States of Jersey

Prevention of Suicide in Jersey

A Framework for Action

2015-2020

Title	Preventing Suicide in Jersey: A Framework for Action (2015-2020)
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Purpose of the Document	The purpose of this policy document is to set out the strategic direction for the reduction of suicide in Jersey.
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Foreword

Suicide is a challenging and sensitive issue in any community, and all the more so in a small one. The impact of a death by suicide can be far reaching and difficult to manage for family, friends and the local community.

We have seen deaths by suicide of young people in our community. This has called us to question how, as an island community, we can provide better support and care to those in our community when they are at their most vulnerable.

The stigma associated with mental health problems, suicide, contact with services and even seeking help can increase the risk to vulnerable people in our community. We all have a role to play in challenging stigma. We need to get better at talking together about mental health and suicide. The issues need to be out in the open. It is normal to go through times of low mood and dissatisfaction with life. Often we can push through with our own resolve and with the support of others. Sometimes though, people go on to have more significant problems and may experience suicidal feelings. At these times it is important to be able to talk to someone and to seek help rather than keep the feelings to ourselves.

The factors that can ultimately lead to suicide are complex. No single organisation, acting alone, can prevent suicide. To ensure suicide in Jersey is reduced, government needs to work collaboratively across agencies and across the wider community hand in hand with the voluntary sector to address the wide range of factors that we know lead to increased suicide risk.

A broader multi agency mental health strategy to improve the overall mental health of the population is being developed. This is important as suicide prevention starts with better mental health for all. Although this Framework for Action needs to be considered alongside the wider mental health strategy, it specifically focuses on the prevention of suicide for groups of people who have been identified as vulnerable or at high risk. Government departments will take the lead, and will be responsible for ensuring that all stakeholders are engaged and involved. Wider government strategies and emerging policy will also have an impact on the physical and mental health and wellbeing of the population.

However, preventing suicide is not just about government and services. We need to recognise and mobilise community resources including family, friend and kinship networks. A sense of connectedness to our family, friends and community are central to how we, as individuals and as a community, thrive and flourish. In order to address the unique challenges we have as an island community, we also need to capitalise on our unique strengths. By working together, using all of our resources, we can minimise the risk of vulnerable people completing suicide.

Dr Susan Turnbull
Medical Officer of Health

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Executive Summary

This document scopes the nature and size of the problem of suicide in Jersey and proposes ways of reducing it. As a cause of early death, suicide represents a real public health problem for our community. Many more years of life are lost by suicide than other more common causes of death that tend to occur later in life. This strategy will address suicide across the life course in recognition that suicide is a risk for adolescents, adults and older adults alike. Suicide is not an inevitable outcome, it can be prevented. The prevention of suicide is a shared responsibility requiring a breadth of sustained approaches and actions across services, agencies and the community.

Vision

Our vision is a Jersey community where people live full and fruitful lives, participate fully in their community and contribute economically to society.

Guiding Principles

- Life is valuable
- People at risk of suicide should receive support that is timely, high quality and proportionate to their need
- We have a duty of care to protect the vulnerable in society
- The Framework and resulting actions are evidence-based

Aim

To reduce suicide in Jersey

Objectives:

The Prevention of Suicide Framework for Action has identified four high level objectives on which to base its actions.

Objective 1: Improve mental health and wellbeing in vulnerable groups

Objective 2: Reduce stigma about suicidal feelings

Objective 3: Reduce the risk of suicide in high-risk individuals

Objective 4: Improve information and support to those bereaved or affected by suicide

Introduction

Suicide is a tragic event, which often occurs as a consequence of complex combined multiple factors rather than one single isolated issue. Suicide at a population level can be preventable and is a significant public health issue that was first raised as a specific public health concern in Jersey through the Medical Officer of Health Report 2001. The Jersey Suicide Prevention Strategy was launched in 2003 and taken forward in 2007 by a multi-disciplinary forum. Since then, significant progress has been made.

This document provides the further direction that the States of Jersey and its key partners will take to reduce suicide in Jersey across the life course. Learning from the previous strategy has been used to underpin this Framework for Action.

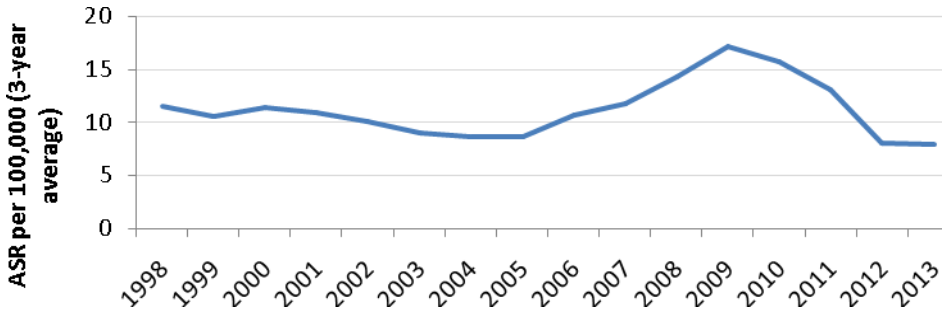
Our vision is a Jersey community where all people live full and fruitful lives, participate fully in their community and contribute economically to society. Promoting and enhancing positive emotional and mental health and wellbeing will help to prevent suicide. Good mental health is the foundation for wellbeing. It is being able to realise our personal potential, cope with everyday stresses of life whilst working productively and contributing to our community. It is about feeling good and functioning well, building strong and positive relationships with others. It is enhanced when we can reach our personal and social goals and achieve a sense of purpose in society. The people in Jersey need to be mentally resilient and able to function well, be healthy and equipped to cope with adversity and change. There is increasing evidence to suggest that positive mental health and wellbeing leads to a more fulfilled life at home, with our families and the wider community we live in and vice-versa. Our mental health, like our physical health, will vary throughout our lives whether we are young or old, we work or not, regardless of what we do and where we live.

An absence of mental wellbeing does not equate to a diagnosis of mental illness. One person may have a low level of mental wellbeing, without a diagnosis of mental illness. Another might have a diagnosis of mental illness but have a high level of mental wellbeing. The causes of mental ill health are complex and can affect up to one in four people and, just like physical illnesses, can be treated successfully leaving the individual free to live a full and rewarding life, participate fully in their community and contribute economically to society.

Suicide and the local context

Graph 1 below shows the rate of suicide in Jersey from 1998 to 2012, using three-year rolling averages*. This shows a peak in suicides in 2009 (17 per 100,000), which then reduces between 2010 and 2013 (8 per 100,000).

Graph 1

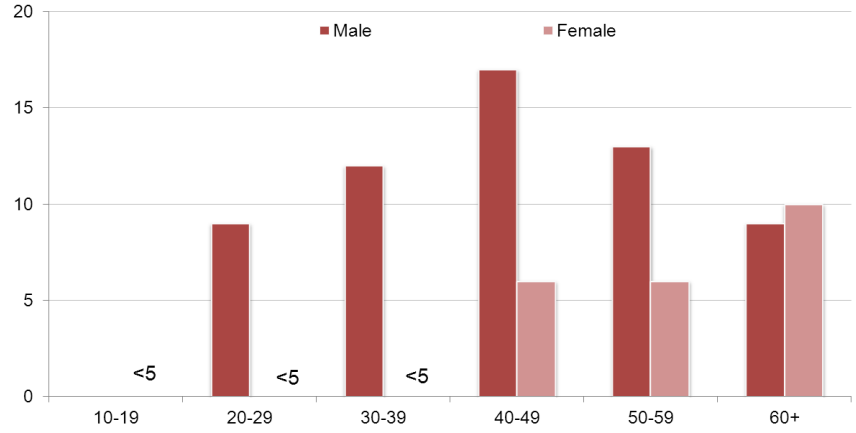


Source: Jersey Health Intelligence

The most recent rate for suicide in Jersey is 8 per 100,000. This is lower than the most recent available European rate which was 12.3 per 100,000 in 2010. Rates in Europe vary significantly between countries from a low of 8 or less per 100,000 in many southern European countries to over 17 per 100,000 in the Baltic States and central Europe[1].

Reported suicide death rates across the European Union are four to five times greater for men than women. Graph 2 shows actual numbers of completed suicides by age group and gender between 2007 and 2012 in Jersey. This shows that in those less than 60 years old, men are more likely to complete suicide. In the over 60 age bracket women were slightly more likely to complete suicide. During the period 2007-2012 men aged between 40 and 49 were more likely to complete suicide than for any other age group.

Graph 2



Source: Jersey Health Intelligence

* Due to Jersey's small population, suicide rates can fluctuate year to year. Three year rolling averages are an average of the current year and the two previous years. Doing this allows trend data to be seen.

Review of deaths by suicide

Reviews of deaths by suicide were commissioned through the 2003 Suicide Strategy. A research team from the University of Southampton carried out a study of suicide in Jersey covering the period from 2000 to 2008 and then an additional study of 2009 was carried out due to concern of an increase in suicides over that year[2]. Although the extended study added a focus on working age men, the review found no further or different contributing factors than during the previous period. The learning from this research helps build an understanding of the local context. The research particularly notes the disparity in suicide amongst young males and a need to target preventative efforts at this age group where other known risk factors exist. There is significant attention drawn to the presence of depressive symptoms and a need for better management of the signs and symptoms of depression across all services but particularly in primary care. The presence of stigma about depression and mental illness as well as a lack of public understanding of the availability of successful treatments was highlighted as a barrier to earlier intervention. Additionally, the role of alcohol was thought to contribute both in the long term for those who misuse alcohol as well as having a disinhibiting role in the immediate events leading to death by suicide. These research findings, as well as a review on progress of recommendations made, will help inform the development of local action within this Framework.

In addition to commissioned research, the Jersey Safeguarding Partnership Board (SPB) has a role in reviewing deaths by suicide. The SPB in its current form was created in 2013 and operates under the auspice of a States Memorandum Of Understanding. The SPB has an Independent Chair and is represented by in excess of 16 representative bodies. The SPB has a broad responsibility for Safeguarding both adults and children. As part of its function, the SPB has responsibility for commissioning, developing and delivering Serious Case Reviews (SCR) which would include circumstances culminating in the death of a person where lessons can be learnt.

The SPB has been consulted as part of the development of this strategy and learning derived from recent SCRs have also helped inform the strategy.

Local and national policy context

This Framework for Action has drawn upon key national policy documents including: 'Preventing suicide in England' cross-government outcomes strategy (2012)[3]; Scottish Government 'Suicide Prevention Strategy 2013-2016[4]; the World Health Organisation's (WHO) 2012 framework 'Public Health Action for the Prevention of Suicide[5] and 'No Health Without Mental Health': a cross-government mental health outcomes strategy for people of all ages (2011)[6].

The Jersey Health and Social Services Department (HSSD) Business Plan (2015) aims to improve health and social outcomes by reducing mortality, disease and injury in the population. Reducing the suicide rate will contribute to reducing preventable death[7].

The Prevention of Suicide Framework for Action will be supported by wider strategic context and is placed alongside related strategies and under the States of Jersey Common Strategic Plan. There are strong strategic links to the Mental Health Strategy, the Alcohol and Licensing Strategy[8] and Building a Safer Society and other States of Jersey strategies and policies which contribute to increased resilience. Acknowledging these links will ensure we make the best use of available resources and help to ensure strategies work together to achieve common aims.

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Objective 2: Reduce stigma about suicidal feelings

Objective 3: Reduce the risk of suicide in high-risk individuals

Objective 4: Improve information and support to those bereaved or affected by Suicide

Objective 1: Improve mental health and wellbeing in vulnerable groups

The following groups have been identified for prioritising action that intervenes early and supports the development of good mental health that will be protective against suicide risk.

- People who misuse alcohol and drugs
- The unemployed
- Survivors of abuse
- People living with long term physical and mental health conditions
- Young people who present with complex interacting needs
- Minority groups (ethnicity, race, religion, sexuality and orientation)

People who misuse alcohol and drugs

The relationship between attempted or completed suicide and alcohol use disorders is complex but well established. In Jersey, alcohol consumption is high compared to other countries, including France and the UK[9]. The University of Southampton research team analysed inquest file data, which showed that 37.2% of individuals who completed suicide

had consumed alcohol at the time of the event leading to their death. Similar to the UK there was evidence in Jersey of widely held dysfunctional attitudes towards alcohol use and the safe levels of alcohol consumption.

The States of Jersey Alcohol and Licensing Strategy 2014 has a breadth of actions that will be supportive in combating alcohol as a risk factor in suicide. Actions such as addressing pricing, access to alcohol and binge drinking all have an existing evidence base in contributing to lowering suicide.

The unemployed

Unemployment may make people feel less connected to society, or that they are a burden to their family or friends. It is a known risk factor for suicide, with the length of unemployment being strongly correlated to this risk[10]. In the United Kingdom (UK) previous periods of high unemployment and/or severe economic problems have been accompanied by increased incidence of mental ill health and higher suicide rates[11]. Similarly in Jersey the peaks of higher than average suicide rates in 2009 occurred within a period of economic downturn although the research by the University of Southampton did not determine any such links.

Unemployment among young people is of particular concern, with prolonged periods of unemployment often leading to a sense of hopelessness and lack of motivation. Young people who are unemployed are twice as likely to be prescribed anti-depressants. Anti-depressants alone do not cause increased risk but together these factors increase vulnerability to suicide[12].

Survivors of abuse

Being a past or present victim of violence and/or abuse is associated with a higher risk of mental health problems and related suicidal feelings. It can lead to a number of psychosocial problems associated with a heightened suicide risk, including: social isolation and exclusion; poor educational achievement; conduct, behavioural and emotional problems in children, and antisocial and risk-taking behaviours[13].

People living with long-term physical and mental health conditions

People who live with long-term conditions including physical illness, disability and chronic pain can experience periods of depression that may remain undiagnosed and untreated. Some long-term conditions are associated with an increased risk of suicide. There is specific evidence that receiving a diagnosis of conditions such as cancer, coronary heart disease and chronic obstructive airway disease is associated with a higher risk[14]. For example, the risk of suicide is significantly increased among cancer patients, particularly within the first few months after diagnosis[15].

People with one long-term condition are two to three times more likely to develop depression than the rest of the general population[16,17]. People with three or more conditions are seven times more likely to have depression[18]. Many medical treatments for long-term physical health conditions (for example, chronic pain medication, insulin treatment) also provide people with ready access to the means of suicide. With regards to mental health, people with long-term mental health conditions, such as schizophrenia, are also known to be at greater risk of self-harm and suicide[19]. About one in three people with bipolar disorder will attempt suicide at least once[20].

Young people who present with complex interacting needs

In the UK, one in 20 children and young people at any one time are affected by depression and related conditions, such as anxiety[21]. Looked after children or care leavers are particularly vulnerable to suicidal feelings and self-harm[22]. The risk is greater when they have mental health problems or behavioural disorders, misuse substances, have experienced family breakdown, abuse, neglect or mental health problems or suicide in the family.

The risk of suicide among young people may increase when they identify with other people who have taken their own life, such as high-profile celebrities or another young person[23]. There may also be a risk of copycat suicides in a community, particularly in a small Island like Jersey. There is already strong evidence that media reporting and portrayals of suicide can lead to this copycat behaviour, especially among young people and those already at risk[24].

Minority groups (ethnicity, race, religion and sexual orientation)

Research indicates that there are higher rates of mental health disorders and elevated risk of suicide attempts among Lesbian, Gay, Bisexual and Transgender communities compared to the general population[25,26]. There is also a link between ethnic minority groups, poverty and unemployment, both of which can be risk factors for suicide[27,28]. Evidence also suggests that some ethnic minority groups have higher rates of mental health conditions such as schizophrenia, which further increases the risk[29,30].

Information from professional groups in Jersey suggests that local minority groups have a different relationship with health services, and do not access care in the same way as other population groups. This may compound hereditary risk factors for disease and mental health conditions, which may in turn lead to an increased risk of suicide. However, exact rates of suicide and suicide risk among ethnic minority groups are not known, due to the fact that information on ethnicity is not currently collected through the death registration process.

Objective 2: Reduce stigma about suicidal feelings

People with mental health difficulties and those requiring mental health services often feel stigmatised. On average, one in four people who die by suicide in the UK have been in contact with mental health services in the 12 months before the suicide. The Southampton University study of suicides highlighted that around 27% of people who died by suicide were in contact with Jersey mental health services in the year before death. Judgemental attitudes towards mental illness, the expression of suicidal ideas and psychiatric care and treatment were found to be common. Similarly, some people were fearful of being referred to mental health services, or about the possibility of being detained under the local mental health act; others were concerned about the potential impact on job prospects or their social standing.

People may, from time to time, think about taking their own life. Being open and talking about suicide risk in a responsible way can help protect those that may be experiencing vulnerability to suicide. The stigma of suicide and mental illness increases barriers to seeking help and therefore escalates risk for some individuals. Additionally, the role of the local culture and communication networks should be considered in approaches to the sensitive management of information following a death by suicide. This strategy will engage the public in reflecting on attitudes to suicide, mental health and seeking help. In recent years the use of the internet, social media and mobile device applications have been increasing. The way the public receive information is changing. In particular, young people aged 16-24, have been referred to as 'digital natives'[31], a term which represents a group that has grown up with internet and mobile phones and are fundamentally different in the way that they communicate, seek information, engage, interact and entertain themselves. The internet is a natural space for them and is fully integrated into their lives. New technologies provide opportunities for new ways of working to understand and develop information and the way we communicate with the public and key priority groups. However, we also need to be aware of the potential negative effects that exposure to certain web sites, blogs and social media content can have on people who may be experiencing periods of higher suicide risk.

The media can have a very significant impact on and influence public views and attitudes to suicide. There is also a well recognised link between inappropriate news media reporting of suicides and imitative or 'copycat' behaviour. The need for the media to avoid reporting specific details about methods and sites of suicide is crucial[32]. Locally, the media have been provided with Samaritans guidance on sensitive and responsible reporting. However, with staff and editorial teams subject to change, continued vigilance into the local reporting of suicides is of paramount importance.

Objective 3: Reduce the risk of suicide in high-risk individuals

Compared to other jurisdictions with larger populations, Jersey has a unique opportunity in the identification of suicide risk in individuals and in working toward a reduction and de-escalation of suicide risk amongst individuals with known high risk factors. The opportunities for multi-agency working, sharing information and joint case planning for key individuals can work to keep people protected, making help available when it is most needed. Local research has demonstrated that a majority of those who have died by suicide were in contact

with local services in the year before their death. In the study by the University of Southampton, 77% of individuals were seen in primary care settings in the year before death, with 40% of the total being seen in the last month, and 21% in the last week. Additionally, around half (51%) of individuals had presented to local emergency services in the year before death, around 19% being in the last month, and 6% in the final week. These presentations to services are not always due to the presence of mental health issues. People who are in distress and who may be contemplating suicide are therefore likely to come into contact with a range of local services and agencies. Identifying these contacts provides an opportunity for us to act together to reduce risk.

However, Jersey's island life also has its own challenges with the University of Southampton research indicating factors that can act to compound other vulnerabilities. For example the research highlighted issues around personal privacy and difficulties in maintaining this within the confines of a small island where people live and work in close proximity. This reduces the opportunity and ability to separate different aspects of life off from one another. Findings also demonstrated the impact of suicide on families and the wider community. Suicide affects the lives of many other people and has specific harmful effects including an increased risk of suicide completion on those closest to those who have died.

People at particularly high risk in Jersey include:

- Young people who self harm and have suicidal feelings
- Men aged 30-50 years with two or more known risk factors including a history of self harm, mental ill health, drug and alcohol misuse, involvement with the criminal justice system, unemployed, attempted suicide, death by suicide by family /friend, Autism Spectrum Disorder
- Adults over 60 years with a life limiting condition and/or untreated depression and/or are socially isolated

Young people who self harm and have suicidal feelings

The relationship between suicide and self-harm is complex. However those who self harm are known to be at higher risk of completing suicide.

For some people, self-harm can be a way of coping with distressing thoughts or situations and is primarily used with no intention of fatal effect[33]. Even so, there is a significant correlation between frequency of self-harming behaviour and increased likelihood of fatality[34]. Around 3-4% of those admitted to hospital for self-harm will die by suicide within 10 years[35,36].

Rates of self-harm are highest among young people, particularly teenagers. It is estimated that nationally (UK) 1 in 15 young people self-harm[37] with girls four times more likely than boys[38]. The prevalence of self-harm among young people in Jersey is unknown. However, young people, less than 18 years have the highest rate of presentation to the Emergency Department for self-harm[39].

Emerging concerns are growing around the use of social networking sites locally and regarding the role of the media on self-harm and suicide. Studies from other countries show how suicide web-sites can facilitate suicide pacts among strangers who meet on the internet

and then plan their suicide together[40]. Although information is anecdotal and not underpinned by local data, efforts should be made to consider ways of addressing these issues.

Men 30-50 years with two or more known risk factors including for example: history of self harm; drug and alcohol misuse; criminal history; unemployment; financial poverty; mental ill health; Autism Spectrum Disorder; attempted suicide and death by suicide of family or a close friend

Local data shows that, although suicide rates in Jersey have decreased from 2009, they remain high for men. The research conducted by University of Southampton between 2000 and 2008 showed a distribution of suicide being highest in young men 25-34 years. We also know that young men typically used violent methods, where there is limited scope for intervention after the event leading to death. Violent methods in men were positively correlated with alcohol consumption.

A key message from a report by the Samaritans highlights the need for suicide prevention strategies to address the profound disconnection documented to cause the peak in suicide risk for mid-life men. Socio-economic and gender inequalities can lead to avoidable differences in health and length of life. These inequalities are compounded by societal attitudes regarding how men 'should' behave[41].

Men and women aged 60 years or more with a life limiting condition and/or untreated depression and/or are socially isolated

In Jersey, 17,291 of the population are above working age (defined as 59 years inclusive for women, and above 64 years inclusive for men)[42]. Research conducted by the University of Southampton shows that suicide in those aged 65 and above is also higher than average in Jersey.

The risk of depression increases with age and is associated with increased risk of mortality and risk of physical illness. A diagnosis of depression in those over 65 increased subsequent mortality by 70%[43]. The National Institute for Health and Clinical Excellence (NICE) states that all acts of self-harm in people older than 65 years of age should be regarded as evidence of suicidal intent until proven otherwise because the number of people in this age range who go on to complete suicide is much higher than in younger adults[44].

Social isolation is an identified risk factor within suicide risk assessment for all groups. However, it has been specifically identified for older people within the literature. Loneliness and low social interaction are predictive of suicide and poor social integration has been shown to enhance the suicide risk among older people. Importantly, the loss of social connectedness increases suicide risk in older people independent of the presence of mental disorders.[45],[46],[47] Therefore, older populations continue to be a high priority in the planning of our health services with commitment required to addressing the specific mental health needs of this vulnerable group.

Reducing the means of suicide across high risk individuals.

Restricting access to means of suicide has the potential to prevent suicide and save lives. Many international suicide strategies work to reduce the means to suicide at population level. Jersey has acted in the past to prevent the trend of jumping from car parks by fitting safety barriers. Very low numbers of suicide completion in Jersey do not provide the same potential for a population level approach. A focus on reducing the means amongst high-risk individuals holds more potential benefit. The availability of known disinhibiting factors such as use of alcohol and other substances of misuse could however be addressed at both the individual and population level.

Objective 4: Improve information and support to those bereaved or affected by suicide

Suicides have a profound effect on families and friends[48]. Research suggests that family and friends bereaved by a suicide are at increased risk of mental health and emotional problems themselves, and may also be at higher risk of suicide[49]. Suicide can also impact the wider local community by affecting neighbours, school friends and work colleagues, as well as involved professionals such as emergency, rescue and healthcare workers, teachers, police officers and faith leaders plus witnesses to the incident.

It is important that all providers of care and support are vigilant to the potential vulnerability of family members when someone takes their own life. Effective and timely emotional and practical support for families bereaved or affected by suicide is essential to help the grieving process, prevent further or longer-term emotional distress, and support recovery.

It is important to:

- provide effective and timely support for families bereaved or affected by suicide
- have in place effective local responses following a suicide
- provide information and support for families, friends and colleagues who are concerned about someone who may be at risk of suicide.

Post-suicide community level interventions can also help to prevent copycat and suicide clusters. This approach may be adapted for use in schools, workplaces, health and care settings.

There is some evidence that referral to specialist bereavement counselling and other bereavement support can be helpful for people who actively seek it[50], although evidence for the effectiveness of these interventions is currently limited[51].

Delivery, Monitoring and Measuring Effectiveness

Delivery

The Suicide Prevention Steering Group is responsible for ensuring the strategic direction, monitoring, evaluation and ongoing development of this Framework for Action (for Terms of Reference see Appendix 1). Key departments and agencies are represented on this group to ensure actions are appropriate to local need as well as engaging the necessary commitment towards planned action. The Steering Group is accountable to relevant government Chief Executive Officers who in turn report to the Chief Executive Officer of the Chief Ministers Department. The Steering Group will report annually on progress. In addition, the Steering Group will put in place an annual forum on the prevention of suicide to ensure all relevant departments, agencies and related colleagues have the latest local information and up-dates.

Detailed actions will be worked up annually from the high level plan in table 1. Key stakeholders made up of multi-agency organisations representing statutory and non-statutory services will be led by Steering Group members in detailing and delivering evidence based interventions carried out under the strategy. In addition, cross-cutting themes such as workforce training will be planned and delivered in a co-ordinated approach ensuring appropriate skill development across the objective areas. The high level actions will also be cross referenced into the lead projects being delivered through the Mental Health Strategy. This will ensure best use of capacity and resources of key stakeholders supporting related actions that both improve mental health and reduce suicide risk. Preventing suicide also requires a cross government approach. Therefore, interdependencies with wider policies that may have an effect on the broader socio-economic and cultural determining factors of suicide will be ensured.

Monitoring and Measuring Effectiveness

In order to monitor and evaluate the effectiveness of interventions under this Framework for Action, local validated indicators that objectively and effectively monitor progress including ‘process’, ‘impact’ and ‘outcome’ measures will be used. Action plans will also include milestones and implementation time frames for planned interventions. A programme for the on-going audit of suicide and self-harm will assist in responding to any emerging trends in suicidal behaviours and methods or risk groups and settings. This will include closer working between the Prevention of Suicide Steering Group, Viscount’s office, Police and related service

Table 1: Objectives and high level action

Objective 1: Improve mental health and wellbeing in vulnerable groups 1.1: Ensure relevant Mental Health Strategy actions take account of the needs of those groups identified as being at higher risk of suicide. 1.2 Review and identify best model for tier 2 early intervention in schools and colleges 1.3 Review existing curriculum practice and approach to mental health prevention as part of curriculum delivery in schools and colleges 1.4 Develop formal network across state and 3rd sector services to identify and maximise opportunities to co-ordinate approach and support	**Objective 2:** Reduce stigma about suicidal feelings 2.1: Promote sensitive reporting of suicide and portrayal of suicide in the media 2.2: Encourage seeking urgent help early to avoid emerging crisis, and promote ways of publicising help available 2.2: Develop information provision about suicide that helps support reduction of suicidal ideation 2.3: Deliver and review effectiveness of integrated multi agency training on managing self-harm and suicidal ideation, and on performing risk assessment
Objective 3: Reduce the risk of suicide in high-risk individuals 3.1: Identify appropriate risk assessment tools to identify high risk individuals taking into account the different drivers and risk factors for different populations/age groups 3.2: Developing a framework for multi agency working with those identified as high risk 3.3: Delivering and reviewing effectiveness of integrated multi agency training for those working with high risk individuals. 3.4: Monitor complete suicides annually to identify trends that will inform future interventions. 3.5 Support the development of a multi-agency Vulnerable Adult Risk Management process	**Objective 4:** Improve information and support to those bereaved or affected by suicide 4.1: Have in place effective local responses following death by suicide & establish Safeguarding Partnership Board (SPB) multi-agency policy & procedure. 4.2: Provide information and support for families friends and colleagues who may be concerned about someone who may be at risk of suicide 4.3: Seek to secure service user feedback 4.4: Provide effective and timely support to families bereaved or affected by suicide 4.5: Delivering and reviewing effectiveness of integrated multi agency training on supporting those bereaved by suicide

A detailed annual action plan will be developed to ensure delivery of prioritised work over annual period.

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Appendix 1

Steering Group Terms of Reference

Terms of Reference: revised October 2015
The revised Terms of Reference will provide updated information about the aims of the Prevention of Suicide Steering Group.

Purpose of the Steering Group
The Steering Group was originally established in 2003. A new membership has been established to co-ordinate the development of the revised Prevention of Suicide Framework for Action involving membership from States of Jersey Services and the Voluntary and Community Sector to:

- Provide a lead for the implementation of the Prevention of Suicide Framework for Action (2015-2020).
- Provide a strategic role in effective identification and planning of priorities to take forward around suicide prevention.
- To facilitate engagement of stakeholders to:
    - Encourage and share best practice and continuous practice improvement
    - To develop and deliver strategic action
- Undertake an annual evaluation of the Prevention of Suicide Framework (2015-2020) updating on specific outcomes of the action plan.
- Co-ordinate an annual Prevention of Suicide Forum to communicate the progress of the framework to key stakeholders.
- To co-ordinate communication of strategic aims to the people of Jersey.

In the co-ordination and development of this work the steering group will recognise the interdependencies between the prevention of suicide agenda and the wider work of the Mental Health Strategy and where relevant ensure best use of capacity and resources to achieve shared action.

Membership of the Steering Group
Membership of the Steering Group will include representatives from Public Health, Psychological Therapies, Adult Mental Health Services, Police, CAMHS, Education Sport & Culture, Samaritans and Primary Care. Membership will be reviewed annually.
All members of the Steering Group will be:

- Senior managers representing their respective services
- Actively involved in representing their organisation around Suicide Prevention

Delegation

Each senior manager will delegate responsibility to a member of their team to attend Steering Group meetings in their absence.

Structure of the Steering Group

- The steering group meetings will be chaired by a Steering Group Member. The meetings will be chaired by the Head of Health Improvement from March 2014 to March 2016.
- The chair will be reviewed annually with the next review in March 2016.
- The administrative duties and taking of minutes will be resourced by Public Health. A set of minutes with actions and priorities will be delivered and tracked within two working weeks after each steering group meeting.
- The roles of group members will be reviewed annually.
- The chair will facilitate each meeting for the full period of their duties.
- Members of the Steering Group will make decisions by reaching consensus as a group.
- A quorum (the minimum number of people required to make a decision) will include the chairman and a minimum of three people.

Quorum Membership

Public Health	Head of Health Improvement
Psychological Therapies	Director of Psychological Therapies and Assessment Service and Jersey Talking Therapies
Samaritans	Director of Samaritans Service
Education Department	Principle Education Psychologist
Adult Services	Director of Adult Services
Police	Police; Head of Crimes Services
CAMHS	Child & Adolescent Mental Health Service; Lead Clinician/Child & Adolescent Psychiatrist
Children's Services	Head of children's Services
Primary Care Body	Representative GP

Group Meetings

- Face- to-face meetings will be held quarterly, in the first year (2014-2015) after which scheduling will be reviewed and potentially reduced to bi annually.
- The group will use email as a means to communicate across the group.

Venue

To be held in Maison Le Pape or alternative venue identified by members of the group

Finance and Resources

HSSD has identified the Prevention of Suicide Framework for Action as an important priority and has agreed to resource the Steering Group programme which covers, meetings, administration and programme support within current resources. There is no specific financial resource or budged allocated to the Prevention of Suicide Framework for Action. Future prioritised actions with resourcing needs will be funded from within existing Department budgets or require submission of a business case with estimated costs of the programme of work.

Accountability

In order to fully discharge its responsibilities this Steering Group will seek delegated decision making powers from relevant Chief Executive Officers in relation to all aspects of the Suicide Prevention Steering Group.