B., Lloyd, K., (2013) High-Risk Occupations for Suicide. *Psychol Med* 43 1231-1240

[39] Isle of Wight Joint Strategic Needs Assessment 2011-12

[40] Isle of Wight Community Mental Health Profiles 2013 Public Health Observatory

[41] Reynolds CF, Perel JM, Frank E et al (1999). Nortriptyline and interpersonal psychotherapy as maintenance therapies for recurrent major depression: a randomised controlled trial in patients older than 59 years. Journal of the American Medical Association 281(1): 39–45.

[42] Dewey ME, Saz P (2001). Dementia, cognitive impairment and mortality in persons aged 65 and over living in the community: a systematic review of the literature. International Journal of Geriatric Psychiatry 16(8): 751–761.

[43] McCrone, P., et al (2008) *Paying the Price. The Cost Of Mental Healthcare in England to 2026*. Kings Fund

[44] *Self-harm, suicide and risk: Helping people who self-harm. Final report of working group* Royal College of Psychiatrists June 2010

[45] Murphy, E., et al (2012) Multicenter cohort study of older adults who have harmed themselves: risk factors for repetition and suicide. *British Journal of Psychiatry*, 200:399 - 404

[46] (www.britishlegion.org.uk/media/33529/reviseex-serviceprofile.pdf).

[47] ONS 2010/2011

[48] O'Reilly, D., Rosato, M., Connolly, S., *et al* (2008) Area factors and suicide: 5-year follow-up of the Northern Ireland population. *British Journal of Psychiatry*, 192, 106–111.

[49] Hawton, K., Harriss, L., Hodder, K., *et al* (2001) The influence of the economic and social environment on deliberate self-harm and suicide: an ecological and person-based study. *Psychological Medicine*, 31, 827–836.

[50] (General Lifestyle Survey (2009))

[51] www.nta.nhs.uk/facts-prevalence.aspx

[52] NUS Services Ltd. *Mental Distress Survey Overview* (2013)

[53] www.gov.uk/government/publications/children-looked-after-by-local-authorities-in-england-including-adoption (Local Authority Tables - Table LAA1)

[54] www.gov.uk/government/publications/characteristics-of-children-in-need-in-england-year-ending-march-2012 (Main table - Table D1)

[55] www.gov.uk/government/publications/youth-justice-statistics(Supplementary Tables - Table Ch9)

[56] Gunnell D , and Lewis G BJP 2005;187:206-208

[57] Cited in Guidance on action to be taken at suicide hotspots (2006) CSIP p4

[58] *Statistical update on suicide*. September 2012. DH

[59] *Preventing Suicide in England: A Cross-government outcomes strategy to save lives* HMG/DH 2012 p35

[60] Qin, P., Agerbo, E., Mortenson, P.B., (2002) Suicide risk in relation to family history of completed suicide and psychiatric disorders: a nested case-control study based on longitudinal registers. *Lancet* 360: 1126-1130. Cited in *Preventing Suicide in England: A Cross-government outcomes strategy to save lives* HMG/DH 2012 p35

[61] *Self-harm, suicide and risk: helping people who self-harm* (2010) Royal College of Psychiatrists

[62] Blood, R.W., Pirkis, J. & Holland, K. Media *Reporting of Suicide Methods*. Crisis 2007; Vol. 28(Suppl. 1):64–69. Cited in media guidelines for reporting suicide and self-harm (2008) Samaritans.

[63] *The Future of Local Suicide Prevention Plans in England: Report by the All Party Parliamentary Group on Suicide and Self-Harm Prevention* January 2013

[lxiv] Risk and Protective Factors for Suicide and Suicidal Behaviour: A Literature Review (2008) The Scottish Government

[65] While, D., Bickley, H., Roscoe, A., Windfuhr, K., Rahman, S., Shaw, J., Appleby, L., Kapur, N., (2012) Implementation of mental health service recommendations in England and Wales and suicide rates, 1997—2006: a cross-sectional and before-and-after observational study. *Lancet* 379: 1005-1012. Cited in *Preventing Suicide in England: A Cross-Government Outcomes Strategy to Save Lives* HMG/DH 2012