# 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 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.

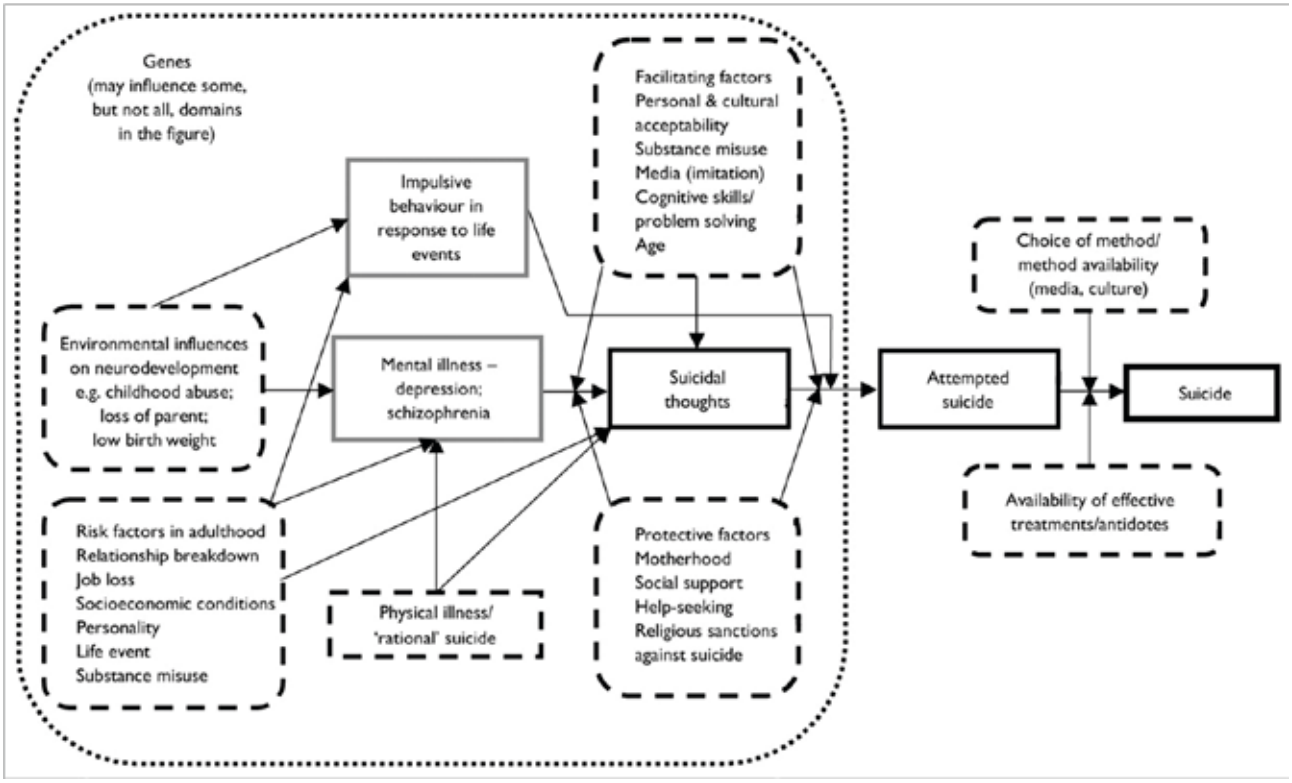


*Figure 1: Life course influences on suicide*[56]

## 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.

## 6.1 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.

## 6.2 Support the bereaved

**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