GD2023/0019

Saving Lives; **Ending Suicide.**

Isle of Man Suicide Prevention Strategy
2023 – 2027

PublicHealth

Contents

If you are struggling, there are people you can talk to:

Samaritans:
Provide a 24-hour confidential telephone service for anyone feeling desperate or suicidal or going through any sort of personal crisis, including bereavement.

Free Helpline: 116 123
Email: jo@samaritans.org

Information on other local and UK support can be found on **www.gov.im/wellbeingsupport**

Foreword

Suicide is personally the most painful thing I have ever dealt with as a doctor. It often leaves behind a deeper scar on family, friends and carers than any other kind of death. I think that reflects a deep sense of tragedy. Life is such a precious but tender flower, but when snatched in an untimely way leaves an aching hole.

Most of us have an instinct that we are more than a bag of chemicals. That we are special. The desire to tackle suicide that many of us share is linked to a sense a transcendence; a beautiful and eternal flame that burns within which echoes far beyond the last heartbeat, and which gives us a drive to fight to preserve our life and the life of those around us. To care for the vulnerable and strive to make each person's life filled with sufficient meaning, purpose and sense of identity that we do not lose hope and give in to despair when faced with the inevitable headwinds of life.

The international movement that developed the ambition of 'Zero Suicide' may seem somewhat naive, or at least aspirational. Perhaps it is. But it clearly stems from a heart that cares. I recognise that caring and compassionate heart as a feature of Manx culture and that gives me hope that this strategy will be widely supported. I commend this public health strategy to you.

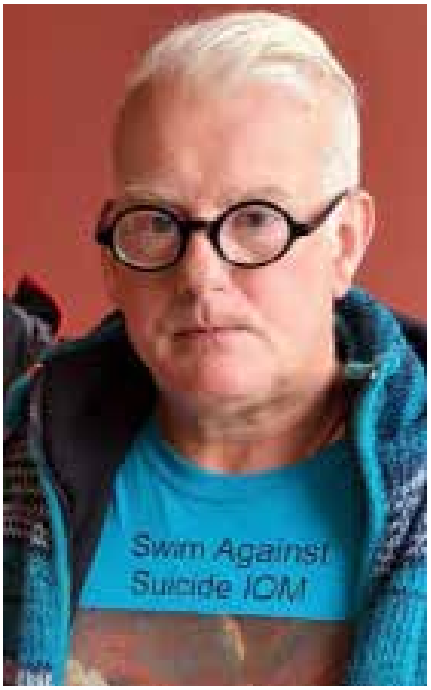
By **Professor Hugo Van Woerden**,
Interim Director of Public Health

Public Health's Vision

The Isle of Man is a place where suicide is a thing of the past. People never get to the point where suicide seems like the only option; there is always a better solution.

Individuals and communities have the resources to deal with challenges, and grow to be the best version of themselves.

Introduction



My name is David Higson. I lost my only adult son Martin to Suicide 3 ½ years ago. As a result I wanted to do something positive. I set up Bereaved Survivors of Suicide Isle of Man; a peer support group to help others in a similar situation as myself. The total devastation that Suicide leaves behind is something that no one should have to suffer. Suicide ruins lives, both the life of the person lost and the loved ones left behind.

Worldwide, suicide takes a life every 40 seconds, which is around 800,000 people. The Isle of Man is not exempt. But suicide is preventable if we can spot the warning signs early. We need to become a Community Nation; a nation that comes together and supports our residents in need, in a caring, focused and meaningful way.

Suicide should never become the only option to a person when they feel trapped. Life can be extremely challenging at times. When somebody feels a situation has become hopeless, we need to step alongside and help them find a way out.

As a society we need to encourage the members of our community to value themselves and their own special unique individuality. We need to talk openly about the causes of suicide, it will not disappear by ignoring it.

I want our community, government and third sector to strive and work together to achieve an Isle of Man with Zero Suicide.
I support this strategy and its ambition.

Achieving Zero Suicides will be challenging, but the loss of one life to Suicide is one to many. We have the desire to save lives, to help and protect the valuable members of our community. Do you? I hope that everyone will feel an obligation to join us in this fight to make the Isle of Man a place where there is NO MORE SUICIDE. Become partners with us to stop this devastation on the Isle of Man.

David Higson.

Background

In the 16 years from 2006 to 2021 156 people took their own lives on the Isle of Man. Each represents a desperately sad tale, and devastation for those left bereaved. But suicide is not inevitable, and is never the only option.

Most people have had a crisis, where stress feels overwhelming. And yet, the crisis has passed. Most people who take their lives do not want to die, but cannot see any other way out. Suicide is a permanent solution to a temporary problem.

The reasons why someone takes their own life are usually complex. Layers that build up, making someone want to escape. The response to suicide needs to be equally far reaching, with all departments of government, the third sector and communities working together.

The starting point of this strategy is that suicide is preventable. If this is the case, the logical ambition for the Isle of Man is 'zero suicides'.

The case for Prevention

Local suicide intelligence is essential to understand the profile of suicide on the Isle of Man, who appear to be most risk and where to target resources. Data is gathered in a number of ways:

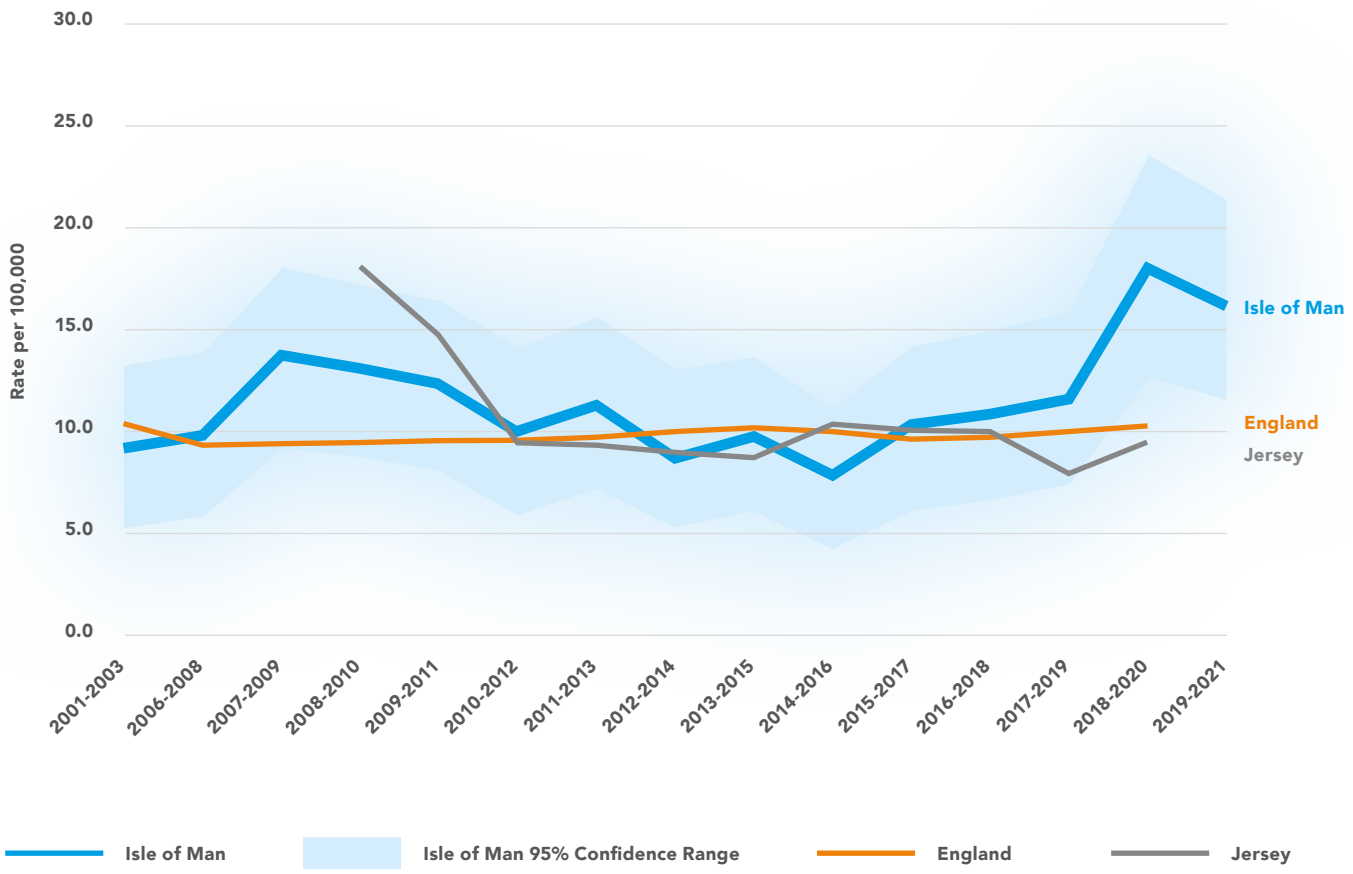
1. Mortality statistics, as part of the Public Health Outcomes Framework (PHOF)
2. Suicide Audit
3. Real time data

'Suicide' is a Coroner of Inquest's verdict; a sudden death has to wait for an inquest before it can be declared a suicide. Mortality statistics gathered annually by Public Health refer to 'year of registration' rather than 'year of death'. A suicide audit goes into more detail from Coroner's records, giving profile information, the context, risk factors and services involved. Real time data gives an opportunity for a rapid response, by the early identification of emerging trends and possible clusters of suspected suicides.

Overall trends and benchmarking

(PHOF 2006-2021 156 cases)

Age Standardised Mortality Rate - Suiccide/Undetermined Intent

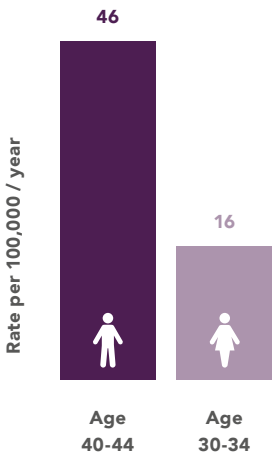


- Until 2019, the overall rate of suicide had been stable for at least ten years
- At about 10 per 100,000, the rate was statistically similar to the UK and Jersey
- In 2020, there were 24 deaths registered as suicide. Some of this increase was due to reduced number of inquests during 2019 due to the early stages of the pandemic. However audit and real time data into the date of death shows there was a significant increase in suicide, and suspected suicide deaths in 2019, 2020 and 2022.

Demographics

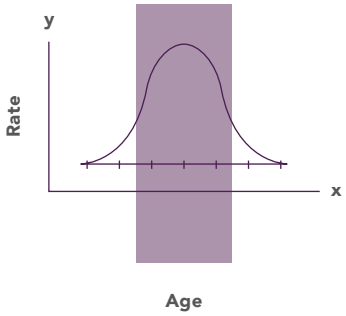
Age and Sex (PHOF)

Highest suicide rates by age and sex



From 2006-2021

From 2006-2021 59% of suicides occured during the 25 years between 35-59 years old



- Men died by suicide 3 times more frequently than women.
- The age band for men with the highest number of deaths was 40-44, with a rate of about 46 per 100,000 per year. For women it was 30-34 with a rate of about 16 per 100,000 per year.
- There were more deaths by suicide in middle age, with 59% of all suicides occurring in the 25 years between 35 and 59 years of age.

(Suicide Audit 2016-21 65 cases)

Place of Birth	Ethnicity	Gender / Orientation	Living Situation
42% born on the Isle of Man 97% were resident	97% White British (compared to 95% in general population – Census 2021)	3% were recorded as being LGBT	35% lived alone (14% of general population live alone – Census 2021)
Housing Status	**Employment**	**Occupation**	**Relationship Status**
37% owned their own home (compared with 64% in general population - Census 2021) 14% were in social housing (compared with 16% in general population - Census 2021)	41% employed or full-time education (55% in general population), 24% retired (21% in general population), 33% unemployed or unable to work (8% in general population - Census 2021)	Of those employed, elementary occupations and skilled trades accounted for 42%. (compared to 22% of overall workforce – Census 2021)	63% were in a relationship (41% were living with their partner)

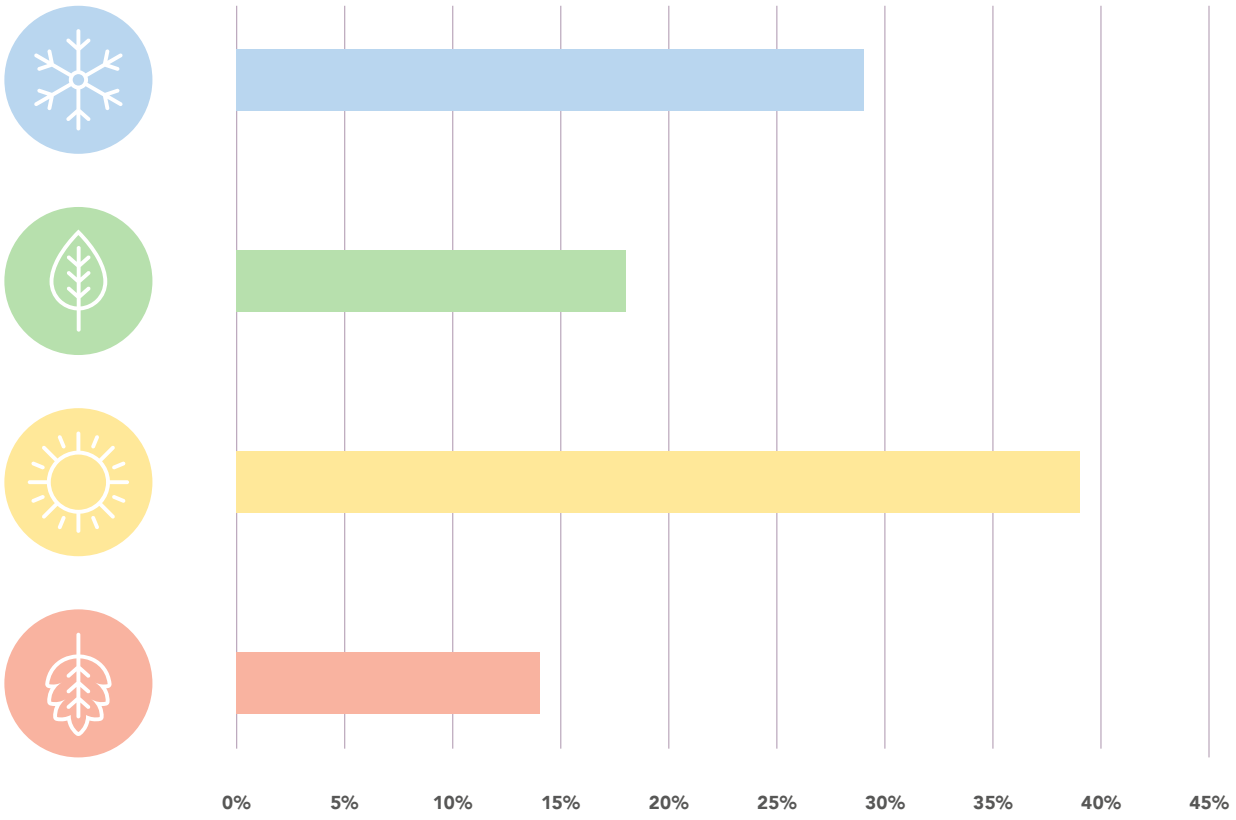
62% of suicides happened in their own home.

28% were in a public place. There were no 'hotspot' locations.

31% had drank alcohol at the time of death

Of those who died by overdose, 75% of drugs taken were prescribed

Season of Death

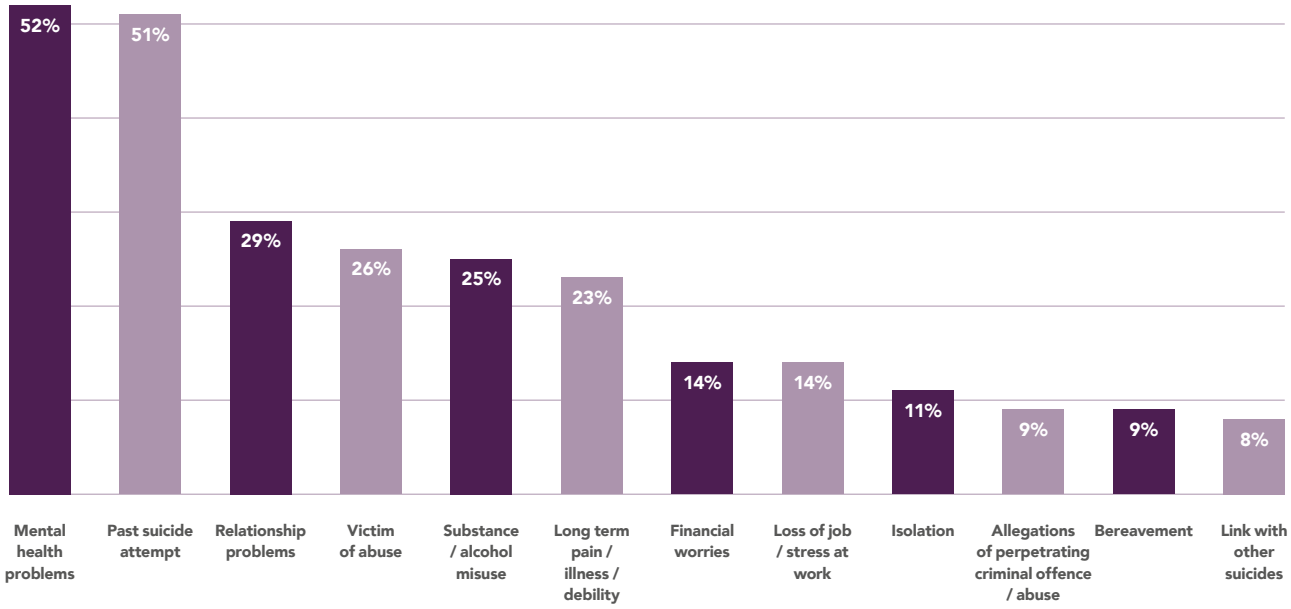


The summer season saw the most deaths between 2016-20 (with only one of these being non-resident). The methods used are very similar to other nearby jurisdictions

Risk Factors

Risk factors	Risk factors by age
The 5 most common risk factors were mental health problems, past attempts, relationship problems, being a victim of abuse, and substance / alcohol misuse	By age group, the most common risk factors were: Under 25 – substance misuse 25-44 – mental health problem / past attempt 45-64 – mental health problems Over 65 – long term pain, illness, debility

Other risk factors
5 (8%) had direct links to other suicides
3 (5%) were carers
3 (5%) were ex-motorcycle racers or relatives of motorcycle racers who had died whilst competing
In 2020, 4 (19%) experienced stressors relating to the COVID 19 pandemic



- The most common risk factors are mental health problems and past suicide attempts, followed by relationship problems, victim of abuse, substance / alcohol misuse and long-term pain / illness / debility.
- The distribution of risk factors varies with age. For example substance / alcohol misuse is more significant in younger age groups, whereas long-term pain / illness / debility plays more of a part in older groups.

Contact with Statutory Services

Known to mental health services

52% had been under the mental health services in the 12 months before their death, 37% were current service users

Diagnosis

The most common diagnosis was mild to moderate depression or anxiety (33%), followed by substance / alcohol misuse (23%)

Current prescription

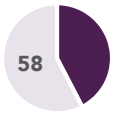
52% of entire group were prescribed antidepressants

Living situation

The proportion of mental health service users who lived alone was similar to those who died by suicide in general (38% compared to 37% respectively), however more lived in rented accommodation (50% compared to 34% respectively).

Last contact with Primary Care

58% of last contacts with GP's of entire group were mental health related

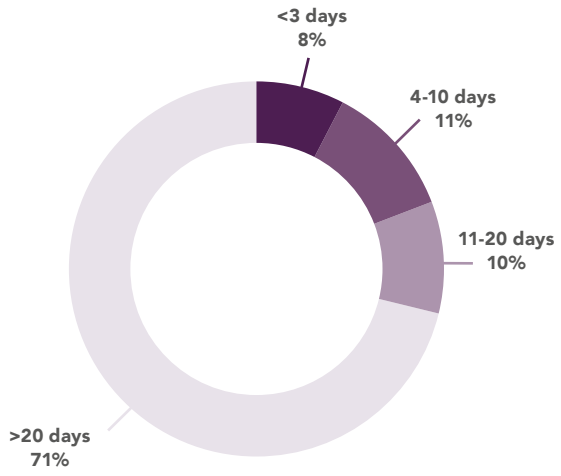


Past suicide attempts

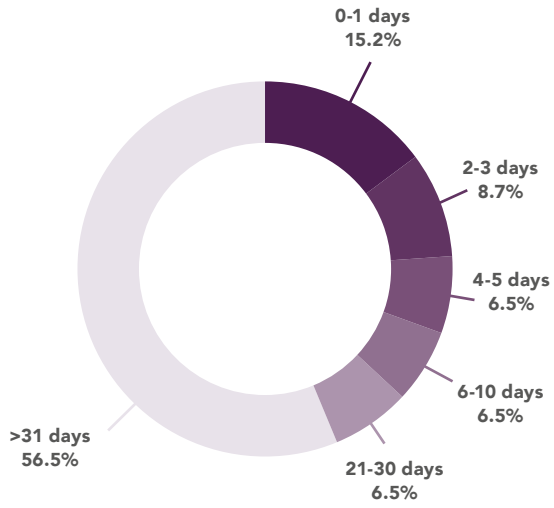
51% of the 65 had a history of at least one past suicide attempt. 12% had 2+ serious attempts.

Time between last review and death

Days between last contact with GP/Primary Care and DoD



For those current to Mental Health Services, days between last contact and DoD



*11-20 days 0.0%

- A little over a third of people who died by suicide were open to mental health services at the time of their death
- 1 in 5 of people who died by suicide saw their GP within 10 days of their death.
- Of those current to mental health services nearly one quarter had contact in the 3 days running up to their deaths.
- The most common diagnosis was mild / moderate depression or anxiety and over a half of all those who died by suicide were on antidepressants.

The Cost of Suicide

The lifetime cost of each death by suicide in European countries for those of working age was estimated to be £1.67 million in 2009 (equivalent to £2.26 million in 2019)[1]. 30-40% covers the direct costs, such as police, inquest and healthcare, and indirect costs relating to loss of productivity and earnings. Intangible costs (equivalent to compensation costs) associated with pain and grief account for the remainder[2]. Estimates vary on how many people are affected by each suicide – ranging from 6 to 60 people[3].

There were 127 people of working age who died by suicide between 2006 and 2020. Using the EU estimate above, suicide may have cost the Isle of Man economy between £86 and £114 million in this 15 year period, which includes societal harms. The European study[1] showed investment in suicide prevention is highly cost effective.

What are we doing already?

Although this is the first Island wide Suicide Prevention Strategy, there are a lot of suicide prevention initiatives already in place on the Isle of Man.

In recent years, interrupted by the pandemic, Public Health have been focusing on gathering the data needed to inform a strategy and develop the structures needed to deliver it.

The multiagency 'Suicide Prevention Group' was established in 2020, with core members including senior representatives from all of the key government departments, the third sector and experts by experience. This is supported by a wider stakeholder group, including voices from diverse minority groups. The aim was to reduce the suicide and attempted suicide rate on the Isle of Man, and provide the partnership and coordination to deliver this.

We have been gathering quality data (as sampled above), which allows us to compare rates with other jurisdictions, but more importantly tells us what areas we need to prioritise.

Suicide is complex; there is rarely a single cause, with factors building up through someone's life. Suicide prevention, therefore must start in childhood. All Manx schools deliver Personal, Social, Health and Economic (PSHE) education, which is designed to increase the resilience of our young people; equipping them with the tools to deal with life's crises.

Mental Health Services in Manx Care provide a range of interventions from talking therapies, to crisis support, acute care and assistance to recovery. It is in the process of evolving to give more emphasis to helping people earlier.

There are many excellent third sector organisations on the Isle of Man who help people who are considering or who may go onto consider suicide. These include Motiv8, Isle Listen, Mind Matters, Shine, The Samaritans, Bereaved Survivors of Suicide and Cruse Bereavement Care.

But preventing suicide is not simply about mental health support. Education, housing, employment, finances, leisure, physical health, family, our community and environment, are all key to our wellbeing. It is only through a combination of helping individuals and improving the bigger picture, that we will achieve our ambitions.

Setting the ambition

Even though it might not seem the case at the time, every suicide is preventable. Over a life course traumas and inequalities can add up to the point that after a suicide it seems like it was inevitable. However, each of these points are opportunities to intervene. If people are helped to develop better skills on how to deal with problems, if communities are supported to be more watchful of people struggling, if early help is available, then the point where someone thinks they have no options can be averted.

In principle, every suicide is preventable. If this premise is followed, then no amount of suicides are acceptable.

For zero suicides to be a serious ambition, it must be accompanied by a culture of improvement. If a suicide does occur it must not be met with blame or be evidence of failure. Instead the primary response should be compassion and support for those bereaved, but it is also a chance to reflect on what happened, and learn how we can do things better.

How do we move towards zero suicides?

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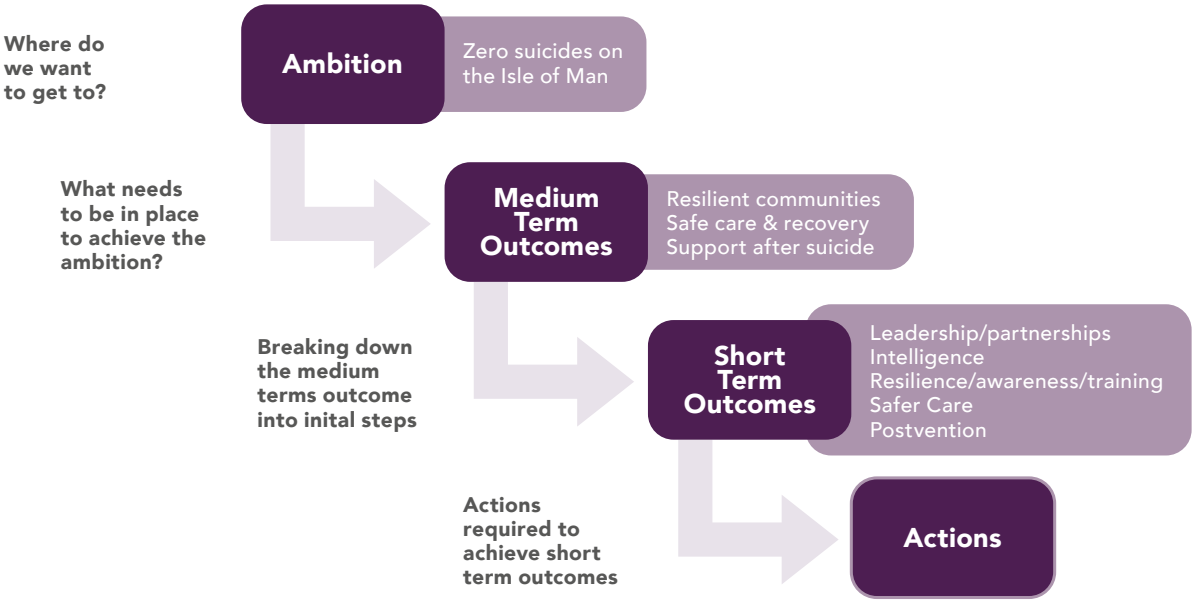
Developing the strategy



Medium term outcomes

- **Resilient communities**

We have strong, cohesive communities where people feel they belong. They are committed to promoting health and well-being and understand the importance of prevention.

People are able to talk openly and freely about suicide and mental health, they know how to respond, and they know, and feel confident in, the services available. Individuals feel safe and supported within their community; there are people they trust and are able to talk to.

- **Safe care and Recovery Plus**

We work with people in contact with mental health services to ensure their safety. All staff have the skills to identify risk and respond appropriately. Service users know what to do if they are struggling. They feel supported and safe, whilst still given the freedom to grow.

The environment, policies and procedures are robust and evidence-based to ensure everyone receives a best practice service.

Recovery is such that after the immediate care, individuals are supported to grow stronger and more resilient.

- **Best response after suicide, or attempted suicide**

Relatives, friends, social groups, and staff members feel supported as they negotiate the grief and trauma following the sudden death by suspected suicide of a loved one. This support may be from a community who know how talk to people in grief, a specialist third sector, or accessible public services. Support is flexible, individual, and at a pace that suits.

Individuals and their families are supported through the crisis following an attempted suicide, and then helped to grow to a point where it will not happen again.

Following a suspected suicide or attempted suicide, trends, possible clusters and learning points are quickly identified and mitigation measures promptly instigated.

Short term outcomes

The 'short term outcomes' are the focus for the 5 year life of this strategy.

- **Partnerships / leadership**
  - A suicide prevention network linking statutory, private, third sector, leisure groups, community bodies and experts by experience within the Isle of Man. The network extends overseas, to UK national and regional suicide prevention initiatives for supervision, best practice, and benchmarking. The network contains strategic and operational relationships.
  - The culture is of co-ownership, co-production and respect. The driving force is continual evidence-based improvement; no blaming, just learning.
  - Suicide is complex and prevention must tackle a range of risk factors to be most effective. Suicide prevention is actively incorporated into a wide range of boards and other strategies, programmes and policies.
  - Working together, across sectoral boundaries is the norm.
- **Intelligence – better understanding of risk, evaluate & monitor progress**
  - There is a Suicide Prevention Profile dataset capable of describing the pattern of suicide locally, associated risk factors and service involvement, and tracking progress against this strategy. Methods of collection are comparable to similar datasets in the UK to allow benchmarking.
  - A rolling annual Suicide Audit gives contextual information for suicides locally.
  - There is a mechanism of rapidly gathering information following a suicide to:
    - Identify and offer support to those affected,
    - Detecting emerging themes and possible clusters,
    - Discover ways suicide prevention can be improved.
- **Prevention**

Prevention is at the heart of the strategy. There are 3 levels of prevention:

  - Primary prevention – stopping mental health problems before they start
    - Individuals (especially young people) and the community are more resilient, wellbeing is promoted and people have the 'tools' to deal with crisis.
    - The health and wellbeing of high risk groups is improved at a population level.
  - Secondary prevention – early detection and intervention to prevent escalation
    - People with emerging mental health problems get the support they need to avert further deterioration.
    - People with increasing suicide risk factors are supported at an individual level to prevent the onset of suicide related behaviour.
  - Tertiary prevention – targets recovery and reducing the risk of relapse
    - People displaying suicide related behaviour are helped to keep themselves safe, recover from the crisis and be more robust moving forward.

Priority areas in next 3 years

The reasons behind suicide are complex and diverse. We cannot focus on all areas of prevention at once. In this strategy, the areas we will focus on are:

- Resilience / awareness / training
- Postvention
- Safer care

Outcomes for these areas are as follows:

- **Resilience / awareness / training**
    - Individuals (especially young people) and the community are more resilient, wellbeing is promoted and people have the 'tools' to deal with crisis.
    - The community are able to talk about suicide. They know what to do if they are concerned about someone.
    - We have a competent, and caring workforce able to screen, engage and treat suicide behaviour at a level commensurate to their role.

- **Postvention**

Compared to people bereaved by other causes, those bereaved by suicide are more likely to struggle with everyday activities such as work, relationships and social functioning. Friends and relatives of people who die by suicide have a 1 in 10 risk of making a suicide attempt after their loss.

- Those bereaved by suicide are supported
- Rapid interventions to prevent further suicides are put in place
- Contagion / clusters identified quickly and responded to
- There is a sensitive and responsible media.

- **Safer care**

Although only a little over a third of people who die by suicide are current to secondary mental health services, they are clearly a high risk group.

- Those with mental health needs get the best care, at the earliest opportunity, with the least amount of disruption to their lives
- Those in crisis get meaningful and accessible support
- Self-harm and attempted suicides are prevented and responded to following best practice
- Every service user knows how they can keep themselves safe
- Transitions between services are managed with safety as a priority
- Specialist mental health services, A&E and primary care deliver safe care

Universal and Targeted

Actions will be both universal (aimed at everyone) and targeted (particularly focusing on those most at risk, or where interventions maybe most effective). The priority groups are identified with reference to the local data. When it comes to implementation, every action must specifically consider each priority group relevant to that action, alongside the universal response.

Suicide Prevention Action Plan

The following Action Plan describes the headline actions required to achieve the short-term objectives i.e. the next 5 years.

Area and Objectives		What we're doing already	What we plan to do	Lead agencies
1 - Partnerships / Leadership				
1.1	Suicide prevention network including community action	**Suicide Prevention Group (SPG)** - established in 2020 by the Director of Public Health, this high level, cross-government, cross-sector group works at the strategic level to reduce suicide on the Isle of Man. **Membership of UK suicide prevention initiatives** – Public Health IOM are members of the UK's National Suicide Prevention Alliance, and Zero Suicide Alliance.	• Join **National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)** • Establish a **Suicide Prevention Network.** This network will consist of individuals, groups and organisations who are committed to suicide prevention, and will grow organically as other prevention initiatives take hold.	Public Health Public Health
1.2	Culture of improvement – 'no blame, just learning'	**Mortality Reviews** **Serious Incident Reviews** – aligned to Royal College of Psychiatrist's guidelines.	• Establish a Suicide Review Panel to operate alongside other death review panels to focus on uncovering opportunities to prevent further deaths. • Work with Manchester University to analyse deaths by suicide in Mental Health Service users, for learning and service development opportunities.	Public Health / DHSC
1.3	Links with all boards	The Health, Learning and Social Policy Board, a sub-committee of Council of Ministers, will be provided with regular updates on the delivery of the strategy.	• Map and influence all overlapping fora and initiatives. • Promote the importance of the wider determinants of health	Public Health
1.4	System wide collaboration to increase capacity and capability		(see above)	

Area and Objectives		What we're doing already	What we plan to do	Lead agencies
2 - Intelligence				
2.1	A data set capable of tracking progress of strategy	Partial **Public Health Outcomes Framework**	Develop a **Suicide Prevention Profile** - analogous to the PHE profile this gathers together suicide data, related risk factors and contacts with related services.	Public Health

Area and Objectives		What we're doing already	What we plan to do	Lead agencies
2 - Intelligence				
2.2	Better understanding of risks	**Suicide Audit** - This examines and collates relevant information from Coroner's records. Collectively it provides a better understanding of local risk factors.	Finalise **Suicide Audit** and use results to inform other suicide prevention objectives. Suicide audit data gathering to become an annual norm.	Public Health
2.3	Real time intelligence	**Real time suicide intelligence** - the 'Suspected Suicide Rapid Response' became operational in 2021. Real time data is able to identify emerging themes and possible links to other suicides.	Develop a real time database, alongside suicide audit information, that's capable of spotting emerging trends and links with other suicides.	Public Health

Area and Objectives		What we're doing already	What we plan to do	Lead agencies
3 - Resilience / awareness / training				
3.1	Individuals (especially young people) and the community are more resilient, wellbeing is promoted and people have the tools to deal with crisis	**Personal, Social, Health and Economic (PSHE) education.** PSHE, which includes Relationships and Sex Education (RSE), is taught in all Manx schools. It aims to prepare young people how to cope with various life challenges. However, it is not a protected subject listed in the Education Act 2001 or Education Curriculum Order 2011, and is therefore subject to 'timetable pressure'. There is considerable variation between schools on how PSHE is taught and quality assurance is difficult. Some local third sector and private sector organisations provide health and wellbeing courses, for individuals or groups, communities or workplaces. Some are free but most attract a fee.	• All schools review of PSHE, to ensure quality resilience training for children and young people across the island, with an emphasis on 'choice'. • Online safety promotion (with reference to Samaritans internet safety guidelines). • Develop specific wellbeing support for staff in vulnerable roles	DESC
3.2	A community (particularly community gatekeepers) are able to talk about suicide	During the pandemic, the multi-media **Are you OK?** campaign included an article on suicide prevention. This included a call to action for members of the community to complete the free online training provide by the Zero Suicide Alliance. There has also been other one-off awareness raising events such as **Stamp out Suicide.** However, awareness raising has not been done in a targeted manner, e.g. focusing on high risk groups, and reach and effectiveness have not been measured.	**Community suicide prevention awareness plan** targeted to main high risk groups. This will include strategy and implementation, including commissioning.	Public Health / Manx Care

Area and Objectives		What we're doing already	What we plan to do	Lead agencies
3 - Resilience / awareness / training				
3.3	Workforce trained to an appropriate level	There are several third sector and private sector organisations providing suicide prevention awareness training. These include **Applied Suicide Intervention Skills Training (ASIST), Level 2 Award in Suicide Awareness and a Level 3 Award in STEPS Towards Suicide Reduction.** However coverage is piecemeal and linked to personal interest.	**Strategic workforce development plan** -Together with other wellbeing topics, we will explore the possibility of establishing a government wide Workforce Development Plan of tiered awareness / training according to role and strategic development.	Public Health / LeAD

Area and Objectives		What we're doing already	What we plan to do	Lead agencies
4 - Postvention				
4.1	Those bereaved by suicide are supported	In addition to the aims mentioned in 2.3, the **Suspected Suicide Rapid Response (SSRR)** group identifies groups or individuals who maybe at increased risk because of their association with the deceased. Action plans are drawn up to mitigate these risks. **Cruse Bereavement Care and Bereaved Survivors of Suicide** have specific expertise in supporting people affected by suicide.	Commission a specific Suspected Suicide Rapid Response Outreach service. This would: • provide the initial exchange of information between the SSRR group and those affected, • provide bridging support until no longer required or generic support engaged. • proactively re-establish contact at significant points such as anniversaries or around the time of the inquest. This service would work in conjunction with a non-clinical support service for people in suicidal crisis (see Action 5.2)	Public Health / DHSC
4.2	Rapid interventions to prevent further suicides are put in place		Consolidate function of SSRR	Public Health
4.3	Contagion / clusters identified quickly and responded to		Improve data collection & interrogation to better identify links between suicides, suspected suicides and attempted suicides (See Action 2.3)	Public Health
4.4	Sensitive and responsible media	Samaritans Media Guidelines for reporting suicide has been circulated to IOM media.	Media to be included in 'community suicide prevention awareness plan' (See Action 3.2) Online safety promotion (See Action 3.1)	Public Health

Area and Objectives		What we're doing already	What we plan to do	Lead agencies
5 - Safer care				
5.1	The best care, at the earliest opportunity and least disruption	**Kooth and Qwell** - government sponsored, free online E-Counselling service young people aged 11 to 17 years, and adults respectively, who are experiencing low-level anxiety, stress or depression. **Primary Care at Scale -** Psychotherapists embedded within primary care that can be directly accessed by GP's. **Isle Listen in Schools -** aim to prevent escalation of mental health problems through providing education and early support of low-level health and wellbeing concerns. **Mind Matters -** commissioned third sector service to reduce **Child & Adolescent Mental Health Services (CAMHS)** waiting lists. **Shine -** private company providing various psychotherapies	• Benchmark against the **National Institute for Health and Care Excellence [NICE] guidelines for depression**, and address identified gaps. • **Thrive -** an integrated model health and wellbeing in Children and Young People, involving a collaboration between women & children services, education and mental health services. • **Recovery College** Mental Health Services in collaboration with University College Isle of Man (UCM) will develop a prospectus of resilience and self-help subjects. • Work with Manx Care and DHSC on their plans to significantly increase the capacity of CAMHS.	Public Health/ Manx Care DHSC / Manx Care DHSC/Manx Care/DESC DHSC/Manx Care/Public Health
5.2	Accessible and meaningful crisis support	Signposting to **Samaritans** (e.g. anyone feeling emotionally distressed or suicidal can call Samaritans for help on 116 123) **Crisis Response & Home Treatment Team (CRHTT)** **Mental Health Police Liaison Service** allowing street triage and rapid assessment in police custody.	• Commission a specific service of non-clinical support for those experiencing suicidal crisis, to work alongside the SSRR outreach service (Action 4.1). Expand CRHTT to allow separation of functions to 'Rapid Assessment' and 'Home Treatment'.	Manx Care / DHSC
5.3	Self-harm and attempted suicides are prevented and responded to following best practice	All clinical staff in MHS trained in **DICES® risk management DBT (Dialectical Behavioural Therapy)** for Emotionally Unstable Personality Disorder	Benchmark against **NICE Self-harm: assessment, management and preventing recurrence**, and address identified gaps.	Public Health / Manx Care
5.4	Every service user knows how they can keep themselves safe		Move emphasis from 'risk management plan' to a more collaborative and enabling 'personal safety plan'	Manx Care
5.5	Transitions between services are managed with safety as a priority		Review clinical pathways for all major mental health conditions with reference to NICE guidelines to ensure robust transition arrangements.	Health and Care Transformation/ Manx Care
5.6	Specialist mental health services, A&E and primary care deliver safe care.		Benchmark against, and implement **Safer Care (NCISH Toolkit)**, and other NCISH recommendations Independent scrutiny of the safety of care provision by the **Care Quality Commission (CQC)**	Public Health/ Manx Care DHSC / Manx Care

Glossary

PHOF – Public Health Outcomes Framework
SPG – Suicide Prevention Group
NCISH – National Confidential Inquiry into Suicide and Safety in Mental Health
PSHE – Personal, Social, Health and Economic education
RSE – Relationship and Sex Education
ASIST – Applied Suicide Intervention Skills Training
SSRR – Suspected Suicide Rapid Response
CAMHS – Child and Adolescent Mental Health Services
NICE – National Institute for Health and Care Excellence
CRHTT – Crisis Response and Home Treatment Team
CQC – Care Quality Commission
DBT – Dialectical Behavioural Therapy

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4. The DICES® acronym is a registered trademark used by APT, the Association for Psychological Therapies, in risk assessment and management in mental health. It stands for;
   Describe the risks; Identify all the possible options; Choose your preferred option; Explain your choice; Share the decision with others. It summarises a course from APT (The DICES® Risk Assessment and Management System) which features an approach to risk assessment and management which hinges on the research on the effectiveness of checklists.
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If you are struggling, having read this document, there are people you can talk to:

Samaritans:

Provide a 24-hour confidential telephone service for anyone feeling desperate or suicidal or going through any sort of personal crisis, including bereavement.

Free Helpline: 116 123

Email: jo@samaritans.org

Information on other local and UK support can be found on **www.gov.im/wellbeingsupport**

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