STATES OF JERSEY

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MULTI STOREY CAR PARKS: IMPROVED SAFETY MEASURES

Lodged au Greffe on 20th September 2005
by Deputy J.A. Bridge of St. Helier

STATES GREFFE

PROPOSITION

THE STATES are asked to decide whether they are of opinion –

to charge the Environment and Public Services Committee to consult with the Home Affairs and the Health and Social Services Committees and to erect physical barriers in multi-storey car parks in order to reduce the risk of suicide.

DEPUTY J.A. BRIDGE OF ST. HELIER

REPORT

This proposition is fairly straightforward. I am asking the States Assembly to charge the Environment and Public Services Committee to erect physical barriers in the multi-storey car parks where in conjunction with the Home Affairs Committee and the Health and Social Services Committee they have identified there to be a suicide risk.

The catalyst for this proposition was the recent front-page report of the Chief of Police's concerns about the suicide risk from multi-storey car parks in Jersey.

To an extent I have to say "mea culpa", because when I left the Home Affairs Committee in 2002 I did not follow this issue up personally. I wrongly assumed that the work had been done, as a commitment had been given by the Public Services Committee of the day and money had been allocated in the Public Services Business Plan of 2002 – 2004.

The number of suicides and attempted suicides from multi-storey car parks has been doing the rounds of Committee agendas since 25th April 2002. I have asked the Greffe to perform a search of all Home Affairs, Health and Social Services, Public Services (now Environment and Public Services) Minutes. I have attached those minutes for members' convenience.

I believe that this issue has dragged on long enough and it is time for Environment and Public Services to get on with the work immediately.

I have summarised below a few points in the minutes of the various Committees involved which I hope will persuade members that the issue has been thoroughly aired from all possible angles and all that is required now is for Environment and Public Services to start work on erecting physical barriers immediately.

On 25th April 2002 the Home Affairs Committee discussed the matter of suicide risk from multi-storey car parks. Item A.8 read as follows –

> "The Committee further noted that liaison with the Public Services Department/Committee had given rise to investigation, by that Committee, of the possibility of introducing physical improvements to multi-storey car parks in order to prevent persons from accessing the outside ledges of car parks; the matter in terms of cost viability, had been included in the 2002 – 2004 Business Plan of the Public Services Committee."

By the time the Home Affairs Committee met on 5th September 2002 there had been one suicide on 10th July 2002 and an attempted suicide occurred on 5th September 2002. The Committee was concerned not to have heard anything from the Public Services Committee. The minutes stated –

> "…having received no indication from the Public Services Department of any progress that had been made to improve safety, agreed to inform that Committee **of its grave concern**…".

Post the meeting on 5th September, I understand that the President was made aware of the fact that the Public Services Committee had met on 8th July 2002 and agreed to approve a one-off payment of £35,000 from the Car Park Trading Account. The minute of item B.2 of the agenda stated –

> "The Committee was reminded that Ove Arup and Partners Limited had been commission (*sic*) to produce an Engineering Report in August 2001 the purpose of which had been to review aspects relating to vulnerable people in car parks and parapet walls… whilst it (the Committee) recognised that it did not have any statutory requirement to do so, it would approve a one off spend of £35,000 from the Car Park Trading Account to be allocated to this purpose.".

On 9th September 2002, the President of the Home Affairs Committee wrote to the President of the Public Services Committee in the following terms –

> "Whilst I can see the merit in establishing a Working Party to look at suicide generally, I think that

something needs to be done as a matter of urgency at the multi-storey car parks to make it less easy for people to be able to take their own lives".

On 16th September 2002, the Health and Social Services Committee minutes concur with the views of the Home Affairs Committee, stating at B.10 –

> "…a coordinated approach between the relevant Committees would be helpful but **felt that the £35,000 approved by the Public Services Committee should be targeted on known ways of reducing the possibility of impulsive actions in car parks and rendering them "jump-proof".**

Between the meeting of the Home Affairs Committee on 5th September 2002 and its next meeting on 24th October 2002 there were 3 further suicide attempts from car parks. The minutes recorded the Committee's continued concern. Item A14 stated –

> "…each incident presented a range of life-threatening dangers, both to the individual concerned, police officers and members of the public, as well as trauma to all involved".

On 21st November the Home Affairs Committee received a report from the Chief of Police in which he stated that –

> "it appeared to be generally accepted that **the erection of physical barriers in old car parks was the only realistic course of action** and that no alternative solution had so far been identified".

Further, the Committee discussed whether Human Rights Legislation when enacted in Jersey, would have an impact. The minutes stated at item A.12 –

> "…it had been recognised in the United Kingdom that car park owners, having identified the risks to its patrons, had a clear duty of care under the provisions of human rights legislation and that this might have an impact in Jersey when local human rights legislation was enacted.".

The Health and Social Services Committee met on 27th March 2003 and reiterated their concern in the following terms –

> B.6 "The Committee, aware that the issue formed part of the Public Services Committee's current Business Plan, decided to **request the Public Services Committee to address the situation as a matter of urgency.".**

The Health and Social Service Committee met on 4th June 2003 and "endorsed the prioritised action plan of the multi-agency steering group and requested that a copy of the report be forwarded to other Committees for whom the prevention of suicide was also a matter of concern." (A.18).

On 18th August 2003, the Public Services Committee minutes recorded –

> A.8 "The Committee noted that a multi-agency Steering Group… had for sometime been actively examining ways of reducing the incidence of suicide in Jersey. One of the Group's recommendations (the placing of Samaritan posters in the multi-storey car parks) was being pursued…The wording of the posters was presently under review.".

The Home Affairs Committee at its meeting on 24th February 2004 recorded that since the previous occasion on which the matter of suicide risk from car parks had been raised on its agenda there had been 7 further attempted suicides from car parks. The Committee was "**extremely concerned that no action had been taken by the Environment and Public Services Committee with regard to this issue.**"(A.21)

This is the last minute that has been made available to me on this issue so it appears that the issue has not been discussed at Committee level since then by the Environment and Public Services Committee.

I have not provided a cost in this report. However, I am sure that the Environment and Public Services Committee will be able to provide detailed and up-to-date costings. I can talk about the human cost – the trauma to the individual, their family and friends, the trauma to the Police Officers, Ambulance Personnel and Paramedics, and trauma to hospital staff and members of the public.

I hope that this proposition does not have to be debated and will happily withdraw it if the President of Environment and Public Services is willing to make a Statement in the Assembly outlining the proposed work, an appropriate start date and completion date.

There are financial/manpower implications arising from this proposition.

The former Public Services Committee made £35,000 from the Car Park Trading Account in 2002 for the purposes of suicide prevention. The cost viability was in the 2002 – 2004 Business Plan of the Public Services Committee. Obviously, the figures will have changed and I am sure that the Environment and Public Services Committee are able to provide up-to-date figures in their comments.

APPENDIX A

1060/136(30)

HOME AFFAIRS COMMITTEE

25th April 2002

Police - prevention of suicides in multi-storey car parks. 1060/136(30)

Dir.
C.of P.
P.S.C.(2)

A8. The Committee received a report dated April 2002, prepared by the Chief Officer, States of Jersey Police, in connexion with the prevention of suicides and attempted suicides in multi-storey car parks located in St. Helier.

The Committee noted that over the last three years there had been an increase in suicides and attempted suicides from such buildings, and that each incident presented a range of life threatening dangers, both to the individual concerned, Police Officers and other members of the Public, as well as trauma to all those involved.

The Committee further noted that liaison with the Public Services Department/Committee had given rise to investigation, by that Committee, of the possibility of introducing physical improvements to multi-storey car parks in order to prevent persons from accessing the outside ledges of car parks; the matter in terms of cost viability, had been included in the 2002-2004 Business Plan of the Public Services Committee.

The Committee formed the view that there was an unacceptable level of multi-storey car park suicides and suicide attempts, which, if left unaddressed, would continue with the subsequent detrimental effect on all those involved, the cost factor of fatal accidents, (ranging from £2-£8 million), and the general risk factors exposed to Police Officers and members of the Public.

The Committee decided to urge the Public Services Committee to give priority to taking effective steps to improving the security of multi-storey car parks in order to reduce the risks for all concerned. The President agreed to speak to the President of the Public Services Committee in this regard at the earliest opportunity.

The Greffier of the States was directed to send a copy of this Act to the Public Services Committee.

J M Newcombe

Greffier of the States

STATES GREFFE
28 MAY 2002
FORWARDED

PSC – 8th July 2002

Confidential: exemption 3.2(a)(xiv)
Report by Ove Arup and Partners Limited - relating suicides from car parks and proactive measures to be taken.
1060/136(30)

HealthSSC(2)
H.Aff.C.(2)
C.E.O.
C.I.Aud.
T.O.S.
Encl.

B2. The Committee received and considered a report dated 27th June 2002, prepared by the Department in connexion with suicides from car parks.

The Committee recalled that there had recently been a certain level of publicity relating to death by suicide from car parks and that certain concerned organisations were seeking assistance in this respect. The Committee was reminded that Ove Arup and Partners Limited had been commission to produce an Engineering Report in August 2001 the purpose of which had been to review aspects relating to vulnerable people in car parks and parapet walls.

Having given careful consideration to the detailed report, the Committee accepted that it would be minded to show a commitment to reducing the problems of suicides in the Island, and whilst it recognised that it did not have any statutory requirement to so, it would approve a one off spend of £35,000 from the Car Park Trading Account to be allocated to this purpose. The Committee agreed that a working party should be formulated in this connexion and noted that the Health and Social Services and Home Affairs Committees would be asked to make similar commitments.

The Greffier of the States was requested to send a copy of this Act to the Health and Social Services and Home Affairs Committees' respectively.

1060/136 (30)

HOME AFFAIRS COMMITTEE

5th September 2002

Police: prevention of suicides in multi-storey car parks. 1060/136(30)

Dir.
C.of P.
P.S.C.(2)

A13. The Committee, with reference to its Act No. A8 of 25th April 2002, received a report prepared by the Chief Officer, States of Jersey Police, in connexion with attempted suicides in multi-storey car parks located in St. Helier.

The Committee recalled that during the last three years, there had been an increase in suicides and attempted suicides from such buildings and that each incident presented a range of life threatening dangers, both to the individual concerned, police officers and members of the public, as well as trauma to all those involved. It further recalled that it had urged the Public Services Committee to give priority to taking effective steps to improving the security of multi-storey car parks in order to reduce the risks for all concerned.

The Committee was informed that a male aged 27 had apparently committed suicide by jumping from an upper floor of Green Street car park in the early hours of 10th July 2002 and that an attempted suicide from a car park had taken place on 1st September 2002.

The Committee, having received no indication from the Public Services Department of any progress that had been made to improve safety, agreed to inform that Committee of its grave concern at the situation and advising that the Home Affairs Committee would feel bound to bring a proposition to the States seeking to secure preventive measures being effected without further delay.

The Director was requested to take the necessary action.

C M Newcombe

Greffier of the States

STATES GREFFE
02 OCT 2002
FORWARDED

1060/136 (30)

States of Jersey

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Deputy R C Hacquoil
President
Public Services Committee
States Greffe
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September 9th 2002

Dear Robin

Suicides from Car Parks

At its meeting of the 5th, the Home Affairs Committee received a paper from the Chief Officer, States of Jersey Police on the subject of the multi-storey car park suicide threat.

I am aware that the Public Services Committee received a report on suicides from car parks from the Director of Traffic and Transportation at its meeting on the 8th July, and that as a consequence your Committee agreed to a one-off spend of £35,000 to be allocated from the Car Park Trading Account, and that they agreed that a Working Party should be set up in this connection.

Since that meeting there has been a suicide at Green Street multi-storey car park on the 10th July, and an attempted suicide from Sand Street car park on the 1st of this month.

My Committee is extremely concerned about this issue. You will be in possession of an Act of the Home Affairs Committee of the 25th April, when it agreed to urge your Committee to give priority to taking effective steps to improving the security of multi-storey car parks in order to reduce the risks for all involved.

I must re-iterate that request. Whilst I can see the merit in establishing a Working Party to look at suicide generally, I think that something needs to be done as a matter of urgency at the multi-storey car parks to make it less easy for people to be able to take their own lives.

I should be pleased to meet you as soon as may be in order to discuss this matter.

Yours sincerely

DEPUTY ALASTAIR LAYZELL
President

1060/136(30)

HEALTH AND SOCIAL SERVICES COMMITTEE

16th September 2002

Confidential: exemption 3.2(a)(xiv)
Public Services Committee: measures to prevent suicides from car parks
1060/109(78)
1060/136(30)

B10. The Committee, with reference to its Act No. B6 of 27th March 2002, received and considered Act No. B2, dated 8th July 2002, of the Public Services Committee in connexion with proactive measures to be taken to reduce the incidence of suicides from public car parks.

The Committee welcomed the commitment given by the Public Services Committee to reducing the problem. It agreed that a co-ordinated approach between the relevant Committees would be helpful but felt that the £35,000 approved by the Public Services Committee should be targeted on known ways of reducing the possibility of impulsive actions in car parks and rendering them 'jump-proof'.

C.E.
P.S.C.(2)
H.Aff.C.(2)

The Committee noted that the Act referred to a similar commitment being invested by the Health and Social Services and Home Affairs Committees. The Committee decided to make it clear, however, that it had not made such a commitment.

The Greffier of the States was directed to send a copy of this Act to the Public Services and Home Affairs Committees.

Greffier of the States

04 OCT 2002

1060/136(30)

HOME AFFAIRS COMMITTEE

24th October 2002

Police: prevention of suicides in multi-storey car parks. 1060/136(30)

Dir.
C.of P.
P.S.C.(2)
Emp.SSC(2)

A14. The Committee, with reference to its Act No., A13 of 5th September 2002, received an update prepared by the Chief Officer, States of Jersey Police, in connexion with the prevention of suicides in multi-storey car parks. It recalled that increasing concern had been expressed that there had been an increase in suicides and attempted suicides from such buildings and that each incident presented a range of life threatening dangers, both to the individual concerned, police offices and members of the public, as well as trauma to all involved. The Committee further recalled that it had requested the Public Services Committee to respond to the situation to secure appropriate preventive measures and that it had proposed to bring proposals to the States requiring the implementation of such measures if no action was taken. The Committee was advised that, since its meeting on 5th September, a further three attempted suicides relating to car parks in the town area had taken place, which had necessitated the deployment of a significant number of officers in connexion with the incident.

The Committee noted that a group had been established by the Public Services Committee to consider the issues and that an action plan had been drawn up to address each of the following areas -

Primary prevention - education at schools and youth clubs, etc.
Early intervention - including GPs, social workers, midwives, district nurses, Shelter, Roseneath, Prison
Crisis intervention - Police, Mental Health Unit, other agencies
Post intervention - specialist medical practitioners, clergy, support workers, charities.

A workshop to be facilitated by the Medical Officer for Health for Hampshire to which all interested parties would be invited to attend was scheduled to take place in November 2002 and it was suggested that representatives of the Shelter Trust and Outreach charities should be linked in with the discussions.

The Chief Officer, States of Jersey Police, was requested to investigate the liability aspects associated with health and safety requirements in view of the inherent dangers as aforementioned.

The Greffier of the States was requested to send a copy of this Act to the Public Services and Employment and Social Security Committees for information.

Greffier of the States

1060/136 (30)

HOME AFFAIRS COMMITTEE

21st November 2002

Police: prevention of suicides in multi-storey car parks. 1060/136(30)

Dir. C.of P. P.S.C.(2)

A12. The Committee, with reference to its Act No. A14 of 24th October 2002, received an update from the Chief Officer, States of Jersey Police, in connexion with the prevention of suicides in multi-storey car parks. It recalled that concern had been expressed at the increase in the number of suicides and attempted suicides from such buildings and that each incident presented life-threatening dangers, not only to the individual concerned but to police officers and members of the public, notwithstanding the trauma to all involved. It further recalled that a group had been established by the Public Services Committee to address the issues and that an action plan had been drawn up in consultation with agencies including the Jersey Shelter Trust, Roseneath and the Prison.

The Committee noted that a further suicide attempt from a car park had been made on 28th October 2002 which, fortunately, had been prevented by the intervention of a member of the public before the arrival of the police, but that the incident further highlighted the significance of the problem.

The Chief Officer, States of Jersey Police, reported that he had discussed preventive measures in the United Kingdom with Detective Inspector R. Holmes of the Hostage and Extortion Unit, Scotland Yard, and it appeared to be generally accepted that the erection of physical barriers in old car parks was the only realistic course of action and that no alternative solution had so far been identified. New car parks were designed with the aim of placing these structures in appropriate locations in order to prevent incidents.

The Committee was advised that, whilst the Public Services Committee, in its report relating to suicides in car parks dated 8th July 2002, stated that "the Committee does not have any liability in the event that a person chooses to take their own life from a car park", it had been recognised in the United Kingdom that car park owners, having identified the risks to its patrons, had a clear duty of care under the provisions of human rights legislation and that this might have an impact in Jersey when local human rights legislation was enacted.

The Committee noted the paper and requested the Greffier of the States to send a copy of this Act to the Public Services Committee for information.

STATES GREFFE
10 DEC 2002
FORWARDED

Greffier of the States

HSSC – 27th March 2003

Confidential: exemption 3.2(a)(i)
Recent suicide in Patriotic Street Car Park.
1060/109(78)
1060/136/23 (16)

C.E.
P.S.C.(2)
M.O.H.

B6. The Committee, mindful of a recent suicide which had occurred at Patriotic Street Car Park, recalled, with reference to its Act No. B11 of 5th July 2000, that it had brought the lack of safety at the above car park to the attention of the Public Services Committee. In view of the history of suicide attempts from the car park, the Committee had stated that it would support the framing in of this car park to enhance security and safety.

The Committee, aware that the issue formed part of the Public Services Committee's current Business Plan, decided to request the Public Services Committee to address the situation as a matter of urgency. The Medical Officer of Health was requested to liaise with the Chief Executive Designate of the Public Services Committee accordingly.

The Greffier of the States was directed to send a copy of this Act to the Public Services Committee.

HSSC – 4th June 2003

Suicide prevention. 1061/6(516)

A18. The Committee received Mr. A. Heaven, Senior Health Promotion Officer, in connexion with his report on action resulting from the Medical Officer of Health's report on Suicide (2001).

C.E.
E.P.S.C.(2)
Ed.S.C.C.(2)
H.Aff.C.(2)
Encl.

The Committee was advised that a multi-agency steering group, through a consultative process, had identified a prioritised action plan, detailed in the above report, to reduce the incidence of suicides in Jersey. It was noted that the financial cost of the identified actions represented no new or additional costs to Health and Social Services but rather placed emphasis on service redesign and development where appropriate, ensuring that issues relating to suicide were considered in other areas of strategy development and improving the connexions between voluntary and statutory agencies who had a role to play in preventing suicide.

The Committee endorsed the prioritised action plan of the multi-agency steering group and requested that a copy of the report be forwarded to other Committees for whom the prevention of suicide was also a matter of concern.

The Greffier of the States was directed to send a copy of this Act together with the accompanying report to the Education, Sport and Culture, Home Affairs and Environment and Public Services Committee accordingly.

1060/136 (30)

ENVIRONMENT AND PUBLIC SERVICES COMMITTEE

18th August 2003

Multi-storey car parks: suicide prevention. 1060/136(30)

C.E.O., P.S.D. HealthSSC(2)

A8. The Committee considered a report, dated 10th July 2003, prepared by the Director of Traffic and Transportation concerning suicide prevention and the reduction of incidents of suicides and attempted suicides from the Island's multi-storey car parks.

The Committee noted that a multi-agency Steering Group, which included officers from the Public Services Department, had for some time been actively examining ways of reducing the incidence of suicide in Jersey. One of the Group's recommendations (the placing of Samaritan posters in the multi-storey car parks) was being pursued, although the current wording on the posters was considered inappropriate for display in car parks. The wording of the posters was presently under review.

The Committee also noted an Act, dated 4th June 2003, of the Health and Social Services Committee which endorsed the prioritised action plan which had been produced by the Steering Group.

The Committee expressed its support of its officers in being actively involved with, and seeking measures to reduce, the possibility of members of the public committing or attempting suicide and, having expressed its willingness to work with the other agencies involved, agreed to the request to place suitable posters in the multi-storey car parks under its administration.

The Director of Traffic and Transportation was directed to take the necessary action, and the Greffier of the States was directed to send a copy of this Act to the Health and Social Services Committee.

Greffier of the States

1060/136(30)

HOME AFFAIRS COMMITTEE

19th February 2004

Police: prevention of suicides in multi-storey car parks. 1060/136(30)

C.of P.
Dir.
E.P.S.C.(2)

A21. The Committee, with reference to Act No. A12 of 21st November 2002, of the Committee as previously constituted, received a report dated 2nd February 2004, from the Deputy Chief Officer, States of Jersey Police, in connexion with preventative measures in relation to suicides in multi-storey car parks.

The Committee recalled that concern had been expressed at the increase in the number of suicides and attempted suicides from such buildings and that each incident presented life-threatening dangers, not only to the individual concerned but to Police Officers and members of the public. A discussion had been held with Detective Inspector R. Holmes of the Hostage and Extortion Unit, Scotland Yard, regarding preventative measures used in the United Kingdom and it appeared to be generally accepted that the erection of physical barriers in old car parks was the only realistic course of action and that no alternative solution had so far been identified.

The Committee was advised that since its meeting in October 2002, there had been seven further attempted suicides in car parks in the town area. There had been three incidents at Minden Place car park, two incidents at Sand Street car park and two incidents at Patriotic Street car park. These figures highlighted the fact that this issue continued to be very relevant.

The Committee, having noted the above incidents of attempted suicide, was extremely concerned that no action had been taken by the Environment and Public Services Committee with regard to this issue. The Committee was minded to lodge "au Greffe" a report and proposition, the purpose of which would be to request the States to charge the Environment and Public Services Committee with taking preventative matters, as detailed above.

The Greffier of the States was requested to send a copy of this Act to the Environment and Public Services Committee.

Greffier of the States

STATES GREFFE
31 AUG 2004
FORWARDED

APPENDIX B

Suicide Prevention Strategy
Update 2005

Introduction

The Suicide Strategy will be a part of the business plan for the Mental Health Directorate and Public Health Services for 2006-2009. This paper updates the Health and Social Services Committee on the action resulting from the Suicide Prevention Strategy, endorsed by the Committee in 2002. It also describes the current picture regarding suicide rates in Jersey following work undertaken by the Public Heath Intelligence Unit.

Background

Suicide was raised as a public health concern in Jersey, in a section of the 2001 Annual Report of the Director of Public Health Services:

Over the past three years, the Health Promotion Department has been working in partnership with representatives from the statutory and voluntary sector on ways to reduce the number and impact of suicides in Jersey. This paper gives a brief update of the developments over the previous 12 months and the areas of work prioritised for the coming year.

The work around suicide prevention received formal political support through the newly formed Health and Social Services Committee in 2002. The activity resulting from the Suicide Prevention Strategy is currently resourced from existing budgets of those key stakeholders. Support from both senior level service managers and local politicians, continues to be vital in assisting with the effective development and implementation of the strategy.

Suicide Prevention Strategy is implemented through a Steering Group which meets quarterly to Co-ordinate and implement operationally, agreed areas of work derived from the strategy's action plan. The work of the Steering Group has been supported by the creation of four Operational Groups who are responsible for providing 'hands on' implementation of the priorities set by the Steering Group. The four Operational Groups cover the four major divisions of the strategy:

Current Preventative Activity

Primary Prevention:

These interventions are aimed at society in general and designed for the whole population. They aim to raise understanding around the issue of suicide and the related areas of public mental health.

Action completed so far:

- Directory of Mental Health Services complied and distributed
- Peer led evaluation of Secondary School Bullying Policy
- Audit of resources currently held across services relating to suicide
- Development of resource specifically targeting young people and suicide

Action Planned 2005/6

- Piloting of assessment tool for mapping young peoples emotional resilience

Secondary Intervention:

Secondary (early) interventions encompass interventions which are concerned with effective reduction of the intensity, severity and duration of risk behaviours for suicide. Activity concerning the improvement of health intelligence regarding suicide is also consistent with this stage of intervention.

Action completed so far:

- Development of suicide component of mental health training for voluntary agencies
- Improvements in the collation and recording of deaths by suicide

- Agreement of a definition for key terms from which to code A/E activity

Action Planned 2005/6

- Audit of A/E recording of self harm and attempted suicide

Crisis Intervention:
The situation and context for this range of interventions is one of crisis where there is imminent danger and high risk of suicide.

Action completed so far:

- Posters with emergency help lines located in suicide hot spot areas
- Support the development of A/E Liaison Psychiatric Service
- Work has begun to develop a suicide prevention pathway

Action Planned 2005/6

- Planned audit and training re crisis intervention at primary care level*

Post-Vention:
This describes interventions focused on those left behind following a suicide. It encompasses a broad range of activities including survivor and professional accounts to improve services.

Action completed far:

- Specific resource developed and disseminated detailing supporting agencies for those bereaved by suicide
- Workshop delivered by Survivors of those bereaved by suicide to front line services
- Mental Health Service critical incident policy completed

Action Planned 2005/6

- Planned training to front line emergency staff to be delivered by key voluntary agencies*

**Denotes activity dependent on successful growth bid funding being agreed for 2006*

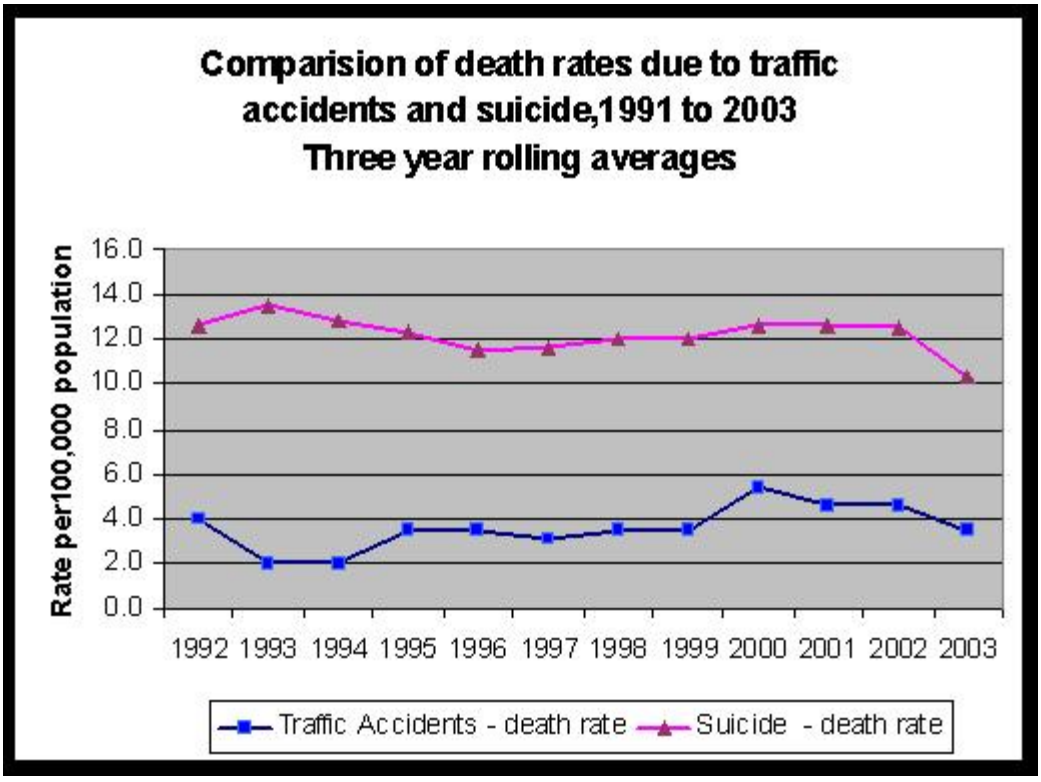
Recent Public Health Intelligence

An important part of the Suicide prevention strategy has been to improve the data collection and analysis in order to inform preventative activity. This work has been led by the Public Health Intelligence Unit.

The analysis of the relevant data tells us that suicide remains a major contributor to local mortality. Mortality refers to the number of people who have died, in this case from suicde, during a given period within a given population. The mortality rate is the number of people who die expressed as a proportion of a standardised population of 100,000. By expressing the mortality as a rate we are able to compare our rates with other countries (Graph 1.1 and 1.2) as well as other causes of mortality (Graph 1.0).

Jersey has a higher number of suicides than England and Wales. Comparison between standardized rates of suicide show that on average England & Wales have seven suicides per year per hundred thousand where as Jersey has twelve per year per hundred thousand.

After Circulatory Desease and Cancers, Suicde and Road Traffic Accidents are the biggest cause of mortality within the Jersey population. The graph below shows the marked difference between traffic accidents and suicde. The working partnerships formed around accident prevention are currently better formed and developed at present which is partly due to established funding streams.



Locally we can show an overall reduction in suicide rates, which is comparable to that reported in the English Suicide Prevention Strategy Annual Report (2004) whose main message of this report is that there have been reductions in the suicide rates in the key at risk groups of young men.

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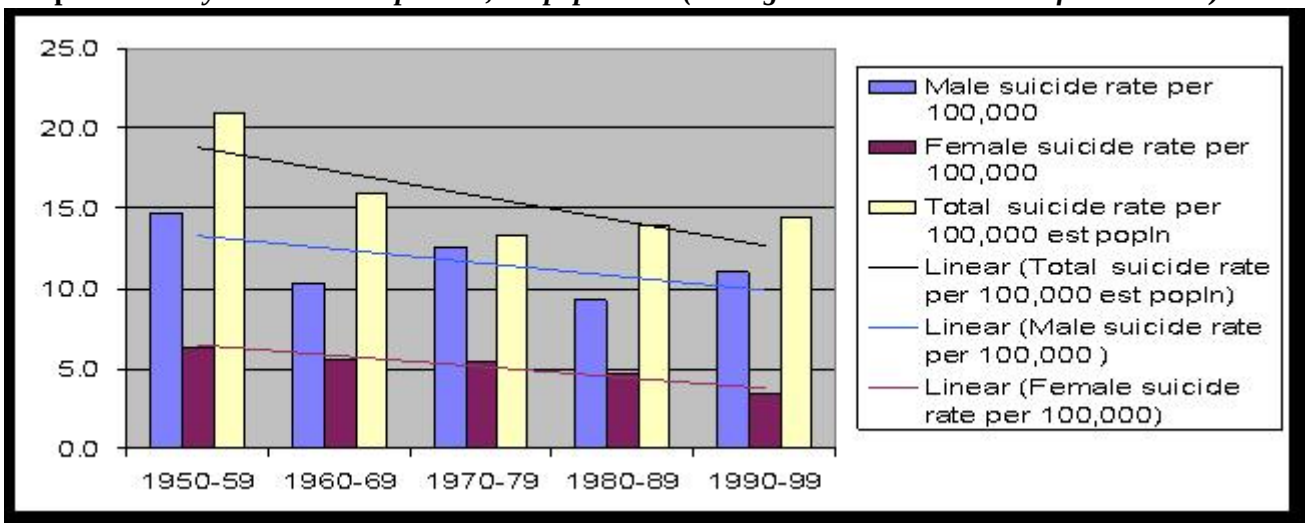
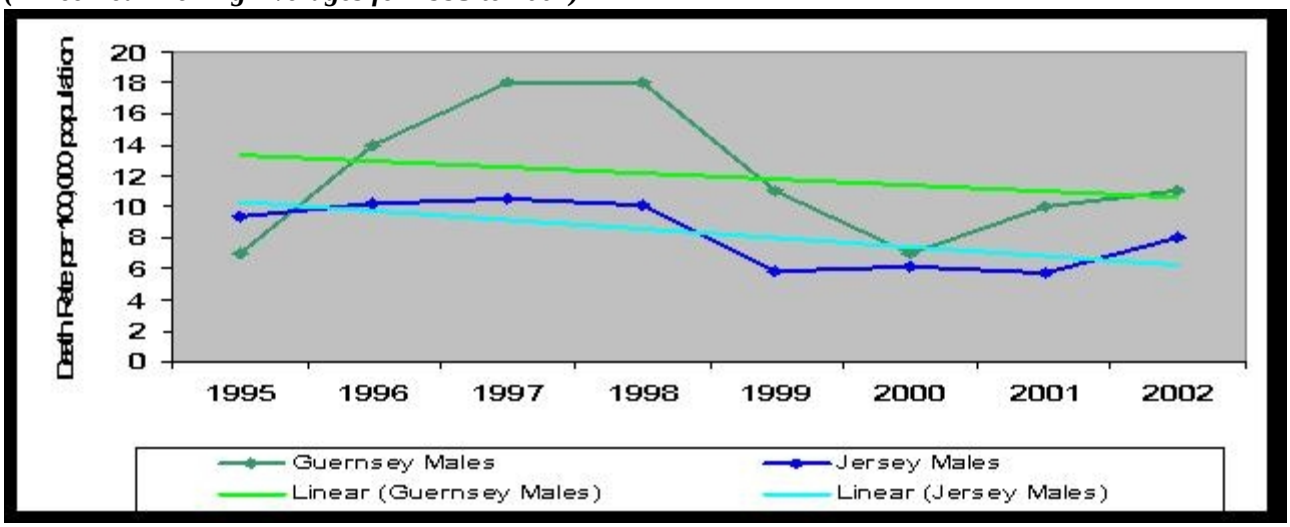
Graph1.1: ***Jersey Suicide Rates per 100,000 population (Average annual rate over last four decades)***



By comparing rates for both the Jersey and Guernsey we can show a slight downward trend in male suicides over the past eight years which are both in line with UK observations.

Figure 1.2: Suicide Mortality Rates for Males in Jersey & Guernsey
(Three Year Rolling Averages for 1995 to 2002)



Despite suicide rates decreasing slightly, Jersey still has a higher suicide rate per hundred thousand than England. Furthermore, there is an uneven distribution of suicide according to age and gender across the local population. In Jersey male suicides in age groups 20-24, 25-34 & 45-64 are approximately twice the rate for England and Wales as is the suicide rate for 35-44 women. The suicide rate for Jersey women aged 65 + is four times that of England and Wales.

Summary

High suicide rates in Jersey were first formally recognised as a public health issue in 2001. Holistic approaches to suicide prevention continue to be implemented locally within existing funding streams. Public Health intelligence is improving with regard suicide and is increasingly being used to help inform practice in this area.

Whilst actual numbers of individual suicide appear small in number those bereaved by suicide in Jersey suggest that approximately 65 people per year experience both the short and long-term physical and mental effects of losing someone close to them through a suicide. It is generally accepted that the impact lasts a lifetime.

Recommendation

- The Health and Social Service committee are asked to continue their support for the work of the Suicide Prevention Strategy.

07 March 2005
Jill Birbeck: Assistant Director Public Health (Health Intelligence)
Andrew Heaven: Assistant Director Public Health (Health Promotion)

APPENDIX C

STATES OF JERSEY
HEALTH AND SOCIAL SERVICES COMMITTEE

Public Health Services
(Suicide Prevention)

Proposal

This paper looks to inform the Health and Social Services Committee of the action resulting from the Medical Officer of Health's report on Suicide (2001). This work has been led by a multi-agency steering group which has as a result of a consultative process, identified prioritise for action. The overall aim of this group is to reduce suicides in Jersey.

Introduction

Suicide is a devastating event. The effect of a suicide clearly has a big impact on those immediately surrounding the person, including friends, family and associates and also professional staff who might have been involved with the individual both before and after the event.

Suicide is defined as a fatal act of self injury (self harm) undertaken with more or less conscious self-destructive intent, however vague and ambiguous (New Textbook of Psychiatry 1999).

The report of the Director of Public Health Services (DPHS) (2001) described the nature and extent of the problem in Jersey and identified action in the form of a co-ordinated and multi agency response which would intervene at various points along the preventative cycle.

According to the DPHS Report 2001 there have been on average 13 deaths from suicide and undetermined causes in Jersey per annum in recent years. This accounts for 2% of all deaths and 7% of all potential years of life lost through deaths before the age of 75 years. The age standardised mortality rate for suicides and undetermined death in Jersey is 14.3 deaths per 100,000. This compares with a national rate of 9.18 per 100,000 (1996-98) in England. The average rate of 58 countries is 14.5 per 100,000 population.

Figures seen in Table 1 (below) show the differing methods of suicide used between 1996 and 2000. We know that there are trends in relation to methods of suicide and that wider social factors can play a part in influencing the overall methods of suicide. The number of people who attempted suicide and were unsuccessful is not known.

Table 1. Number of deaths by method and by sex for all suicides and undetermined deaths in Jersey 1996-2000.

Method	Males	Females
Car Exhaust	7	3
Hanging	25	3
Overdose	4	6
Gunshot	2	0
Other	8	3
Jump from height	5	1
Total	51	16

(Source: DPHS Annual Report 2001)

Our understanding of underlying factors which may or may not contribute toward suicide locally is currently poor. It is anticipated that a local audit of suicide (currently being undertaken) over the past five years will add to our understanding of how different aspects of Jersey life can impact suicide and suicide attempts.

Background

Following a facilitated workshop which involved over 25 delegates from all agencies providing relevant services, a strategy was formulated based on the information and priorities articulated during the day. A multi agency steering group is currently beginning the process of delivering on specific areas of work as outlined in the strategy. A description of the prioritised action which will be taken forward by the steering group in its first year is set out below.

It is important to note that the financial cost of the actions outlined below represent no new / additional cost to Heath and Social Services. Rather the emphasis is on:

- Service redesign and development where appropriate.
- Making sure that issues relating to suicide are considered in other areas of strategy development.
- Improving the connections between voluntary and statuary agencies who have a role to play in preventing suicide.

Primary Prevention

Description of Activity	Action	Lead Agency:
Develop public awareness campaign focusing on mental health	Co-ordinate audit of current information/leaflets available, relevant to the prevention of suicide. Identify gaps in terms of target audiences.	Health Promotion Unit

Description of Activity	Action	Lead Agency:
Develop directory of services for both professionals and service users in relation to mental health issues.	Develop directory appropriately in light of findings from above audit	Soroptimist's, Jersey Focus on Mental Health, Health Promotion Unit.

Description of Activity	Action	Lead Agency:
Evaluate and examine school policies re bullying and barriers to counselling support for young people.	To identify how the proposed Youth Action Teams and Youth Intervention Programmes will impact on the proposals in the Suicide Prevention Strategy in order to ensure a joined up approach whilst minimising the risk of duplicating services or activities.	Margaret Brown from Education Service will liaise directly with Kathy Bull who has an overview of all of the Youth Action Teams.

Secondary Prevention

Description of Activity	Action	Lead Agency:
Co-ordinate the responses to reducing risk of suicide attempts within car parks	Meeting to arrange placement of Samaritan's signs in car parks.	Gary Milne, Samaritans and Alan Muir, Public Services Department

Description of Activity	Action	Lead Agency:
Develop co-ordinated and prioritised plan for training in relation to suicide across agencies.	Revise suicide/depression component of existing 10-week mental health training programme available to statutory, voluntary and private sector Review organisations that have accessed training with view to identifying gaps and broadening out	Ronan Mulherne, Ian Dyer, Gerry Conway – Adult Mental Health Services.

	offers of training.	

Description of Activity	Action	Lead Agency:
Establish corporate H&SS agreement on most effective means of assessing suicide risk.	To review current processes of assessing risk in relation to suicide	Ronan Mulherne, Ian Dyer – Adult Mental Health Services

Description of Activity	Action	Lead Agency:
Identify ways of improving risk assessment and communication between Police and Prison during transfer	To await outcome of Rosemary Wools Health Needs Assessment of the prison due for completion in June/July 2003.	Mark Warren – Adult Mental Health Services

Crises Intervention

Description of Activity	Action	Lead Agency:
Identify patients at risk of suicide following risk assessment in A&E.	To review current processes of assessing risk in relation to suicide	Ronan Mulherne, Ian Dyer – adult Mental Health Services.

Description of Activity	Action	Lead Agency:
Review accessibility of out of hour's services with a view to increasing capacity of outreach group to intervene in crises.	Crises Resolution Team to come on line in Jan 2004.	Ian Dyer – Adult Mental Health Services.

Post Intervention

Description of Activity	Action	Lead Agency:
Identify ways of expanding critical incident review to include all agencies that may be involved.	To understand and support how the work on protocols for critical incident reviews and the existing Clinical Psychology service around debriefing fit together. To begin to develop clear service development strand, out of the resultant critical incident review protocol.	Public Health (including Health Promotion), Social Services and Adult Mental Health Services.

Recommendations/Conclusion

The committee are asked to endorse the:

- prioritised action plan of the multi-agency steering group.
- prioritised actions of the steering group to the Committees for whom suicide is also an issue (Education Sport & Culture, Home Affairs, Environment & Public Services).

APPENDIX D

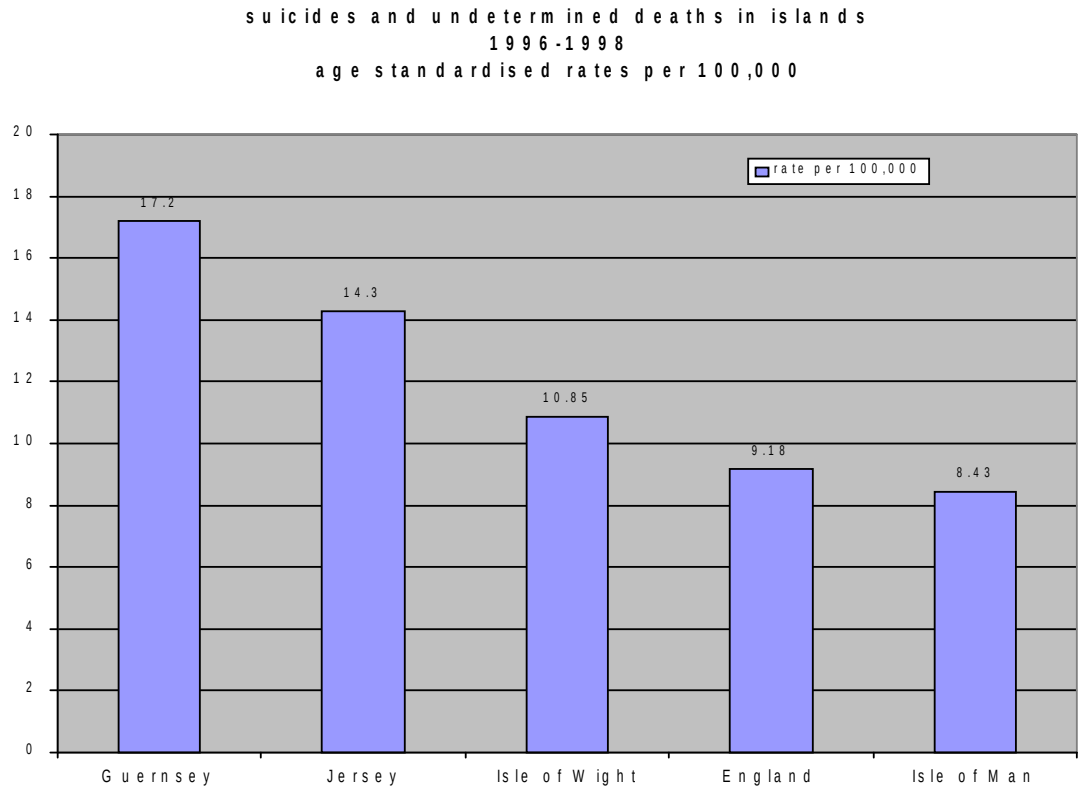
SUICIDE

Why are they important?

There were on average 13 deaths from suicide and undetermined causes in Jersey per annum in recent years. This accounts for 2% of all deaths, and 7% of all potential years of life lost through deaths before the age of 75 years.

The age standardised mortality rate for suicides and undetermined death is 14.3 per 100,000 (five year average 1996-2000). This compares with a national rate of 9.18 per 100,000 (1996-98) in UK. [see figure 1]

Figure 1



What do we know about suicides?

Suicide rates vary with age. They also vary with gender. Suicide rates were higher in older age groups, but these rates have been falling steadily over the past 50 years. In contrast since 1982 in the UK there has been a 75% increase in suicide rates in men aged 15 – 24 years. Since the mid-1970s there has been an increase in the number of suicides among men, but a decrease amongst women. Male suicides now outnumber female suicides by 3 to 1, despite the much higher prevalence of depression in women.

Some people are known to have an increased risk of suicide. About 40% of people committing suicide have a past history of deliberate self-harm. About 1% to 2% of those who deliberately harm themselves in any year will commit suicide in the subsequent 10 years. However, the highest risk of suicide is seen among patients recently discharged from mental health hospitals. Figure 2 shows the estimated magnitude of increased risk of suicide for different groups. To put this into perspective, only 2% of people in high risk groups will commit suicide in a year. More than one-third of people who commit suicide do not belong to any of the high risk groups.

Table 1 Increased risk of suicides in different groups compared with general population

h risk group	Estimated magnitude of increased risk
ents in the 4 weeks following discharge from mental th hospitals	x 200 (males) x 100 (females)
ohol and drug misusers	x 20
aritan clients	x 20
ory of deliberate self-harm	x 10-30
ent or ex-mental health user	x 10

One study was carried out in the North of England 8 years ago looking at all the suicides that occurred over 5 years[1]. There were 105 cases and most occurred among men aged 20-50 years. Forty cases (38%) had been in contact with mental health services at some time in the past, and 41 cases (39%) had been to see their family doctor in the three weeks prior to death. Just over one-third had some form of physical illness or disability at the time of death, and in twenty cases the evidence suggested that this was a key factor. The most common precipitating factor was relationship problems which were identified in 32 cases (10 women, 22 men).

How big is the problem in Jersey?

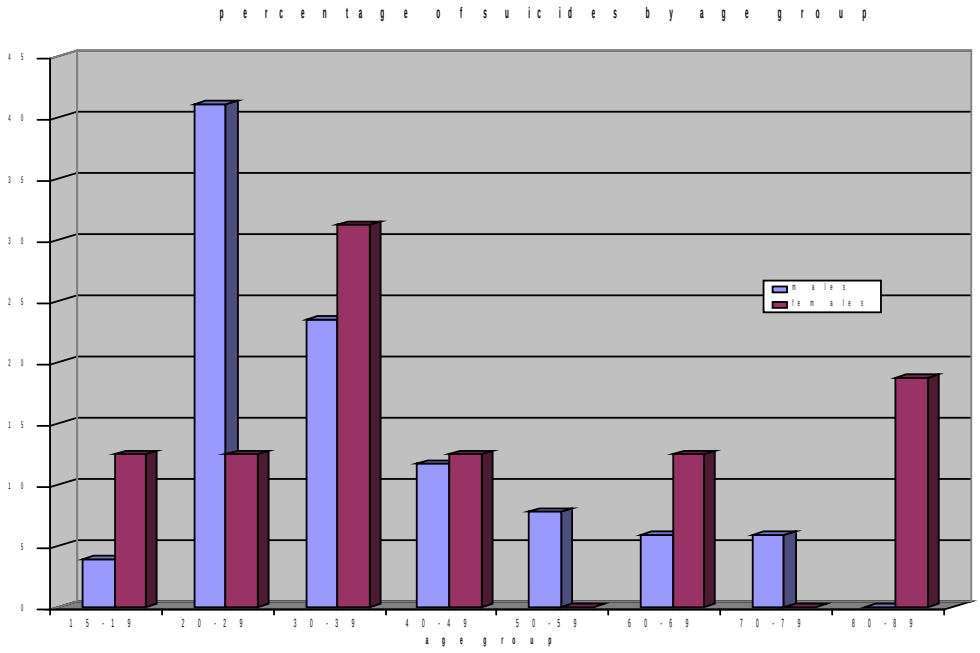
On average there have been 10 or 11 suicides per year and 2 or 3 cases where people have brought about their own deaths but an open verdict has been returned at the inquest because suicidal intent was nor proved.

Table 2 Total numbers of suicides and relevant "open verdict" deaths by agegroup and sex Jersey 1996-2000

der	Age group							
	15-19	20-29	30-39	40-49	50-59	60-69	70-79	80+
ales	2	2	5	2	0	2	0	3
es	2	21	12	6	4	3	3	0

There are three times as many men as women, and more than half the deaths are in persons aged 20-39 years. The percentage of all suicides and undetermined deaths by age group is shown in figure 2.

Figure 2 Percentage of all suicides and undetermined deaths, 1996-2000, by agegroup



The different methods of suicide are an important part of the analysis in order to try to identify preventable opportunities.

Table 3 Numbers of deaths by method and by sex for all suicides and undetermined deaths in Jersey 1996-2000

method	males	females
Car exhaust	7	3
Hanging	25	3
Overdose	4	6
Jump from height	5	1
Gunshot	2	0
Other	8	3

Hanging accounted for nearly 50 % of deaths in men. The only significant difference between men and women is that women are more likely to take an overdose, usually involving drugs which have been prescribed. 5 who jumped to their death did so from a multi-storey car park. There is scope for prevention here, by erecting adequate barriers.

What can be done about suicides?

It is often assumed that there are known effective measures which can be put in place to reduce suicide rates. There are two problems in measuring the effectiveness of suicide prevention initiatives.

- interventions aimed at high risk groups cannot have any impact on six out of ten suicides. This is because these people will not have been in contact with health services and identified as being at high risk. Although family doctors are often the point of first contact, their experience of suicide will be relatively limited. On average, a family doctor in Jersey will experience a suicide in his/her practice once in every seven or eight years.

- potential interventions have not been adequately tested. The gold standard in evaluating clinical interventions is known as a randomised controlled trial. It has been estimated that using this method, to test whether a given intervention could reduce suicide rates by 15%, the study would have to involve 13 million people.

Local audits

A different approach is to treat a case of suicide as a "critical incident" which must be subject to a special review. Such reviews should be part of the routine clinical risk management procedures which health services are expected to carry out. These local reviews should be carried out in a systematic way and involve professionals from all relevant disciplines. The lessons learnt in each case must be widely shared so that all professionals can contribute to improving the care of patients at risk. This approach has been adopted in Jersey and will be formally incorporated in a new H&SS policy on dealing with "significant events" – events where the health of patients has been put at actual or potential risk, or where there is an adverse outcome.

The UK has a national Confidential Inquiry into Homicides and Suicides by Mentally Ill People. This inquiry has a remit to identify factors which may be related to the suicide and to make recommendations on prevention. Particular actions have been identified that would reduce the availability of common methods for suicide. These include new designs for car exhausts; limiting the quantity of paracetamol available over the counter (now only available in packets of 16); improved licensing and regular amnesties of firearms.

Targeted treatment

Another approach is to improve the management of people with mental health problems in the community by targeting high risk groups. Although suicide rates are higher in people suffering from depression, it is not possible for the family doctor to predict which individuals will commit suicide. Rather, the issues which need to be addressed are the recognition and management of depression by family doctors. A training programme for Swedish family doctors about recognising and treating depression resulted in a reduction of suicide rates.[2] Suicide rates in Sweden were much higher than those in the UK at the time of the study, and this may have contributed to the apparent success. Given that up to 50% of all suicides are committed by clients with undiagnosed or inadequately treated depression, a similar training programme for local family doctors is recommended.

Since those people who have deliberately harmed themselves are known to be at high risk it would be reasonable to target this group. There are arrangements which include an urgent psychiatric assessment for the immediate care of the group of patients who present in the Accident and Emergency department due to deliberate self-harm. Those who identified as having serious mental health problems are diverted to the care of the mental health services.

Getting it right

A number of initiatives could be introduced in order to reduce the number of deaths by suicide in Jersey. Such measures may also reduce the occurrence of deliberate self-harm which is more prevalent than suicide.

It is worth noting that deliberate self-harm is not necessarily a failed suicide attempt – it may be a way of trying to resolve some unbearable pain or life crisis. As such, the whole issue is worthy of consideration in its own right.

The interventions will be discussed in four categories[3]:

- Primary Prevention
- Early Intervention
- Intervention
- Post Intervention

Setting the goals for suicide prevention

The goals of suicide prevention, along with intended target groups, must be clearly identified. The factors implicated in suicide are complex and interrelated.[4] There is at present a lack of research around the nature of suicide in Jersey. For example, the rates may be different between young people who have always lived in Jersey and those who have come to the island recently. Without this information, the only option is to assume that the target groups identified in the UK are applicable to Jersey. The difficulty with this approach is that suicide patterns vary, even in similar and relatively proximate cultures:

"Many possible environmental and social explanations for national and regional variations have been considered including climate, latitude or annual light/dark cycles, ethnicity, policies, alcohol consumption and social and

political systems. However, another factor of undoubted importance is variance in societal attitudes about suicide and efficiency of reporting suicide, although regional variations are also present in the United States despite presumably similar reporting procedures."[5]

Primary prevention

This intervention is aimed at society in general and is designed for the whole population. It aims to raise understanding around the issue of mental health and suicide and to reduce the stigma attached to mental health problems. This prejudice can often be seen in Jersey, for example in the reaction of the community when application is made to place people in rehabilitation in local supervised accommodation. Mental health should not be a taboo subject.

A variety of methods should be used, including:

1. A sustained public information campaign which would focus on:
    - A 'potted history' of suicide placing the present day approach into a historical and cultural context
    - A 'first hand' experience of suicide, possibly from someone who has attempted suicide at some point, or a family member or friend of someone who has taken their own life
    - The role of the statutory and voluntary agencies who are able to assist with those who may be experiencing suicidal feelings
2. The development of a suicide resource (information and training packs) for use by educational institutions and community groups.

Early intervention

Early intervention is the "effective reduction of the intensity, severity and duration of risk behaviours for suicide. Therefore, early intervention strategies encompass improvement in the detection, assessment and management of people at risk." [6]

Certain groups of people are generally acknowledged as particularly vulnerable with regard to the potential for suicide. These are:

- People with depression type illnesses
- People who abuse alcohol and other substances
- Young males (15 - 24) and older males (65+)
- Those who are socially isolated
- Newly imprisoned males

Each lead agency should have a written policy which sets out their approach to the groups mentioned above, and addresses:

- Assessment of current training, protocols and general levels of awareness in relation to suicide
- Evaluation of the services with an emphasis on looking for gaps in both provision and knowledge base, with regard to new research and approaches in the field of suicide treatment and prevention
- Maximises improvements in the overall provision of holistic support for those who are at risk of suicide that could be made by joint working with other organisations

There is good evidence of the effectiveness of guidelines to improve the management of people with depression in primary care, and the introduction of such schemes in Jersey should be facilitated.

One outcome from local audit is a better understanding of the Jersey pattern of suicides. This may identify "hot spots", places or methods for committing suicide that are amenable to local interventions – for example installing safety netting and barriers at places where people commonly jump. It would be possible to reduce access to some of the methods of suicide in Jersey. For example, the installation of safety barriers around certain car parks which have become notorious for their use in suicide attempts.

Intervention

It is important to decide what approach to take in providing services for those who are seriously and imminently at risk of

suicide, or have already recently attempted to take their own life. The situation context is usually one of crises.

The creation of assertive outreach teams in the UK has been viewed with ambivalence by both professionals and users of mental health services. Whilst the government defended the creation of a more aggressive approach to mental health, many are wary of the implications around the erosion of Human Rights, particularly around enforced treatment in the community. However, in relation to the treatment of suicide, it is clear that compulsory treatment in the hospital presents further risks and is far from a problem free solution:

"Both absolute numbers and rates of suicide in psychiatric inpatients have increased progressively in several European countries during the last three decades." [7]*

Post intervention

This describes the range of support services which may take place after a suicide has occurred. The additional benefit is the possible prevention of future suicide for those who experience exposure at an early age.

The shock wave created by a suicide has the potential to impact upon:

- Family and friends of the deceased
- Professional and support services involved with the deceased

It is important that the needs of both groups are addressed appropriately. These can be provided by existing or additional counselling and bereavement services, and those existing or additional services which can provide practical support and help, e.g. Citizens Advice Bureau.

The staff in professional and informal support services who are involved with a suicide, particularly a violent suicide or the death of a young person, can suffer long standing detrimental effects on mental and physical well-being. Emergency service personnel who are routinely involved in fatalities, may experience a more profound effect through the accumulative effect of multiple exposure. Support services for these people are crucial and can lead to the protection of the well-being of staff, with an increased ability to cope with exposure to traumatic events.

Proposals for action

1 To undertake research in order to gain a clearer understanding of suicide in Jersey, particularly in relation to:

- A historical perspective on the pattern of suicide in Jersey highlighting any trends or patterns around suicidal behaviour
- A clearly identified method for the ongoing collation and analysis of information in relation to suicide in Jersey

2 To raise public understanding around the issues of mental health and suicide.

3 To improve the early detection, assessment and support for those who are at risk of committing suicide.

4 To reduce opportunity for suicide at the 'hot spots' such as car parks.

5 To establish assertive outreach teams.

6 To minimise the harmful impact of the suicide of an individual, upon the wider community.

HATE

I hate myself and want to die
I have no wings but want to fly
I have no tears and need to cry
I hate myself and want to die

I hate myself and want to die
All I ever do is try
I can't go on, my life's a lie
I hate myself and want to die

(Taken from an anthology of poems by a young woman who worked through mental health difficulties at the Young People's Unit, Newcastle General Hospital)