



Department of  
**Health, Social Services  
and Public Safety**  
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# Protect Life A SHARED VISION

The Northern Ireland  
Suicide Prevention Strategy  
**2012 - March 2014**

**(Refreshed June 2012)**



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## REFLECTIONS FROM FAMILIES BEREAVED BY SUICIDE

*“If you’re hurting right now, and you can’t imagine that the pain will ever ease – please know that it will. You are healing, moment by moment, hour by hour, and day by day. Be gentle to yourself. Remember, you are not alone.”*

*“Every adversity, every failure, every heartache carries with it the seed of an equal or greater benefit.”*

*“I dropped a tear into the ocean ... the day they find it will be the day I stop loving you.”*

*“A butterfly lights beside us like a sunbeam  
And for a brief moment its glory and beauty belong to the world  
But then it flies again  
And though we wish it could have stayed  
We feel lucky to have seen it”*

## MINISTERIAL FOREWORD



Like many people reading this document, I have witnessed the pain and anguish felt by the families and friends of loved ones lost to suicide. Having experienced the sense of devastation felt by families and communities bereaved by suicide, I have made suicide prevention one of my top priorities since taking up office in May 2011. It is therefore important that I record my appreciation and thanks for the central role that bereaved families have played in both the development and ongoing implementation of the “Protect Life - A Shared Vision” suicide prevention strategy. Their courage in the face of personal tragedy is truly inspirational.

There has been a lot of excellent work since the publication of the “Protect Life” Strategy in October 2006. Progress to-date has included the establishment of the Lifeline 24/7 crisis response helpline, delivery of awareness raising public information campaigns, regional and local training programmes, and the development of community based suicide prevention initiatives. However, despite our best efforts to-date, suicide rates remain unacceptably high with 313 deaths recorded in 2010, the largest ever in a single year.

Clearly more needs to be done, although we also need to ensure that the value of the good work already delivered is not judged solely on the basis of achievement of an arbitrary reduction target, which was set a time when recorded suicide patterns were much different. While it is probably impossible to quantify the number of lives saved through our combined efforts, we do need to evaluate the impact of our services, in order to be able to demonstrate the positive outcomes from our work. We also need to think innovatively about what more we can do, and how we can do things differently in order to maximise the return from our combined efforts.

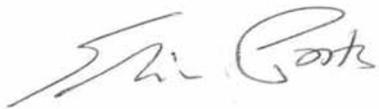
Early intervention for positive mental health and wider measures to improve our quality of life are undoubtedly part of the long-term answer. This will involve addressing the underlying issues that contribute to increased risk of suicide in local communities such as alcohol misuse, unemployment and employability, existing mental illness, and low educational attainment. However, we must also bear in mind that the specific circumstances of every person who becomes suicidal are unique. Frontline preventative action to care for people who face this situation will remain essential.

There is no doubt that we face a difficult challenge to reduce suicide rates across Northern Ireland in the time ahead, particularly in light of the additional threat posed by the current economic downturn. It is therefore more important than ever that we continue to work together to reduce the high incidence of suicide and self-harm in our local communities. The health service alone cannot resolve all the associated causal factors and, as highlighted in this refreshed strategy, action across government and across all sectors will be necessary to address the issues that impact negatively on our mental wellbeing and which increase the risk of suicide in our communities.

From the Government's perspective, the Executive has agreed that all departments should play a pro-active role in determining actions in support of suicide prevention. It is equally important that we learn from the experiences of organisations and individuals in the voluntary, community, and faith sectors and that we work in partnership across sectors. The media also has a very important role in relation to suicide prevention, both in terms of awareness raising and sensitive reporting of suicides.

I am keen to push the boundaries, and I intend to continue to meet with international experts, health professionals, bereaved families, and representatives from the voluntary and community sectors to ensure that we leave no stone unturned in our quest to tackle suicide and self-harm in our local communities.

Suicide prevention is everyone's business.

A handwritten signature in black ink, appearing to read 'Edwin Poots', written in a cursive style.

**EDWIN POOTS MLA**

Minister for Health, Social Services and Public Safety

## KEY TERMS

Mental Health & Emotional Wellbeing Promotion	An approach characterised by a positive view of mental health, which aims to engage with people and empower them to improve their health, rather than emphasising illness or deficits.
Deliberate Self-Harm	An act of self-poisoning or self-injury irrespective of the purpose of the act.
Suicidal Behaviour	A general term to describe thoughts and acts of self-harm.
Suicide	The act of deliberately ending one's own life
Suicide Prevention	Identifying and reducing the impact of risk factors associated with suicidal behaviour, and identifying and promoting factors that protect against engaging in suicidal behaviour.
Suicide Rate	The number of suicides per 100,000 people in the population. Using the suicide rate rather than the actual number of suicides allows comparisons to be made between different geographical areas and groups within the population.
Suicide Risk	The risk of suicide in the near future, sometimes the terms refers to a person's life in general, i.e. on a lifetime basis.



## CHAPTER 1 - OVERVIEW

### BACKGROUND

1.1 Northern Ireland has witnessed significant increases in suicide rates in recent years with almost a doubling in the number of deaths recorded as suicide since the late 1990s. (Trends in suicide and self-harm in Northern Ireland over recent years are outlined in Appendix 1 and Appendix 2). In response to this increase, the “*Protect Life*” Northern Ireland Suicide Prevention Strategy was published by DHSSPS in October 2006.

1.2 The total annual investment by the Department in the implementation of “*Protect Life*” in recent years has been £6.7 million, of which £2.2 million is invested to support communities in developing local suicide prevention initiatives. Most community groups involved in suicide prevention also attract funds from other sources, including fund raising events, which they direct towards prevention initiatives and services. In addition, statutory and voluntary mental health services contribute towards the drive against suicide and self harm.

1.3 “*Protect Life*” contained over 60 actions and its implementation has included;

- Community led suicide prevention and bereavement support services.
- Local research into suicide.
- GP Depression Awareness Training.
- Enhanced crisis intervention services.
- All-island public information campaigns.
- Lifeline 24/7 Crisis Referral Helpline.
- Establishment of the Deliberate Self Harm Registry.
- Development of local suicide cluster emergency response plans.

1.4 “*Protect Life*” was designed with a five year lifespan from 2006 to 2011. In 2010, the Northern Ireland Suicide Strategy Implementation Body proposed that *Protect Life* be refreshed and extended for two further years in order to maintain momentum in addressing suicide prevention. This proposal was accepted by the Department and this “refresh” extends the Strategy’s lifespan to the end of the 2013/14 financial year. Independent overall evaluation of the Strategy is being taken forward during 2012. The evaluation findings will help inform the development of the new suicide prevention policy from 2014 onwards.

## REFRESH METHODOLOGY

1.5 A number of pieces of work were undertaken to help inform the refresh of “*Protect Life*”; these were:

- An international review of evidence and best practice on suicide prevention.
- Updated statistical analysis (See Appendices 1 & 2).
- Formal engagement with community/voluntary sector stakeholders and families bereaved by suicide.
- A review of the strategic action plan progress to date.
- A re-examination and identification of the main risk factors for suicide.

1.6 The findings and learning from these pieces of work, together with the evaluation of individual components parts of the strategy, have informed the revision of the Strategy’s Action Plan, which now includes evidence and priority ratings for each action.

## POLICY CONTEXT

1.7 The policy context has changed significantly since “*Protect Life*” was published in 2006. The Review of Public Administration (RPA) led to the establishment of new Health and Social Care structures including the Health and Social Care Board, five Health and Social Care Trusts, and the Public Health Agency. Since implementation of RPA, the Department’s role is to exercise strategic direction over the Health and Social Care system by way of policy, legislation, strategy, standards and guidelines governing the services that are to be delivered. The Department is also responsible for allocating resources to its Arms Length Bodies (ALBs), which ensures commissioning of relevant programmes; monitoring and holding to account.

1.8 The principal service objectives for ALBs are detailed annually in the Health and Social Care Commissioning Plan Direction. In relation to suicide and self harm prevention, the Department therefore sets the direction of suicide prevention policy and overarching strategy (as in “*Protect Life*”), and holds its ALBs to account for providing/ commissioning effective suicide and self-harm prevention services in line with the Strategy.

1.9 Other major policy developments have included the Bamford Review, new policy on drugs and alcohol, and policy development on mental health and wellbeing.

## BAMFORD

1.10 The Bamford Review was an independent assessment of mental health and learning disability which led to the publication of a report in 2007 containing recommendations on: prevention of mental ill-health; mental health legislation; a shift to community-based services; development of specialist services; and workforce training. The Bamford Action Plan 2009 – 2011 was designed to implement these recommendations and significant progress has been made on a number of actions that have a direct bearing on suicide and self harm prevention. These include:

- Improving access to psychological therapies.
- Making a cognitive behavioural therapy programme available through GP surgeries.
- Improving referral for people with mental health needs who present at A&E departments.
- Improving crisis intervention services.

A follow on 2012-2015 Bamford Action Plan is being developed for publication in 2012.

## DRUGS AND ALCOHOL

1.11 The link between alcohol and deliberate self harm/suicide attempts is now well established. Research indicates that one in three adolescents was intoxicated at the time of their suicide attempt<sup>1</sup> and that heavy drinkers<sup>2</sup> are at particularly high risk of suicide. Studies<sup>3</sup> suggest that more 'explosive' drinking patterns and cultures (e.g. irregular, heavy drinking occasions) are linked to a higher incidence of suicide. This is particularly concerning for Northern Ireland where there is a well established pattern of binge drinking amongst younger adults.

1.12 DHSSPS led the development of a cross-sectoral strategy, *New Strategic Direction for Alcohol and Drugs* (NSD), to reduce the harm related to both alcohol and drug misuse in Northern Ireland. The revised NSD was launched in January 2012. Some progress has been made in this area: the proportion of men in Northern Ireland who drink over the recommended weekly limit has fallen from 33% in 2002/3 to 27% in 2010/11; the proportion of adult drinkers who binge drink has fallen from 38% in 2005 to 32% in 2008 and to 30% in 2011; and the proportion of young people (aged 11-16) who reported getting drunk in 2010 was 23% against a baseline of 33% in 2003.

1 David A. Brent M.D. et al, 1986. Psychopathology and its relationship to suicidal ideation in Childhood and Adolescence.

2 Rossow 2000.

3 T Norstrom, 1988. Alcohol and Suicide in Scandinavia.

G Gmal, J Rehm, and A Ghazinouri. 1998. Alcohol and Suicide in Switzerland: an aggregate-level analysis.

M Ramstedt. 2001. Alcohol and suicide in 14 European Countries.

- 1.13 DSD and DHSSPS have also been working together on liquor licensing and related issues, and DHSSPS supported DSD in bringing regulations that could be used to ban irresponsible promotions. The two Departments have also issued a joint consultation on the principle of introducing a minimum unit price for alcohol in Northern Ireland in March 2011.
- 1.14 It is recognised in NSD that as many 40,000 children in Northern Ireland may be living in a family where there is an alcohol/drug problem is a major issue and this could be damaging their mental wellbeing. This issue is often referred to as “hidden harm” on the grounds that these young people may not be known to services and often do not know where to turn for help. To support and address the needs of these children, DHSSPS launched a Regional Hidden Harm Action Plan in 2008.
- 1.15 In tackling so called “legal highs”, legislation has now been passed in Westminster that will allow emerging substances to be placed under a temporary ban while a full consideration is given to their harm. At a local level, DHSSPS have established an early warning system, known as the drug and alcohol monitoring and information system, which will allow to more quickly identify new substances as they emerge in Northern Ireland and react appropriately.

## STRATEGIC FRAMEWORK FOR PUBLIC HEALTH

- 1.16 A new strategic framework is being developed to replace the Investing for Health Strategy and will provide overarching policy for action on improving public health and reducing health inequalities. In doing so, it will set the strategic direction for addressing many of the wider social and environmental factors that influence suicide rates in our communities. Central to the new strategy framework is a focus on the most disadvantaged in society, in particular the most disadvantaged neighbourhoods and population groups, with an emphasis on community involvement in both the design and delivery of programmes based on local need.

## MENTAL HEALTH PROMOTION

- 1.17 A new Mental Health and Wellbeing Promotion Strategy is being developed to define the aim, objectives and priority actions for the promotion of mental health and wellbeing in Northern Ireland during 2012 to 2017. It will focus on building the mental and emotional resilience of the whole population and of specific “raised risk” groups so that people can improve their ability to adapt and recover from adverse circumstances or events. There will be close links between the new strategy and “Protect Life” given the potential for mental health improvement to impact on reducing the incidence of suicide in the long term.

1.18 Other significant policy developments since 2006 that have the potential to impact on suicide and self-harm prevention are outlined below.

Policy/Strategy	Overview
<b><i>Tackling Sexual Violence and Abuse 2008-2013 (DHSSPS)</i></b>	Sets out how government intends to tackle sexual violence and abuse through: prevention; protection and support for victims/survivors and their families.
<b><i>Sport Matters: the NI Strategy for Sport and Physical Recreation 2009-2019 (DCAL)</i></b>	Acknowledges the role of sport and exercise in helping to combat stress. The Strategy contains proposals for improving health, including promoting positive mental health.
<b><i>Draft Early Years Strategy (DE)</i></b>	Evidence shows that a focus on intervention in the early years is where the greatest gains can be made in terms of securing lifelong positive mental wellbeing and strong emotional resilience. Investment in early years also brings significant benefits later in life across other areas such as education, employment, reduced violence and crime.
<b><i>Healthy Child, Healthy Future: A framework for the Universal promotion Programme in Northern Ireland, 2010. (DHSSPS)</i></b>	An updated health programme for 0-19 year olds, <i>Healthy Futures</i> offers access to a universal core programme of preventative care with additional or targeted services for those identified with specific needs and risks.
<b><i>Healthy Futures 2010 – 2015, The Contribution of Health Visitors and School Nurses in Northern Ireland’.</i></b> (DHSSPS)	Recognises that Health Visitors have a crucial role in the promotion of infant mental health and recommends a service focus on early intervention, mental health promotion to encourage positive relationships, and integrated working on infant mental health between health visiting and providers such as Sure Start. <b>There is a substantial bank of evidence to indicate that strong infant/parent attachment protects against the risk of self harm &amp; suicide in later life.</b>
<b><i>Draft Sexual Orientation Equality Strategy and Action Plan (OFMDFM)</i></b>	Highlights the difficulties and challenges LGBT people experience in accessing services and the impact this can have on both their physical and mental health.

Policy/Strategy	Overview
<b>Older Peoples Strategy – “Ageing in an Inclusive Society”, 2005 (OFMDFM)</b>	Aims to tackle issues of financial and social exclusion, to deliver services which will improve the health and quality of life for older people, and ensure that they live safe and secure in their own homes and communities.
<b>“Our Children and Young People – Our pledge”. Ten year strategy for Children and Young People in Northern Ireland, 2006-2016. (OFMDFM)</b>	Seeks to deliver improved outcomes (including health outcomes) for all children and young people. It aims to narrow the gap in outcomes between those who do best and those who do worst by ensuring more targeted provision.
<b>Rural Anti-Poverty/Social Inclusion Framework 2008-2011 (DARD)</b>	Acknowledges the link between poverty, exclusion and mental health. Identifies mental health issues associated with the rural environment.
<b>Government Anti Poverty and Social Inclusion Strategy for Northern Ireland – Lifetime Opportunities 2006 -2020 (OFMDFM)</b>	A strategy which sets out how the Northern Ireland Executive proposes to tackle poverty, social exclusion and patterns of deprivation based on objective need in Northern Ireland.
<b>Housing and Health – Towards a Shared Agenda 2001, reviewed in 2006 (NI Housing Executive)</b>	Acknowledges clear links between poor living/housing conditions and poor mental health. Makes recommendations to create healthier living environments and to support healthy lifestyles.

## ENVIRONMENTAL CONTEXT

- 1.19 The primary change in the environmental context since 2006 has been the economic downturn, and associated rise in unemployment. This is of considerable concern as studies indicate that unemployed people are at 2-3 times more at risk of suicide<sup>4</sup>. International research also indicates that a 1% increase in unemployment is met with a corresponding 0.79%<sup>5</sup> increase in suicide.
- 1.20 Recent research in the Republic of Ireland highlighted the correlation between high levels of suicide and unemployment, and it suggested that there was a higher rise in women than in men<sup>6</sup>. Further analysis also highlighted that job insecurity was associated with a 33% greater risk of common mental disorder, and that in Hong Kong 24% of all suicides in 2002 concerned people in debt. The Institute of Public Health in Ireland has published research on the impact of the recession and

4 Platt S, Hawton K. Suicidal Behaviour and the Labour Market. In: Hawton K, Van Heeringen K, eds. The International Handbook of Suicide and Attempted Suicide. New York: Wiley, 2000: 310-84.

5 David Stuckler et al, July 2009. The Public health effect of economic crises and alternative policy responses in Europe: an empirical analysis.

6 Paul Corcoran and Ella Arensman, December 2009. Suicide and employment status during Ireland's Celtic Tiger economy. M Ramstedt. 2001. Alcohol and suicide in 14 European Countries.

unemployment on men's health which found that there were strong links between unemployment/economic downturn and mental ill health, especially in men<sup>7</sup>.

- 1.21 An important recent policy development in relation to the recession and its impact on mental wellbeing is the development of a strategy for those young people "Not in Education, Employment or Training" (NEETS) with the aim of reducing the number in this group and improve their opportunities to more out of poverty. The Department of Employment and Learning is leading cross-departmental work on the strategic approach to this issue.

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<sup>7</sup> Institute of Public Health. June 2011. Facing the Challenge – The Impact of Recession and Unemployment on Men's Health in Ireland.



## CHAPTER 2 - PROGRESS OF “PROTECT LIFE” TO DATE

### IMPLEMENTATION CONTEXT

- 2.1 The aim of the original “*Protect Life*” strategy was to reduce the overall Northern Ireland suicide rate by 10% by 2008 and by a further 5% by 2011. “*Protect Life*” did not specify a baseline for these reduction targets. The baseline was set later in a public service agreement target for the 2008/11 Programme for Government which sought a 15% reduction by 2011 from a baseline of 12.6 deaths per 100,000 of population annually over the period 2004 to 2006. The achievement of this target would see an average annual death rate of 10.7 per 100,000 of population over the three year period 2010 to 2012.
- 2.2 The latest provisional three-year rolling average death rate is 16.5 (4th quarter 2008 to 3rd quarter 2011). As the target was set on a three year rolling average, it will not be known for sure if it has been achieved until mid 2013 when the figures become available. However, the recent trends suggest that it is highly unlikely the target will be met.
- 2.3 The publication of “*Protect Life*” in 2006 coincided with an unprecedented increase in recorded suicide rates in Northern Ireland during 2005 and 2006, with an almost doubling in the annual recorded number of deaths from the start of the decade. As the 15% reduction target was partially based on much lower numbers of recorded deaths prior to 2005, this had an almost immediate negative impact on the potential for achieving this target. The reasons for the sharp increases in 2005 and 2006 are not fully known. However, it is believed that the introduction, in late 2004, of more robust recording procedures, which provide a more accurate assessment of the actual Northern Ireland suicide rate, may be part of the explanation.
- 2.4 The Strategy has also been implemented against a backdrop of increasing economic hardship, high levels of deprivation, relatively high levels of mental ill-health, and communities coming out of conflict. These circumstances, despite the strenuous suicide prevention efforts highlighted in this chapter, are likely to have militated against the achievement of the reduction target.
- 2.5 The reduction of the Northern Ireland suicide rate remains our goal. However, given the wide range of broader social, economic and environmental factors that have an influence on suicide, it is important not to rely solely on a suicide reduction target as the only gauge of the impact of “*Protect Life*”. This was noted in the October 2008 NIAO report on the Performance of the Health Service in Northern Ireland which acknowledged that the suicide rate is “*an unreliable indicator of health patterns*” and that “*relative impact of the Strategy on suicide is important for planning but is difficult to estimate*”. Therefore, as part of the strategy refresh, a new aim and a number of new objectives have been developed to help provide a better assessment of the wider impact of our efforts to address suicide and self harm.

## INITIATIVES PROGRESSED UNDER PROTECT LIFE

- 2.6 The remainder of this chapter provides an overview of the main initiatives and programmes taken forward under “*Protect Life*” to-date. Progress against individual Protect Life actions is set out in the revised Action Plan.

Figure 1: Overview of programmes implemented under Protect Life

Initiative / Programme	Detail	Progress
<p><b>Public information campaigns</b></p>	<p>Major multi-media campaigns designed to de-stigmatise mental health, and promote awareness of issues relating to suicide and self-harm have been delivered by the Public Health Agency and former Health Promotion Agency.</p> <p>See <a href="http://www.mindingyourhead.info">www.mindingyourhead.info</a></p>	<p>First phase March 2007 to March 2008 branded as “it’s Me” and “Share It”, focused on promoting, protecting and enhancing mental wellbeing and the prevention of suicide and self-harm.</p> <p>Second phase June 2008 to January 2012 branded as “The Mask”, and “Lifeline” awareness running from May 2008 supported the Lifeline crisis response helpline.</p> <p>Third phase October 2011 and ongoing branded as “Under the Surface”. Focuses on raising awareness of the early warning signs of mental health problems and to encourage help seeking behaviour.</p>
<p><b>Lifeline service 0808 808 8000</b></p>	<p>A pilot suicide prevention telephone helpline targeted at young people was established in North and West Belfast area in 2006. The helpline received an average of 100 calls per day, approximately 50% of which were received from outside North and West Belfast. Given the demand for this service the regional “Lifeline” 24/7 crisis response telephone helpline with “wraparound” support was established in early 2008.</p>	<p>Lifeline receives an average of 1800 calls per week and makes approximately 400 referrals to associated wraparound support services each month.</p> <p>A total of 324,779 calls made to Lifeline February 2008 to January 2012 (inclusive).</p> <p>73,239 “wraparound” support sessions attended by 13,271 face-to-face clients Feb 2008-January 2012 (inclusive). 20,456 Lifeline referrals received Feb 2008-Jan 2012.</p>

<b>Initiative / Programme</b>	<b>Detail</b>	<b>Progress</b>
<p><b>Lifeline service</b> <b>0808 808 8000 Cont'd</b></p>	<p>In addition to immediate access to comprehensive clinical assessment by a professionally qualified counsellor via the crisis telephone helpline, the Lifeline service provides callers with follow on counseling/support services.</p> <p>Lifeline is delivered from two regional hubs located in Derry/Londonderry and Belfast.</p>	<p>Contract re-tendered in 2011, new contract awarded for 4 year period (renewable annually) to Contact NI.</p> <p>Ongoing project management and monitoring of the service by PHA.</p>
<p><b>Training</b></p>	<p>Training in suicide awareness and mental health awareness for a range of health and social care professionals, and community “gatekeepers” (teachers, youth workers, clergy, trade union officials, taxi drivers, hairdressers, community workers, sports coaches, etc) is a recognized intervention for preventing suicide.</p> <p>Evidence based training programmes include Applied Suicide Intervention Skills Training (ASIST) and Mental Health First Aid Training (MHFA) and Safe Talk.</p> <p>PHA has developed and implemented a training action plan in support of “Protect Life”. This is currently being refreshed for 2012/13 and includes a timeframe for the delivery of ASIST and MHFA, and arrangements for the co-ordination, monitoring, and quality assurance of training.</p>	<p>GP depression awareness training was rolled out across NI, between February 2007 and March 2008. Coverage reached 81% of GP practices.</p> <p>GP focused suicide and depression awareness training continues to be provided on a regular basis. Work is ongoing to support the mainstreaming of depression awareness training into existing professional training &amp; development.</p> <p>July 2009 – present: 166 MHFA courses were delivered in NI and 4513 MHFA course materials were distributed. 4513 people have attended a MHFA training course to date in NI.</p> <p>Since 2004, ASIST training has been delivered to approximately 31,000 people throughout the island of Ireland (20,000 in the Rol and 11,000 in the North of Ireland).</p>

Initiative / Programme	Detail	Progress
<p><b>Deliberate Self Harm (DSH) response</b></p>	<p>DSH is a common reason for general hospital presentation and is the most important risk factor for future suicide, particularly among males<sup>8</sup>.</p> <p>Two DSH projects are supported under <i>Protect Life</i>.</p> <p><b>DSH REGISTRY</b> – which collates data on the incidence and nature of self-harm behaviour in order to inform the future delivery of services in this field. It is linked with the national Registry of Deliberate Self Harm in the Republic of Ireland. The findings from the Western Area pilot report are available at:</p> <p><b><a href="http://www.dhsspsni.gov.uk/2_YEAR_REPORT.PDF">HTTP://WWW.DHSSPSNI.GOV.UK/2_YEAR_REPORT.PDF</a></b></p> <p><b>DSH Mentoring pilot</b> – which provides mentoring and counselling, via local community groups specialising in this field, to people who present at A&amp;E units as a result of self harm. Now renamed the SHINE (Self-harm Interagency Network) service.</p>	<p>Operational at 3 A&amp;E sites in the Western Trust Area since 2007. Two annual reports have been produced and details of some 2,692 presentations have been recorded.</p> <p>Following evaluation of the Western Area project, the Registry has been extended to the Belfast Health and Social Care Trust area and is being rolled out to A&amp;E sites across Northern Ireland.</p> <p>The SHINE project has received 950 referrals of which 783 (83%) have taken up the option of counselling with the Zest self-harm organisation.</p>

8 Professor Keith Hawton, foreword. Northern Ireland Registry of Deliberate Self-Harm (Western Area), Two Year Report: 1 January 2007 - 31 December 2008.

Initiative / Programme	Detail	Progress
<p><b>Mental Health Services</b></p>	<p>Around 30% of people who have died by suicide in Northern Ireland over the past decade have been clients of mental health services within the 12 months prior to their deaths. Clearly, mental health services have a pivotal role in suicide prevention. Developments since 2006 include:</p> <ul style="list-style-type: none"> <li>- A set of principles to underpin the delivery of services to those at risk of self-harm or suicide who attend GPs, Out-of-Hours doctors and A &amp; E Departments has been disseminated by DHSSPS.</li> <li>- Additional investment in community services including Crisis Response and Home Treatment teams, and in Child &amp; Adolescent Mental Health Services (CAMHS) crisis intervention teams.</li> <li>- Draft CAMHS Policy Guidance developed and issued for consultation. Includes a proposed service model for CAMH services.</li> <li>- Psychological therapies (talking therapies) are used in a range of settings as early intervention, treatment, care and support.</li> </ul>	<p>Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services - First issued September 2009 and revised in May 2010.</p> <p>£6.16m allocated since 2007/08 in community services &amp; £1m per annum from 2007/08 in CAMHS. New purpose built CAMHS facility in Beechcroft opened during 2010/11 increasing the total number of beds from 28 to 33.</p>

Initiative / Programme	Detail	Progress
<p><b>Mental Health Services Cont'd</b></p>	<p>- A "Card Before You Leave" protocol is in operation in all A&amp;E departments. This scheme offers those patients presenting to A&amp;E as a result of self harm, and who are assessed as not in need of immediate detailed mental health assessment, an appointment for assessment the next day.</p>	<p>Psychological Therapies Strategy was published June 2010 &amp; additional funding made available to enhance related service development.</p> <p>To be evaluated during 2012.</p>
<p><b>Community-led services &amp; bereaved families</b></p>	<p>Support for local communities to develop and deliver suicide prevention initiatives and services such as bereavement support, counselling, awareness and intervention training, awareness raising, and complementary therapies.</p>	<p>£3.2 million funding per annum to support community implementation of "Protect Life".</p> <p>On average 80 groups supported annually. The community support programme is being evaluated by PHA.</p>
<p><b>Community Emergency Response Plans</b></p>	<p>Suicide is known to be contagious; a single death can trigger suicide attempts amongst those with a connection to the deceased. Where this happens, the term "suicide clustering" is sometimes used. It is important to identify linked suicides early and to activate a planned and co-ordinated response to prevent further deaths. Depending on the circumstances, this response needs to involve a wide range of organizations such as local community groups and primary care, local clergy, youth services, schools, social services, mental health services, PSNI, and the local council.</p>	<p>Community emergency response plans have been developed for a number of areas. From April 2012 Plans are to be in place for all areas. This work is being led by PHA.</p>

<b>Initiative / Programme</b>	<b>Detail</b>	<b>Progress</b>
<p><b>Pupils' Emotional Health and Wellbeing</b></p>	<p>Schools and other places of education are key settings for the development of emotional resilience in children and young people – a key protective factor against suicide.</p> <p>Counselling support which is independent of the schools is accessible to all pupils of post primary age.</p>	<p>The Revised NI Curriculum, which incorporates a personal development strand, has been in place in all schools from the 2009/10 school year.</p> <p>Department of Education in partnership with DHSSPS, PHA and other statutory and voluntary sector is developing a 'Pupils' Emotional Health and Wellbeing Programme' (now known as PEHAW). Elements of the programme are already in place with further strands to be launched throughout 2012.</p> <p>Since January 2007, all pupils in post primary schools have had access to independent counselling support which is independent. This service was extended to pupils of post primary age in special needs schools from January 2011.</p>
<p><b>Media reporting</b></p>	<p>The media has an important role in suicide prevention, both in terms of awareness raising and sensitive reporting of suicides.</p>	<p>Updated media guidelines issued in October 2009 which include advice on the new communication technologies.</p> <p>PHA launched a new media monitoring service, in conjunction with the Samaritans, in October 2010. The service identifies insensitive reporting and brings to the attention of the relevant media source.</p>

<b>Initiative / Programme</b>	<b>Detail</b>	<b>Progress</b>
<p><b>The Internet and suicide</b></p>	<p>The internet is an extremely valuable resource for the provision of information and advice on suicide prevention, and for the promotion of positive mental health and wellbeing. Unfortunately, some websites promote &amp; encourage harmful actions including cyber bullying, eating disorder, self-harm, and suicide.</p>	<p>Updated Home Office guidance “Good Practice for the Providers of Social Networking and Other User Interactive Services” issued in 2007.</p> <p>UK Council on Child Internet Safety, established following the publication of the Byron Report in 2008. DHSSPS is represented on the Council.</p> <p>The NI Anti-Bullying Forum (NIABF) has produced ‘What is Cyber Bullying – A Leaflet for Parents and Carers’ – this on the Department of Education’s website.</p>
<p><b>Local research</b></p>	<p>Service Provision Mapping - North and West Belfast. Research into the provision/ activities of mental health and emotional wellbeing.</p> <p>Churches Research Programme. An exploration of the problems and barriers faced by clergy in the delivery of pastoral care to families bereaved by suicide.</p> <p>Northern Ireland Lifestyle and Coping Survey. A study investigating the prevalence of adolescent self-harm in Northern Ireland and the associated factors.</p> <p>National Confidential Inquiry Longitudinal Study into Suicide and Self Homicide by People with Mental Illness in Northern Ireland</p>	<p>Published February 2009</p> <p>Published March 2009</p> <p>Published October 2010</p> <p>Published June 2011</p>

Initiative / Programme	Detail	Progress
<p><b>Local research Con'd</b></p>	<p>'Facing the Challenge – The Impact of Recession and Unemployment on Men's Health'  <b>Author: The Institute of Public Health (IPH)</b></p> <p>Mapping mental health services in the West Belfast area. Research to inform the development of new referral pathways between primary/secondary care and community/ voluntary sector.</p> <p>Providing Meaningful Care - exploring experiences of suicidal young men.  <b>Author: MOORE STEPHENS</b></p> <p>Breaking the Silence in Rural Areas – 'Rural mental health, stigma, services and supports within the SWARD Region'  <b>Author: JASON DONAGHY CONSULTING HOLYWELL CONSULTANCY LTD</b></p> <p>Suicide in Northern Ireland: A Comparison of Service Use and Needs in Urban and Rural Settings.  <b>Author: PROF. GERARD LEAVEY, (NI Association of Mental Health).</b></p>	<p>Published in June 2011</p> <p>Published October 2011</p> <p>Published December 2011</p> <p>Published in January 2012</p> <p>Findings from 1st stage of study to be published 2012. Due to be completed in January 2013</p>

Initiative / Programme	Detail	Progress
<p><b>Local research Con'd</b></p>	<p>Geodemographic factors associated with deliberate self harm and death by suicide: a within and between neighbourhoods analysis.  <b>Author: PROF. BRENDAN BUNTING (University of Ulster).</b></p> <p>The Trouble with Suicide – Mental Health, Suicide and the Northern Ireland Conflict.  <b>Author: MIKE TOMLINSON (Queen’s University Belfast)</b></p> <p>Trauma, Health and Conflict in Northern Ireland                      – A study of the epidemiology of trauma related disorders and qualitative investigation of the impact of trauma on the individual.  <b>Author: Northern Ireland Centre for Trauma and Transformation and the Psychology Research Institute, University of Ulster.</b></p>	<p>Due to be published 2012 with peer review in 2013</p> <p>Published June 2007</p> <p>Published October 2008</p>

Initiative / Programme	Detail	Progress
<p><b>Co-operation and sharing of best practice</b></p>	<p>As part of this co-operation, an All-Island Action Plan on suicide prevention has been developed between the Department of Health, Social Services and Public Safety, the Department of Health and Children and the National Office of Suicide Prevention in the South. The plan contains a rolling programme of actions which are reviewed and updated at the North South Ministerial Council; current actions include media monitoring, training, self-harm, and public awareness campaigns.</p> <p>Many of the issues faced in Northern Ireland are also challenges for colleagues in England, Wales, Scotland, and the Republic of Ireland. A Five Nations joint working forum facilitates the sharing of best practice between the nations and enhance co-operation on mutually beneficial areas of work.</p> <p>At a local level, the NI Executive has agreed that all government departments should play a pro-active role in determining actions in support of suicide prevention. A Ministerial Co-ordination group has also been established to further enhance cross-departmental co-operation, and to monitor progress on relevant issues.</p>	<p>Ongoing</p>

## CHAPTER 3 - LEARNING

- 3.1 This refresh of “*Protect Life*” has drawn on learning from a number of sources including: an extensive review of evidence of best practice worldwide<sup>9</sup>; evaluation of component parts of the strategy; experience from strategy implementation to date; feedback from a formal process of engagement with community groups; the findings from local research; response to the Health Committee’s 2008 Inquiry into Suicide and Self-harm, and statistical analysis of suicide trends and patterns in Northern Ireland. This chapter summarises the learning from these sources (the detail is set out in **Appendix 3**).
- 3.2 The recurring themes are: training for frontline service providers and community “gatekeepers”; an enhanced focus on addressing deliberate self harm; the influence of alcohol; further addressing access to lethal means of suicide; continuation of campaigns to highlight suicide awareness and reduce stigma associated with mental ill-health; improved referral with HSC and between statutory and voluntary services; better integration of service delivery; better follow up with discharged mental health patients; use of social networking and IT communications to reach younger people; specific rural initiatives; greater focus on males from deprived areas; and an enhanced focus on the needs of older people.
- 3.3 These findings/themes have helped inform the refresh of “*Protect Life*”. Indeed, a number of the issues highlighted in **Figure 2 below** and detailed at **Appendix 3** are already being addressed through specific actions in the “*Protect Life*” *Action Plan*. Where there has been limited progress on the major issues identified above, new actions have been developed for the refreshed “*Protect Life*” *Action Plan*. Not all of the findings from the learning can be actioned under the refreshed strategy as some of the issues will require a longer timeframe to develop new actions. Where the latter is the case, these matters will be considered during the development of the next phase of suicide prevention policy.
- 3.4 The key learning highlighted above has also contributed to the development of new objectives and performance indicators at Chapter 4.

Figure 2: Key Learning

Source of learning	Key findings & recommendations
<p>National Suicide Research Foundation: Review of the Evidence Base</p>	<p>Explore possible further restriction of access to means and methods of suicide, particularly at bridges and reduction of painkiller pack size and outlets where it can be obtained.</p> <p>Develop clinical guidelines for all HSC staff on dealing with people who are at risk of suicide/self harm; implement NICE guidelines for the assessment and aftercare of self harm patients.</p> <p>Deliver services (including psychological treatments and talking therapies) geared at the reduction of repeat self harm.</p> <p>Continue with public information campaigns to destigmatise mental health and promote awareness of suicide and self harm.</p> <p>Inclusion of positive mental health promotion and coping skills in the school curriculum.</p> <p>Suicide awareness/positive mental health training for community “gatekeepers” and those working with survivors of abuse.</p> <p>Suicide proofing of the custody environment and follow-up support for people recently released from custody.</p> <p>Provision of appropriate support services for marginalised and disadvantaged groups.</p> <p>An enhanced focus on older adults including early interventions, such as CBT, to treat depression.</p>

<b>Source of learning</b>	<b>Key findings &amp; recommendations</b>
<p>Evaluation of component parts of “Protect Life”</p>	<p>Target suicide awareness/prevention training at those most likely to come into contact with people at risk of suicide and continue to offer suicide awareness training to primary care professionals.</p> <p>Sustain/reinforce campaigns to reduce stigma associated with mental ill-health.</p> <p>Improve health professionals’ knowledge of the wider range of Lifeline services.</p> <p>Improve monitoring and evaluation of the “Community Support Package”.</p> <p>Need for longitudinal research to identify the impact of suicide prevention services on clients.</p> <p>Continued need for crisis intervention, but with additional focus on promoting long term mental health of targeted groups.</p>
<p>Experience of implementation of “Protect Life”</p>	<p>Peaks in hospital attendance as a result of deliberate self harm (DSH) around 1am and at weekends linked with alcohol consumption. Most Lifeline crisis calls are also received at weekends and/or late at night.</p> <p>Review the support needs of repeat self-harmers. Intervention such as follow up counselling for patients treated at A&amp;E Departments for DSH reduces the incidence of repeat self harming.</p> <p>Need to reduce stigma around mental health issues &amp; encourage a help-seeking culture amongst males.</p> <p>Relevant training is a priority for all frontline staff.</p> <p>Need for enhanced working relationships between A&amp;E departments and mental health services.</p> <p>Consider the need for “places of safety” for people in severe emotional distress.</p>

Source of learning	Key findings & recommendations
<p>Community feedback process</p>	<p>Encourage closer co-operation within community and voluntary sectors, particularly in sharing information/best practice.</p> <p>Develop sector standards for community-led services and carry out a cross-sectoral review of delivery structures.</p> <p>Improve service interfaces and handovers between providers.</p> <p>Lack of longer term recurrent funding impedes community providers.</p> <p>Consideration should be given to greater use of social media, particularly as part of outreach.</p> <p>Maintain “sensitive” public information campaigns.</p>
<p>Local research</p>	<p>Main difference between suicide rates in NI and other UK countries is in young people and the fact they were also more likely to be living in the poorest areas. Indicates a need to maintain a focus on the prevention of suicide/emotional resilience building amongst young men from deprived areas.</p> <p>Around 30% of suicides are by people who have been in contact with mental health services. Immediate post discharge is a high risk period. Risk assessment of, and contact with, patients who have been discharged needs to be improved. There is a need to continue to address stigma associated with mental illness.</p> <p>Need greater focus on addressing self harming, including promotion of awareness of sources of help.</p> <p>Secondary schools within more deprived catchment areas should be prioritised for support with self harm prevention.</p>

Source of learning	Key findings & recommendations
<p>Local research Cont'd</p>	<p>Suicidal young men tend to have unrealistic views of what it was to be a 'successful' man; this contributes to low self-esteem, and personal stress.</p> <p>Need to build stronger emotional resilience and coping skills amongst young men and to provide proactive 'outreach' prevention services that are responsive to their needs.</p> <p>Social networking technologies used by young people should be utilized to improve contact with vulnerable people in this age group.</p> <p>Longer-term support, once the initial risk of suicide has been removed, is necessary.</p> <p>Strong links between unemployment/ economic downturn and mental ill health, especially in men.</p> <p>Post Traumatic Stress Disorder, much of it a legacy of the conflict, is a specific and significant health need among Northern Ireland's adult population.</p> <p>The term "mental health" is associated with mental illness in rural areas and is seen as a lifelong condition with associated negative stereotyping and stigma.</p> <p>The rural culture of self-reliance and stoicism works against help seeking.</p> <p>Regional media campaigns are seen to be rurally insensitive.</p> <p>More localised and strategic collaboration needs assessment and joint planning is required.</p> <p>Initiatives needed that communicate effectively about positive health and self-esteem in relation to male unemployment.</p> <p>Clergy feel that churches should be involved in tackling suicide but generally lack any training in this area.</p>

Source of learning	Key findings & recommendations
<p>Analysis of suicide trends</p>	<p>Males account for over three quarters of suicides in Northern Ireland.</p> <p>Urban areas have a higher average suicide rate than rural areas &amp; the suicide rate in the most deprived areas is almost three times that in non- deprived areas.</p> <p>36.8% of all suicides involved persons between the ages of 15 to 34, and 24% of suicides were in the 35 to 44, age bracket. The average age for all deaths by suicide was 41 years of age.</p> <p>Between 2005 and 2009, 30.7% of all deaths occurring in the 25 to 34 years age bracket were attributable to suicide.</p> <p>Three quarters of all self-harm admissions are for persons aged under 45. The highest average admission rates for self harm are within the 15-24 years age group.</p>
<p>Health Committee Inquiry Report</p>	<p>Expand range of “at risk” groups to include rural dwellers and older people.</p> <p>District councils and sporting bodies have potential to make a significant contribution to suicide prevention.</p> <p>Enhanced focus on tackling deliberate self-harm.</p> <p>Increased collaboration with the media to ensure more sensitive reporting.</p> <p>Greater committee to suicide prevention by all Government Departments.</p>

Key findings & recommendations		
Source of learning	Risk factors	Protective factors
<p>Suicide risk and protective factors</p>	<ul style="list-style-type: none"> <li>- Alcohol &amp; drug misuse, the relationship being particularly strong for suicide rates in young people</li> <li>- Existing mental illness such as depression</li> <li>- Undiagnosed and untreated mental health problems</li> <li>- History of previous self harming behaviour</li> <li>- Unemployment</li> <li>- Inappropriate media reporting of suicide</li> <li>- Sexuality issues</li> <li>- Being within the criminal justice system</li> <li>- Experience of traumatic life event(s) such as abuse</li> <li>- Absence of strong parental attachment in infancy</li> <li>- Recent separation of young men from partner/children</li> <li>- Long term consequences of sexual abuse in childhood and adolescence.</li> </ul>	<ul style="list-style-type: none"> <li>- Supportive relationships</li> <li>- Secure employment</li> <li>- Social engagement</li> <li>- Educational attainment</li> <li>- Secure emotional attachment in infancy</li> <li>- Effective clinical care for mental, physical and substance disorders</li> <li>- Ready access to a variety of clinical interventions</li> <li>- Support for help seeking</li> <li>- Restricted access to highly lethal means of suicide</li> <li>- Positive, strong infant/parent attachment</li> <li>- Skills in problem solving, conflict resolution and nonviolent handling of disputes</li> <li>- Physical health and activity.</li> </ul>

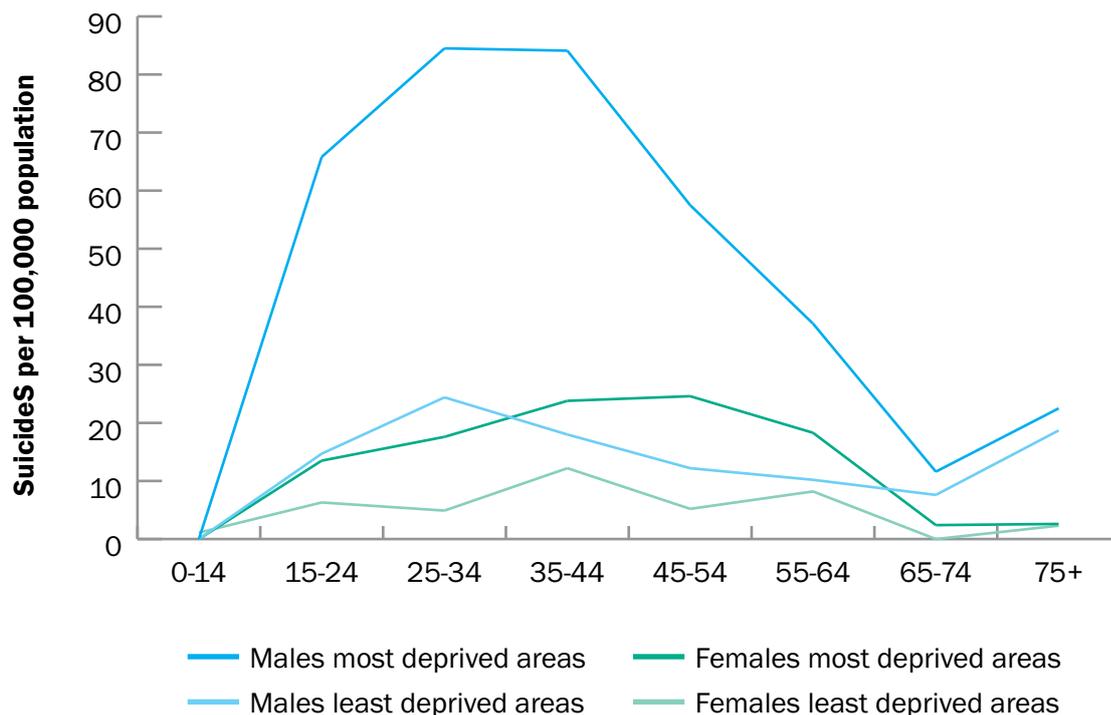
Source of learning	Key findings & recommendations
<p>Childline in Northern Ireland</p>	<ul style="list-style-type: none"> <li>- From 1st April 2010 until 31st March 2011 a total of 22, 464 counselling interactions were carried out. 868 were related to suicide as a primary concern. 430 were female and 128 were male (310 are unknown).</li> <li>- Every day, on average in the UK eight children and young people talk to ChildLine specifically about suicide.</li> <li>- The number of children telling ChildLine that feeling suicidal is their main reason for calling tripled in the five years from 909 in 2003/04 to 2,925 to 2007/08.</li> <li>- The top three additional problems mentioned by children and young people who called ChildLine about feeling suicidal were family relationship problems, depression/mental health and self-harm.</li> <li>- Children and young people told ChildLine that they felt that their concerns were not taken seriously by parents or by health professionals.</li> <li>- Children and young people who call ChildLine about feeling suicidal can be very lonely and often do not believe that there is anyone they can talk to about their problems. For many, ChildLine is literally a lifeline.</li> </ul>

## CHAPTER 4 - AIMS AND OBJECTIVES

### AIM

- 4.1 It was acknowledged in the 2006 “*Protect Life*” Strategy that reducing suicide in Northern Ireland would be a difficult and ongoing challenge. Experience has reinforced this view and confirmed that the health and social care sector alone cannot deliver a sustained reduction in the suicide rate. Given the wider range of social and personal factors that influence suicide, the NI Audit Office, as previously noted in Chapter 2, has advised that the suicide rate is an unreliable indicator of health patterns and that the relative impact of “*Protect Life*” on suicide reduction is difficult to estimate.
- 4.2 Whilst maintaining a long term goal of reducing suicide rates in Northern Ireland, the refreshed strategy therefore sets a new aim which allows for better assessment of the impact of the Strategy, and which is supported by a number of new objectives. Given the learning from the implementation to date, it is also important that the new aim focuses on the issue which has the potential to make the biggest impact in terms of lives saved. With a marked differential in suicide rates between deprived and non-deprived areas, particularly for males in the 15 to 45 age group, (**see Figure 3**) it is considered that reducing this differential has the best potential to save lives. The new aim therefore is “*to reduce the differential in the suicide rate between deprived and non-deprived areas*”.

**Figure 3: Crude suicide rate (2008-10) by age group and gender most deprived and least deprived areas**



caution is advised when analysing or interpreting these figures due to the small numbers involved.

## OBJECTIVES

- 4.3 The refreshed Strategy Action Plan sets out next steps in relation to each action and provides the route map for the delivery of the new aim.
- 4.4 In support of the aim and in light of the learning accrued since 2006, a number of new or revised objectives have been set. These are valid for the relatively short lifespan of the refreshed Strategy and also take account of the objectives set for “*Protect Life*” in 2006. Some of the common themes arising from the various sources of learning are not reflected in the new, revised objectives as it is clear that these issues will take a longer time to be effectively addressed. Therefore, longer term objectives have also been identified to help inform the development of policy for suicide and self harm prevention from 2014 onwards.

### Refreshed *Protect Life* objectives

<b>Objective 1:</b>	<b>Increased awareness of suicide and mental health related issues</b>
Indicators:	New public information campaigns.  Survey results and evaluation of public information campaigns evaluations.
<b>Objective 2:</b>	<b>Improved services for people who are in emotional crisis and those people with pre-existing mental health problems</b>
Indicators:	Assertive outreach in place for patients who miss mental health service appointments.  Availability of “Places of Safety/ Quiet Rooms”.  Level of repeat A&E attendance by individuals in emotional distress.  Level of complaints about services.  Inclusion of these recommendations as actions within the Bamford Action Plan 2012/15.  Implementation of recommendations of the National Confidential Inquiry into Suicide and Homicide by People With Mental Illness in Northern Ireland (2011).

<b>Objective 3:</b>	<b>Enhanced focus on self harm prevention and response services</b>
Indicator:	Implementation of NICE guidance on the longer term management of self-harm.  Availability of support services for people who self-harm.  Uptake of support services.
<b>Objective 4:</b>	<b>Increased uptake of suicide prevention/ mental health awareness training</b>
Indicators:	Number of training sessions provided for community gatekeepers.  Number of frontline health care professionals, including GPs, trained in suicide prevention/mental health awareness.
<b>Objective 5:</b>	<b>Improved awareness amongst healthcare staff of Lifeline crisis response helpline</b>
Indicators:	Lifeline evaluation surveys.  Levels of referrals.
<b>Objective 6:</b>	<b>Enhanced outreach services for males at risk of suicide in deprived areas</b>
Indicators:	Number of targeted outreach programmes.  Level of uptake of support services/programmes.
<b>Longer term objectives</b>	
<b>Objective:</b>	<b>Further restrict access to means of suicide</b>
Possible indicators:	Inclusion of suicide risk assessment as a clause in relevant public sector building tenders.  Deaths by suicide in in-patient facilities.  Audit of the quantities of paracetamol tablets being sold in retail outlets.

<b>Objective:</b>	<b>Improved integration/ coordination within and across sectors</b>
Possible indicators:	<p>Existence of agreed service standards for all sectors.</p> <p>Cross sectoral risk- assessment process developed.</p> <p>Referral pathways established between the statutory, voluntary, and community sectors.</p> <p>Combined community group bids for provision of suicide prevention and bereavement support services.</p>
<b>Objective:</b>	<b>Enhanced focus on the needs of older people</b>
Possible indicators:	<p>Older people represented on the Suicide Strategy Implementation Body.</p> <p>Targeted outreach programmes developed.</p>
<b>Objective:</b>	<b>Enhanced focus on the needs of rural communities</b>
Possible indicators:	Targeted interventions developed including signposting to relevant support services.

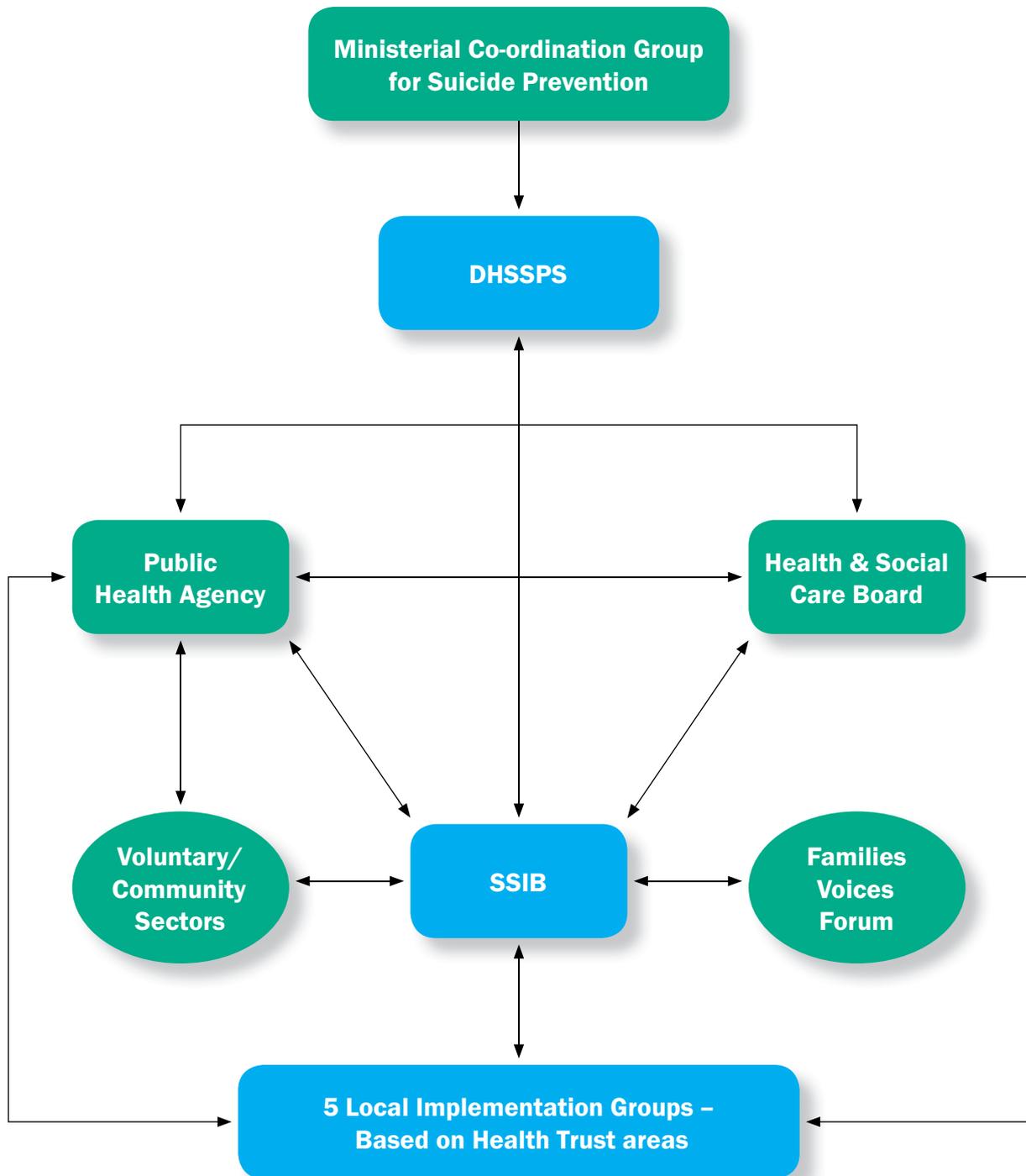
4.5 The overall evaluation of the “*Protect Life*” Strategy, which will be taken forward during 2012, will also help inform the development the next phase of the local suicide prevention policy from 2014 onwards.

## CHAPTER 5 - IMPLEMENTATION

### IMPLEMENTATION ARRANGEMENTS

- 5.1 The implementation of the refreshed “*Protect Life*” will take place within existing implementation arrangements. The Public Health Agency (PHA) will be responsible for the overall co-ordination of implementation. With the support of the HSC Board and Health and Social Care Trusts, the PHA will also work with other relevant statutory bodies and community/voluntary organisations on the development and delivery of innovative suicide prevention initiatives.
- 5.2 The regional cross-sectoral Suicide Strategy Implementation Body (SSIB) will continue to provide an advisory and challenge function, whilst the Families Voices Forum will give families bereaved by suicide a strong voice in the implementation process. Local suicide prevention implementation groups will continue to operate within each Health Trust area to advise on the development of local action plans and ensure these plans take account of local needs. They also oversee the allocation of the suicide prevention funding within local communities.
- 5.3 In terms of cross-departmental working, the Ministerial Co-ordination Group on Suicide Prevention was established in 2006 to ensure that suicide prevention is a priority for all relevant Government Departments, and to enhance cross-departmental co-operation in this area. The Group is chaired by the Health Minister and membership initially included the Minister for Education and the two Junior Ministers. It has since been expanded to include the Ministers for Justice, Culture, Regional Development, Social Development and Employment and Learning.
- 5.4 The NI Executive has also agreed that all government departments should play a pro-active role in determining actions in support of suicide prevention. Consideration will therefore be given to ensuring more regular meetings of the Ministerial Co-ordination Group to drive forward cross-departmental working on the prevention of suicide and self harm.
- 5.5 The model below illustrates the structural arrangements for implementation of the refreshed “*Protect Life*”.

**Figure 4: Refreshed Protect Life implementation structures**



5.6 Implementation also needs to take account of arrangements for the delivery of the new Mental Health and Wellbeing Promoting Strategy later this year and the Bamford Action Plan 2012/2015.

5.7 DHSSPS will however, continue to support the rollout of this Strategy by setting priorities and outcomes in the relevant commissioning plans for the Health and Social Care system, which are revised and updated on an annual basis.

## CO-OPERATION AND SHARING OF BEST PRACTICE

- 5.8 The parallel implementation of “*Protect Life*” and the Republic of Ireland’s Suicide Prevention Strategy, “*Reach Out<sup>8</sup>*”, has been of particular relevance, as this has facilitated mutually beneficial North/ South working on suicide prevention. As part of this co-operation, an All-Island Action Plan on suicide prevention has been developed by the two jurisdictions. This plan contains a rolling programme of actions which are regularly reviewed and updated at the biannual health and food safety sectoral meetings of the North South Ministerial Council. Current actions include media monitoring, training, self-harm, and public awareness campaigns.
- 5.9 Many of the issues faced in Northern Ireland are also challenges for England, Wales, and Scotland. A Five Nations joint working forum (including the Republic of Ireland) facilitates the sharing of best practice between the nations, and enhances co-operation on mutually beneficial areas of work. The learning from the refreshed “*Protect Life*” Strategy will therefore be shared with colleagues in the Five Nations joint working forum.

## INNOVATION

- 5.10 While it is crucial to learn from best practice and take account of existing evidence, it is also important to be innovative when implementing the Strategy, where appropriate and safe to do so. The Suicide Strategy Implementation Body will continue to encourage and to suggest creative solutions, such as the original mentoring and Deliberate Self-Harm Registry pilot projects, for consideration and development by the lead delivery partner.

## RESOURCES

- 5.11 Total annual DHSSPS funding for the implementation of “*Protect Life*” is £6.7m. This is made up of £3.2m for the implementation of “*Protect Life*” actions (including over £2m in community support) and £3.5m for the operation of Lifeline (including its wraparound support services). The funding is allocated and managed by the PHA and HSC Board.

## MONITORING

- 5.12 While the PHA has overall responsibility for the implementation of the “*Protect Life*” strategy, and SSIB provides advice and challenge, the refresh has identified the need for an enhanced focus on the monitoring arrangements for the delivery of the Strategy Action Plan. In view of this, the Department’s Population Health Directorate, which has sponsorship responsibility for the PHA, will provide a monitoring focus on progress in implementation of the refreshed Strategy Action Plan.



## CHAPTER 6 - REVISED ACTION PLAN

### IMPLEMENTATION ARRANGEMENTS

- 6.1 The refreshed “*Protect Life*” Action Plan now includes a “red, amber, green (RAG) status” progress assessment and an overview of progress against each of the original actions. The availability of evidence for action carried forward from the 2006 Action Plan is also provided with priority ratings identified for each of the actions. Where progress on the Action plan is not coded green, there will need to be renewed focus on implementation of the relevant actions. The Action Plan also identifies “next steps” for taking forward each of the actions.
- 6.2 The actions are split between those which address population-wide issues in the wider context of suicide prevention and those which are targeted at sections of society most at risk of suicide and self harm. While the actions have been allocated priority ratings, it is recognised that some actions may require additional unforeseen work to allow for completion of specific tasks. Any proposed revisions to the Action Plan will be undertaken by the PHA and HSC Board/ Trusts, in consultation with the SSIB and the Department.
- 6.3 The new actions (detailed in Section A of the refreshed Action Plan) resulting from the learning to date and reflecting the new objectives are outlined below. These are:
- a) Provide early access to local information to allow for early identification of suicide and self-harm clusters.
  - b) Commission and encourage further local research into the underlying causes of suicide and self-harm.
  - c) Establish robust monitoring and evaluation protocols to allow for enhanced assessment of the effectiveness of the Strategy’s actions, and associated interventions.
  - d) Enhance cross-departmental/sectoral support for the implementation of the “*Protect Life*” Strategy and Action Plan.
  - e) Development of a regional code of practice for the voluntary and community sectors.
  - f) Suicide/self-harm, awareness and positive mental health & wellbeing training for sports coaches.
  - g) Identify specific arts and sports interventions that have been most successful in improving mental health.

- h) Encourage organisations in the culture, arts and leisure sector, including locally well-known personalities, to support public information campaigns promoting both emotional wellbeing, and awareness of the protective factors relating to suicide and self-harm.
- i) Provide rural dwellers with community based “Health Checks”, which will include signposting to advice services on mental health related issues.
- j) Develop internet guidelines to restrict the promotion of suicide and self-harm, and to encourage the circulation of positive mental health messages.
- k) Develop mental health services which reach out proactively and assertively to vulnerable people at times of emotional crisis, and to develop “Places of safety” for people at risk of suicide.
- l) Develop a network of “One Stop Shops” to provide information, education, sign posting, and referrals for a range of public health issues, and particularly in relation to alcohol and drug misuse.
- m) Develop a range of targets and associated indicators for the next phase of the “Protect Life” Strategy.

6.4 The actions which have been completed, or progressed substantially, are outlined in Section B. It is however, recognised that the progress made to date in relation to these actions will need to be continually monitored to ensure that standards are maintained. These include:

- a) Implementation of a targeted information campaign aimed at enhancing the mental health and wellbeing of the workforce, including those who have been made redundant.
- b) To work with the National Union of Journalists, and the Association of Editors, in relation to implementation of media guidelines in relation to the reporting of suicide and self-harm issues.
- c) Development and implementation of appropriate media monitoring mechanisms.
- d) Implementation of a targeted information and awareness campaign for young males.
- e) Enhancement of the role of the community and voluntary sector in relation to the provision of mentoring/befriending support for young males at risk of suicide and self-harm.

- f) Development of a major public information campaign that aims to promote emotional wellbeing, and to increase awareness of the protective factors relating to suicide and self-harm.
- g) Support and encourage integrated community based suicide/self-harm prevention & bereavement support initiatives and support mechanisms.
- h) Provision of clear and accessible advice for families in relation to the early recognition and response to family members presenting with suicidal and or self-harm tendencies, depression and or mental health difficulties.
- i) Raise awareness of, and ensure availability and timely access to responsive and appropriate suicide and self-harm prevention and intervention services.
- j) Make suicide and self-harm awareness and positive mental health & wellbeing training, including how to deal sensitively with disclosure of self-harm or suicidal ideation, a priority for the key influencers of young people.
- k) Ensure that accessible information and timely support is available across the statutory, community, and voluntary sectors to support people bereaved by suicide.



## APPENDIX 1 - SUICIDE TRENDS AND INCIDENCES

### ANALYSIS OF SUICIDE IN NORTHERN IRELAND

1. Suicide is now one of the major causes of death in young adults in Northern Ireland, particularly in young males, and various studies and surveys have indicated that it is on the rise. Incidents of self-harm are also known to be on the increase. Suicide data is taken from information on deaths recorded by the General Register Office which holds details by gender, age and marital status. The system also records the person's full postcode. This allows various geographical comparisons to be made. These are outlined later in this appendix.
2. During the period 1992 to 2009 there were 3,265 registered deaths from suicide in Northern Ireland. Whilst there can be considerable variation in the number of registered suicides from year to year, the overall trend over recent years has been a rise in registered deaths by suicide and undetermined intent. Over the period, 2005 to 2009, suicide represented 1.8% of the total deaths in Northern Ireland. However, the disproportionate impact of suicide is best illustrated by the fact that between 2005 and 2009, almost a third of all deaths occurring in the 15 to 34 years age bracket were attributable to suicide. This disproportionate effect is further evidenced by the fact that the average suicide rate in the most deprived areas was almost three times the rate in non-deprived areas.

**Figure 5: Number of suicides (1992-2010) in Northern Ireland**

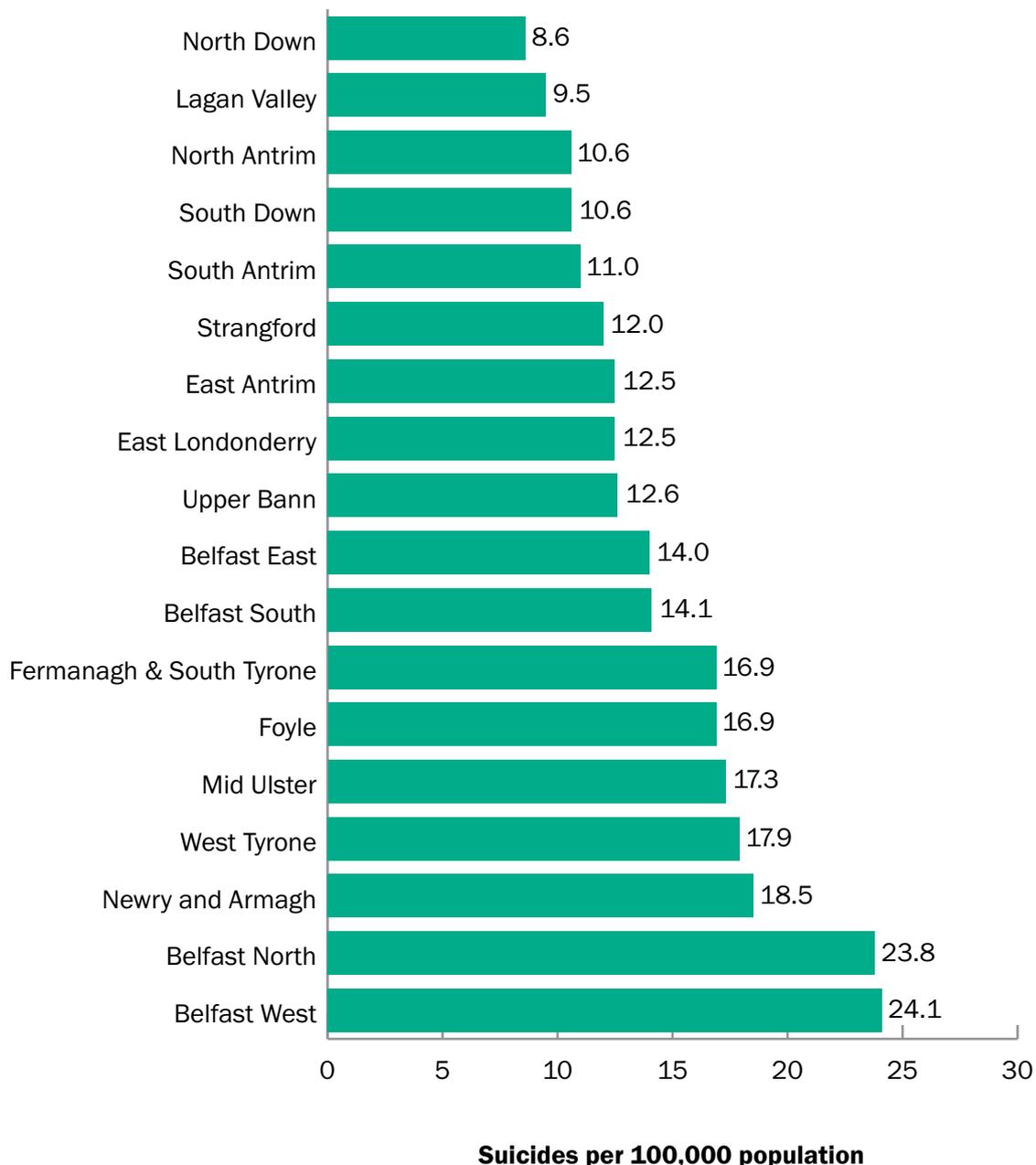
YEAR RECORDED	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
ALL	150	154	185	158	183	144	146	213	291	242	282	260	313
MALE	113	127	140	132	142	112	105	167	227	175	218	205	240
FEMALE	37	27	45	26	41	32	41	46	64	67	64	55	73

## SUICIDES BY ELECTORAL DISTRICTS

### PARLIAMENTARY CONSTITUENCY AREA (PCA)

- The Parliamentary Constituencies of Belfast West, Belfast North, Newry & Armagh and West Tyrone had the highest proportion of all deaths due to suicide. Belfast West and Belfast North had disproportionately higher average suicide rates per 100,000 persons (24.1 and 23.8 respectively), while the lowest suicide rates were in North Down (8.6) and Lagan Valley (9.5).

**Figure 6: Average suicide rate per 100,000 persons by Parliamentary Constituency (2005-09)**

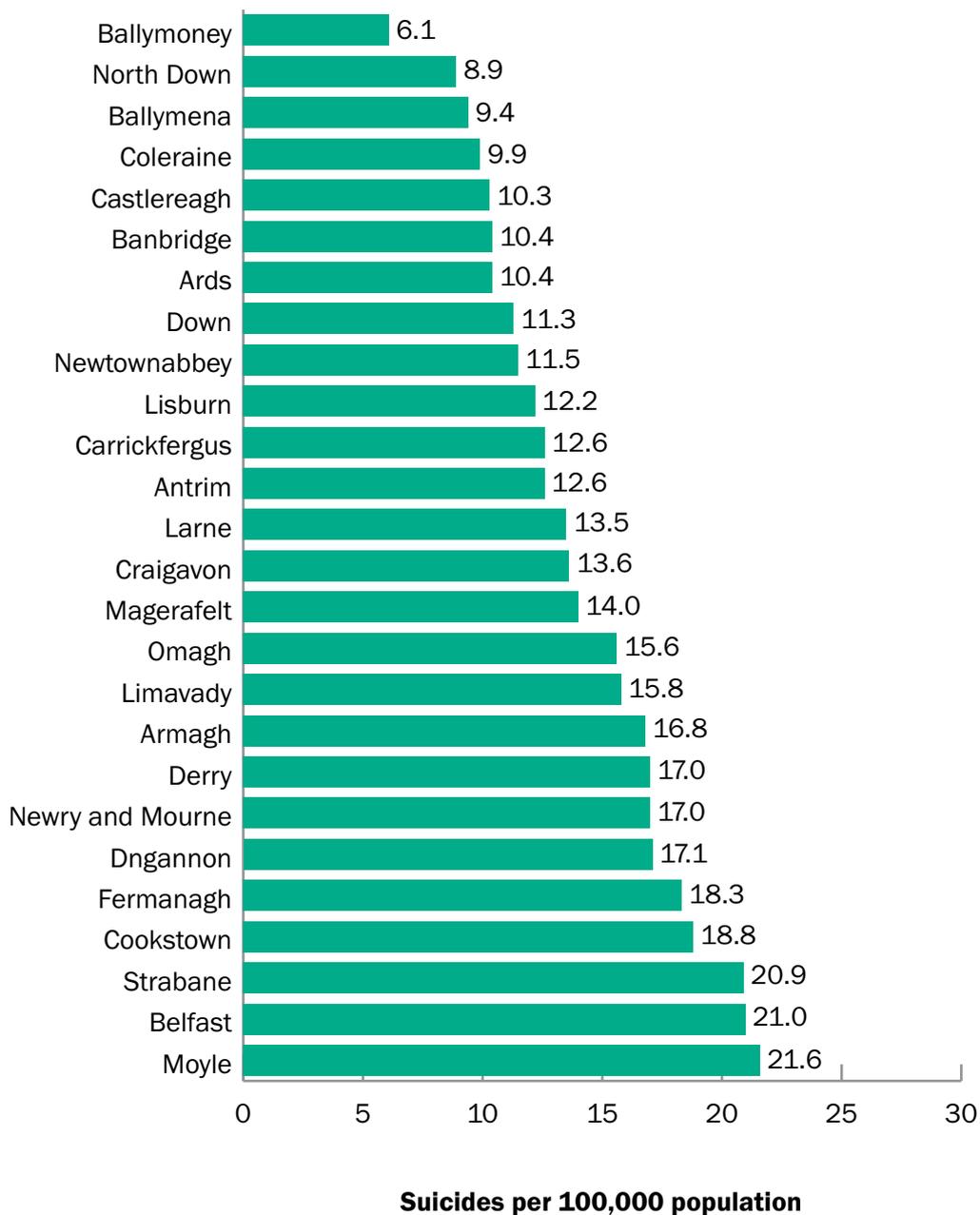


NOTE: Westminster Parliamentary Constituency (2008) boundaries.

## LOCAL GOVERNMENT DISTRICT (LGD)

4. Moyle LGD had the highest average suicide rate per 100,000 persons (21.6), closely followed by Belfast LGD (21.0) and Strabane LGD (20.9), with Ballymoney LGD recording the lowest rate (6.1). There were also relatively high average suicide rates in Cookstown LGD (18.8) and Fermanagh LGD (18.3). However, it is important to note that as the numbers of suicides in LGD areas tend to be relatively small, any increases will lead to large fluctuations and can therefore be misleading with regards to overall trends.

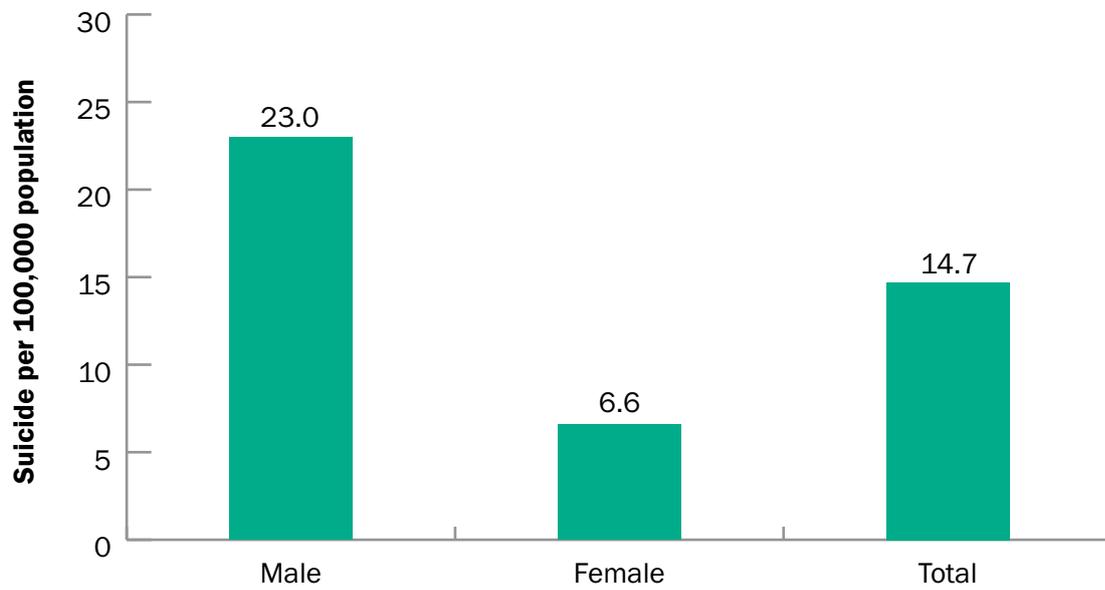
**Figure 7: Average suicide rate per 100,000 persons by Local Government District (2005-09)**



**BY GENDER**

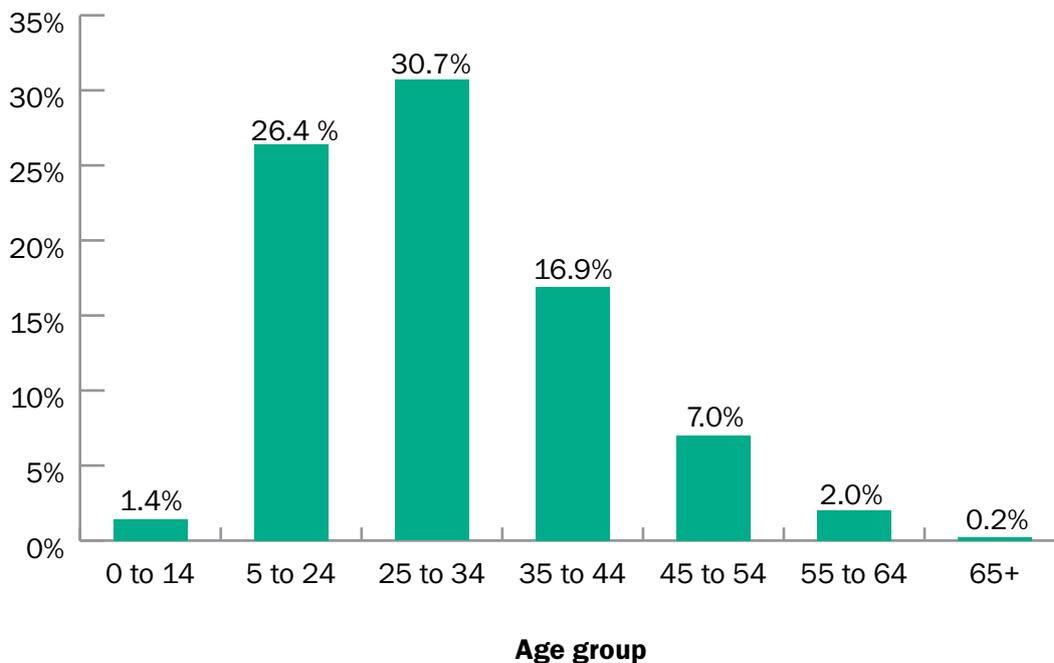
5 In total males accounted for over three quarters of the 1,288 suicides (77.0%) that occurred in Northern Ireland between 2005 and 2009. Figure 8 demonstrates that males accounted for a disproportionately higher rate of suicide per 100,000 population than that of females.

**Figure 8: Average suicide per 100,000 population by gender 2005-09**



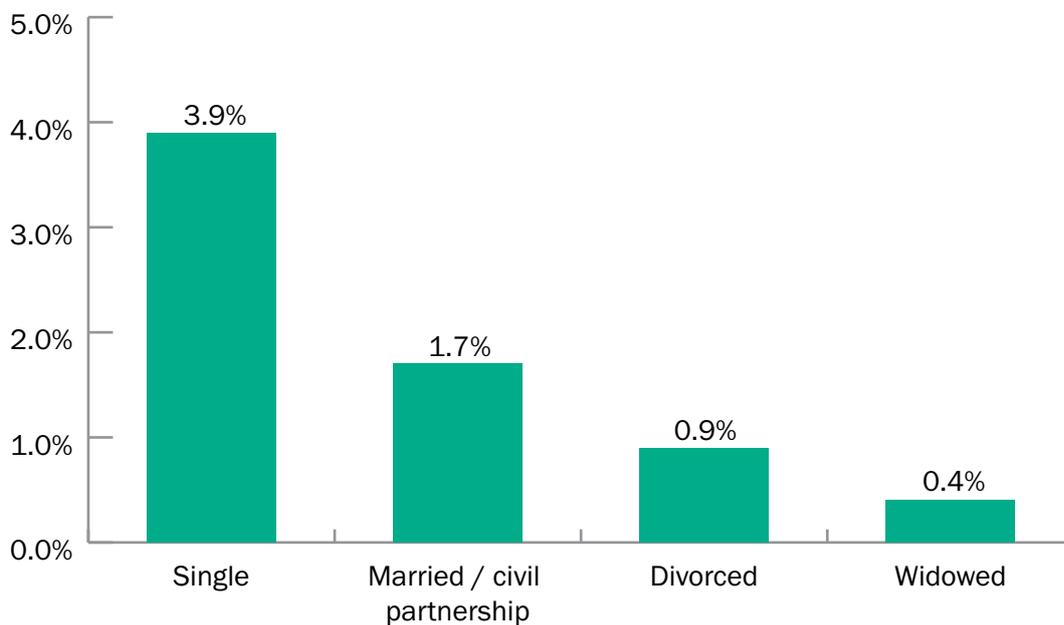
**BY AGE**

6. During the period 2005 to 2009, 36.8% of all suicides involved persons between the ages of 15 to 34, with a further 24% of suicides involving persons in the 35 to 44 age bracket. The average age for all deaths by suicide was 41 years of age.
7. Figure 9 highlights that between 2005 and 2009, 30.7% of all deaths occurring in the 25 to 34 years age bracket, and 26.4% of deaths among the 15-24 year olds, were attributable to suicide. This compares with 16.9% of those aged 35 to 44 years of age. Suicides accounted for proportionately fewer of the deaths of those aged 14 years and under and those aged 55 years and above. These figures further reinforce the disproportionate effect of suicide in local communities.

**Figure 9: Suicide as a proportion of all deaths by age group (2005-09)**

**BY MARITAL STATUS**

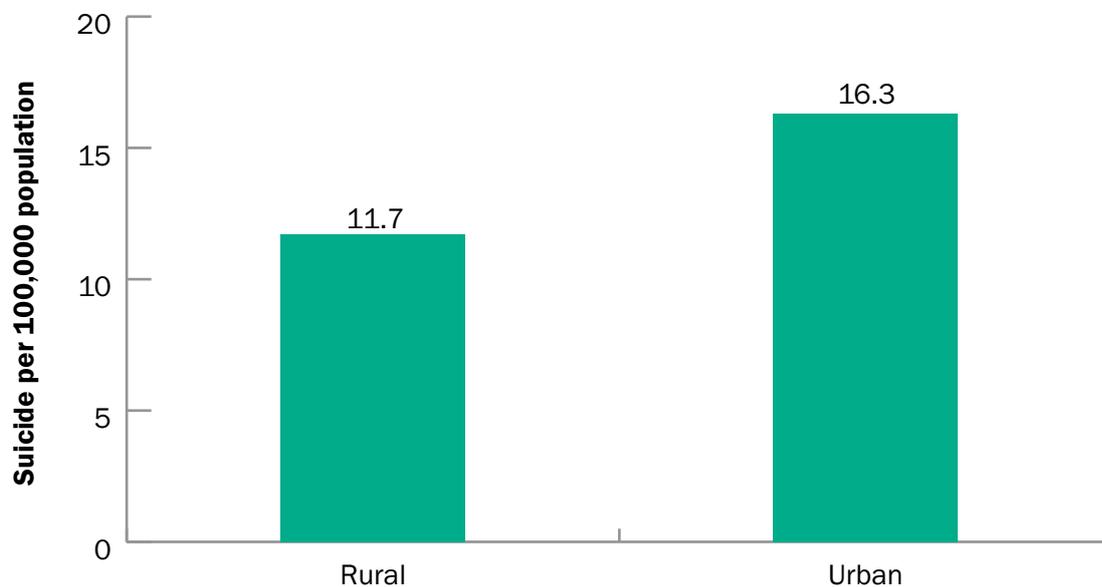
8. Figure 10 demonstrates that during the period 2005 to 2009 the “single” marital status group witnessed the highest number of suicides as a proportion of all deaths at 3.9%, followed by “married/civil partnership” group at 1.7%. The lower suicide levels among the widowed group may be due to the fact that a large proportion of deaths occur in the older population (hence suicides will equal a small proportion of all deaths in the older age groups).

**Figure 10: Suicide as a proportion of all deaths by marital status (2005-09)**

## BY RURALITY

9. Approximately one third of the local population (36.0%) lives in rural areas, and the remaining two-thirds in urban areas. Approximately 48% of the population is aged 34 years or under in both urban and rural areas.
10. Figure 11 highlights that urban areas have a higher average suicide rate per 100,000 persons (16.3) than rural areas (11.7). The proportion of all deaths that are attributed to suicide are however similar in both urban and rural areas (1.8% and 1.6% respectively).

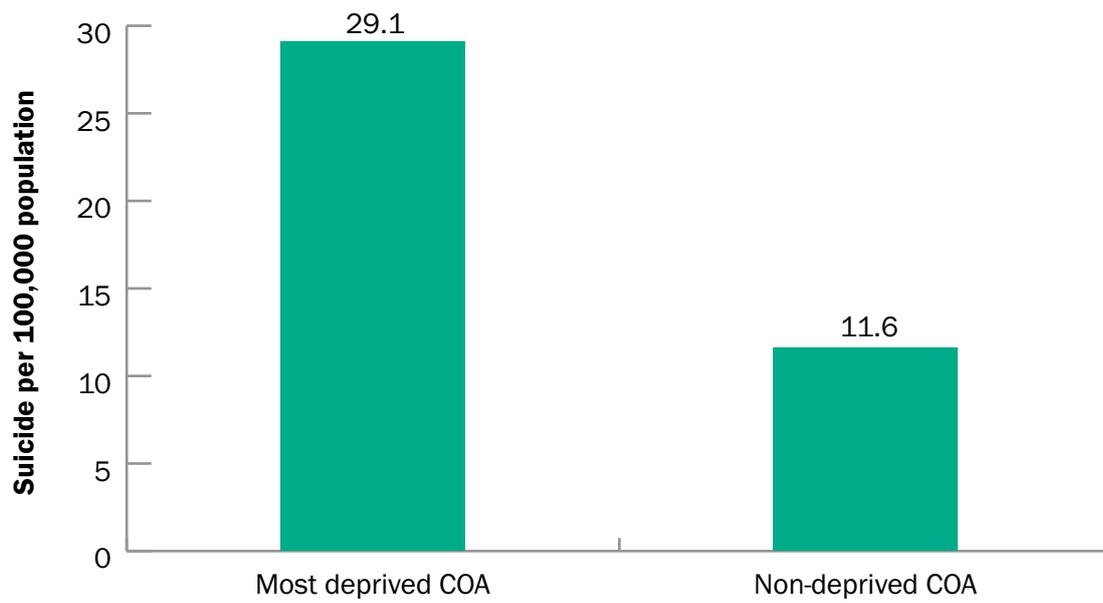
**Figure 11: Average suicide per 100,000 population by rurality (2005-09)**



**BY ECONOMIC DEPRIVATION**

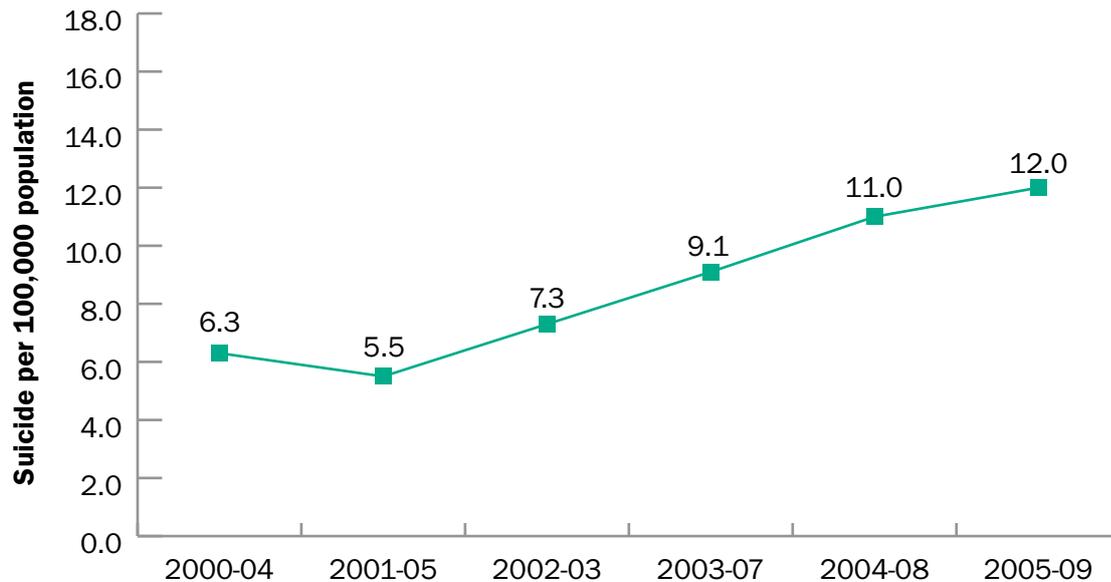
11. Figure 12 demonstrates that the average suicide rate per 100,000 persons in the most deprived Census Output Areas (COAs) (29.1) was close to three times that in non-deprived areas (11.6).

**Figure 12: Average suicide per 100,000 population by deprivation (Census Output Area) 2005-09**



12. Figure 13 considers the gap in the suicide rate (per 100,000 population) between the Economic Deprived areas and the NI average, and it suggests a widening over time of the gap in this regard.

**Figure 13: Gap in crude suicide rate between the NI average and the economically most deprived areas**



### SUICIDE STATISTICS OVERVIEW

13. Death by suicide in Northern Ireland is highest among males and young adults, and among the “single” marital status group, and the statistics also suggest that suicide is more prevalent in urban and deprived areas. Belfast West & North Parliamentary Constituencies, and the Moyle, Belfast and Strabane LGDs are the area’s most disproportionately affected by suicide, whereas Ballymoney LGD and North Down WPC are the least affected constituencies. The differential impact on the single marital status group can be explained by differences in the gender and age composition of each marital status. Due to the limited equality data for deaths recorded by General Registry Office, it is quite possible that there may be differential impact on other equality groups that have not been analysed such as sexual orientation, disability status, ethnicity and those with/without dependants.

## APPENDIX 2 - SELF-HARM TRENDS AND INCIDENCES

### ANALYSIS OF SELF HARM IN NORTHERN IRELAND

14. The term self-harm covers a wide range of behaviours including habitual self-cutting and poisoning, which involves differing degrees of risk to life and suicidal intent. When considering rates of self-harm, it is important to remember that Deliberate Self Harm (DSH) represents the most significant risk factor for future suicide. Incidents of self-harm which result in admissions to hospital are recorded in the DHSSPS Hospital Inpatients System (HIS) which uses the International Statistical Classification of Diseases and Related Health Problems (ICD), the same as used in the classification of deaths.
15. HIS records gender and age of the patient and their full postcode. This allows for geographical comparison by parliamentary constituency and by local government district.
16. Over the five year period 2005/06 to 2009/10, the number of admissions to hospital as a result of self-harm increased by 3.1%. Considerable variation in the number of admissions exists during these years ranging from a low of 4,103 in 2006/07 to a high of 5,094 admissions occurring in 2007/08. During the full five year period there were a total of 23,268 admissions to hospital due to self-harm, which represents 0.9% of all hospital admissions during this period.

**Figure 14: Number of hospital admissions as a result of self-harm**

Year	2005/06	2006/07	2007/08	2008/09	2009/10	Total
Admissions as a result of self-harm	4,482	4,103	5,094	4,966	4,623	23,268
All admissions	470,372	480,938	497,873	510,908	504,888	2,464,979
% of all admissions	1.0%	0.9%	1.0%	1.0%	0.9%	0.9%

17. While the numbers of admissions to hospital for self-harm as a percentage of total admissions is relatively low, it is important to note that the DSH Registry has highlighted that approximately 40% of hospital attendances do not result in admissions and therefore the reported self-harm figures substantially underestimate the true size of the problem. Rollout of the DSH Registry across Northern Ireland will in future allow for greater clarity with regards the actual number of DSH attendances at hospital accident and emergency units.
18. The Registry of Deliberate Self Harm is linked with the national Registry of Deliberate Self Harm in the Republic of Ireland. Monitoring of self-harm presentation in accident and emergency units is also well established in several centres in the UK, allowing for comparative analysis of information. Figure 10 compares self-harm rates across a range of cities in NI/ ROI/ GB during 2010, and it demonstrates that the second highest incidence rates were in Derry CC and the lowest rates in Oxford.

**Figure 15: Self-harm rates across a range of cities in NI/ ROI/ GB during 2010**

	<b>Males</b>	<b>Females</b>	<b>Total</b>
<b>Limerick</b>	636	699	667
<b>Derry CC</b>	589	652	621
<b>Cork</b>	640	424	528
<b>Manchester*</b>	460	587	527
<b>Waterford</b>	372	348	359
<b>Dublin</b>	346	358	351
<b>Leeds*</b>	291	374	333
<b>Galway</b>	317	323	319
<b>Oxford*</b>	285	342	314

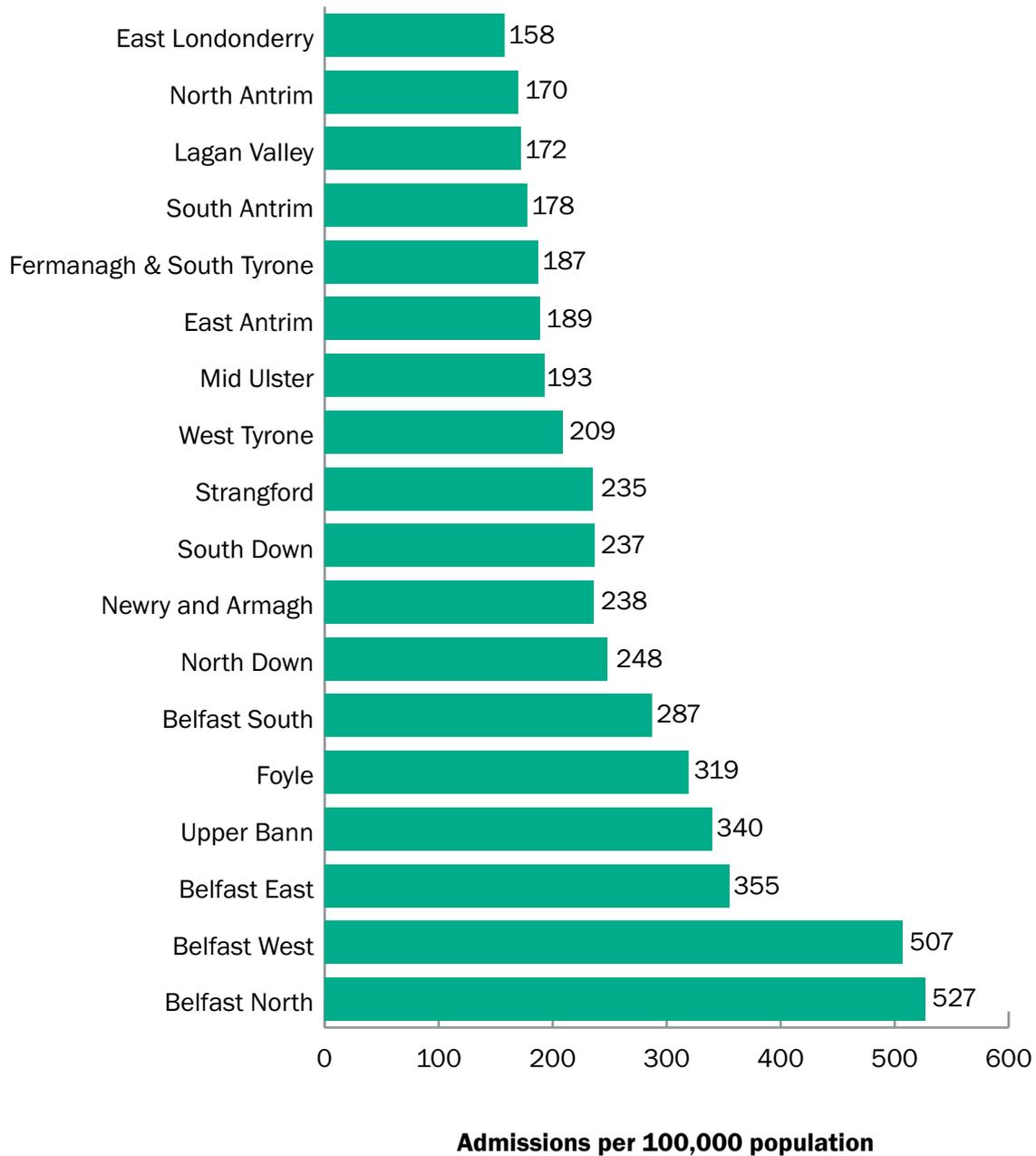
### **SELF-HARM BY ELECTORAL DISTRICTS**

19. In order to compare the level of self-harm that is prevalent within key groups, the average number of admissions each year between 2005/06 and 2009/10 is expressed as a ratio per 100,000 persons within the total population.

### **PARLIAMENTARY CONSTITUENCY AREA (PCA)**

20. Belfast North (527) and Belfast West (507) WPCs had the highest admission rates for self-harm per 100,000 persons. East Londonderry WPC had the lowest admission rate for self-harm with an average of 158 admissions per 100,000 persons.

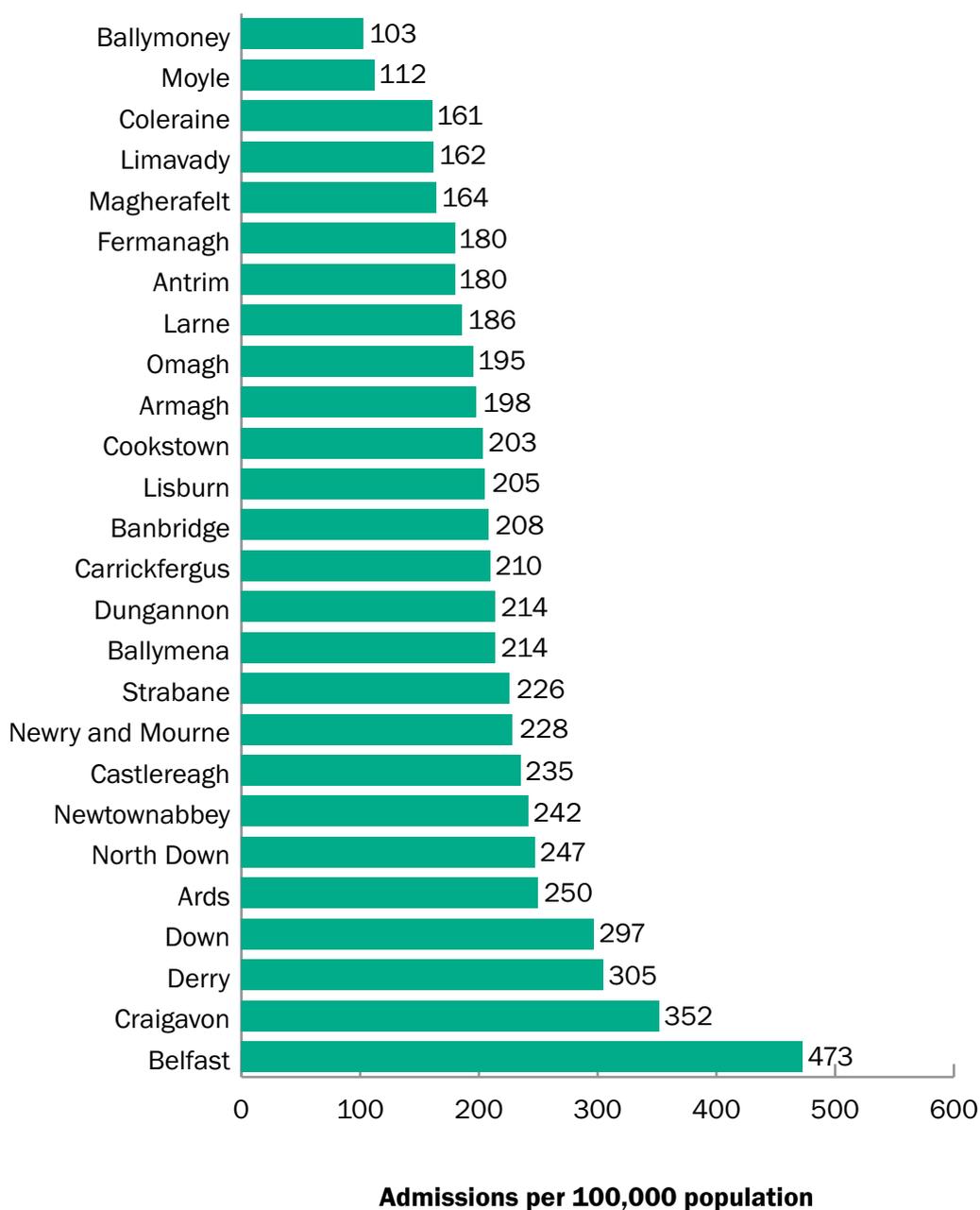
**Figure 16: Standardised self-harm admission rate per 100.000 persons by Parliamentary Constituency (2005/6 - 2009/10)**



### LOCAL GOVERNMENT DISTRICT (LGD)

21. The highest average admission rate for self-harm per 100,000 persons occurred in Belfast LGD (473). Admission rates were also relatively high in Craigavon (352), Derry (305) and Down (297) LGDs. In contrast, Ballymoney and Moyle LGDs had the lowest admission rate for self-harm with rates of 103 and 112 admissions per 100,000 persons respectively.

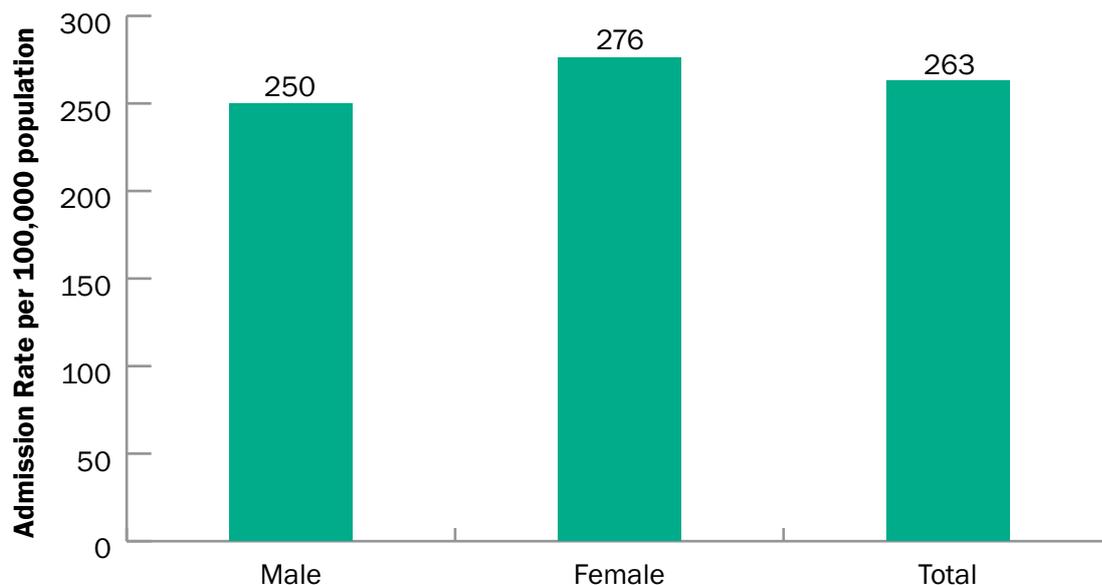
**Figure 17: Standardised self-harm admission rate per 100.000 persons by Local Government District (2005/6 - 2009/10)**



**BY GENDER**

22. Females accounted for 12,417 (53%) of the total admissions to hospital for self-harm between 2005/06 and 2009/10. Overall, an average rate of 263 admissions (Figure 18) per 100,000 persons was made as a result of self-harm over the period.

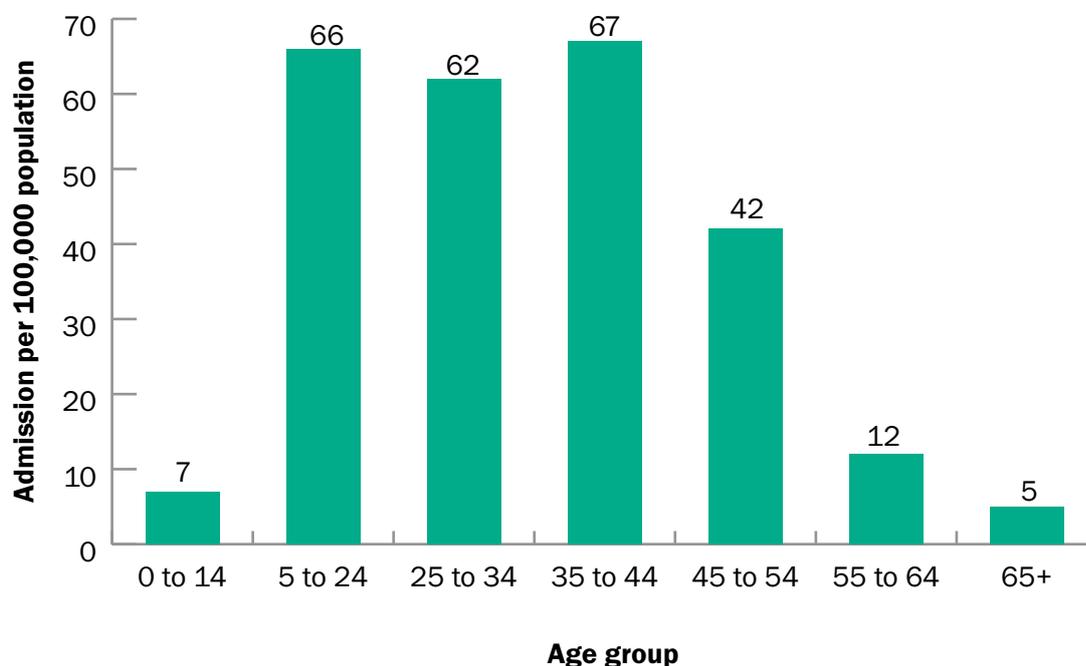
**Figure 18: Standard self-harm admission rate by gender (2005/6 - 2009/10)**



**BY AGE**

23. Three-quarters of all self-harm admissions (75.9%) between 2005/06 and 2009/10 were for persons aged under 45, with the highest average admission rates for self-harm falling within the 15 and 24 years age group.

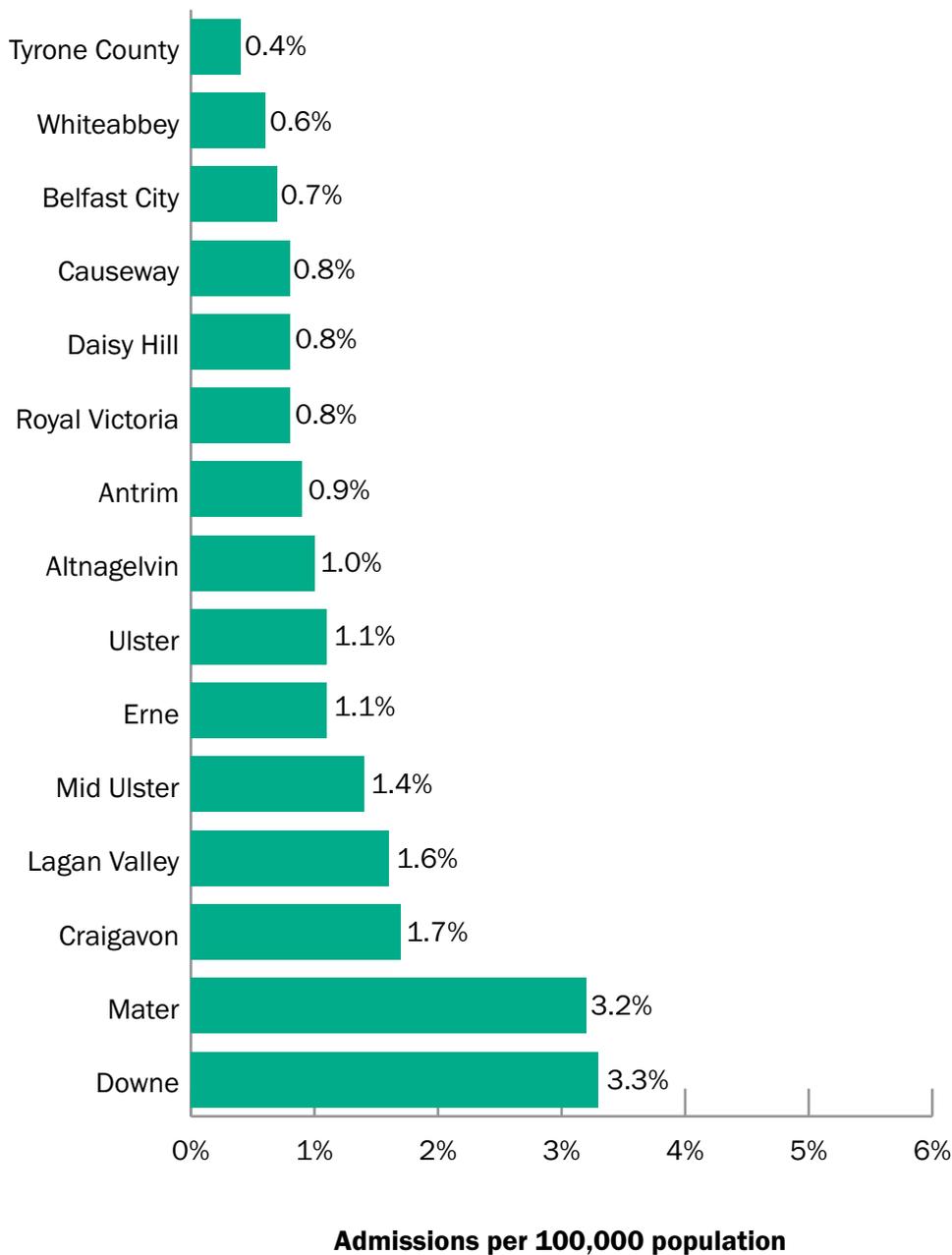
**Figure 19: Standard self-harm admission rate by age group (2005/6 - 2009/10)**



**BY HOSPITAL**

24. Figure 20 highlights admissions to local hospitals for self-harm, and it identifies the Downe and Mater Hospitals as having the highest admission rates for self-harm as a proportion of all admissions.

**Figure 20: Self-harm admission as percentage of all admissions by hospital (2005/6 - 2009/10)**



### SELF-HARM STATISTICS OVERVIEW

25. Despite the current lack of regional information about the total attendances at Accident and Emergency units for self-harm, it is clear from self-harm hospital admission rates that self-harm is more prevalent for females, and also for the 16 to 44 age group. Whilst it is unlikely that the apparent differential impact on females and certain age groups would totally disappear, some of the differences may be explained by other equality information, e.g. religion, marital status, sexual orientation etc. In order to provide enhanced data in this field, the Department is in the process of rolling out the DSH Registry in Northern Ireland.
26. While the incidences of deliberate self-harm by LGD are broadly consistent with their corresponding suicide rates, with the notable exception of Moyle LGD, it is worth noting the higher self-harm rates recorded in areas such as Castlereagh and North Down. The disparity between the self-harm and suicide rates recorded in these areas will need to be considered in light of the importance of DSH as a future predictor of suicide.

## APPENDIX 3 - KEY LEARNING

### Source of learning: National Suicide Research Foundation: Review of the Evidence Base

#### Overview:

An extensive review of the national and international literature and research evidence, published between January 2006 and August 2009, was undertaken to update the evidence base for the refreshed “Protect Life” Strategy. This included reviewing the available evidence for all of the original “Protect Life” action. Further information is in the full evidence review document, which is available at <http://www.dhsspsni.gov.uk/review-of-evidence-base.pdf>

#### Findings:

Substantial and consistent evidence has been found for the following suicide prevention interventions:

- Restriction of access to means and methods of suicide, including identification of “hotspots, the promotion of safer prescribing, a reduction in the accessibility of certain over the counter drugs, and restriction of access to firearms. Evidence particularly strong for barriers on bridges and withdrawal of prescription painkiller co-proxamol (distalgesic).
- Development of clinical guidelines for all HSC staff on dealing with people who are at risk of suicide/ self harm.
- Programmes that enhance the coping and problem solving skills of those who self harm, and which reduce the risk of repeat self harm. This includes various psychological treatments, including talking therapies and CBT. The evidence indicated a substantially higher risk of suicidal behaviour among deliberate self harm patients who do not receive a psychosocial or psychiatric assessment. It also pointed to significant benefits of enhanced prediction of risk of repeated suicidal behaviour (non-fatal and fatal) using a structured assessment tool in addition to clinical judgement.

There is considerable evidence of beneficial outcomes from the following interventions:

- Public information campaigns that aim to de-stigmatise mental health, and promote awareness and understanding of issues relating to suicide and self harm.
- Support for community-based suicide prevention initiatives, including provision of local suicide prevention/ mental health and wellbeing support networks.
- Inclusion of positive mental health promotion, and coping and life-skills, in the school curriculum and ensuring that children and young people are protected from all forms of bullying.
- Suicide awareness and positive mental health and well-being training for teachers, youth workers, community gatekeepers, and all frontline emergency and health and social care staff, prison and police custody staff, and (where possible) identified “listener” inmates.
- Promotion of a help seeking culture, particularly among young people.
- Information campaigns aimed at enhancing the mental health and wellbeing of all members of the workforce.

**Findings Cont'd:**

- Suicide proofing of the custody environment in prisons and police stations, and follow-up support for people recently released from custody.
- Provision of pro-active suicide awareness/intervention programmes for staff and carers who support people with mental health conditions.
- Support networks in local communities for all survivors of abuse and suicide awareness training for people working with survivors of abuse.
- Provision of appropriate support services for marginalised and disadvantaged groups in particular: lesbian, gay, bi-sexual, and transgender groups, rural communities, ethnic minorities, and those people who are economically deprived.
- Raising awareness of the enhanced risk of suicide and self-harm among people in high risk occupations.
- Provision of appropriate services for all prisoners with mental health difficulties, including the development of appropriate “listener” groups.
- Ongoing monitoring of the mental health, including suicide risk assessment, of remand and sentenced prisoners.
- Provision of follow-up support for people who have recently been released from custody.
- Early interventions, such as CBT, to treat depression and suicidal behaviour among older adults.

There was also evidence of the possible influence of the new technologies on the occurrence of suicide.

**Recommendations:**

- Explore possible further restriction of paracetamol pack size, and the number of outlets where it can be obtained.
- Enhanced focus on restricting access to the means of suicide through a potential discrete action on this issue.
- Implementation of NICE guidelines for the assessment and aftercare of self harm patients.
- Regional implementation of cognitive behavioural therapy and post traumatic stress interventions in mental health services.
- Monitor long term effects of interventions restricting access to lethal means in order to verify substitution effects.
- An enhanced focus on older adults.
- Enhanced focus on addressing the strong correlation between alcohol abuse and deliberate self harm.
- Implementation of CBT and PST interventions in mental health services on a regional basis, although further evaluation of effectiveness among males who self-harm may be required
- Consideration of Inclusion of a specific action on suicide and the internet in the next phase of “Protect Life”.

<b>Source of learning: Evaluation of component parts of “Protect Life”</b>
<b>Overview:</b>
Various component parts of the Strategy have been evaluated at different stages over the past 4 years. This table outlines the main findings and recommendations from these evaluations. It should be acknowledged that some of these recommendations have already been implemented and, where this is the case, are not included in the summary, at the end of this chapter, of findings and actions to take forward.
<b>All island evaluation of Applied Suicide Intervention Skills Training</b> (evaluation conducted 2010)
<ul style="list-style-type: none"> <li>• More cost effective to target ASIST at those who are more likely to come into contact with people at risk of suicide.</li> <li>• Potential to explore use of other suicide prevention programmes such as Safetalk.</li> <li>• Improve central co-ordination &amp; enhanced trainer quality assurance.</li> </ul>
<b>Mental Health First Aid training -pilot delivery in the CAWT region</b> (evaluation conducted 2007)
<ul style="list-style-type: none"> <li>• Trainees reported high levels of confidence and motivation after receiving this training.</li> <li>• Future delivery should have evaluation built in to ensure the quality of the programme is maintained, and has an impact at community level.</li> </ul>
<b>GP depression awareness training</b> (evaluation conducted October 2007)
<ul style="list-style-type: none"> <li>• 20% of GPs adopted new approaches to the diagnosis of depression post training.</li> <li>• Fall in the proportion of GPs prescribing anti-depressants for more than half of their patients.</li> <li>• GPs less likely to use anti-depressants as the first course of action in the treatment of mild or moderate depression.</li> <li>• Training should be continued in revised form.</li> <li>• PHA should examine other approaches to communicating course content such as e-learning and the provision of the course materials and resources on a dedicated website or portal.</li> <li>• Consider broadening the focus of the course to include children, adolescents and the elderly.</li> </ul>

**Public Information campaigns** (evaluation conducted 2007- 2009)

- Half of the people exposed to the campaigns reported that they encouraged them to consider how best to improve their mental health.
- Level of stigma was significantly less for those exposed to the campaigns.
- Campaigns are making progress in reducing stigma and increasing help seeking and should be sustained and reinforced.

**Lifeline** (evaluation conducted 2008- 2010)

- Unprompted awareness of Lifeline has increased and 66% of people who were aware of Lifeline said they would definitely consider using it if they needed someone to talk to.
- Lifeline awareness amongst key health professionals was as follows: Practice managers (71%), GPs (66%), health visitors (63%), and nurses (62%).
- 78% of those surveyed in the voluntary and community sector were aware of Lifeline.
- 25% of GP's who had heard of Lifeline had referred/ signposted a patient to the service. Only 9% of health visitors and 2% of nurses had made a referral.
- Main reason given for health professionals not referring to Lifeline was lack of knowledge about the service, including details about the expertise/ training of call handlers.
- More effective mechanisms needed to target key groups such as young males.
- Campaign materials should include more information about the wider services offered by Lifeline.
- Need for increased levels of awareness amongst health professionals about the wider range of Lifeline services.
- Encourage health professionals who make home visits to carry Lifeline cards to distribute to 'at risk' patients.

**N & W Belfast Health Action Zone evaluation of local Suicide Prevention Action Plan** (evaluation conducted in September 2009)

- Funding has provided significant opportunity for cross-sectoral working within the community, and local organisations have added value through volunteer input and fundraising.
- Evidence of successful co-operation, joint working, inclusion and integration in service delivery, and a more holistic approach to service provision in the area.
- Service recipients have better coping abilities, are less socially isolated and appear to have a more positive attitude to the future.
- A monitoring and evaluation framework should be established, and linked to any funding allocated to community groups.
- Need for longitudinal research to identify the impact of services on beneficiaries possibly over 2 to 5 years.
- Continued need for crisis intervention, but with greater focus on promoting long term mental health of targeted groups such as young pregnant women and children in early years.

**Source of learning: Experience of implementation of “Protect Life”****Overview:**

The main findings from our experience in implementing “*Protect Life*” generally and from the delivery of a number of pilot projects and services such as the DSH Registry, the Self-Harm Mentoring Service (SHINE), and Lifeline is set out below.

**Findings:**

- Highest prevalence rates were among the 20-24 year old age group for both genders.
- Repeat incidence accounted for one in five of all self-harm attendances.
- Clear peaks in hospital attendance around 1am and at weekends indicating link with alcohol consumption.
- Alcohol featured as a contributing factor in 56% of episodes.
- Drug overdose was the most common method (73%), particularly among females, with self-cutting the second most common method.
- 80% of patients did not self-harm in the 6 month period after referral into project.
- Of those with a history of repeated self-harm, 50% showed a reduction in the frequency of self-harming behavior post-referral.
- Clinical Outcomes Routine Evaluation (CORE) assessment scores showed that 88% of patients achieved a significant improvement in the four psychological aspects of their lives after counselling.
- 57% of the referrals received have subsequently returned to work, gone into further education/job skills training, or been referred for specialised practical support
- Suicide, depression, and anxiety are the top three caller issues.
- Most frequent referrals are to Out of Hours GP service, PSNI and Northern Ireland Ambulance Service.
- Lifeline receives higher per capita call rate from Belfast Trust.
- Most Lifeline crisis calls are received at weekends and/or late at night.
- Caller gender profile is 30-50% males and 40-60% female.
- Caller age profile is 50-60% over 25 and 40-50% under 25.
- Long term planning/ recurrent funding cycle to enable local services to embed.
- Enhanced self-harm reduction interventions.
- Increased knowledge sharing and networking
- Need for regional consistency.
- Provision of relevant and timely information, including through the use of new technologies.
- Need to ensure that Mental Health Services are responsive/ accessible, and reach out assertively to vulnerable people.
- Enhanced focus on male culture of not sharing their feelings.
- Reduced stigma around mental health issues.

**Findings Cont'd:**

- Enhanced co-ordination and linkages between youth and adult mental health services/ primary care.
- Enhanced consultation time required for GPs when dealing with patients at increased risk of suicide.
- Training needs to be prioritised for all frontline staff, and embedded in their training development plans.
- Need for sensitive reporting of suicide on the internet.

**Recommendations:**

- Enhanced working relationships between A&E departments and mental health services ensuring appropriate protocols are in place.
- Review of support needs of repeat self-harmers.
- Need to ensure that staff rotas are consistent with patterns of demand.
- Enhanced mental health promotion and preventative work with young people to support the work of Mental Health practitioners.
- Evaluation feedback from the Primary Care Liaison Team was extremely positive regarding the pilot's contribution to the overall care of the patients.
- Early intervention for positive mental health, and wider measures to improve the quality of life.

**Source of learning: Community feedback****Overview:**

In light of the key role played by the Community and Voluntary sectors in the development of "Protect Life", an extensive process of engagement with representatives from these sectors was undertaken as part of the Strategy refresh. This ongoing engagement took place between August 2008 and September 2011, and it included workshops and the online surveying of a cross sector of community, voluntary, statutory, and bereaved families representatives.

**Findings:**

- Need for closer co-operation between Community and Voluntary sectors, particularly in relation to sharing information/best practice.
- Need for development of sector standards for community-led services.
- Need for cross-sectoral review of delivery structures.
- Need for development of integrated services across the Community/ Voluntary Statutory sectors
- Recurrent funding required for community providers.
- Potential for use of social media.
- Development of sensitive public information campaigns.

**Recommendations:**

- Development of an integrated strategy for the community and voluntary sectors.
- Review of best practice re existing local support groups.
- Maintenance/ expansion of sensitive public information campaigns.
- Enhanced focus on service interfaces and handovers between providers.
- Use of social media as part of integrated outreach approved.

**Source of learning: Community feedback****Overview:****National Confidential Inquiry into Suicide and Homicide by People with Mental Illness**

The National Confidential Inquiry report into Suicide and Homicide by People with Mental Illness in Northern Ireland is based at the University of Manchester, and it examined longitudinal trends in suicide and homicide over the period 2000 to 2008. The Inquiry also collates details of people who die by suicide while in touch with Mental Health Services.

<http://www.dhsspsni.gov.uk/suicideandhomicideni.pdf>

**Findings:**

- Hanging was the most common method of suicide amongst men, and self-poisoning in women.
- The largest difference between suicide rates in NI and other UK countries was in young people, who were also more likely to be living in the poorest areas and with less contact with mental health services.
- 29% of all suicides were by people who had been in contact with mental health services in the previous 12 months.
- Alcohol misuse was a common feature of patient suicide and has become more common.
- Social adversity and isolation were common amongst patient suicide cases (Eg: high levels of unemployment).
- Immediate post discharge is a high risk period.
- Lack of mental health service contact with bereaved family and multi-disciplinary review in 21% of cases.

**Recommendations:**

- Continue to address stigma associated with mental illness.
- Maintain a focus on the prevention of suicide/emotional resilience building amongst young men from deprived areas.
- Improve risk assessment of, and contact with, patients who have been discharged.
- Address self harming.
- Provide targeted alcohol/drug misuse interventions for people with mental illness.
- Reconsider the practice of intermittent in-patient observation.

<b>Source of learning: Community feedback Cont'd</b>
<b>Overview: Coping and Lifestyle Study</b>
Research into the prevalence of adolescent self-harm in Northern Ireland involved completion of an anonymous questionnaire survey completed by 3,596 pupils aged 15-16, from secondary and grammar schools across Northern Ireland <sup>10</sup> . The full report is available at <a href="http://www.dhsspsni.gov.uk/ni-lifestyle-and-coping-survey-2010.pdf">http://www.dhsspsni.gov.uk/ni-lifestyle-and-coping-survey-2010.pdf</a>
<b>Findings:</b>
<ul style="list-style-type: none"> <li>• 10% of pupils had engaged in self-harm, although more frequent amongst girls.</li> <li>• Influences included knowing other people who self-harm, the Internet, &amp; social networking sites.</li> <li>• Stressors associated with self-harm included sexual abuse, concerns about sexual orientation, bullying and experience of “The Troubles”.</li> <li>• Prevalence is lower in Northern Ireland in comparison to England, Scotland, and the Republic of Ireland.</li> <li>• Boys with sexual orientation concerns were at 10 times greater risk of self-harm.</li> </ul>
<b>Recommendations:</b>
<ul style="list-style-type: none"> <li>• Promote awareness among staff and students, including sources of help.</li> <li>• Schools should reach out to at-risk families.</li> <li>• All schools should have a critical incident response plan.</li> <li>• Further research on link between self-harm and girls, and adolescent help-seeking is required.</li> <li>• Secondary schools and those within more deprived catchment areas should be prioritised.</li> <li>• Promote exercise, especially among boys.</li> <li>• Promote responsible internet coverage of self-harm.</li> </ul>
<b>Overview: The Trouble With Suicide – Mental Health, Suicide and the Northern Ireland Conflict: A Review of the Evidence</b>
<ul style="list-style-type: none"> <li>• The purpose of the ‘Trouble with Suicide’ research<sup>11</sup> was to get behind the debate on the degree to which the conflict has permeated Northern Irish society and affected mental well-being, with special reference to suicide.</li> </ul>

10 O'Connor, R.C. (2010). Northern Ireland Lifestyle and Coping Survey.

11 Mike Tomlinson, June 2007. The Trouble with Suicide – Mental Health, Suicide and the Northern Ireland Conflict: A Review of the Evidence.

**Findings:**

- The impact of “the troubles” on mental health and suicide is complicated and contradictory.
- Idea that conflict increased social cohesion is questionable.
- Lack of systematic evidence regarding the prevalence of known risk factors for depression and suicide amongst those in frontline of the troubles.
- Possible conflict related affect on the death registration process as some suicides were recorded as ‘accidental deaths’.
- Firearms became more prevalent as a method of suicide during the conflict, but have declined in recent times.

**Recommendations:**

- Consider sociological autopsy of suicides to highlight risk factors associated with social context, including community/ family experience, and social isolation.
- Work with relevant groups, including with ex-prisoners, to provide better evidence of mental health needs and suicide risk.
- Further research needed on suicides involving firearms.
- Greater clarity required around ‘trauma’ and its transmission

**Overview:****Providing Meaningful Care: A local research report into the experiences of young men and how this can inform mental health services**

<http://www.publichealth.hscni.net/publications/providing-meaningful-care-using-experiences-young-suicidal-men-inform-mental-health-car>

**Findings:**

- Suicidal young men had unrealistic views of what it was to be a ‘successful’ man, which contributed to low self-esteem, and personal stress.
- Possible suicide prevention role for peers who had tried to take their own life.
- Suicide attempt survivors continually had to try to come to terms with their suicidal thoughts.
- Fundamental importance of close relationships with family and friends in protecting against suicide.
- Building stronger emotional resilience and coping skills amongst young men and providing prevention services that they are more willing to access are vital.
- Potential value in having more community-based informal ‘drop-in’ suicide prevention centres.

**Recommendations:**

- Enhanced ‘pro-active’ ‘outreach’ approaches to suicide prevention.
- Increased awareness, especially among young men, of relevant services.
- Health service to utilise social networking technologies used by young people.
- Service planning should be sufficiently flexible to allow for support to be longer-term once the initial risk of suicide has been removed.

<b>Source of learning: Community feedback Cont'd</b>
<b>Overview:</b> <b>Promoting Positive Mental Health and Preventing Suicide – Men’s Health Forum.</b>
<b>Findings:</b>
<ul style="list-style-type: none"> <li>• Research identified ten key principles for effectively engaging young men in suicide prevention work:</li> <li>• Focus on ‘mind fitness’ not ‘mental health’.</li> <li>• Develop trust, safety and non-threatening male-friendly environments.</li> <li>• Consult and involve young men in programme delivery and development.</li> <li>• Find a ‘hook’ that will appeal to young men.</li> <li>• Target programmes to those young men most in need.</li> <li>• Begin interventions early.</li> <li>• Use language that is positive/ solution-focused.</li> <li>• Consider use of role models and social marketing.</li> <li>• Promote peer support and mentoring</li> <li>• Evaluate what type of suicide prevention interventions work with young men.</li> </ul>
<b>Overview:</b> <b>Facing the Challenge - The Impact of Recession and Unemployment on Men’s Health in Ireland. IPH</b>
<b>Findings:</b>
<ul style="list-style-type: none"> <li>• Strong links between unemployment/ economic downturn and mental ill health, especially in men.</li> <li>• Size of problem under-estimated due to inadequate service responses and reluctance of many men to talk about their problem.</li> </ul>
<b>Recommendations:</b>
<ul style="list-style-type: none"> <li>• Development of targeted information and awareness campaign.</li> <li>• Need for men to be able to access services that are responsive and understanding of their needs.</li> <li>• Support &amp; encourage the establishment of new men’s groups.</li> </ul>

**Overview:****National Suicide Research Foundation analysis of the Rol Suicide Support & Information System (May 2011)****Findings:**

- Specific risk profiles identified included:
- Undiagnosed and untreated mental health problems;
- Alcohol and drug abuse;
- History of deliberate self harm;
- Being adversely impacted by the recession;
- Recent separation of young men from partner/children;
- Long term consequences of sexual abuse in childhood and adolescence.

**Overview:****Trauma, Health and Conflict in Northern Ireland – A study of the epidemiology of trauma related disorders and qualitative investigation of the impact of trauma on the individual****Findings:**

- Post Traumatic Stress Disorder (PTSD) is a specific and significant health need among Northern Ireland's adult population.
- Women are more at risk of developing PTSD.
- Participants who met the PTSD criteria were more likely to have had one or more additional health disorders.
- One in five of those receiving psychological therapy and medical services for major depression have, or have had, PTSD.
- Only one third of people who met the criteria for PTSD sought help, due to perceived lack of/ awareness of services for trauma related conditions.
- 50% of trauma related events experienced by participants were related to the conflict in Northern Ireland.

**Recommendations:**

- Improved public awareness of Post Traumatic Stress Disorder (PTSD).
- Development of service pathways for people with trauma related needs.
- Enhanced mental health services to better identify, assess and treat trauma related disorders.
- Services treating adults with major depressive disorder should routinely assess for PTSD.
- Need for a proactive, supportive outreach service that encourages help seeking.

**Source of learning: Community feedback Cont'd****Overview:****Breaking the Silence in Rural Areas: Rural mental health, stigma, services and supports with the SWARD Region**

Initiated by the Niamh Louise Foundation, the aim of this research was to examine the issues of rural mental health, stigma and services within four district council areas – Fermanagh, Dungannon, South Tyrone, Cookstown and Magherafelt.

**Findings:**

- Mental health as a term is most generally associated with mental illness within the rural reaches of the South West Action for Rural Development (SWARD) region; seen as something from which an individual will not recover and will have for life, and is generally referred to in negative and stereotyping terms such as ‘psycho’, ‘schizo’, ‘mad’ and ‘nutter’ etc.
- Poor mental health is a major issue within the four district council areas of Fermanagh, Dungannon, Cookstown and Magherafelt.
- The rural culture of self-reliance and stoicism, combined with a heightened awareness of neighbours business and movements works against the propensity to admit to needing and then seeking help to self and others.
- There is a high need for a range of mental health services and supports within the SWARD rural community; availability of rural mental health services and supports are on the whole viewed as being low to moderately available; accessibility to the services and supports is viewed as low; and effectiveness of the services and supports which address mental health needs of rural constituents are viewed as low to moderate.
- Mental health provision for the LGBT, minority ethnic, farmer and young male groups is far from adequate, as is provision across rural stakeholders generally.
- Regional media campaigns are seen to be rurally insensitive.

**Recommendations:**

- Regional media initiatives focusing on mental health and well-being should give greater attention to the rural community and ‘at risk’ groups and should be supported by more localised and targeted communication activities.
- Consideration given to the piloting of a young persons’ smart phone app that specifically addresses the issue of mental health and emotional wellbeing.
- ‘Skype’ considered as potential part of solution in addressing mental health and emotional wellbeing needs of rural constituents and indicated at risk groups.
- Greater emphasis given to rural mental health research and rural at risk groups by DHSSPS, Public Health Agency and other agencies and organisations.
- More effort and resources directed at the issue of self harm. Consider developing ZEST NI initiative across the SWARD region.
- More localised and strategic collaboration, needs assessment and joint planning to address the full spectrum of mental health needs.

**Overview:****Facing the Challenge – The Impact of Recession and Unemployment on Men’s Health**

Conducted by the Institute of Public Health (IPH), this piece of research examines the link between unemployment and the recession on men’s health.

**Findings:**

- Almost universal experience of responding frontline projects saw health issues for men as being directly related to the recession, to unemployment or to the threat of unemployment.
- Mental health issues rated as more significant than physical health issues.
- Stress and anxiety and difficulties in communication most commonly identified related issues
- Increase in demand for help and support from men due to health problems directly related to unemployment and/or recession.

**Recommendations:**

- Making the case: ‘Cutbacks cost Money’.
- Initiatives needed that communicate effectively about positive health and self-esteem in relation to male unemployment.
- Improvement in understanding and approach taken by mainstream service providers in communication and positive outreach; targeted and accessible service provision; integration amongst key service provision areas; ‘basic humanity’ in dealing with clients.
- Formation of working partnerships and ‘mutual recognition’ between local and mainstream.

**Source of learning: Community feedback Cont'd****Overview:**

**Churches Research Programme. An exploration of the problems and barriers faced by clergy in the delivery of pastoral care to families bereaved by suicide. An exploration of the problems and barriers faced by clergy in the delivery of pastoral care to families bereaved by suicide.**

<http://www.compasswellbeing.org/Site/28/Documents/Dealing%20with%20suicide%20-%20March09.pdf>

**Findings:**

- Clergy feel that tackling suicide is a major issue and feel that faith based organisations should be involved in tackling it.
- Clergy generally lack any training as part of ministry for dealing with mental illness and suicide and have little awareness of advice and support services for mental health problems experienced by congregation members and others. They indicated that they would benefit by attending training on mental illness and suicide but are concerned about peer-perceptions of inadequacy, perceived hostility from secular organisations and lack of time for these activities.
- Theological perspectives on suicide and the sanctity of life, while still crucially important to clergy, are not a deterrent to offering compassionate pastoral care.
- Clergy are often unsure about how to approach a family following suicide. The importance of careful and sensitive choice of language was stressed; the fear of upsetting or offending families through a misjudged remark is particularly worrying.
- Most clergy feel that the best response they can offer to families is 'to be there' and offer a 'passive' response. Although religion and spirituality can be comforting, a religion-couched message to families bereaved through suicide was regarded as sometimes unwanted and unhelpful.
- An inter-faith dialogue and response to dialogue is both desirable and possible. Much interfaith connection currently exists and was thought useful but for some clergy there must be recognition that the beliefs and value systems within different faith groups preclude a straightforward, homogenous response to suicide.

**Recommendations:**

- Faith based organisations need to recognise the huge demands on their clergy in their pastoral care, from dealing with emotional distress through mental health problems to bereavement by suicide. Stress awareness and management would be a useful part of training for ministry.
- Clergy would appreciate clear, formal guidelines on the pastoral approach to suicide which would include all problematic areas for clergy – everything from how to respond to that first phone call to how to conduct a funeral in such circumstances and almost anything that would give them direction beyond common sense approaches upon which they usually rely.
- Clergy could be better supported throughout the years of their ministry by creating formal structures of peer-support (pastor pastorum).
- Some clergy may benefit from professional counselling support particularly following suicide by a member of the congregation.
- Clergy should be provided with education and awareness-raising regarding mental health problems, symptom recognition and the appropriate response and referral as part of the theological college curriculum.
- Health and social care agencies should recognise the pivotal community role of clergy. There is an urgent need for dialogue between clergy and mental health professionals.
- The provision of seminars and workshops that would be of greatest benefit to clergy would cover a complete programme on suicide awareness and bereavement by suicide.
- A set of guidelines for clergy on how to respond to people bereaved through suicide need to be drawn up collaboratively.

**Source of learning: Community feedback Cont'd****Overview:**

**Mapping mental health services in the West Belfast area. Research to inform the development of new referral pathways between primary/secondary care and community/ voluntary sector.**

**Findings:**

- The West Belfast area faces many challenges because of the high levels of socio-economic deprivation. The high levels of deprivation are linked to high levels of mental health and well-being difficulties, and these may be under-reported within GP QOF figures.
- A wide range of mental health and well-being services are provided by the statutory, community and voluntary sectors and GPs. In addition to service provision in West Belfast, many of these services are also provided to communities outside the area.
- Organisations frequently deal with people with emotional distress and mental ill-health and the information from the mapping exercise showed that over 10,000 people or contacts received counselling and advocacy in the community and voluntary sectors in the last year and almost 16,000 people or contacts received general support in the community and voluntary sectors.
- Some organisations reported during consultation that they currently operate at capacity. The issue of capacity to address need should therefore be taken into account in any discussions about the potential to address duplication of services.
- Although one organisation has waiting times of eight months for complementary therapies, most organisations provide services immediately or in less than two weeks.
- The community and voluntary sectors mainly provides services at Tiers 1, 2 and 3 in the Four Tiered Model of Care, particularly in relation to drugs and alcohol, anxiety, addictions and depression. The majority of specialist mental health and well-being services are provided by the Trust at Tiers 3 and 4.
- There were varying gaps in services identified by organisations participating in the mapping exercise. These centred on four themes: target populations, service types, lack of resources and joint working between organisations and sectors.
- The community sector and voluntary sector providers of mental health and emotional well-being services are a significant source of employment.
- It is estimated that £22.2 million is spent on mental health and well-being services in the area, giving an estimated per capita spend of £264. This investment in services should however, be set against the estimated cost to society of mental ill-health. It is estimated that the direct and indirect cost of mental ill-health in Northern Ireland is £3 billion. Based on a simple population share, the cost of mental ill-health in West Belfast would be £148 million – although this figure could be much higher, given the levels of deprivation and existing mental health issues within the area.
- A number of non-health service bodies provide funding for mental health and well-being projects or services in West Belfast.
- Approximately £7 million is provided to community and voluntary organisations for mental health and well-being services. This equates to 32% of the overall spend on mental health and well-being services.

- The community and voluntary sectors are over-reliant on short-term/non-recurring funding (62% of funding identified through the mapping exercise was non-recurrent). This has consequences in terms of the time organisations have to devote to seeking funding, uncertainty in terms of future service provision, and stress for staff. It also has implications in terms of sustainability of services provided and in terms of the knowledge referrers have of the services available and confidence in their sustainability.
- Most referrals to the community and voluntary sectors are self-referrals. There are some cross-referrals within the community and voluntary sectors, and between that sector and the statutory sector.
- The rate of referrals amongst GP practices varies. This reflects a combination of factors such as awareness of services available, confidence in the quality of services provided and patient choice.
- There is potential for developing a more integrated pathway of care with multiple points of entry and clear signposting across the range of services and service providers.
- There was a preference not to have a single point of entry to all mental health and well-being services across all sectors.
- Amongst the challenges identified during consultation was the development of a system of referral and cross-referral which is integrated, based on effective channels of communication and feedback in a way does not 'swamp' any part of the system.

#### **Recommendations:**

- To support referrers in having confidence in the quality of services provided, the West Belfast PCP should work with service providers in the statutory, community and voluntary sectors to develop policies, procedures, quality assurance mechanisms and governance arrangements. In particular, organisations should ensure that policies are developed and implemented in relation to drugs, alcohol and suicide and self-harm.
- The West Belfast PCP should review the gaps in services identified through the mapping exercise and consultation on the pathway of care under the themes of target populations, service types, funding and joint working, to determine how these may be addressed.
- The pathway of care should enable people to access support and care at multiple points, with clear signposting and referral arrangements where they need to move across the pathway of care. It should be computer-based (online) with links to general and specific sections of NICE Guidelines and the Northern Ireland Service Framework for Mental Health and Well-being. A website containing the pathway of care should also contain a database of providers of mental health and well-being services.

**Source of learning: Community feedback Cont'd****Recommendations Cont'd:**

- The West Belfast PCP should develop or agree a common screening tool for mental health to be used for initial assessment and should consider undertaking more detailed work as follows to cost the services and pathways for specific mental health disorders.
- Wherever possible, counselling should take place in community and voluntary sector organisations by accredited counsellors.
- Money should follow referrals and, wherever possible, community sector and voluntary sector organisations should receive funding on a three-year rolling basis (initially reviewable annually), linked to Service Level Agreements. Flexibility should be built in to the Service Level Agreements to cover not only specified numbers of inputs but also facilitates additional funding of inputs that are over and above those contracted.
- Discussion should take place between all funders and the LCG and PCP to agree a methodology for the pooling and subsequent allocation of resources for mental health and well-being services (both treatment and preventative) across West Belfast.

**Source of learning: Review of risk/protective factors for suicide****Overview:**

Research has helped to confirm that suicidal behaviour consists of a range of components that act together and which vary from one individual to another. Whilst acknowledging that suicide risk factors are multiple and interrelated, they are commonly identified as being either “distal” or “proximal” exposures.

Distal risk factors represent a threshold that increases individual risk for later vulnerability to proximal risk factors. A distal risk factor is not generally sufficient in itself to precipitate suicidal behaviour. Most suicidal behaviour is triggered when a proximal risk factor, such as a stressful life event, is combined with one or more distal risk factors.

Proximal risk factors are more closely related temporally to the suicidal event itself, and can act as precipitants. Such “triggering” events often differ with age, gender, and other demographic factors. In themselves, proximal risk factors are not sufficient for suicide. It is the combination of powerful distal risk factors with proximal events that can lead to the conditions for a suicide attempt.

Both distal and proximal risk factors can and do co-occur in individual, family, and community domains, and their co-occurrence is likely to be associated with the greatest risk for suicide. It is important to note that many individuals may have one or more risk factors and not be suicidal; on the other hand, the likelihood of suicide or suicidal behaviour increases with an increasing number of risk factors. Where someone has a combination of many of these factors, it may make sense to be assessed for suicidality regularly by a mental health professional.

### Findings:

#### Distal risk factors

- **Prior suicidal behaviours** - Previous suicide attempts and/or a family history of suicide attempts or completed suicide.
- **Deliberate Self harm** - Deliberate self-harm, and in particular repeat self-harm, represents the most important risk factor for future suicide<sup>8</sup>
- **Mental illness** - Any psychiatric diagnosis is a risk factor for suicide, particularly depression, bipolar disorder, substance use disorders, and personality disorders. People with more than one diagnosis are at elevated risk, there is consistent high association between psychiatric and addictive disorders with suicide.
- **Substance misuse** - The relationship being particularly strong for suicide rates in young people.
- **Early traumatic life events** - Child abuse (sexual or physical), serious parental neglect.
- **Personal characteristics** - Impulsivity, aggression, disruptive anti-social behaviour, poor inter-personal problem solving skills.
- **Disturbed family context** - A dysfunctional family environment with multiple stressors has been shown to contribute to suicidality. A family history of mental illness can increase the risk of suicide among adolescents and young adults.
- **Gender** - in Northern Ireland, males are three times more likely to die by suicide than females.
- **Sexual orientation** - Bisexuality and homosexuality are risk factors, particularly in adolescents.
- **Low socio-economic status/unemployment** - Especially in males.
- **Genetic loading** - There is increasing research interest towards the genetic basis/ pre-disposition for suicidal behaviour, however, there is, as yet, no inconclusive evidence.
- **Neurobiological disturbances** - Abnormalities such as serotonin system dysfunction.

**Findings Cont'd:****Proximal risk factors**

- **Stressful life events** - Major loss, humiliation, inter-personal conflicts, separations. Many people who make suicide attempts report a significant stressful event immediately prior to the attempt. The loss of a job, death of a loved one, major financial loss, or divorce may precipitate an attempt. An individual's perception of stress is highly subjective and determines the extent to which the stress increases suicide risk. The type of stressor also varies across the lifespan. An intense stressor in a young person might be a relationship loss or a humiliating experience, while in an older person it is more likely to be the death of a spouse, suspicion of a terminal illness, or perceived loss of independence.
- **Intoxication** - International research also indicates that 1 in 3 young people were intoxicated at the time of their suicide attempt. Intoxication, outside of a substance abuse diagnosis, is an immediate risk factor for suicide.
- **Functional impairment** - From physical illness or injury.
- **Suicide in the social milieu** - Exposure to suicidal behaviour of others, such as a friend, peer or media figure. This type of "contagion" is a potential precipitant to suicide, particularly in young people.
- **Sensationalist media reporting**
- **Accessible means** - Through firearms, poisons, medication, etc
- **Recent onset of suicidal thoughts** - Most suicide attempts occur within one year of first having suicidal thoughts. For this reason, this one-year window is seen as a critical time for treatment.
- **Incarceration** - Can be a precipitant for suicidality & to suicide, although individuals who end up in prisons often have a high number of distal risk factors as well. This is a complex causal relationship.
- **Occupation** - Some occupational groups are also at higher risk of suicide. Includes doctors (especially anaesthetists), nurses, dentists, pharmacists, veterinary surgeons and farmers. All of these professions have in common easy access to highly lethal poisons or drugs.

**Protective factors**

Many of the protective factors include those conditions and circumstances which help to strengthen mental wellbeing and emotional resilience such as:

- Physical health and activity;
- Supportive relationships;
- Secure employment;
- Social engagement;
- Educational attainment; and
- Secure emotional attachment in infancy
- Other protective factors include: Effective clinical care for mental, physical and substance disorders;
- Easy access to a variety of clinical interventions;
- Support for help seeking;
- Restricted access to highly lethal means of suicide; and
- Skills in problem solving, conflict resolution and nonviolent handling of disputes.

**Source of learning: Health Committee Inquiry into the Prevention of Suicide and Self Harm****Overview:**

This report was issued in May 2008 and the NI Executive approved the cross-departmental response in March 2009. The Committee's report is available at: [http://www.niassembly.gov.uk/health/2007mandate/reports/report27\\_07\\_08r.htm](http://www.niassembly.gov.uk/health/2007mandate/reports/report27_07_08r.htm)

The Executive response is available at: [http://archive.niassembly.gov.uk/health/2007mandate/reports/report27\\_07\\_08r.htm](http://archive.niassembly.gov.uk/health/2007mandate/reports/report27_07_08r.htm)

Most of the recommendations in the report have been fully implemented.

**Recommendations:**

- Strategy could be enhanced in a number of areas, e.g. by the establishment of a suicide prevention directorate and by expansion of "at risk" groups to include rural dwellers and older people.
- Ongoing involvement of bereaved families and community groups is vital.
- Opportunity exists to strengthen links between "Protect Life" and other mental health strategies through implementation of Bamford.
- Stakeholder involvement has been considerable; however, local authorities and sporting bodies could make a significant contribution.

**Source of learning: Updated Statistical Analysis****Overview:**

- As part of this strategy refresh process, the Department has updated its analysis of suicides and self-harm in Northern Ireland in recent years and in particular its impact on various Section 75 equality groups. Suicide information is taken from information on deaths recorded by the General Registrar's Office, although information is only generally available for gender, age and marital status.
- Similarly, self-harm is recorded in the Hospital Information system, which only holds information on gender and age. Incidents of self-harm which result in admissions to hospital are recorded in the DHSSPS Hospital Inpatients System (HIS) which uses the International Statistical Classification of Diseases and related health Problems(ICD), the same as used in the classification of deaths.

**Findings:**

- Males accounted for over three quarters of the 1,288 suicides (77.0%) that occurred in Northern Ireland between 2005 and 2009.
- From 2005 to 2009, 36.8% of all suicides involved persons between the ages of 15 to 34, and 24% of suicides were in the 35 to 44, age bracket. The average age for all deaths by suicide was 41 years of age.
- Between 2005 and 2009, 30.7% of all deaths occurring in the 25 to 34 years age bracket were attributable to suicide.
- Urban areas have a higher average suicide rate per 100,000 persons(16.3) than rural areas (11.7).
- The average suicide rate per 100,000 persons in the most deprived Areas (29.1) was almost three times that in non- deprived areas (11.6).
- Females accounted for 12,417 (53%) of the total admissions to hospital for self-harm between 2005/06 and 2009/10.
- Three quarters of all self-harm admissions (75.95) between 2005/06 and 2009/10 were for persons aged under 45.
- Highest average admission rates for self -harm was within the 15-24 years age group.

**Source of learning: Northern Ireland Stakeholder Feedback from Major Conferences****Findings:**

Northern Ireland suicide prevention practitioners and professional staff have participated in a range of major conferences on suicide. A summary of their reported main learning points is set out below.

**Recommendations:**

- Highly visible leadership across the community - from politicians, church leaders, health, education and employment leaders - contributing to a more coherent, united suicide prevention movement is vital.
- Importance of meaningful engagement with crisis service users and carers in how services are designed, delivered and evaluated – including a clear strategy to bring closer engagement with service seekers/service users and carers.
- Need for in-depth consideration of the strengths and limitations to the US logic model for crisis helpline support and follow up, to help establish what works best at crisis point.
- There are opportunities to learn from the marketing of crisis counselling and support services by the Veterans Administration crisis helplines in the US, particularly when outreaching to men and the use of chat and text contact.
- Need for an integrated health care systems approach between the C&V sector and the Trusts with particular reference to accessing urgent /emergency mental health assessments.
- Need for “safe places” within communities where individuals in crisis and/or their carers can have timeout to reduce the intensity of the crisis.
- A case management approach for complex cases - ie individuals with high levels of risk/distress who present to numerous services such as A&E, mental health services, community support, etc on a regular basis - is well established in Scotland. Under this approach one organisation takes the lead in coordinating care with the service user and enhances the communication between the organisations to prevent the individual from falling “through the net”. Consider a pilot in Northern Ireland.
- Funding/resourcing should require collaborative approaches and clear joint working protocols. There should be an audit of current service providers and a re-examination of roles and responsibilities with a view to bringing clarity and cohesion about ‘who does what, when, how and where’. This then needs to be communicated to all stakeholders in suicide prevention.
- Training on suicide prevention for all frontline workers – teachers, social workers, A&E staff, emergency services staff, youth workers, etc.
- Standardised assessment for those at risk of suicide across both the statutory and VCA sectors.
- Develop a set of protocols and principles for all agencies who deliver crisis services leading to designation of accredited crisis centres to which statutory sector will have confidence to make referrals.
- Greater integration of mental health, suicide prevention, & substance misuse services and strategies.

## APPENDIX 4 - TECHNICAL NOTE ON ECONOMIC COSTS OF SUICIDE

### DIRECT COSTS

- Emergency Services costs: in Northern Ireland an emergency ambulance attends most instances of suicide – the average cost of an emergency journey by NIAS is estimated to be £363 (DHSSPS calculation for 2010/11); there will also be costs attributable to Police Service and Coroner Service attendance at instances of suicide, and Police/ Courts Services follow-up investigations – it has not been possible to quantify these in monetary terms. In some instances NIFRS may be called on to help retrieve the body. It has not been possible to obtain a cost figure for this.
- Post Mortem costs: average cost of £1,534 in 2010/11, (Source: Forensic Services Branch, DoJ)
- Funeral and Wake costs: average of £6,801 for UK in 2010 (Source: Sun Life Direct).
- Total Direct Costs of suicide are assumed to be approximately £8,698 per suicide fatality.
- Self-harm hospital inpatient treatment costs: £2.674m for 2010/11 (Source: DHSSPS – HRG costs). Other HSC treatment costs for self-harm i.e., A&E, Outpatient, community and personal social services costs are likely to be significant and, in some cases long-term. It has not been possible to quantify these costs or the costs of self-harm counselling services provided in NI by the voluntary and community sector.

### INDIRECT COSTS

- UK Department for Transport's (Transport Analysis Guidance (TAG) Unit 3.4.1, April 2011) value of a prevented road fatality which corresponds to the value of lost output, estimated at £0.560m, uplifted to 2010/11 prices by the UK GDP deflator.
- Value of unpaid work on activities such as volunteering, caring for relatives and general housework: figures (in 2005 prices (£)) have been adopted from Scottish Executive paper, "Evaluation of the First Phase of *Choose Life*" (September 2006) and uplifted to 2010/11 prices (£) by application of the UK GDP deflator, resulting in average values for men and women of £68,455 and £149,695 respectively.
- Self-harm lost output costs for NI have been estimated based on the approach used in a study done for the Republic of Ireland, "The Economic Cost of Suicide and Deliberate Self-harm in Ireland," by Kennelly, Ennis and O'Shea (2004). There were 4,822 NI admissions (events) in 2010/11 for self-harm. Lost output costs per person from the RoI study for 2002, were adjusted for the sterling/euro exchange rate and uplifted to 2010/11 prices by application of the UK GDP deflator. For NI in aggregate these costs are: £2.845m (for paid work) and £1.119m (for unpaid work – housework, volunteering etc.). No adjustment has been made for relative RoI/NI wage rates.

## INTANGIBLE COSTS (APPLIES TO SUICIDE CASES ONLY)

- Data from the UK Department for Transport's TAG Unit 3.4.1, April 2011 provides information on the value the public places on prevention of road fatalities. This provides specific data on the intangible costs of death including pain, grief and suffering and lost life experiences for both the victim and their relatives.
- The value from TAG for the intangible human costs is £1.067m per fatality, uplifted by the UK deflator to 2010/11 prices.

**Figure 21: Estimated Economic Costs of Suicide & Self-harm in Northern Ireland for 2010/11**

	Males (n = 240)	Females (n = 73)	All Persons (n = 313)
<b><i>Suicides</i></b>			
Direct Costs (£)	-	-	2,722,500
Indirect Costs (£)			
Paid	-	-	175,280,000
Voluntary	16,429,200	10,927,700	27,356,900
Intangible Costs (£): (£1.67m per person)	256,080,000	77,891,000	333,971,000
<b>Total Costs of Suicide (£):</b>	-	-	<b>539,330,400</b>
<b><i>Self-Harm</i></b>			
Direct (hospital) treatment costs (£):	-	-	2,674,000
Indirect Costs (£):			
Paid	-	-	2,845,000
Voluntary	-	-	1,118,700
<b>Total Costs of Self-harm (£):</b>	-	-	<b>6,637,700</b>
<b>Total Costs of Suicide and Self-harm (£):</b>	-	-	<b>545,968,100</b>

## APPENDIX 5 - IMPACT ASSESSMENT

14. As part of the development of the original “Protect Life” Strategy, the Department used the Integrated Impact Assessment Screening Tool to determine if the Strategy had any negative economic, health, rural, environmental, social, human rights, homelessness, victims, or community safety impacts. Additional consideration was given to the Strategy’s equality impacts. The Department considered that the policy should impact positively on the health and emotional wellbeing of the general population, and that the Strategy and Action Plan does not adversely impact on any of the Section 75 groups and therefore a full Equality Impact Assessment was not required.
28. The conclusions from this screening exercise are available online at **<http://www.dhsspsni.gov.uk/impact-assessment-05-06.pdf>**
29. In light of the above findings, and given that this document is a refresh of the original Strategy rather than the development of a new policy, no formal impact screening has been undertaken on this occasion. It should be noted that the Strategy refresh has been overseen by the regional Suicide Strategy Implementation Body, which contains representatives from many of the Section 75 groups. Development of the next phase of the local suicide prevention Strategy will include a further public consultation exercise and a new equality impact screening.
30. The Bamford Review of Mental Health and Learning Disability (NI) also identified significant gaps in resources for mental health services. This refreshed “Protect Life” Strategy continues to support the implementation of the Bamford Action Plan (2012 - 2015).

## APPENDIX 6 - SUICIDE STRATEGY IMPLEMENTATION BODY (SSIB)

- Mr. Colm Donaghy, Belfast Health and Social Services Trust (Chair)
- Mr. Colin Loughran, Action Mental Health
- Mr. Pat Lynch – AWARE Defeat Depression
- Ms. Anne Donaghy, Ballymena Borough Council
- Mr. Gerard Treacy, Department of Agriculture and Rural Development
- Ms. Dorothy Angus, Department of Education
- Mr. Stephen Jackson, Department of Enterprise and Learning
- Mr. Cyril Anderson, Department of Enterprise, Trade and Investment
- Mr. Chris Deconnick, East Belfast Community Development Association
- Mr. Bobbie Cosgrove, East Belfast Bereaved Family Representative
- Ms. Maura Sharkey, Families Voices Forum
- Reverend John McClure – Four Churches Representative
- Mr. Ronan Henry, Department of Health, Social Services and Public Safety
- Mr. Gerard Collins, Department of Health, Social Services and Public Safety
- Mr. Martin Bell, Department of Health, Social Services and Public Safety
- Mr. Colin McMinn, Department of Health, Social Services and Public Safety
- Mr. Dennis Chirgwin, Department of Justice
- Ms. Barbara McGread, Department of Social Development.
- Ms. Fiona McClements, Dungannon Borough Council
- Mr. Chris Deconnick, East Belfast Community Development Association
- Ms. Anne Bill, Forum Against Substance Abuse
- Mr. Aidan Murray, Health and Social Care Board
- Mr. Michael Doherty, Lenadoon Community Counselling Project
- Ms. Jo Murphy, Lighthouse
- Mr. Pam Hunter, Nexus
- Mr. Graham Logan, Northern Ireland Association of Mental Health
- Ms. Catherine McBennett, Niamh Louise Foundation
- Mr. Stuart Buchanan, North Down YMCA.
- Mr. Philip McTaggart, PIPS
- Mr. Seamus McCabe, PIPS, Newry and Mourne
- Ms. Yvonne Cooke, Police Service Northern Ireland
- Ms. Mary Black, Public Health Agency
- Ms. Madeline Heaney, Public Health Agency
- Mr. Brendan Bonner, Public Health Agency

- Mr. John O'Doherty, Rainbow Project
- Dr Philip McGarry, Royal College of Psychiatrists
- Ms. Deborah Gavin, Rural Support
- Ms. Suzanne Costello, Samaritans
- Ms. Fiona Molloy, South East Trust
- Mr. Eamonn McCartan, Sport NI
- Ms. Claire Curran, Survivors of Suicide
- Mr. Barry McGale, Western Health and Social Services Trust

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**NOTES**



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June 2012