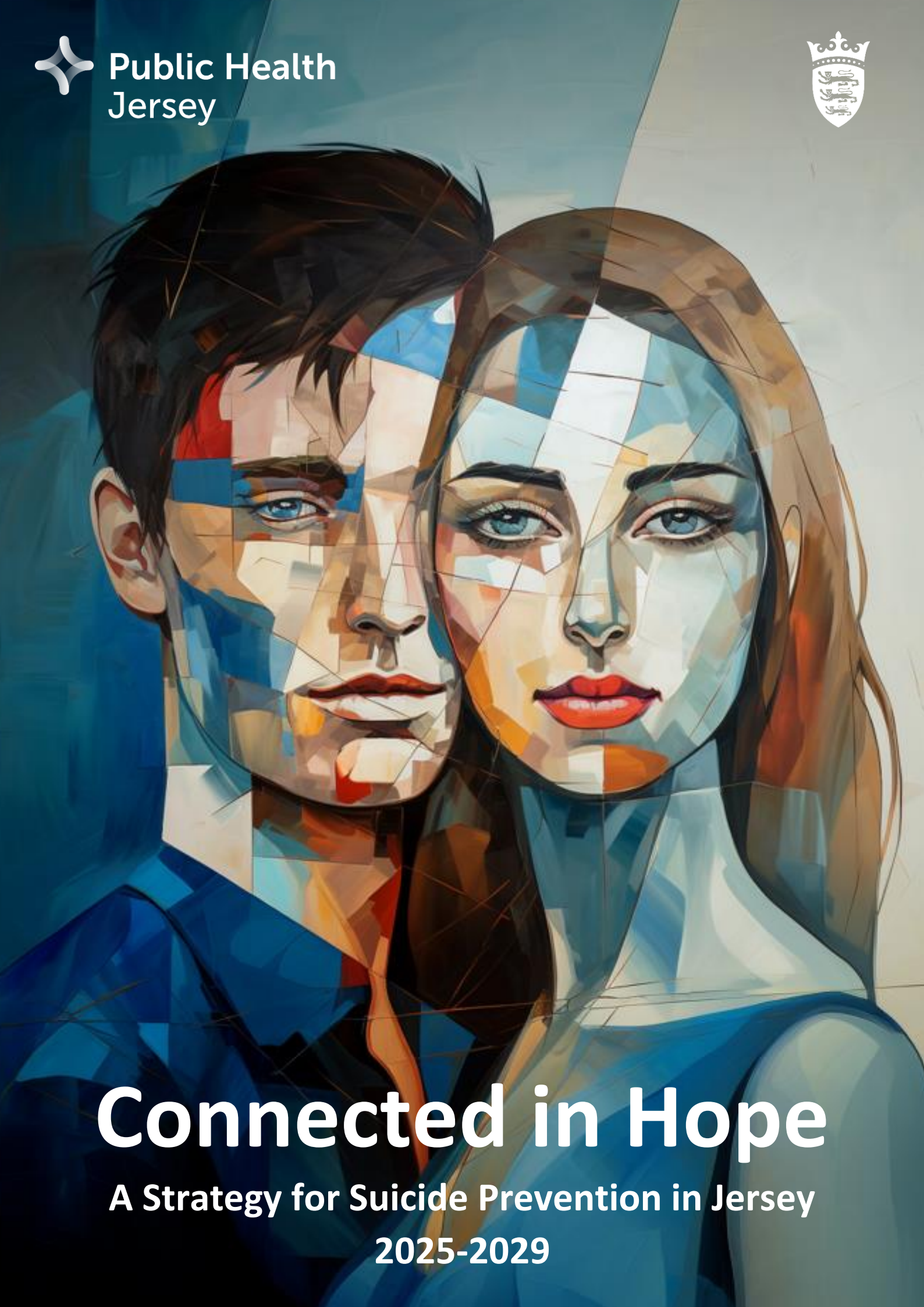
Public Health
Jersey



Connected in Hope

A Strategy for Suicide Prevention in Jersey 2025-2029

Acknowledgement

Public Health Jersey and Health & Care Jersey would like to thank everyone who contributed in any way to the development of this strategy. Special thanks go to those with lived experience of contact with suicide (both suicide attempts and bereavement), who openly shared their experiences throughout the process. Their input has highlighted the benefit of being *Connected in Hope*.

"The front cover of this strategy was digitally generated and approved by the Suicide Prevention Steering Group."

Foreword from the Minister for Health and Social Services

As Minister, I am profoundly aware of the devastating impact that suicide has on individuals, families, and communities. Every loss is a tragedy, and every life matters. This Suicide Prevention Strategy outlines a clear, compassionate, and comprehensive approach to saving lives and supporting those affected by suicidal thoughts and behaviours.

Our approach is built on prevention, early intervention, and the provision of accessible mental health services. By focusing on improving public awareness, reducing stigma, and ensuring individuals at risk receive the care and support they need, we aim to create a society where mental health is treated with the same urgency as physical health.

This strategy emphasises collaboration across government, health services, education, and community organisations, as we recognise that suicide prevention is a shared responsibility. It is only through collective action and ongoing commitment that we can make meaningful progress in reducing suicide rates and supporting those in crisis.

I am committed to ensuring that the resources are in place to make this strategy a reality. Together, we can work to prevent suicides, support those at risk, and provide hope for a brighter, healthier futures for all. I'm sure we all stand united in our mission to save lives and build a safer, more supportive environment.

Deputy Tom Binet

Minister for Health and Social Services

April 2025

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Executive Summary

Suicide prevention is of critical importance in Jersey. Every year, Islanders die by suicide. Each death affects individuals, families and the community directly and indirectly in so many ways. Whilst work has been done in the area of suicide prevention in Jersey, there is still much more to do. Suicides are not inevitable. There are many ways in which services, communities, individuals, and society as a whole can help to prevent suicide, and we must collectively do all that we can to prevent suicide from occurring, in order to save lives.

This Strategy has been developed through gaining an understanding of the risk factors for suicide, the circumstances and learning from deaths by suicide in Jersey, the support and services currently available, and the insights of people with experience of loss from suicide or at risk of suicide, as well as professionals and other stakeholders.

Significant stakeholder engagement was undertaken to develop this strategy, and this has informed the priorities and actions set out within the strategy. In particular this highlighted the need to increase awareness of services and support available, increase training in suicide prevention and support for health and social care staff, and review the support and information provided to those bereaved and affected by suicide.

The Strategy aims to prevent and reduce suicide in Jersey, with the goal of elimination of suicide.

We aim to achieve this through the delivery of 4 key objectives:

- Ensuring appropriate support is available to those at risk of suicide, and those affected by it
- Ensuring effective system coordination and joint working to prevent suicide
- Ensuring the availability of data, monitoring and on-going learning over time
- Strengthening and supporting workforce capability and confidence in relation to suicide prevention across the Jersey system

The Strategy identifies a number of key actions that will be undertaken during the period of 2025-2029; These will be reviewed, updated and added to on an annual basis.

Implementation and evaluation of the effectiveness of the Strategy will be overseen by a refreshed Suicide Prevention Alliance group, which will produce an annual report on progress and any further actions identified.

1. Introduction

Jersey's previous suicide prevention strategy - 'Prevention of Suicide in Jersey; A Framework for Action' - was published in 2015 (1). It spanned the period from 2015 to 2020 and featured a range of objectives.

The delivery of the strategy was coordinated by a multi-agency group, although much of this work was paused during the Covid pandemic. A number of key actions have been taken related to the strategy, including the review of the early intervention model used in schools and colleges; work with the local media to ensure sensitive reporting of suicide; the implementation of an adult mental health crisis response service; a significant investment in primary mental health and counselling services; a review of post-suicide responses supported by the delivery of training; and the promotion of online Zero Suicide Alliance training for all islanders.

In 2022, Jersey's Minister for Health and Social Services committed to the development of new suicide prevention strategy for the Island. There was widespread recognition that the strategy would work synergistically with Jersey's population health prevention strategy, 'Seizing the Opportunity' (2), and a range of other areas of work across and beyond mental health.

This strategy has also been influenced by the University of Manchester National Confidential Inquiry into Suicide and Safety in Mental Health, which provides a database, monitoring and findings related to people aged 10 and above who died by suicide, and which Jersey contributes to. Their annual report makes recommendations for clinical practice and policy that will improve safety.

The vision for the Strategy is to work towards Jersey being an Island where no one dies from suicide, and people receive support to prevent this when required. Through building a comprehensive understanding of suicide in Jersey, and the factors that may impact upon this, collective actions can be tailored to focus on and achieve this.

2. Definition

Suicide is defined as a deliberate act that intentionally ends one's life (3).

Mental disorders, physical disorders, and substance abuse are common risk factors.

Some suicides are impulsive acts driven by stress (such as from financial or academic difficulties), relationship problems (such as breakups or divorces), or harassment and bullying. Those who have previously attempted suicide are at a higher risk for future attempts (4).

Every suicide is both an individual tragedy and a terrible loss to society. It affects a number of people directly, and often many others indirectly. The impact of suicide can be devastating psychologically, spiritually and financially for those affected.

The term 'died by suicide' is preferred to 'committed suicide', as it avoids the suggestion of criminal intent (5). In some instances, it is considered preferable for the word suicide to be avoided entirely; some common alternative terms are shown below in Table 1.

Table 1. Alternative terms to "died by suicide"

Alternative terms	
Completed suicide	Loss of life to suicide
Chose to leave	Took one's own life

Assisted suicide is defined as the act of deliberately assisting another person to kill themselves. The Jersey assisted dying legislation would come into effect in Summer 2027 and therefore is not considered within this strategy (6).

3. Suicide in Jersey

3.1 Numbers and Rates

Due to a number of outstanding inquests and uncoded deaths, the number of deaths for more recent years should not be considered definitive; comprehensive information on deaths by suicide is only available up to 2021. Deaths are included here where the cause of death was recorded as 'intentional self-harm' or 'undetermined intent', the classification is based on the International Classification of Diseases, Tenth Revision (ICD-10) (22), this international standard helps in maintaining comparability of statistics across countries and over time.

The number of deaths due to suicide in 2022 has been confirmed to be higher than 10[I].

Figure 1 gives the number of suicides by year in Jersey since 2007. The highest number was in 2009, coinciding with a period of recession.

Figure 1. Number of deaths due to suicide in Jersey (2007 to 2021)

Some of the differences in the numbers of suicides between years are likely to be due to the variation inherent in a small population, as well as the prevalence of risk and protective factors.

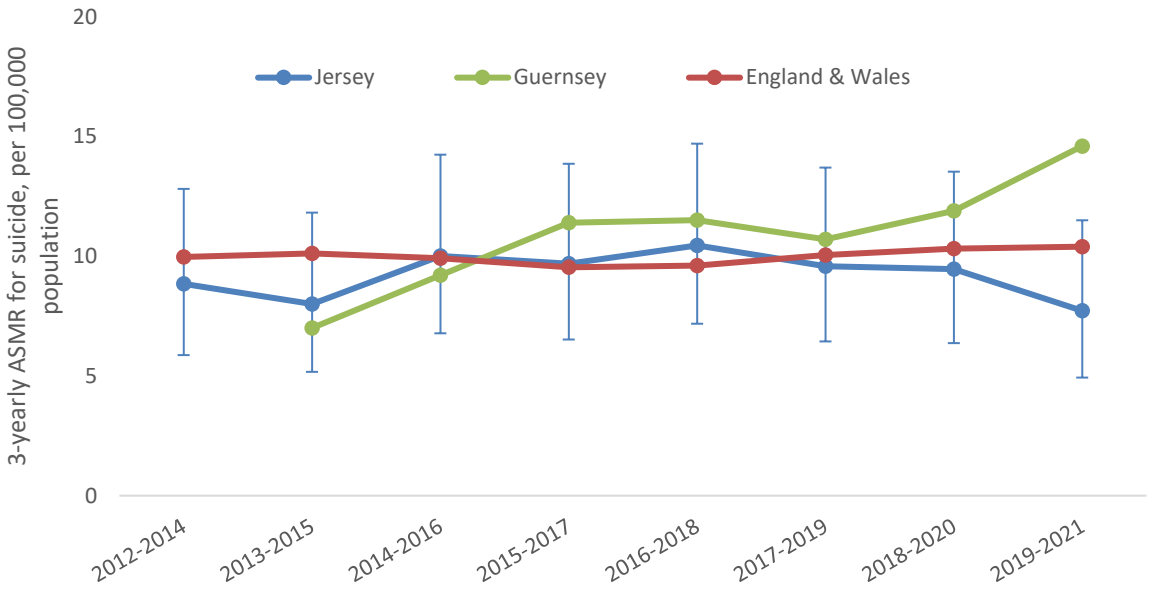
Over the 2019-2021 period, Jersey had an age standardised suicide death rate of 7.6 deaths per 100,000 people, statistically similar to the rate over the past decade.

The age standardised rates of suicide in Jersey, Guernsey and England are shown in **Error! Reference source not found.**. Although there is some variation in the rates between Jersey

[I] While Public Health intelligence has provided a provisional number for the number of suicide deaths, it is important to note that 2% of deaths for 2022 remain uncoded.

and the other jurisdictions, this is not statistically significant. Note the wide confidence intervals[II] for Jersey rates, due to the small number of deaths used in the calculation.

Figure 1. 3- yearly age standardised rates of suicide in Jersey[III], Guernsey[IV] and England over the 2012-2021 period.



3.2 Suicidal Concerns

The States of Jersey Police record all calls where a suicidal concern has been identified. Figure 3 below shows the annual numbers of calls to the police where a suicidal concern was identified in Jersey, between 2018 and 2022.

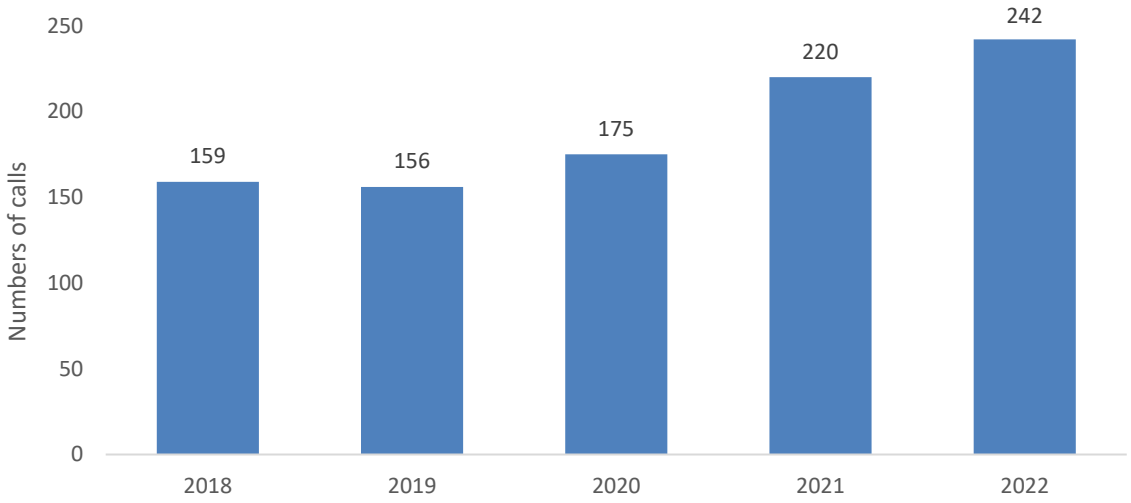
This trend may indicate a growing awareness or willingness to report suicidal thoughts, but it could also reflect an actual increase in suicidal ideation within the population. Further analysis would be needed to distinguish between these possibilities and to assess potential underlying factors contributing to the rise.

[II] Confidence intervals indicate the range within which the variation could be considered due to random fluctuations.

[III] Jersey Mortality report, 2022

[IV] Guernsey mortality report, 2021

Figure 3. Numbers of calls where a suicidal concern has been identified in Jersey over the 2018-2022 period

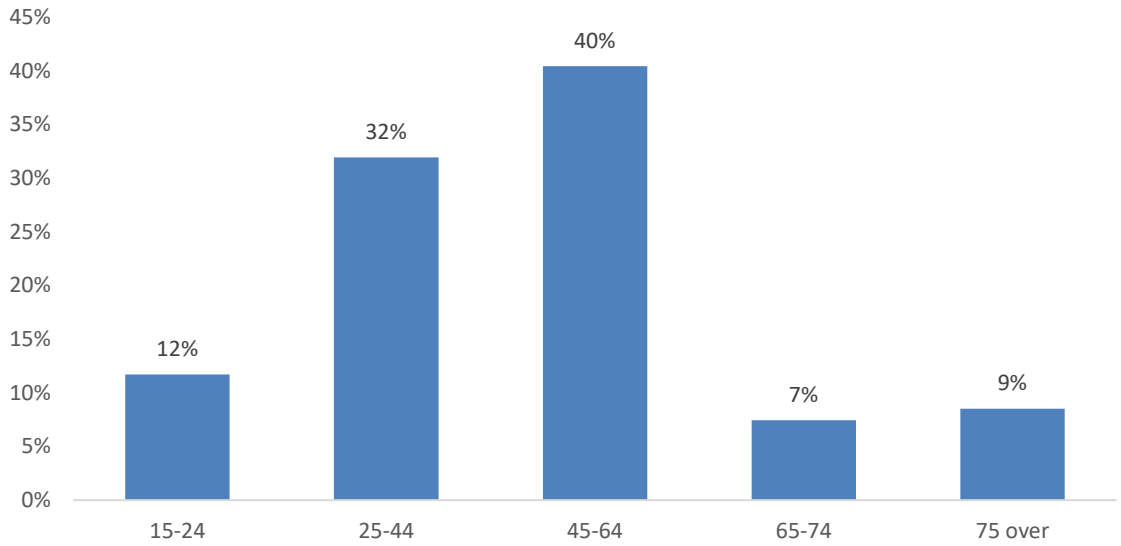


3.3 Demographic Characteristics

Between 2012 and 2021, 68% of all suicides involved men, meaning men were 2.1 times as likely to have taken their own lives as women; for comparison around three-quarters of registered suicide deaths in England and Wales in 2021 were for men (74%) (6).

Analysis of broad age groups indicates that the highest proportion of suicides occurred within the working-age adult demographic (Figure 4).

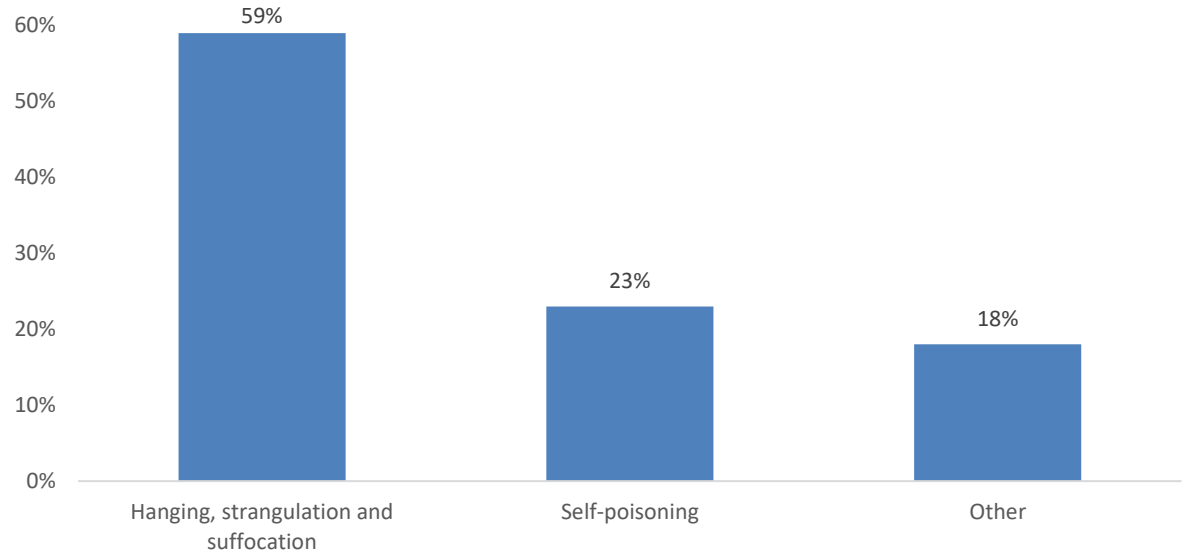
Figure 4. Proportions of suicides by broad age group in Jersey, between 2012 and 2021



3.4 Method

The proportions of suicides by method in Jersey, between 2007 and 2020, are shown below. The method for more than half of the suicides was hanging, strangulation and suffocation.

Figure 5. Proportions of suicides by method in Jersey, between 2007 and 2020



4. Risk factors and Protective factors

Suicide is often the end point of a complex history of risk factors, acting in combination and synergistically (3). The impact of a given risk factor may vary across an individual's life course. The main risk factors for suicide are shown below in Table 2; these are not in any priority order. Addressing the common risk factors linked to suicide is a key component of effective suicide prevention. There is clear evidence of links between suicide and the social determinants of health (such as poverty, housing and employment) (9,10,11).

Table 2. Risk factors for suicide

Risk factor group	Risk factors
Demographic	Age 35-49 Male Gay, lesbian, bisexual, or other sexual orientation
Social	Single or divorced Living alone Lack of secure accommodation Domestic abuse Bereavement Discrimination Bullying Loneliness or social isolation Social media pressure Adverse childhood experiences Experience of a major incident Family history of suicide Suicide cluster in community Criminal or legal problems Media portrayals of suicide Easy access to lethal means
Substance use	Harmful or hazardous alcohol use Drug use
Health	Poor mental health / existing mental health conditions Self-harm Physically disabling or painful illness History of trauma Chronic pain Lack of access to, or engagement with, mental health services Previous suicide attempt
Financial	Unemployment Financial difficulty Harmful Gambling

4.1 Protective Factors

Suicide is not inevitable. There are many ways in which services, communities, individuals, and society as a whole can help to prevent suicide (3). As with risk factors, there is synergy where multiple protective factors are present. However, the impact of protective factors varies between individuals and their presence does not consistently prevent suicide. The main protective factors for suicide are shown in Table 3 (9; 10; 11).

Table 3. Protective factors for suicide

Protective factor group	**Protective factors**
Individual	Coping and problem-solving skills Reasons for living Strong cultural identity
Social	Support from & relationships with partners, friends, family, parish and community Feeling connected to others and social institutions Secure accommodation Reduced access to lethal means Cultural, religious or moral objections to suicide
Health	Access to quality health services
Financial	Stable employment Financial security

4.2. Risk and Protective Factor Profile for Jersey

As part of the development of the strategy, a detailed review of the potential risk and protective factors for the Jersey population was undertaken. This is included as Appendix 2.

Specific areas of concern / focus were identified as follows:

- A significant percentage of the Jersey population are in the male middle-aged bracket, which is identified as being at increased risk.
- In 2021, 31% of households were occupied by a single adult (8).
- In 2022, 30% of adults reported feeling lonely either often or some of the time. Loneliness has been identified in recent years as a specific concern, resulting in some focussed campaigns to seek to address this (12).
- In 2024, 35% of households reported that coping financially was either quite difficult or very difficult, up from just under a third (31%) of households in 2023.
- Jersey ranks highly against comparator nations for alcohol consumption; in 2022, a quarter of those who consumed alcohol reported doing so at hazardous or harmful levels. One third of people reported binge drinking at a frequency of monthly or more,

with rates of hazardous or harmful drinking being higher in men (1 in 3) than women (1 in 6) (19)

- Over recent years Jersey has experienced a number of major incidents, which have had impact on a number of the population, resulting in the development of a bespoke pathway / offer of psychological support for those affected.
- In 2022, there were 2 reported deaths by suicide of young people aged under 16. Again, this had a significant impact on families and the wider community, including young people.
- In 2021, 21% of young people reported having been bullied in the previous year (20).
- 29% of young women in year 10 and 28% of young women in year 12 had reported having self-harmed, with 36% reporting having thoughts of self-harm. Self-harm was more common across pupils with a greater degree of material deprivation.
- A high rate of reported loneliness was prevalent in the 16-34 age group.
- There is an increasing level of prescribing of antidepressant medication and benzodiazepines, which has been identified as a priority for review within adult mental health services.
- Only 51% of the people who had died or were suspected to have died by suicide between 2019-2022 had been in contact with mental health services

Specific priority actions in the Strategy relate to adult males, young people / interventions in education settings, use of antidepressant and benzodiazepine medication, and the implementation of bespoke health promotion / suicide prevention campaigns that will focus on specific areas to reduce risk (such as alcohol use, self-harm, loneliness and seeking help).

5. Services in Jersey

A range of services contribute to suicide prevention in Jersey, and support those who are at risk of suicide in a variety of ways. A service mapping exercise was conducted as part of the development of this strategy, and involved meetings with services to capture their scope, and access and referral arrangements. The detail of this is attached as Appendix 4.

Whilst a range of services are available, it is clear from the review of sudden and unexpected deaths (section 9) that many people who are known or believed to have taken their own lives in Jersey were not in contact with services, and often had not sought to make contact prior to their death. It is not known if this is because they were unaware of the support available, or felt unable to access this.

It is essential that services work together to ensure that opportunities to prevent suicide are present.

For these reasons, key actions within this strategy include the development of a clear directory of services available (including digital services / apps) - which will be supported by promotion & awareness campaigns – and the strengthening of the multi-agency suicide prevention alliance, to ensure effective and coherent joint working.

6. Learning from Suicides

a) Serious Case Review

In January 2023, the Jersey Safeguarding Partnership Board completed a Serious Case Review of five deaths by suicide on the Island. The review identified the presence of multiple risk factors, a lack of multiagency working, and barriers to accessing services were significant. It also highlighted that progress with Jersey's previous suicide prevention strategy, which ran from 2016-2020, had stalled due to a lack of leadership and resources. The review made seven recommendations:

1. Lead system-wide culture change committed to reducing suicides
2. Train a competent, confident, and caring workforce up to date in suicide care
3. Identify patients with suicide risk via comprehensive screening
4. Engage all individuals at risk of suicide in a suicide care management plan
5. Treat suicidal thoughts and behaviours using evidence-based treatments
6. Transition individuals through care with warm, handoffs and supportive contacts
7. Improve policies and procedures through continuous quality improvement

The findings of the Serious Case Review have been considered and incorporated into the priority actions identified within this Strategy.

b) Learning from Incidents

When a death occurs by suicide or suspected suicide and the person was in contact with health or social care services, a Serious Incident report is completed which reviews the circumstances related to their death and their (recent) care and treatment. These reports are frequently then provided to the Viscount and form part of the subsequent Inquest process.

A review of the learning from Serious Incident reports completed between 2022 and mid-2024 identified the following themes, which have resulted in specific actions being taken but were also considered and incorporated into the development of this strategy;

- The importance of effective multi-disciplinary and multi-agency working, care planning, care reviews and supporting documentation
- Importance of effective information sharing, and the specific challenges faced through the use of multiple patient record systems across the system
- The need to consider mental health service responses to non-engagement or disengagement with services / treatment
- Use of medicinal cannabis in people with a history of serious mental illness
- Importance of a joint approach between services to manage the prescribing and long term use of benzodiazepines
- The need to increase access to suicide prevention training
- Need to improve engagement and consistency of support offered to families / carers

c) Audit of Sudden and Unexpected Deaths

An audit undertaken by the Government of Jersey (Public Health & Health and Care) identified 47 sudden and unexpected deaths in Jersey between January 2019 and June 2023. Due to the timescale for Inquests, the number of confirmed suicides in the same period varied slightly when it is available.

Of the 47 sudden and unexpected deaths, 37 were in employment, and six were in receipt of benefits (although it is of note that not all were of working age).

Their accommodation type is shown below in Table 4.

Table 4. Accommodation type for those who died suddenly or unexpectedly in Jersey between January 2019 and June 2023

Accommodation type	Proportions in accommodation type
Owned accommodation	32%
Renting social accommodation	30%
Renting private accommodation	13%
Living with parents	13%
Other	13%

7. Engagement

To inform the development and priorities of this strategy, a programme of public and focused engagement activities ran in 2023, to capture views, ideas and insights. This included a number of open public stakeholder sessions, some focussed sessions (with students, users of mental health services, those effected directly by suicide, and with mental health professionals) and two questionnaires (one public and one specifically for secondary schools). A wide range of topics were raised and discussed, and a full report of the engagement work is available at Appendix 3.

The key themes that were identified from the engagement work are identified below:

- Suicide has a significant impact on families and communities.
- The importance of adopting an evidence-based approach to prevention, with learning from elsewhere. Suicide prevention being everyone's responsibility.
- The need for earlier detection of risk factors, with work to address them.
- Long-term physical and mental health conditions, neurodiversity, pain, trauma, and past self-harm were cited repeatedly as high risk factors.
- Mental health conditions and their symptoms are the risk factors commonly associated with suicidality.
- It can be immensely challenging for people to share their personal experience of suicide, often for fear of not being taken seriously or a lack of perceived worth.
- Peer support was recognised as a source of strength, with much of its success reliant on peers being well matched.
- Healthcare service capacity can sometimes leads to increased wait times (such as psychological therapies) and creates an access barrier.
- Concerns about confidentiality within services sometimes results in users being reluctant to share their names.
- The need for a directory of mental health services and services available to reduce risk of suicide
- There is considerable confusion regarding how and where to access postvention support.
- Improvement needed to the current mental health and suicide prevention training offer in schools.
- Supportive employers adopt corporate mental wellbeing initiatives which have a positive impact on staff.
- Reducing social media use and financial security were seen as key protective factors.
- It is important that Jersey has a suicide prevention strategy, and that this is taken seriously.

The outcomes from the engagement work, and particularly these themes, has contributed to the development of the priority actions within this strategy.

8. Suicide Prevention Strategy: Priority actions

The Strategy aims to prevent and reduce suicide in Jersey, with the goal of elimination of suicide.

We aim to achieve this through the delivery of 4 key objectives:

- Ensuring appropriate support is available to those at risk of suicide, and those affected by it
- Ensuring effective system coordination and joint working to prevent suicide
- Ensuring the availability of data, monitoring and on-going learning over time
- Strengthening and supporting workforce capability and confidence in relation to suicide prevention across the Jersey system

Following a comprehensive review of the engagement findings, the current evidence base on suicide prevention, and other suicide prevention strategies (13; 14;15; 16 ;17), the steering group developed fifteen key priority actions. These seek to enact the strategy's ambition for Jersey being an island where no one dies from suicide. They consider suicide prevention throughout the life course, to ensure that every Islander can benefit from their implementation. Although distinct, each priority action complements other areas of work.

Timescales have been set to ensure the implementation of the actions is sequential. Some deliverables require additional resources, and their implementation is therefore contingent on the availability of these moving forward.

However, all activity planned for 2025 is expected to be cost-neutral.

A refreshed Suicide Prevention Alliance Oversight Group will be established to oversee implementation of the Strategy, forming the governance structure for the coordination, monitoring and evaluation of a detailed implementation plan with specific actions and person-level ownership. The Suicide Prevention Alliance Oversight Group will also produce an annual update against progress and new priority actions, which will be published. The Oversight Group will formally report into the Mental Health Strategic Partnership Board, which is jointly chaired by the Director of Public Health and the Director of Mental Health & Adult Social Care.

A suite of key performance indicators (KPIs) will be created to facilitate the monitoring, reporting, and evaluation of the strategy. These will be linked to the deliverables, so their impact is clear. The strategy deliverables, ownership, timescales, and success criteria are described below,

Objective 1: Ensuring appropriate support is available to those at risk of suicide, and those affected by it

Action	Deliverable	Lead Owner	Timescale
1	Compile a directory of the wellbeing and mental health services available to those living in Jersey, with a focus on the remit and access arrangements of services	Public Health	2025
	Success will be evidenced by clarity on the availability of the services that contribute to suicide prevention in Jersey, and how to access them		

Action	Deliverable	Lead Owner	Timescale
2	Develop a compendium of apps/resources that support suicide prevention, to complement available mental health and wellbeing services and to ensure those at risk have easy access to evidence-based digital support	Public Health	2025
	Success will be evidenced by the availability of digital, evidenced-based suicide prevention resources alongside mental health and wellbeing services		

Action	Deliverable	Lead Owner	Timescale
3	Implement the use of a suicide screening tool with individuals who may be at risk of suicide within target populations, such as adult males and the socially isolated	Health and Care Jersey	2025-2026
	Success will be evidenced by a consistent approach to the identification of individuals who may be at risk of suicide in Jersey, so early preventative intervention may be taken		

Action	Deliverable	Lead Owner	Timescale
4	Develop the discharge planning process for mental health inpatients, to incorporate an evidence-informed approach with a focus on readiness and peer support	Health and Care Jersey	2025
	Success will be evidenced by mental health inpatients having access to co-ordinated, high-quality support prior to, during, and following their discharge		

Action	Deliverable	Lead Owner	Timescale
5	Strengthen the control of medication, with a focus on prescribing practice, antidepressants, benzodiazepines and polypharmacy	Health and Care Jersey	2026-2027
	Success will be evidenced by a reduction in suicides and suicide attempts linked to prescribed medication, particularly antidepressants and polypharmacy		

Action	Deliverable	Lead Owner	Timescale
6	Produce a revised guide for those bereaved by suicide detailing the relevant processes, sources of support, and access arrangements	Police Coroner's Office	2026
	Success will be evidenced by clarity on the availability of the services that contribute to postvention in Jersey, and how to access them		

Action	Deliverable	Lead Owner	Timescale
7	Review the postvention offer in Jersey to ensure it meets the needs of those bereaved by suicide, including suicides outside of Jersey	Health and Care Jersey Thrive Jersey	2025
	Success will be evidenced by the availability of high-quality support for those living in Jersey who are bereaved by suicide		

Objective 2: Ensuring effective system coordination and joint working to prevent suicide

Action	Deliverable	Lead Owner	Timescale
8	Strengthen the suicide prevention alliance in Jersey, and its links to suicide networks in other jurisdictions, as means of providing an effective forum for professional stakeholders to share and collaborate	Health and Community Services Thrive Jersey	2025
	Success will be evidenced by improved sharing and collaboration between the organisations contributing to suicide prevention in Jersey		

Action	Deliverable	Lead Owner	Timescale
9	Design and deliver health promotion / awareness campaigns on suicide prevention and its risk factors, with an initial specific focus on adult males	Public Health	2026-2029
	Success will be evidenced by an improved awareness of the risk factors for suicide, and how to access help, particularly among adult males		

Action	Deliverable	Lead Owner	Timescale
10	Develop a suicide and self-harm prevention package for education settings, with educational resources and universal, targeted, and individual preventative approaches, focusing on secondary education and young females	Children, Young People, Education and Skills	2026
	Success will be evidenced by a reduction in the incidence of self-harm among those in education		

Action	Deliverable	Lead Owner	Timescale
11	Develop resources for employers to support suicide prevention in the workplace, through a focus on suicide prevention in the collaborative development of a mental health workplace toolkit	Public Health Health & Care Jersey	2026
	Success will be evidenced by the adoption of suicide prevention initiatives by employers, appropriate to the scale of the organisation, and an improved awareness of suicide prevention in workplaces		

Action	Deliverable	Lead Owner	Timescale
12	Work collaboratively with media outlets to ensure the reporting of suicide remains sensitive and prevention-focused, by raising awareness, reducing stigma and increasing awareness of support available.	Public Health Health & Care Jersey	2025-2029
	Success will be evidenced by sensitive and prevention-focused media reporting on suicide in Jersey		

Objective 3: Ensuring the availability of data, monitoring and on-going learning over time

Action	Deliverable	Lead Owner	Timescale
13	Work collaboratively across Government of Jersey departments and partner agencies to improve the availability, timeliness and quality of data collected on suicide, risk factors and near misses	Public Health	2025-2029
	Success will be evidenced by access to improved data on suicide and its risk factors in Jersey for monitoring, reporting, evaluation, and planning suicide prevention initiatives		

Objective 4: Strengthening and supporting workforce capability and confidence in relation to suicide prevention across the Jersey system

Action	Deliverable	Lead Owner	Timescale
14	Implement recorded and monitored suicide prevention training for the wider health and social care workforce in Jersey, so that they are aware of the risk factors for suicide and how they may contribute to risk reduction	Health and Care Jersey	2025-2026
	Success will be evidenced by an improved awareness of suicide prevention among the health and social care workforce in Jersey and reduction in suicide risk among those they treat and care for		

Action	Deliverable	Lead Owner	Timescale
15	Review the occupational health / wellbeing and support offers available to staff within HCJ initially and to broader occupational groups, to ensure it meets the needs of staff - particularly those whose roles mean they regularly encounter emotionally challenging situations	Government of Jersey	2025-2026
	Success will be evidenced by staff within Health and Community Services having access to a high-quality occupational wellbeing offer appropriate to their roles		

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Appendix A – Strategy Development

The development of this strategy has been led by the Public Health Directorate of the Government of Jersey.

A Steering Group was established to oversee the development of the strategy. The steering group met monthly, and its membership is shown below.

Member	Organisation
Five members with lived experience of suicide	
Consultant in Public Health Public Health Project Manager Consultant Nurse Public Health Officer Public Health Administrator Crisis and Assessment Team Manager Child and Adolescent Mental Health Service Manager for Looked After Children Interim Associate Director of Education Director of Mental Health & Adult Social Care	Government of Jersey
Chief Inspector	States of Jersey Police
Branch Director	Samaritans of Jersey
Executive Director	Mind Jersey
Co-Executive Director	Focus on Mental Illness
Counsellor and Deputy Team Lead	LV Care
Recovery Lead	Jersey Recovery College
Chief Executive Officer	My Voice
Chief Executive Officer	Silkworth
Co-Founder	Thrive Jersey
Director	The Shelter Trust

Working Group

A working group was established to undertake the development of the strategy. The working group met weekly, and its membership is shown below

Member	Organisation
Consultant in Public Health Consultant Nurse (Mental Health) Public Health Project Manager Public Health Officer Public Health Administrator	Government of Jersey

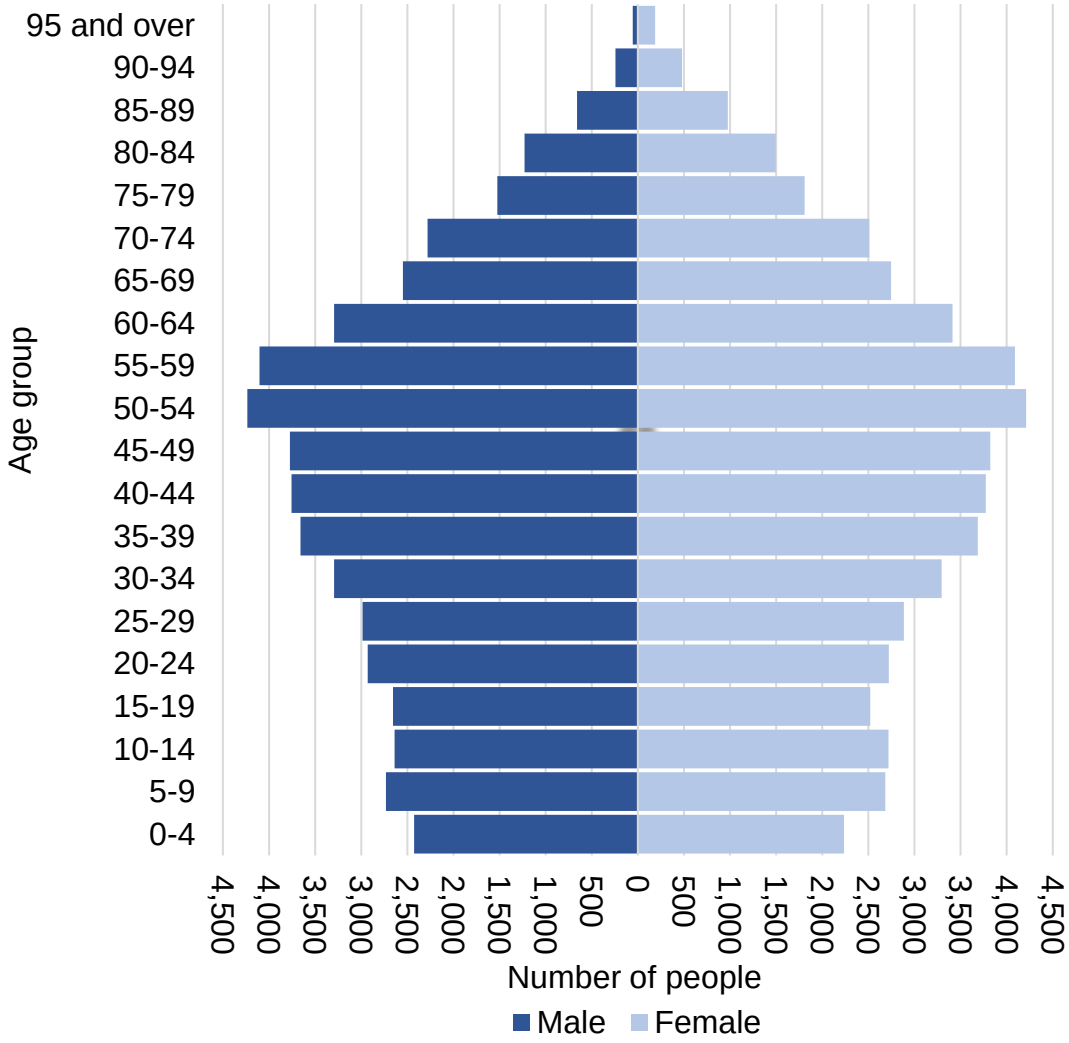
Appendix B – Jersey Population, Risk & Protective Factors

Jersey Population

On 21 March 2021, Jersey had a population of 103,267 (21). This represents an increase of 5,395 since 2011, most of which was driven by migration.

Jersey's population structure is balanced by sex but characterised by a large proportion of adults in middle age, as shown below.

Figure 6: Jersey population pyramid, 2021 (21)



Demographic Risk Factors

Sexual Orientation

In 2021, 2% of those living in Jersey aged 16 and over identified their sexual orientation as gay, lesbian or bisexual. A further 0.2% identified themselves as having another sexual orientation, and 10.7% preferred not to state their sexual orientation.

Social Risk Factors

Marital Status

Between 2001 and 2011, the proportion of adults in Jersey who were married declined. In the same period, the proportion who were either single or divorced increased.

Table A1. Marital status of adults in Jersey in 2001 and 2011

Marital status	2001	2011
Married	44%	40%
Single	30%	34%
Divorced	8%	10%
Widowed	7%	6%
Remarried	8%	8%
Separated	3%	2%

Household Occupancy

In 2021, 31% of households in Jersey were classified as being occupied by either a single adult or a single pensioner.

Loneliness

In Jersey in 2022, 30% of adults reported feeling lonely either often or some of the time. Loneliness was most prevalent in the 16-34 age group. Additionally, 11% of adults reported a low life satisfaction score.

Domestic Abuse

Domestic abuse incidents in Jersey are recorded and classified by the States of Jersey Police. Figure 7 shows the number of domestic abuse incidents annually in Jersey, between 2018 and 2022, whilst A2 shows the risk classification of the domestic abuse incidents recorded in this period. Underreporting is likely to apply, but the rate of this is of course unknown.

Figure 7. Numbers of domestic abuse incidents annually in Jersey, between 2018 and 2022

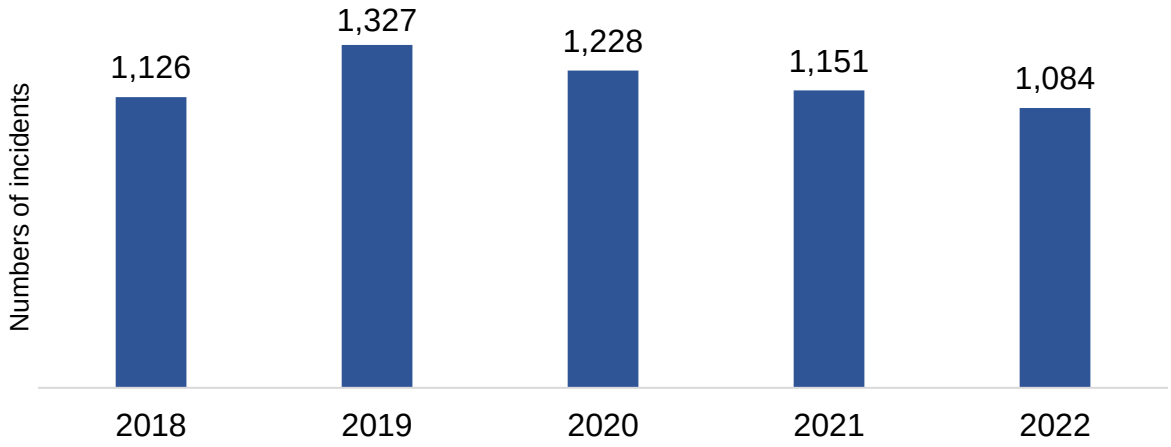
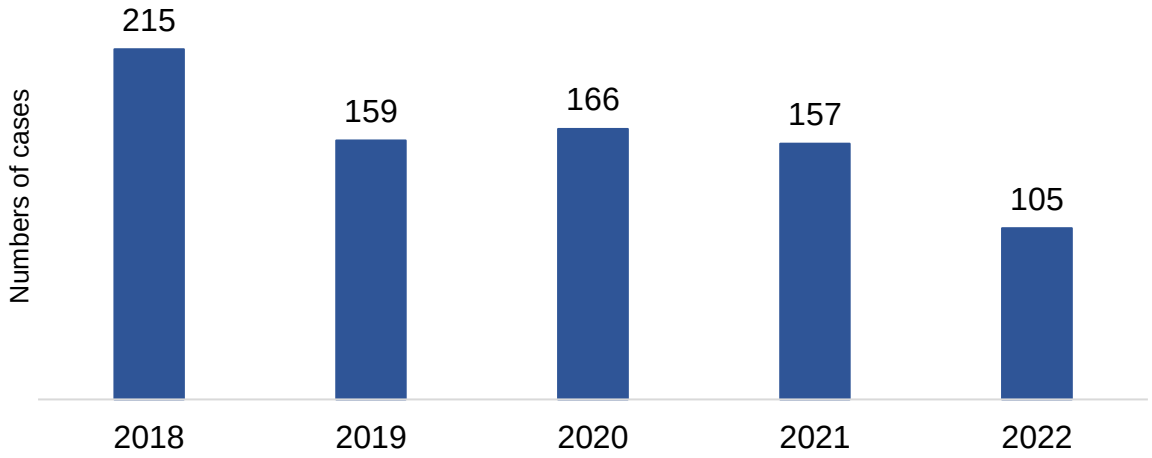


Table A2. Risk classification of domestic abuse incidents in Jersey, between 2018 and 2022

Risk classification	Proportions of incidents
High	34%
Medium	31%
Standard	35%

A Multiagency Risk Assessment Conference (MARAC) is held where a high-risk domestic abuse case requires multiagency input to ensure the safety of a victim. Figure 8 below shows the numbers of MARAC cases annually in Jersey, between 2018 and 2022. The decrease in MARAC cases observed in this period is likely to be due to a change in management, resulting in fewer repeat cases.

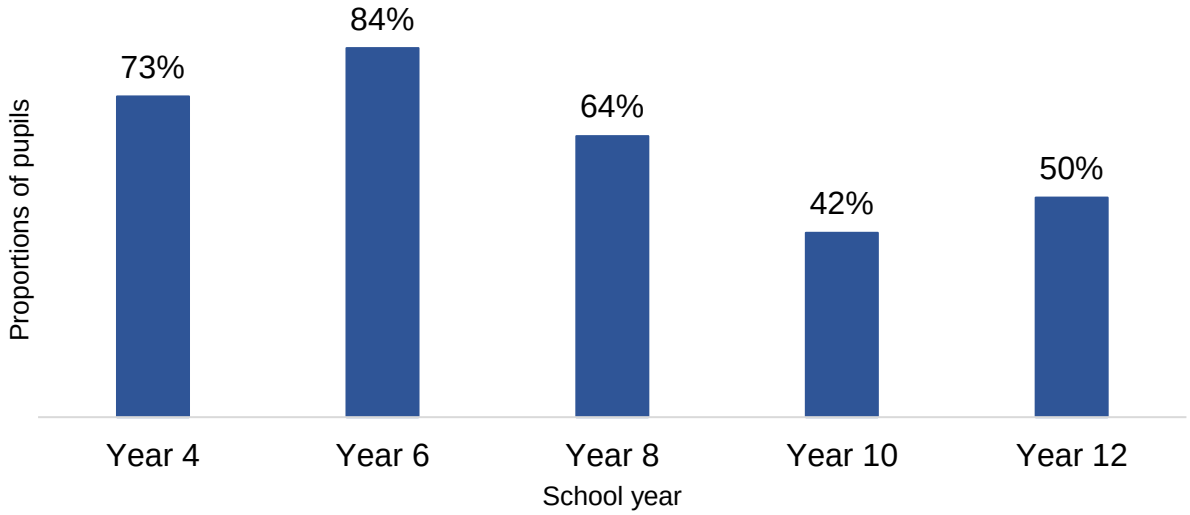
Figure 8. Numbers of MARAC cases annually in Jersey, between 2018 and 2022



Bullying

In Jersey in 2021, 21% of young people reported having been bullied in the previous year. A fear of going to school because of bullying either sometimes, often, or very often was reported by 21% of males and 29% of females. Among females in years 8, 10 and 12, 35% reported receiving inappropriate comments or unwanted attention of a sexual nature. Pupils' feelings on whether their school took bullying seriously varied between school years, being highest in year 6 and lowest in year 10.

Figure 9. Proportions of pupils by school year in Jersey who felt their school took bullying seriously, in 2021 (20)



Social Media

In 2021, 74% of males and 89% of females in years 8, 10 and 12 in Jersey reported having one or more social media accounts in their own name. Among this cohort, 14% of males and 48% of females felt pressurised to look or appear a certain way on social media. Additionally, 16% of males and 36% of females reported receiving a message that made them feel scared on threatened.

Lifestyle Risk Factors

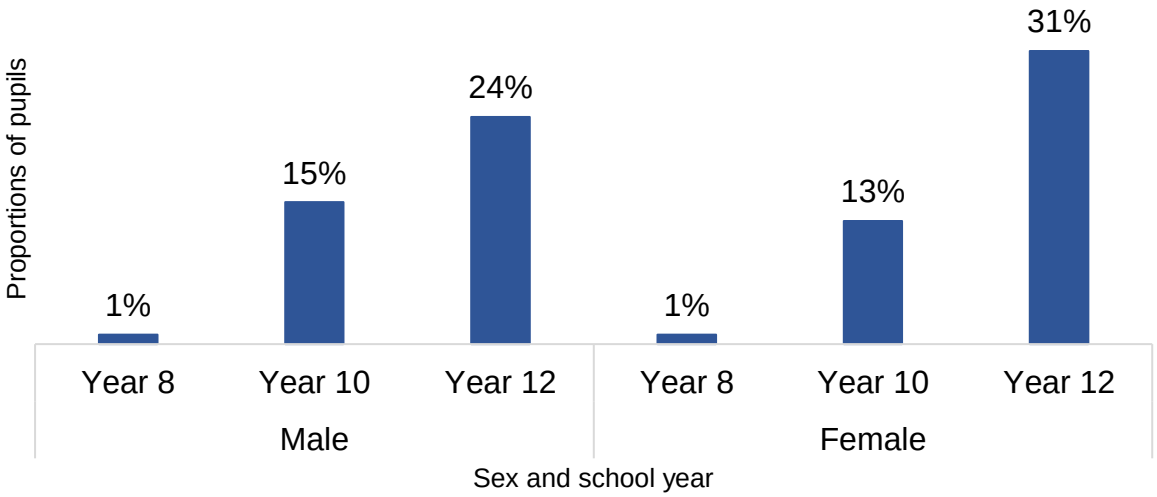
Alcohol

A quarter of those who consumed alcohol in Jersey in 2022 reported doing so at hazardous or harmful levels. Hazardous or harmful alcohol consumption was most prevalent in the 16-34 age group, and more prevalent among males than females.

Drugs

Among pupils in years 8, 10 and 12 in Jersey in 2021, 13% reported taking drugs. This excluded cigarettes, alcohol, and medicines. There was marked variation in reported drug taking by sex and school year (Figure 10).

Figure 10. Proportions of pupils by sex and school year in Jersey who reported having taken drugs, in 2021 (20)

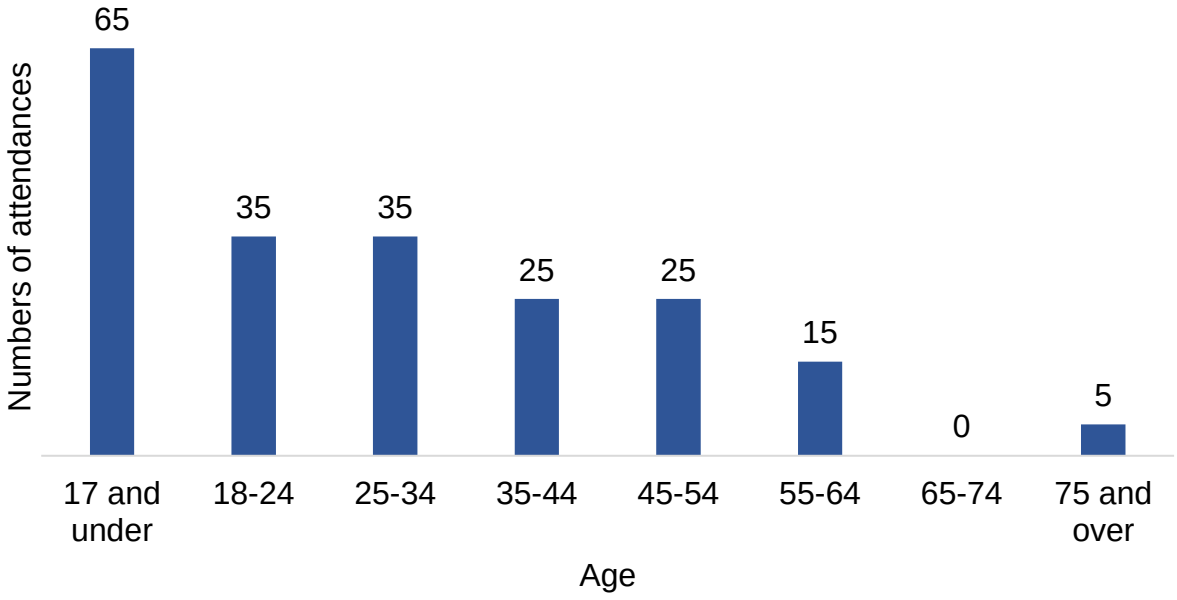


Health Risk Factors

Self-harm

The numbers of accident and emergency department attendances due to self-harm by age group in Jersey, in 2022, are shown in Figure 11. The greatest number of attendances was among those aged 17 and under, and the numbers of attendances declined with an increase in age. The majority of the attendances were linked to prescribed or non-prescribed medication, in particular antidepressants and polypharmacy.

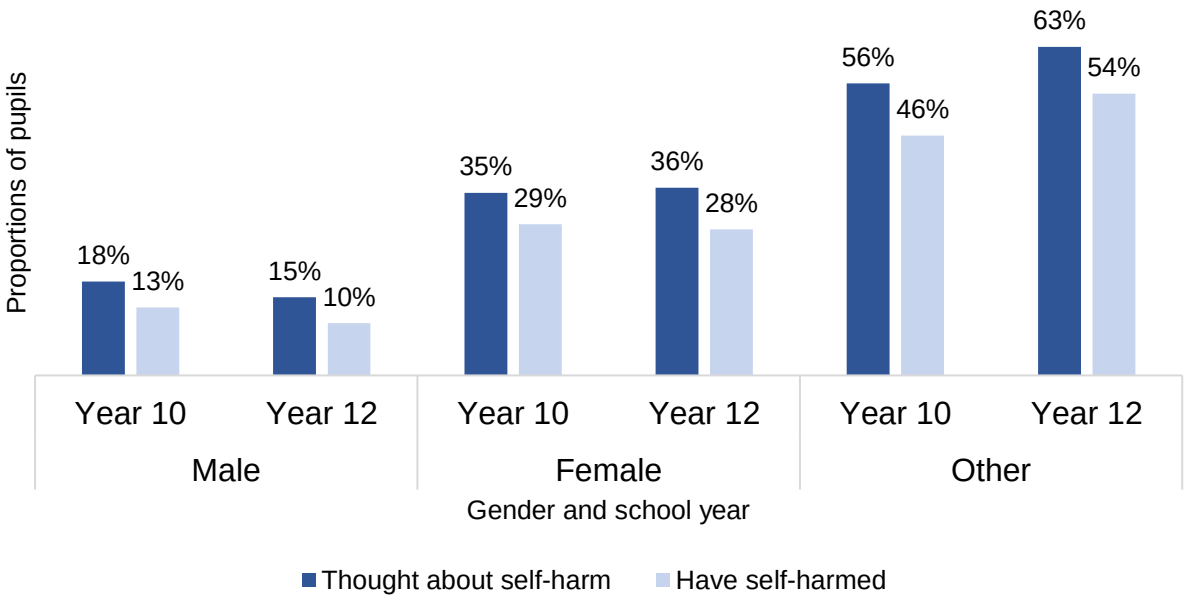
Figure 11. Numbers of accident and emergency department attendances due to self-harm by age group in Jersey, in 2022, rounded to the nearest five



Source: Children's Governance Oversight Group

The proportions of pupils in year 10 and year 12 in Jersey who reported that they had thought about self-harm, or had self-harmed, in 2021 are shown in Figure 12. Those who categorised their gender as other or chose not to specify their gender were most likely to have thought about self-harm, or self-harmed. Females were more likely to have thought about self-harm, or self-harmed, than males. Across all genders and school years, 80% of those who had thought about self-harm proceeded to self-harm. Self-harm was also more common among those pupils with a greater degree of material deprivation.

Figure 12. Proportions of pupils in year 10 and year 12 in Jersey who reported that they had thought about self-harm, or had self-harmed, in 2021 (20)



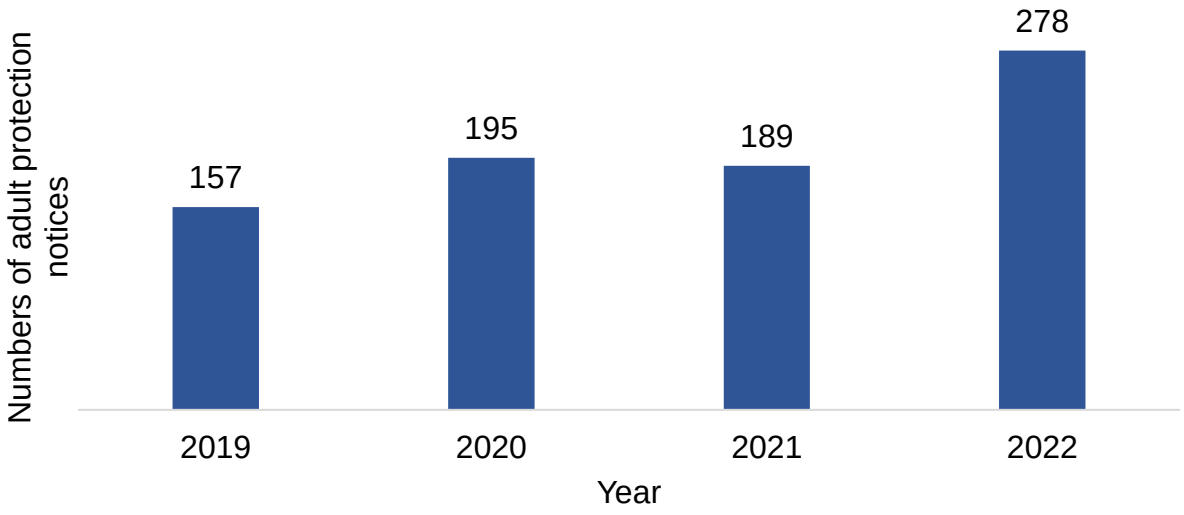
Access to Mental Health Services

An audit undertaken in 2022 investigated the use of mental health services by 39 people who died, or were suspected to have died, by suicide in the preceding four-year period. It found that 20 of these had either recent contact with mental health services or had been referred to and were awaiting contact with mental health services, equating to 51%. For comparison, in the Isle of Man 52% of people who died by suicide had contact with mental health services in the year before their death

Adult Protection Notices

The numbers of Adult Protection Notices - issued by the police when there is a safety or safeguarding concern- for Jersey between 2019 and 2022, are shown below in Figure 1. The rise in adult protection notices in 2022 is linked to an increased focus on welfare by the States of Jersey Police, and improved information sharing and multiagency work.

Figure 1. Numbers of adult protection notices annually in Jersey, between 2019 and 2022



Financial Risk Factors

Unemployment

In 2021, 2% of adults in Jersey were unemployed and either looking for or waiting to take up a job. A further 1% of adults were unemployed and not looking for a job, and 3% were unable to work through sickness or disability.

Financial Difficulty

The proportion of Jersey households that reported coping financially as either quite difficult or very difficult was 35% in 2024. Single parent households, households with children, and households socially renting accommodation experienced proportionally more difficulty. Compared to the previous year, 40% of households described their financial situation as worse, and 19% described it as better.

Among patients of the adult mental health service in Jersey between January 2019 and September 2023, there was no statistically significant difference in the risk of suicide by financial difficulty status. However, the data was self-reported and a degree of subjectivity applies to financial difficulty.

Problem Gambling

In December 2022, Jersey had four bookmakers, operating 20 shops and 78 machines. On the same date there were 45 gambling machines located across 30 pubs and clubs in Jersey. It is of note that there is a dearth in population data on gambling in Jersey; It is however known that there are islanders who experience problem gambling and are in contact with mental health services. This is currently being explored as a specific issue by Health & Community services. On-line gambling has been identified as a specific increasing concern.

Protective Factor Profile for Jersey

Social

In 2022, 82% of adults in Jersey reported socialising face to face with people outside their household, and 84% reported having someone on the Island they could count on to help if they were in trouble. In the latter case the proportion was higher for those born in Jersey. At the same time, 12% reported having someone they could count on outside of Jersey.

In terms of cultural involvement, in 2022 71% of adults in Jersey reported attending one or more cultural events in the previous year. In the same period, 19% reported participating in a cultural activity and 35% reported having volunteered.

With respect to accommodation, 91% of adults in Jersey reported satisfaction with their current housing in 2022. This proportion was even greater for those living in detached and semi-detached houses, and among owner-occupiers.

Financial

In 2024, 28% of households in Jersey reported that they found it easy or very easy to cope financially, an increase of 4% since 2017. The proportion was larger among pensioners, couples with and without children, and those of working age who were living alone.

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Appendix C – Engagement Events

Activity	Details
Engagement sessions	The engagement sessions were advertised on the Government of Jersey website, and via media and social media channels. A total of 11 sessions were held: 3 public stakeholder sessions in Jersey Public Library 1 public stakeholder session in Jersey General Hospital 1 student stakeholder session in Highlands College 1 lived experience stakeholder session with Focus Up (supported by Focus on Mental Illness) 1 lived experience stakeholder session with Support After Suicide (supported by Mind Jersey) 1 lived experience stakeholder session with Collective Voices (supported by Mind Jersey) 1 lived experience stakeholder session with Youthful Minds (supported by Mind Jersey) 1 mental health professional stakeholder session in La Chasse 1 mental health professional stakeholder session in Le Bas Centre
Public questionnaire	The questionnaire was hosted online by Smart Survey and accessed from the Government of Jersey website. It was advertised via media and social media channels
Secondary school questionnaire	The questionnaire was sent via e-mail to the Designated Safeguarding Lead (DSL) for all 11 schools offering secondary education in Jersey
Pop-up sessions	The pop-up sessions were held to promote the public questionnaire and provide paper copies of the questionnaire to those unable to access the internet. Two sessions were held: 1 pop-up stakeholder session in Jersey Public Library 1 pop-up stakeholder session in Jersey General Hospital

Engagement Sessions – Summary

Risk Factors

A broad range of risk factors were raised, some of which were more specific to Jersey. Long-term physical and mental health conditions, neurodiversity, pain, trauma, and self-harm were all cited multiple times. Social risk factors mentioned included a lack of social contact and listening, isolation, loneliness, poor routine, relationship breakdown, abuse, violence, neglect, discrimination, gender dysphoria, bullying, adverse childhood experiences, academic expectations, bereavement, homelessness, poor accommodation, and accommodation with balconies. Perinatal relationship breakdown and the associated issues with residency on the Island were highlighted, as was termination of pregnancy. Financial pressure, burnout, and overwhelm were spoken of. It was acknowledged that events in childhood could lead to a lifelong increase in suicide risk. Veterans and those employed in the healthcare sector were also felt to be at higher risk. There was considerable strength of feeling that risk factors could be detected earlier, and that more could be done to address them.

> *'I know like autism for example, the difference, cause I'm not a super expressive person, that's really common for people with autism. And so, we're really at high risk of suicide'*
>
> *'I think loneliness is really, really problematic'*
>
> *'…significant number of people in Jersey who have had horrendous abuse as children and that has left them in a state of permanent risk'*
>
> *'I'm certainly aware of suicides where people have jumped off balconies. And I'm also aware of people presenting quite frequently, saying they're going to jump off their balcony. So maybe that's just a Jersey-specific factor that might be worth looking at'*

Prevention

Comments on suicide prevention stressed that it was everyone's responsibility. The importance of delivering preventative interventions early was raised, as was the need for interventions to be tailored to individuals. It was felt that Jersey was lacking in a clear suicide prevention approach, and the challenge of addressing this was acknowledged. There was strong support for adopting an evidence-based approach and learning what had worked well elsewhere.

Preventative interventions that were proposed included providing peer support from those with lived experience of suicide, introducing tighter controls on alcohol and drugs (including prescribed cannabis), creating more spaces for children and teenagers to meet, engaging with workplaces, promoting the contact details for support services, developing resilience, community building, and approaching those at risk. Screening for anxiety and depression was suggested, and it was felt that this could be undertaken in the hospital setting. However, it was expressed that the questions used should be easy to interpret, especially

for those who were either neurodiverse or unable to communicate in English. Initiatives to improve physical health were linked with good mental health and suicide prevention. Healthcare settings and schools were deemed suitable venues for hosting suicide prevention initiatives.

Police officers, GPs, social workers, school staff, and postal workers were considered important in improving suicide prevention on the Island. The need to involve employers, charities, and education establishments was viewed as key. Jersey's car parks, cliffs, and piers were reported to be the locations where suicide was most prevalent. It was noted that some of these had preventative measures such as CCTV, but that these could be expanded and improved.

It was felt that emotional literacy was required for suicide to be discussed, and that this often improved with age. The value of talking to people, especially by asking open questions, was raised, as was the need for appropriate language in public communications on suicide. Some felt distress and bullying should be taken more seriously. The use of social media in suicide prevention was mentioned, in particular by the police in the identification of individuals at risk. Notice boards and toilets in pubs were seen as potential locations for sharing information on support services. An improved awareness of the importance of suicide prevention was deemed necessary, and suggestions for achieving this included marking World Suicide Prevention Day, and using notice boards.

'…suicide prevention is everybody's business'

'I think the early intervention is important'

'One size does not fit all'

'…there needs to be more to keep people in touch with their community, because I think that would stop people feeling like being a burden'

'Jersey has hot spots for suicide. I mean the obvious ones, obviously the car parks, particularly multi-storey car parks, and also the cliff at Fort Regent. And there are cliffs as well. There are a hot spot and the piers, particularly the one in town and I think St. Catherine's'

'How would I have been able to have a conversation about suicide when I didn't have the emotional literacy to begin?'

'…language is really, really important'

Personal Experience

Profound emotion was expressed in the articulation of personal experiences of suicide. The immense challenges encountered in speaking about it, often originating from not being taken seriously or a lack of perceived worth, were described. It was revealed that showing concern for someone at risk, even a partner, was also challenging. Some referenced personal suicide attempts and the gratitude they felt for the support they received following these. Others acknowledged the effort they had invested in the suppression of suicidal feelings throughout life, and it was felt that sharing such feelings openly brought hope. It

was stated that suicide attempts could be either impulsive or planned. Attempting suicide was considered a last resort, and the impact on the individual and others was emphasised. The stigma associated with suicidality and mental health was referenced multiple times. It was believed to be greatest among the older generation, men, the Portuguese community, and those employed in the building trade, leading to ostracisation. Despite the magnitude of this stigma in Jersey, it was thought to be worse elsewhere.

> *'I felt like my distress was not taken seriously, was mocked…this made me feel even less of worth'*
>
> *'My wife used to think that if she came back home from work, I might be dead on the couch. She never told me that at the time, she has done since'*
>
> *'There were quite a few of us that went on and told our stories, the important things that were needed. I am hopeful'*
>
> *'Stigma is huge on the Island'*
>
> *'From a Portuguese point of view, if you think suicide and mental health is a stigma here, in Portugal it's even worse. People don't talk about it'*

Peer Support

Several people detailed their experiences of peer support, and the strength they gained from it. Some had accessed peer support through organised groups, others had used informal channels such as friends, and individuals with similar experience recommended by personal contacts. Confidentiality, continuity, and emotional support were greatly valued in peer supporters. Much of the success of peer support was attributed to peers being well matched, although differing speeds of recovery were seen as a potential challenge in sustaining the relationship. It was noted that peer supporters were sometimes balancing the role with other commitments, and that this often made giving peers the assistance they required difficult. Suggestions for peer support groups included expanding their offer, refining their recruitment processes, and working with mental health inpatients earlier in the discharge process. Establishing the Emotions Anonymous programme in Jersey was also proposed, to provide an additional source of peer support.

> *'I remember a woman phoning me. She lost her husband to suicide, and somebody put her in contact with me and she said I hope you don't mind me phoning. She knew I had lost two family members'*
>
> *'I think there's an immediate honesty that comes through that says I may not have been through exactly through the situation that you're going through, but I've been through something that's really, really similar'*
>
> *'It's hard because some of these peer support workers are having to work very long hours to support themselves, so sometimes they can't always make the time to meet the person they're allocated'*

Referral

The experiences of service users and professionals of the referral processes in place were variable. Some felt that referral processes functioned well, with partnership working between the police and the Crisis Team cited as an example of recent progress. Others described complications and delays, caused by inappropriate or incomplete referrals, a lack of clarity on acceptance criteria, and triage difficulties. On occasion, referral problems had led to tension between services. Self-referral was mentioned as an area under development, and it was said that some people would prefer to be signposted rather than referred to a service. Improving the coordination of referrals, the handling of referrals that are not accepted, and referring Islanders to online training were also suggested.

'…the police with the job they are doing…are doing a good job. You would rather have, you know, doesn't matter how many Article 36 you're gonna get…that's fine…at least they are being seen to rather than being ignored'

'…it's a real problem because even for instance, they send a referral through and the referral doesn't fit our criteria and we bounce back to the thing, XYZ need this, you know…there's been a time where the GP then contacted the patient directly, basically throwing the services under the bus, saying oh, they've not taken this referral because of XYZ'

'Just leaving that person with options and saying that, you know, this isn't a rejection, it's just that this service might be more helpful to you'

'You could automatically refer anyone who's triggering above a certain threshold to do an online course'

Services

The majority of comments on services related to healthcare provision. There were reports of positive interactions with services, including staff thanking patients for attending appointments and promoting the range of services available on the Island. Asking service users about suicide was viewed positively, as was the effort that had been made to make premises comfortable. Jersey's mental health charities were praised for their work on risk reduction, but it was recognised they were not often equipped to meet the needs to those in crisis. Recent improvements in the crisis service were identified, along with the benefit conferred to the police and the emergency department.

Insufficient capacity, resulting in long waiting times, was viewed as a major barrier to accessing some services. It was expressed that seeking care privately was not always a viable alternative for many people. There were reports of difficulties with referral processes and the dissemination of information to referrers, particularly in primary care. There was also a perception that primary care services were better equipped to assess physical health problems than mental health problems. This was linked to a general lack of awareness of how best to treat someone who is suicidal and the struggles of some service users to articulate their situation. Confidentiality was raised repeatedly as an issue, with some service users reluctant to share their name for fear of being identified.

The need for a directory of all mental health support services was emphasised, along with the requirement for this to be updated and shared with those working outside of healthcare. Developing the interface between the Government and services in the third sector, involving service users in the design of services, and improving the transition arrangements for mental health inpatient discharge were put forward as suggestions.

'…the number actually going to the police station has dropped as well, which is really good because you don't really want a suicidal person in custody in a police station'

'I don't know what to do because someone's like, I don't want to say my name, and because I don't want to be labelled or because of this and that, then sometimes you have to end up having to call the police'

'It's a big job keeping a directory going for everything and I think sometimes these things start off well and then there's no money and they just sort of fade'

'When I was under CAMHS I did not speak. I basically…they basically said to my parents, like, it's medication or like, she's not talking to us, like I was talking in the appointment but I wasn't talking about whatever I needed to be there for'

'I've had my confidentiality breached before, because I have had bad experiences in mental health before and if you're not in the right place, you feel so vulnerable'

'…when I was in the care…well I say in the care of Orchard House, people would ask me certain questions which may have been about suicide, but I brightened up straight away because it sounded like someone cared'

'Mind Jersey, Jersey Focus on Mental Illness, Jersey Recovery College aren't necessarily the right supports for a suicidal crisis, but can be helpful in refining and assembling tools to make to make it less likely someone will attempt suicide or aid someone who has survived'

'I was in CAMHS for three years, and when I finally got a therapist, she was a godsend'

'…you went into rooms that were like the size of a living room with two huge…like couches in them, like actual proper comfy couches, and you'd go and it felt like you were just in someone's house, and it was lovely'

'You know the services are overworked, overburdened'

'I really need help, please can I access someone and they will go well, yeah, but in about like 8 to 12 months'

Workforce

It was explained that supervision was required for all clinical mental health staff, including locums. A supervision policy had been written and was in the process of being implemented, although the completion of the associated paperwork had been inconsistent. The wellbeing

offer to clinical staff was considered substandard. Assistance with extreme situations occurring during the night was in place, and the potential to share risks and anxiety with colleagues was mentioned. However, regular debriefs and more psychological support within teams were said to be needed, but the challenges associated with recruitment were noted. There was a preference for the use of off-Island support to deal with personal issues, yet the current offer was more extensive for doctors than for other professionals. Networking opportunities with professional counterparts on other small islands were suggested, and there was some recollection of a previous link with Guernsey.

Clinical staff reported undertaking a range of training, but it was often felt that what was prescribed was of limited value. Previous training was said to have been well received but discontinued, causing disappointment. There was a preference for multiagency training packages and sessions delivered by charities. Making suicide training mandatory, and adopting training packages from England, supplemented with the relevant information on local services, were proposed. The challenges of standardising the training of locum staff were recognised.

'We've written a supervision policy now, there was no policy even for supervision, so now there is a policy for supervision and it is supposed to be rolled out in every team'

'If you're working with colleagues, probably two or three, you can share with each other. You can share the risk, you can share your anxiety'

'I think that there should be opportunities for staff to debrief on shift. Just a quick five minute debrief, if something happens'

'I definitely think we should be having a small islands get together, maybe three times a year, where we look at data, where we look at services, where we talk and share ideas'

'…actually we'd really like to do an hour just on how to look after people with mental health problems. You know, that would be better, but we're not asked to do that'

'In England, we used to have some fabulous things on all of this and we just, in Jersey, we try to somehow reinvent the wheel'

Postvention

Jersey's postvention offer drew mixed reviews. There were instances where the support provided to those in grief was praised, but considerable confusion existed regarding how and where to access support. While family networks were seen as a crucial source of assistance, it was expressed that their shared burden of grief sometimes necessitated independent help. Reference was made to the importance of postvention provision being expanded, tailored to the needs of children, and made known to those grieving following suicides outside of Jersey. It was suggested that the notification of suicides could be improved, and that investigations could place a greater focus on service use.

'I think some of the response has been good…some of the response has been misguided and I think it has resulted in some difficulties'

'I've fought it and come through it, but at the time I didn't know who to turn to, who to reach out to'

'She couldn't talk to her parents because they were grieving the loss of their son and so she found it really a strength to be able to go and talk independently, because sometimes it's too painful to be talking to somebody who's also going through that pain too'

'I didn't even think to turn to anybody in Jersey 'cause it happened in the UK'

'We should be notified really, and it should be checked for each suicide as to whether they're under services'

Education Settings

The support available in education settings for young people experiencing mental health problems was described in detail. There were personal accounts from young people of how it had helped them to manage difficulties, and their experiences were largely positive. Building trust in the staff member providing the support was considered key, and there was a preference for them to be employed internally rather than by an external agency. Discretion, accessibility, and approachability were all valued by students. It was felt that the communication between staff and parents about students in difficulty could be improved, as could the selection of those designated to support students. Allowing students to elect staff to be trained in mental health and suicide prevention was proposed, although the burden of dealing with suicidal young people was said to be responsible for teaching staff leaving their profession.

Some people felt that the current mental health and suicide prevention training offer in schools could be improved. It was considered inappropriate to explore sensitive topics with young children, in favour of concentrating on those in post-primary settings. Adopting an evidence-based approach as well as making a clear distinction between mental health problems and wellbeing were considered important.

'I'll go and just cry to her for like ten minutes and just get it all out. And she'll be like are you good? And I would be like, yeah, I think I'm gonna get back to class now'

'You need to do it in such a discreet way because it is so frightening, the concept of your peers finding out'

'I think it would be really good to take a poll in each school, a completely anonymous thing…which teachers would you like to see trained in this?' Which ones could you see yourself approaching, like, if you were struggling?'

'…teachers are leaving in droves, saying…and a quote I heard the other day…just can't deal with another child saying they want to kill themselves'

'I got a seven-year-old, and talking about mental health…she's asking me questions about mental health. I think, no, it's just not appropriate'

'I'm not really certain we understand the evidence about what the right thing to do in schools is'

Workplaces

Feedback on experiences of discussing mental health problems in workplaces was mixed. Supportive employers who adopted corporate mental wellbeing initiatives were described, along with the positive impact this had on their staff. Arranging time off for employees who were struggling, particularly at short notice, was well received. People reported being reticent about their mental health at work, to avoid discussions about their capability. Some managers were observed to be unsure of what to offer, and fearful of getting the offer wrong. Proposals for improvement involved assisting employees with mental health problems through additional support and coaching, holding informal meetings over coffee, developing policies and channels for off-Island support, and marking mental health awareness days.

Training in Mental Health First Aid and counselling was viewed positively, and its expansion was suggested. However, it was expressed that ongoing refresher sessions for those trained in Mental Health First Aid would be of benefit and would prevent the skills gained from being unutilised. Creating spaces in workplaces for providing Mental Health First Aid, and offering it outside of the workplace, were suggested.

'What he came out with next was like, if you take a mental health day, you can message me last minute and just say I need a mental health day. It's fine, we'll find a way to cover it'

'I did the mental health first aid course, it was known that I was a mental health first aider but, you know, I've never had the opportunity to actually carry out those skills'

Digital and Media

Social media was viewed positively as a channel for suicide prevention messages, with its content deemed more trustworthy than official sources. Social media posts from those with lived experience of suicide were particularly well regarded, although the need for social media usage to remain in moderation was stressed. The use of virtual appointments and support meetings was mentioned, particularly in the context of COVID-19, but there was a preference for meeting in person where possible. Portrayals of suicide in the media were criticised for their insensitive approach, and it was felt that clear guidelines on this should be developed for Jersey's media outlets.

> *'Instagram or maybe even TikTok. Yeah, I think for younger people those two are what are used most'*
>
> *'TikTok I've found is an incredible education platform. It's really not…like…governments aren't seeing that as much as it is. There's like statistics that children and teenagers trust TikTok for news more than they trust official news sites'*
>
> *'…need to be far more responsible in the coverage of suicide'*

Other Themes

Some discussions related to the strategy itself. The importance of clarity with respect to its objectives, and ensuring human and financial resource to safeguard its implementation, were emphasised. It was recognised that strategic priorities developed in other jurisdictions may not be transferable to Jersey because of its population size. There was confusion regarding the objectives of the previous strategy, and it was said that it had not made an impact. It was felt that the Government was not always receptive to feedback from Islanders.

Other comments included the issue of capacity in suicide attempts, the recognition of religious institutions as places of safety, Jersey's high cost of living, and the importance of a living wage. Opposition to assisted dying was expressed and it was felt that the topic was contradictory to suicide prevention efforts. There was also enthusiasm for making data on suicide more widely available.

> *'We had a previous suicide strategy. It didn't make any difference'*
>
> *'I personally feel really strongly against the assisted dying'*
>
> *'I'm not too sure what the figures are for suicides in Jersey'*

Public Questionnaire

The questionnaire invited insights on risk factors, protective factors, and other thoughts that Islanders considered important for the development of the strategy. A total of 146 responses were received; 111 of these were from people who had either been affected by

suicide or had someone close to them who had. A summary of the findings is presented below, along with a selection of quotations.

Risk Factors

A wide range of factors were cited by respondents as causing people to consider suicide. Social factors included isolation, a lack of community, bereavement, embarrassment, violence, the feeling of being a burden, and a perceived loss of social status. Abuse was referenced, both during childhood and adult life, and within relationships. Workplace bullying was raised, along with the absence of supportive environments in workplaces for the discussion of mental health. The pressure facing young people to achieve was mentioned, as were restrictions on individuality, and being transgender. The stigma associated with a criminal record, poor accommodation, the negative impact of social media, and a poor response to warning signs were also deemed causative.

Comments on the health factors associated with the consideration of suicide predominantly covered mental health conditions and their symptoms, and healthcare services. With respect to the former, depression, stress, burnout, low mood, psychosis, body dysmorphia, and neurodiversity were listed. Regarding the latter, the length of waiting lists, a focus on crisis care rather than prevention and early intervention, and workforce shortages featured. The side effects of medication and poor food choices were referenced as additional health factors associated with suicide.

Financial factors reported to cause suicide to be considered were gambling, debt, worries about money, and the cost of living and accessing health services. Substance use, in particular addiction, was included in several responses. Some respondents were unsure what caused people to consider suicide, while others felt demographic factors and an inability to see a way out of difficulties were significant. It was also suggested the risk factors for suicide may be too numerous to specify.

'Stress, debt, relationships, sexual abuse and violence. Substance misuse, depression, the list is endless!'

'Lack of community - we have forgotten what this truly is'

'I know from people I have spoken to, that they feel they have become a burden on those around them and that in some way, it would be better for others if they were dead, so that friends and family could stop worrying about them'

'Many workplaces still lack a supportive environment that encourages open conversations about mental health'

'Pressure - on young people, they are faced with huge anxieties and pressure on 'doing well''

'Lack of seeing warning signs and or acting upon them'

'It's too expensive to stay and too expensive to leave. You struggle to save money'

'I think sometimes people just think there is no other way out and can't see light at the end of the tunnel'

Protective Factors

Among the social factors considered to prevent suicide, social media was referenced repeatedly. It was expressed that reducing social media use, particularly among young people, would be beneficial, as would using social media for signposting, and to share resources to promote good mental health. Education on mental illness, mindfulness, sharing feelings openly, and suicide warning signs was proposed. Social and recreational activities such as exercise, arts, and crafts were considered preventative, as were improvements to the built environment including more green spaces and better accommodation.

It was said that introducing mentoring schemes for young people, addressing bullying, and improving bereavement support were key. The value of communication, especially making time to talk and listen to people, was stressed. It was felt employers could contribute to suicide prevention through gaining a better undertaking of how individuals work best and exploring alternative working patterns such as four-day weeks. Legislative change requiring employers to develop and implement mental health policies was also sought. The importance of targeted support for vulnerable groups including the socially disadvantaged and elderly was noted.

Comments on the health-related protective factors for suicide were centred on improving mental health services. Reducing waiting times for therapies, updates on referrals, greater family involvement and opening more drop-in services were considered priorities. Regarding the mental health workforce, it was mentioned that greater continuity, the recruitment of multilingual staff, and training on neurodiversity were needed. Some respondents felt offering alternatives to traditional therapies would be helpful, as would a focus on social prescribing rather than traditional medication approaches. Better information on mental

health resources and how to contact services was requested; it was suggested this could be included in a mental health directory.

Several respondents referenced financial protective features. They explained that greater job security, better wealth distribution, and a reduced focus on material effects would we welcomed. Improving the affordability of health services also featured, as did the remit of Community Savings, and the need for more stringent regulation of gambling. Some responses included expressions of frustration at the lack of long-term suicide prevention initiatives, although the challenges associated with implementation were acknowledged.

'Regular social media posts reminding folk that they are not alone and where they can get help'

'…mindfulness INTHE CIRRICULUM. Show a teen or adult how you can feel lighter through breathwork, affirmations in the classrm, and excersize'

'More green spaces in urban areas (eg squares like in London)'

'A better understanding of how people work, not just going with what seems to be the corporate norm, i.e. researching the benefits of a four-day work week'

'Reaching out… trying to make a positive difference to peoples lives… even just a smile'

'Support those at social disadvantage and our forgotten elderly'

'…less staff turnaround - changing between who you see is not great'

'A decrease in prescribed medications and more social prescribing'

'Highlight the 24/7 Jersey Crisis number'

'…maintain a directory of local resources, such as support groups'

Other Themes

The impact of suicide on families and communities featured heavily in the responses. Some referenced the long-term repercussions of suicide, and the anxiety suicidal thoughts created for others. Positive feedback on recent improvements in mental health service provision featured, with gratitude for the change.

Several respondents commented on the importance of a new suicide prevention strategy for Jersey, and it was stressed that this should be taken seriously. There was enthusiasm for the involvement of stakeholders with appropriate experience in the development of the strategy, and the merit of using statistics was highlighted.

'Its so tragic and such a waste and leaves so many questions'

'I had to bury the gremlins in my head and cook dinner for the kids'

'My blood runs cold at the thought of parents dealing with suicidal teenagers'
'Involve all key stakeholders in writing the strategy'

'I have seen improvements within mental health service (La Chasse) over the 2 years. Thank you'

'Really important the strategy is not a paper exercise but sees meaningful change and is reviewed'

Secondary School Questionnaire

The questionnaire requested information on suicide and self-harm prevention, intervention and postvention initiatives, for students, parents and staff, and the related processes. Seven completed questionnaires were returned. A summary of the findings is presented below, along with a selection of quotations.

Student Initiatives

The initiatives available to students varied between schools. Some described prevention programmes that incorporated elements of intervention and postvention, including education sessions on coping strategies and mental health. In some instances, these were delivered within Personal, Health, Social and economic (PHSE) lessons, and the value of packages provided by Brook and the Samaritans was mentioned. Support resources and safeguarding policies had been made available online, with the rationale that they could be accessed by students while outside of school. The development of a wellbeing guide was also raised as a worthwhile project. Pastoral support had been sought from local churches, although it was acknowledged that it had not been possible to secure physical representation from all faith groups. In terms of postvention, lighting candles and writing cards were stated as options that had been offered to students in mourning.

Some schools focused on targeted approaches for students of concern, rather than universal initiatives. These included the provision of music and art therapy, befriending anxiety groups, timetable changes, and an exit card scheme for self-regulation. Some schools referenced working with CAMHS and the Jersey Youth Service. Discussions with students' families, wellbeing and safety checks, and text messaging were stated as communication channels, and their use extended beyond school hours.

A wide range of professionals were reported to be involved in delivering initiatives for students. These included DSLs, teaching and senior school staff, PHSE leads, school nurses, school counsellors, ELSAs, therapists, special needs education coordinators (SENCOs), and representatives from charities, religious organisations, and other external agencies.

'Prevention work includes awareness raising and education around health coping strategies, mental health and how to access support'

'Support was given by the St Helier town church, and by the Methodists. Other religions were contacted but weren't able to provide in person support'

'We also set up an opportunity to light a candle and write a card, to allow students to express their grief'

'We have developed a therapeutic approach focusing on Music and Art Therapy to help support our students'

'Students can be provided with Exit Cards to allow periods of self-regulation in our Individual Student Needs Hub'

'Individual and timetable support where necessary'

'I provide support to the most at-risk children over the weekend by text messages and if the child send me any messages of distress I will contact the parent'

Parent Initiatives

Initiatives provided by schools for parents included communicating suicide and self-harm warning signs, prevention strategies, and information on support services. The vehicles for these were workshops, parents' evenings, e-mail, and the school website. Some schools described a targeted approach, supporting parents with advice and resources as required. Some schools lacked any specific provision for parents.

Training for parents was delivered by DSLs and their deputies, senior leadership teams, and school pastoral teams. This was supplemented by external input from CYPES, Mind Jersey, CAMHS, and other mental health professionals.

'CAMHs/Mind have delivered a parents information evening on the subject of self-harm'

'Parents are signposted/sent resources on supporting young people who self-harm when appropriate'

'Support given to parents from SLT on a needs basis'

Staff Training

Staff received regular training on mental health, including adolescent mental health, emotional literacy, and mental health first aid. Safeguarding training was provided, in some cases at level 3. It was noted that training often took place during INSET days, and that more opportunities to train would be beneficial. A pilot self-harm scheme to develop guidelines and resources was referenced, as well as opportunities to avail of Government of Jersey initiatives and staff sessions with a school counsellor.

Staff training was delivered by DSLs and school counsellors, as well as external agencies from the public and private sector. CAMHS, the Anna Freud Centre, the Government of Jersey's Virtual College, and Children, Education, Young People and Skills (CYPES) were listed as staff training providers.

'Heads of school and safeguarding leads (DSL and deputies) are trained to level 3'

'We could probably do with a great deal more'

'We are currently members of a pilot self-harm scheme for secondary school'

'3 members of staff have been to the Anna Freud training. 2 members of staff are mental health first aiders'

Processes and Protocols

Some schools had protocols in place for supporting students at risk of self-harm and suicide, while others had planned work in this area. Existing protocols included referral processes and thresholds for determining the level of involvement from the school. The input of external agencies and another school were mentioned with respect to protocol development. Channels for sharing information on students at risk were described, and featured internal and external professionals. The undertaking of risk assessments was also raised. My Concern, a safeguarding software package, was used by several schools for record keeping.

'We have a protocol for 'response to self-harm' which also includes asking about suicidal ideation'

'It was identified by us that a clear, formal and jointly constructed process and protocol is not in place so work on this will be completed'

'A list of 'red students', about whom there are current safety concerns, is shared with staff through our inclusion registers'

'Concern for child is logged on My Concern'

Other Themes

It was observed that suicidal ideation and self-harm often presented together, especially in females. Feedback from students revealed that relationships and support were of greater value than digital offerings. Involving students in the co-design and implementation of initiatives was referenced, as were wellbeing awards. The benefits of sharing of good practice and resources between schools and holding informal collaborative meetings between DSLs were highlighted. Concern was expressed on a lack of access to the Management and Supervision Tool (MaST), a predictive analytics dashboard to support staff in the delivery of mental health care.

'Wellbeing is the central of our current School Development Plan with students taking a leading role in co-designing and implementing these initiatives'

'We share good practice regularly'

'Through informal collaborative meetings with other DSLs of Sixth Form providers, our safety plan template has been adopted and adapted by three other providers'

Appendix D – Services

The table below shows the scope, access and referral arrangements for services in Jersey that contribute to suicide prevention. Where the scope of a service covers other areas, the information included has been limited to that applicable to suicide prevention, intervention, and postvention, and support for those at risk of suicide.

Service	Scope	Access and referral
Adult Mental Health Service	Assessment, diagnosis and treatment of mental health concerns. Consultant nursing service for suicide postvention Jersey General Hospital psychiatric liaison service 8am-8pm, every day	Aged 18 years and over Referral via phone or e-mail by self, carer, family member, professionals
Alcohol and Drug Service	Assessment and safety planning for substance use and associated risks Initial pharmacological management Appointment-based service	Aged 18 years and over Inward referral via phone or e-mail by self and professionals Onward referral to AMHS, GP, therapy services
Autism Jersey	Behavioural and peer support Short breaks and supported living Counselling and mentoring Social activities and events Advice and guidance 24-hour operational care service	No age or gender restriction Inward referral via phone, e-mail or website by self, carer, family member, professionals Signposting to other agencies
Child and Adolescent Mental Health Service (CAMHS)	Crisis management, mental health and neurodevelopmental assessment Therapies Inpatient liaison service 10am-12am, Saturday and Sunday YES project drop-in clinic 10am-6pm, Saturday	Aged 0-17 years old Inward referral via phone or e-mail by GP and other professionals Onward referral to AMHS, GP, off-Island specialists, or discharge

Service	Scope	Access and referral
Citizens Advice Jersey	Debt and monetary advice Basic information on healthcare rights, costs, and support services Practical assistance Drop-in 10am-3pm, Monday-Friday	No age or gender restriction Inward referral via phone or e-mail by self and professionals Onward referral to CLS and charities Signposting to other agencies
Community Bereavement Service (Jersey Hospice Care)	Individual counselling *Looking back, moving forward* support group Couple support Appointment-based service	No age or gender restriction Inward referral via phone, e-mail, or online by self, family member, friend, professionals Onward referral to AMHS
Community Pharmacy	Dispensing of prescription and over-the-counter medications Supervised consumption for Alcohol and Drug Service clients Consultations, advice, and guidance	No age or gender restriction Referral in-person at medical centre pharmacy, shop or supermarket pharmacy Onward referral to crisis team in emergency, or to GP for wellbeing follow-up
Crisis Mental Health Team	24-hour crisis service Mental health assessment and triage within 4 hours	Currently aged 18 years and over Referral via phone by self, carer, family member, professionals
Deputy Viscount (Coroner)	Investigation and Inquiry Findings and recommendations Data provision to the National Confidential Inquiry into Suicide and Safety in Mental Health	Any sudden, unnatural, or unexpected death Any death in police custody, prison, nursing or children's homes, mental health establishment Referral from police
Dewberry House	Sexual Assault Referral Centre (SARC) 24-hour crisis helpline for victims of sexual assault or sexual abuse Support, care, advocacy, aftercare, and counselling Forensic examination	No age or gender restriction Inward referral via helpline from self or police Onward referral to ISVAs (Independent Sexual Violence Advisors), emergency services, crisis team, and other professionals Signposting to Jersey Action Against Rape, and therapy services

Service	Scope	Access and referral
Emergency Department	24-hour emergency assessment and treatment Identified room for patient use while awaiting psychiatric assessment	No age or gender restriction Access via 999 and ambulance, or walk-in Onward referral to other departments and professionals
Family Nursing & Home Care	Preventative support, counselling, and coping strategies Older Adults' Service Antenatal clinic, perinatal mental health screening, and early childhood home visiting programme	Age and gender criteria vary by service Inward referral via phone, e-mail, online form, or fax by self, carer, family, friend, GP, and other professionals Onward referral to GP, AMHS, emergency services, therapy services, charities, and other agencies
Focus on Mental Illness	Behavioural family therapy, user participation group, and mental health campaign work	Aged 18 years and over with severe mental illness Inward referral via phone, e-mail, or online by self, AMHS, other professionals, and charities Signposting to charities and GP
GP Services	Consultations Emotional support Pharmacological management JDOC (out-of-hours GP service)	No age or gender restriction Inward referral via phone, e-mail, or fax by self, carer, family, friend, JDOC, and other professionals Onward referral to AMHS Signposting to therapy services
HCS24	Single point of referral (SPOR) for healthcare services across the Island 24-hour telecare for users of assistive technology and devices	Aged 18 years and over Inward referral via phone or e-mail by self, carer, family, friend, professionals, or telecare alerts Onward referral to crisis or safeguarding team, police, and GP Signposting to General Hospital, Samaritans, and Children and Families Hub

Service	Scope	Access and referral
HMP La Moye	24-hour access to healthcare (with elevated observation levels if required) Pharmacological management Psychiatric assessment, counselling, and therapies Peer listening, user education and employment support	All prisoners Referral via prisoner appointment request form, or by prisoner approaching staff Referral, and signposting on release, to AMHS, CAMHS, and charities
Hospital Chaplaincy	24-hour onsite service providing pastoral care, emotional support, and counselling Point of contact for own faith community	Any hospital patient, visitor, or staff member Inward referral by ward staff or via phone, by self, carer, family, friend, and professionals Onward referral to faith organisations Liaison with chaplaincy teams in the UK
James' Ark	24-hour helpline Coaching and mentoring Triple P Family Transitions Becoming Dad project Super Kids Aftercare Services Support groups Practical advice and guidance	Males aged 18 years and over experiencing difficulties due to separation or divorce or connection to their children Self-referral via phone or e-mail Onward referral to crisis team, police, and therapy services Signposting to Brighter Futures and Legal Aid
Jersey Association for Youth & Friendship (JAYF)	24-hour independent living accommodation for homeless people	Aged 18 to 25 years without serious mental illness Inward self or professional referral via phone, e-mail, or online form Onward referral to other agencies Signposting to Jersey Women's Refuge

Service	Scope	Access and referral
Jersey Domestic and Sexual Abuse Support (JDAS)	Emotional support, practical advice, and guidance Needs assessment, support and safety plans Advocacy	Victims and survivors of sexual abuse Victims and survivors of domestic abuse aged 13 years and over Inward self or professional referral through multi-agency liaison and via helpline, e-mail, or online form Onward referral to multi-agency partners and other professionals, CLS, accommodation providers, charities and therapy services
Jersey Eating Disorders Support (JEDS)	Individual and group support Texting service Self-help books Training	Aged 18 years and over Inward referral via e-mail or online form by self and GP Signposting to GP, AMHS and charities
Jersey Talking Therapies (JTT)	Stepped Psychological Therapies Resource website Post JTT discharge 'booster sessions'	Aged 18 years and over with varying difficulties due to mental health, and alcohol use Inward referral via online form by self and drop-in Onward referral to PATS, AMHS Signposting to GP, Alcohol and Drug Service, other therapy services, and charities
Jersey Women's Refuge	Emergency accommodation and safe house 24-hour helpline Outreach service Counselling, self- development, and resettlement Training to GPs and corporates Education to children and young people	Women, children, and young people with experience of domestic abuse Female survivors of sexual violence Inward referral via phone, e-mail, online and IRIS form, fax, or post by self, family, friend, professionals, and other agencies Signposting to GP, children's services, charities, therapy services, and schools

Service	Scope	Access and referral
Jersey Youth Service	Community and focused groups Targeted Youth Support Youth Enquiry Service (YES project) Drop-in clinic supported by CAMHS practitioner, 10am-6pm, Saturday	Aged 8-25 years for youth service Aged 13-25 years for counselling Inward referral via free phone, text, e-mail, or drop-in by self, CAMHS, schools, police, and other agencies Onward referral to Children and Families Hub, crisis team, and parent or carer
Listening Lounge	Helpline Counselling Peer support Group work Appointment-based service	Aged 18 years and over Inward referral via phone, e-mail, or online form by self, GP, AMHS, and charities Onward referral to GP, JTT, and PATS Signposting to therapy services and agencies Out-of-hours notifications provide crisis links
Mind Jersey	Support after suicide group Counselling Psychoeducational groups Residential accommodation Peer support and care service Children and family service *Triangle of Care* Training Charity shop employment support Daily drop-in centre	No age or gender restriction Inward referral via phone, e-mail, or post by self, GP, mental health services Signposting-in from charities, shelters, prison, and police Onward referral to mental health services and GP
My Voice	Independent mental health advocacy Weekly psychiatric ward visits	No age or gender restriction for severe mental illness, complex personality disorder, or extreme anorexia Inward referral via phone, text, or e-mail by self, AMHS, CAMHS, other professionals Signposting to mental health services, GP, other professionals, Mind Jersey, therapy and recovery services, and other agencies

Service	Scope	Access and referral
NSPCC Jersey	Recovery from the trauma of sexual abuse 24-hour helpline and *Childline* Bi-monthly Jersey Evening Post column regarding safeguarding topics Advice and guidance to schools, and other agencies	Aged 4-17 years, extending to 19 years of age with a learning disability Inward referral via helplines, phone, e-mail, drop-in, SARC, children's services Referrals to CAMHS and children's services Signposting to Mind Jersey, JTT, and Jersey Youth Service
Pain Management Centre	Pain assessment and triage Multidisciplinary assessment Risk assessment and safety plan Pain management programme Persistent Pelvic Pain Service Spinal Assessment Service	Aged 18 years and over with persistent pain for six months or more Inward referral via phone or letter from GP or other health professional Onward referral to crisis team, emergency services, GPs, therapy services, and other professionals
Police Coroner's Office	Procedural coordination and investigations Point of contact for next-of-kin and relatives through Inquest process	Any sudden, unnatural, or unexpected death Internal referral of via instruction from Deputy Viscount (Coroner) Onward referral to other professionals including consultant nurse and suicide prevention lead
Psychological Assessment and Therapy Service (PATS)	Support, therapies, and interventions for complex psychological needs	Aged 17 years and over Referral via adult mental health services Signposting to other mental health services
Samaritans of Jersey	Emotional support 24-hour helpline	No age or gender restriction Inward self-referral via phone, e-mail, or freepost Onward referral to Samaritans' safeguarding team, and occasionally to emergency services Signposting to Mind Jersey or Listening Lounge

Service	Scope	Access and referral
Sanctuary Trust	24-hour staffed accommodation Independent living accommodation Outreach programme	Males aged 18 years and over who are homeless, or are pending homelessness Inward self or professional referral via phone Onward referral to Alcohol and Drug Service, AMHS, other professionals, CLS, and accommodation providers Signposting via website to support agencies
Silkworth Lodge	Service for people affected by substance misuse Counselling Silkteens programme Psychotherapy Pharmacological management Advocacy Charity shop employment support Family support	Aged 18 years and over; counselling and group therapy for ages 13-17 years Inward self or professional referral via phone, e-mail, or fax Onward referral to AMHS Signposting to Mind Jersey, Sanctuary Trust, and Jersey Women's Refuge
Social, Emotional and Mental Health Inclusion Team (SEMHIT)	Advice, guidance, and support Observations in school Assessments to inform individual care plans and setting of behaviour targets Support with school transitions Small group work One-to-one support work	Aged 18 years of age and under in primary, secondary, or sixth form education Inward referral via phone or e-mail by self, parent, family, carer, friend, teacher, SENCO, Children and Families Hub Onward referral to Vulnerable Services Team Signposting to Educational Psychology Team, Children and Families Hub, and other agencies
The Shelter Trust	Emergency, 24-hour accommodation Outreach Key worker service, resettlement, and aftercare Drunk and Incapable Unit Alcohol and Drug Clinic GP-led Primary Care Clinic	Aged 16 years and over who are homeless Inward referral via phone or walk-in by self, and professionals Onward referral to other professionals, social and private accommodation providers

Service	Scope	Access and referral
Thrive Jersey	Community-led suicide awareness and prevention initiative Postvention support Community allotment and 'calm zone'	No age or gender restriction Inward referral via phone, Twitter, Facebook, or post by self Signposting to Community Bereavement Service, therapy services, and charities

Virtual Services

In addition to the services in Jersey displayed above, a range of virtual services for suicide prevention and support exist. The apps and websites frequently recommended in Jersey are listed below

Virtual services	
Choose Life	Resilience Matters Facebook page
Kooth	Stay Alive
Hub of Hope	Togetherall
Papyrus	