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Protect Life 2:

a draft strategy for suicide prevention in the north of Ireland

Department of Health

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MINISTERIAL FOREWORD

There are few things worse than a person believing there is no hope or help available and no feasible course of action other than to take their own life. Each life lost to suicide is a tragic loss of opportunity and potential and each life lost is one life too many.

Suicide is an issue which is much wider than health; it affects us all. I will therefore continue to work with my colleagues on the Ministerial Coordination Group on Suicide Prevention and to apply a cross-government approach to suicide prevention. Above all, we will continue to involve communities and individuals whose lives have been affected by the suicide of family, friends and neighbours. It is only through this co-ordinated working that we can meet the challenge of reducing suicide rates.

Local academic research has shown the impact of transgenerational trauma and high rates of suicide on communities here who have been exposed to years of violence during the period of community conflict. Combined with higher levels of mental health need it is clear that a long-term approach to reduce suicide is a priority for our society.

Suicide rates in the most deprived areas here are three times higher than in the least deprived; for self harm that differential is four times higher. Men continue to be three times more likely to die by suicide than women. As Minister, I am committed to tackling inequalities and I will ensure that resources continue to be focused on reducing these differentials.

This Strategy identifies a number of areas for discrete focus to achieve our purpose of reducing inequalities and the suicide rate in the north of Ireland. In particular tackling repeat self harm which is a major risk factor for suicide; a focus on those who have been bereaved by suicide; and improving the initial response to the care and recovery of people experiencing suicidal behaviour. Our goal is to Protect Life and I believe that this can be achieved through effective evidence-based intervention, treatment and support. I look forward to hearing the views of all stakeholders to this consultation.

Michelle O’Neill MLA
Minister for Health

EXECUTIVE SUMMARY

Overview

North of Ireland context

In the north of Ireland an average of 274 people die by suicide each year and many more are affected by suicidal thoughts at some point in their lives. Self-harm is considered alongside suicide because it is a major risk factor for subsequent suicide. The risk of suicide in the first year after self-harm is between 60-100 times greater than the risk of suicide in the general population. The suicide rate here between 2005 and 2014 has been 15.3 deaths per 100,000 of population.

There is a health inequality aspect to the burden of suicide with the suicide rate in the 20% most deprived areas - at around 30 deaths per 100,000 people - almost twice the average in the north of Ireland and three times the rate experienced in the 20% least deprived areas. The aim of reducing the differential in the rate between the most deprived and least deprived areas average will be retained from the first *Protect Life* strategy.

In addition, there is a gendered aspect to suicide with men three times more likely to die by suicide than women. Males aged 20-50 have the highest suicide rate.

The difficulty in attributing outcomes or impacts to a single suicide prevention strategy is widely recognised since many other factors, such as unemployment and community violence, can exert an influence on suicide rates.

Self-harm is a serious public health issue in its own right. Between April 2013 and March 2014 there were 8,453 presentations at hospital emergency departments here as a result of self-harm. Almost 6,000 people presented and 20% of these on more than one occasion. The rate of self-harm here is 327/100,000 of population - 64% higher than in the south of Ireland. Alcohol was involved in almost half of all presentations.

Priority population groups

While suicide is not exclusive to specific population groups, risk factors provide a clear indication that certain population groups are vulnerable to suicide. The reasons behind the increased risk will vary, but include issues such as victimisation, bullying, isolation, trauma and exposure to violence, hopelessness, and access to lethal

means of suicide. The priority groups identified for suicide prevention are indicated in the text box below:

LGBT people **Migrant populations and ethnic minorities** **Homeless people** **Those who have experienced abuse/conflict, including sexual abuse and domestic violence** **"Looked after" children and care experienced children** **Those with PTSD as a consequence of the conflict in the north of Ireland**	**People who are long-term unemployed** **Certain occupations such as farming, the military (including veteran populations), dentistry, and 'low status' occupations** **Males aged 19 to 55, especially those who live in areas of deprivation** **Those in contact with the justice system** **People with mental illness, including addiction disorder** **Travelling community**

Suicide prevention services

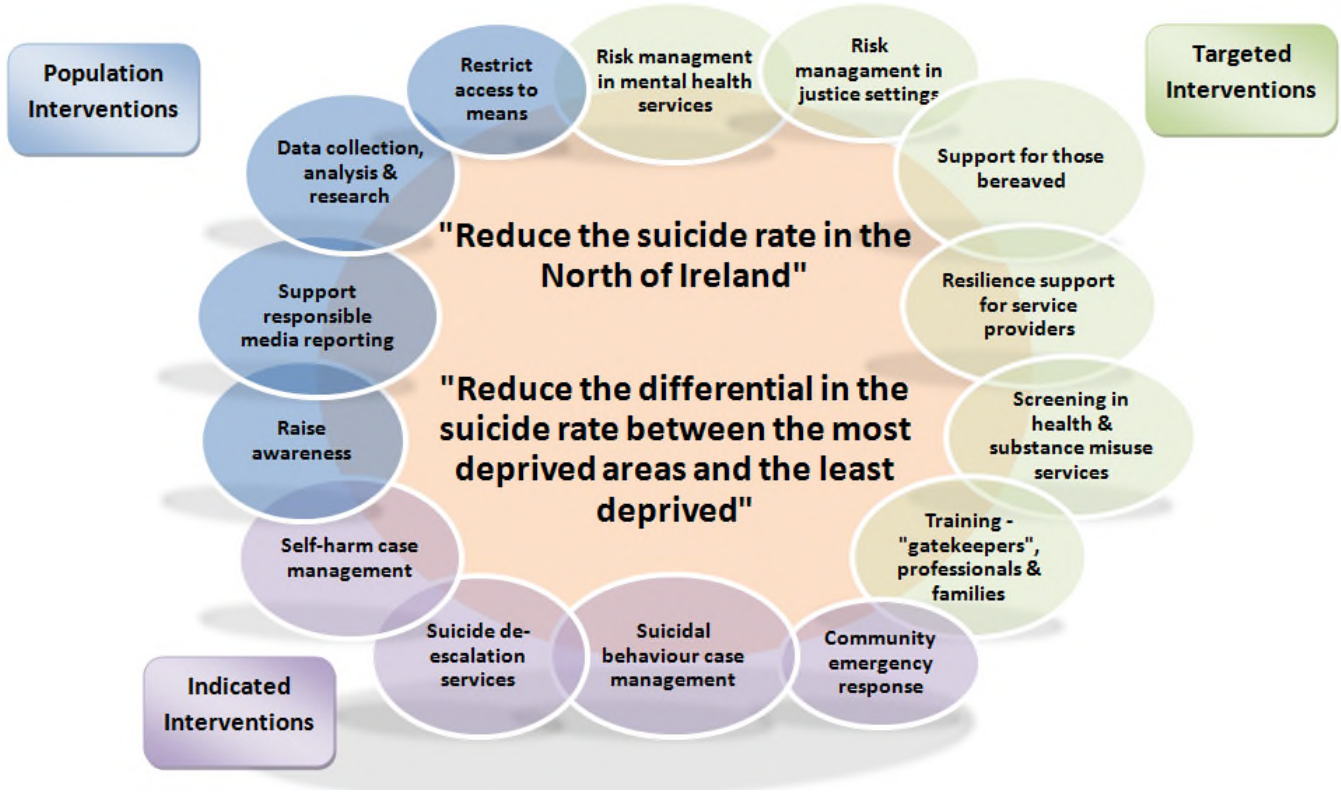
Currently £7m per annum is invested in suicide prevention services in the north of Ireland by the Department of Health (DoH). In addition to this, there is a significant contribution from charities and the community sector; mental health services; and from other Departments. This funding has covered a wide range of services including Lifeline; training; counselling; Self-harm Registry; Self-harm Intervention Service; public information campaigns; and community response plans.

Evidence has supported the continued use of both population-based approaches designed to influence attitudes and behaviours; as well as targeted intervention for groups at higher risk of suicide; and indicated intervention for those in crisis.

Priorities

The proposed priority areas for achieving the aims of the *Protect Life 2* strategy are set out below. It will be essential to ensure that support services and awareness-raising reaches out to all marginalised and disadvantaged groups that are at increased risk of suicide.

We will also seek to raise awareness of high risk occupations and develop a culture of help-seeking among people in occupations that have a high risk of suicide and self-harm.



Objectives

Protect Life 2 will seek to build on what has been achieved through the previous Strategy whilst taking action to address those areas where gaps have been identified or further improvements deemed necessary. Ten objectives, focussing on priority areas and risk factors, have been identified for the Strategy.

Objective 1 – Fewer people who are in contact with mental health services, die by suicide.

28%[1] of people who died by suicide in the north of Ireland were known to mental health services and 50% had been taking medicine for mental illness. Where people at high risk of suicide are known to services, there is an opportunity to reduce that risk and improve patient safety.

Objective 2 – Reduce the incidence of repeat self-harm presentation to hospital emergency departments.

Repeat self-harm is the major risk factor for suicide. Presentation at hospital emergency departments due to self-harm provides an opportunity to act quickly and link those at risk with services.

Objective 3 – Improve the understanding and identification of suicidal and self-harming behaviour, awareness of self-harm and suicide prevention services, and the uptake of these services by people who need them.

Stigma related to suicide remains a major obstacle to suicide prevention efforts. It isolates and may prevent people from seeking help, even though they are in distress. Better understanding of the issues should help reduce stigma and encourage help-seeking behaviour. It should also increase the likelihood of early recognition of suicidal behaviour and suicide risk, thereby improving the chances of early intervention for more people.

Low levels of engagement with mental health services by those who have died by suicide is a cause for concern. This is particularly true for men and probably reflects a reluctance to disclose mental health difficulties. This further highlights the need to raise public awareness of mental health, address stigma around disclosure of suicidal feelings, and encourage help-seeking.

Objective 4 – Enhance the initial response to, and care and recovery of, people who are experiencing suicidal behaviour and to those who self-harm.

Those who are the first point of contact need to have the necessary knowledge, skills and attitudes to deliver compassionate and supportive care. Suicide rates in Scotland have been declining; those responsible for the Scottish *Choose Life* strategy attribute the achievement of a target of training 50% of first responders and health care staff as an important contributory factor for this outcome.

Objective 5 – Restrict access to the means of suicide, particularly for people known to be self-harming or vulnerable to suicidal thoughts.

Reducing access to the means of attempting suicide is a particularly effective prevention intervention because some people make a suicide attempt impulsively in direct response to a personal (and sometimes short term) crisis. The presence of alcohol, particularly alcohol intoxication, increases impulsivity and may create

temporary depression. If lethal means are not available or if the person survives the attempt, suicidal thoughts may pass or there may be time to intervene in other ways or to seek help.

Given that most suicide attempts take place in or near the home and that the most commonly used means are easily accessible, it is recognised that the potential for restricting access to means in all cases is limited. Nevertheless, it is important to be vigilant and to restrict access to means where possible.

Restricting access to means also covers media reporting of suicide which should avoid reporting excessive detail about the methods of suicide.

Objectives for postvention support

Objective 6 – Ensure the provision of effective and timely information and support for individuals and families bereaved by suicide.

Losing a loved one to suicide is one is of life's most painful experiences. The feelings of loss, sadness, and loneliness experienced after any death of a loved one are often magnified in suicide survivors by feelings of guilt, confusion, rejection, shame, anger, and the effects of stigma and trauma. Families and friends bereaved by suicide are at greater risk of depression and future suicidal behaviour and often require specific supportive measures and targeted treatment to cope with their loss.

It is estimated that around six people are intensely affected by every suicide death and a further 60 people are deeply affected. On this basis, an estimated 42,000 people in the north of Ireland have been intensely affected by suicide since 1970 and around 10% of the population have been profoundly affected by suicide.

Objective 7 – Provide effective support for 'self-care' for voluntary, community, and statutory sector staff providing suicide prevention services.

Patient, client or parishioner suicide is very distressing for those who have been supporting the individual on a professional/vocational basis. It can exact a heavy toll on their personal wellbeing and professional confidence. Self-care complements suicide prevention services, and there is a need to consider mechanisms for better

psychological and professional support for those who experience suicide as part of their professional or voluntary practice.

Objective 8 – Enhance responsible media reporting on suicide.

Appropriate media reporting of suicide can make a positive contribution to public understanding of suicide, and to the promotion of help-seeking behaviour and suicide prevention. Inappropriate media reporting causes considerable stress and trauma to those bereaved by suicide and can lead to 'copycat' behaviour, especially among young people and those already at risk.

Objective 9 – Identify emerging suicide clusters and act promptly to reduce the risk of further associated suicides in the community.

There is a risk of 'copycat' suicides, particularly among young people, when a member of a community dies by suicide.

Objective 10 – Strengthen the local evidence base on suicide patterns, trends and risks, and on effective interventions to prevent suicide and self-harm.

The epidemiology of suicide and suicidal behaviour changes needs to be monitored to understand the drivers for suicide and self-harm, and to identify the most at risk groups and individuals. This in turn informs preventative measures and where/at whom these should be targeted. In essence, suicide and self-harm requires ongoing analysis and research.

Governance

The Ministerial Co-ordination group on suicide prevention will continue to provide oversight, leadership and impetus for cross-departmental collaboration and co-ordination. Strategic oversight will continue to be led by DoH who will also continue to support the rollout of the Strategy by setting suicide prevention priorities and outcomes in the relevant commissioning plans for the Health and Social Care system which are updated annually. It is proposed that implementation of the Strategy will be through a new Protect Life 2 Implementation Steering Group chaired by the Public Health Agency. They will be supported by the Suicide Strategy Implementation Body, and Protect Life Implementation Groups. There may be further recommendations around structure arising from the Future Search process in Belfast.

SECTION 1

INTRODUCTION

Chapter 1: STRATEGY PURPOSE, AIMS AND SCOPE

Purpose and aims

The purpose of this strategy is to define priorities and objectives for reducing the prevalence of suicide in the north of Ireland and the differential in suicide rates between the most deprived and least deprived areas here, and to set out an action plan for doing so over the period 2016 to 2021.

The aims are to: gain a better understanding of suicidal behaviour in the north of Ireland; improve the identification of and response to suicidal behaviour; prevent suicide by people in crisis; support recovery from suicidal behaviour and repeat self-harming; and support those bereaved by suicide.

Scope

The strategy focuses primarily on: those who self-harm; those who are in emotional crisis and at risk of suicide; those who are already suicidal; and those who are bereaved by suicide. It also covers population-wide awareness-raising of suicide and suicidal behaviour, and how to respond to this in order to prevent suicide.

There is general consensus that action to address suicide and self-harm must be wide-ranging and address the social determinants that adversely affect our mental health and wellbeing. Policies and programmes that help address the wider societal risk factors for suicide are identified in **Appendix 2** (Policy Context).

The importance of early intervention to enhance the emotional resilience of those groups and individuals who are at risk of poor mental wellbeing is also recognised as this can increase a person's vulnerability to suicidal behaviour in the face of adverse life events. Effective suicide prevention requires measures to sustain positive mental health and wellbeing in people before they become suicidal.

The Department, therefore, intends to develop a specific action plan for the promotion of positive mental health under the Public Health Strategic Framework *Making Life Better*. This will be complementary to the *Protect Life 2* Action Plan and

to the Service Framework for Mental Health which also impacts on the suicide and self-harm agenda.

Principles

The core principles are that strategic action should:

- be evidenced-based, where possible;
- be in effective partnership/collaboration with public and private sector organisations, academia, professional bodies, and voluntary and community agencies - including community groups and organisations representing bereaved families;
- be co-ordinated across government. Improve cross-sectoral, cross-departmental and cross-jurisdictional collaboration in the development and delivery of policy and services which contribute to suicide prevention;
- strive to reduce inequalities in the burden of suicide; and
- achieve measurable outcomes and be amenable to evaluation.

Chapter 2: SUICIDE AND SELF-HARM – THE NORTH OF IRELAND CONTEXT

Introduction

Suicidal ideation, suicidal intent or behaviour, and self-harm are highly complex social and personal issues and worldwide phenomena. The World Health Organisation has recognised suicide prevention as a global imperative given that an estimated 800,000 people die by suicide annually across the globe.[2] In the north of Ireland, an average of 274 people die by suicide each year and many more are affected by suicidal thoughts at some point in their lives.[3]

Suicidal behaviour differs between gender, age groups, social groups, and socio-economic settings. At a population level, disruption of traditional social structures tends to lead to an increase in suicide rates due to loss of social cohesion and common values. This is compounded where there is an increase in adverse social circumstances such as poverty and unemployment.

Self-harm (non-fatal self-poisoning or self-injury, irrespective of the degree of suicidal intent) is considered alongside suicide because it is a major risk factor for subsequent suicide. The risk of suicide in the first year after self-harm is between 60 to 100 times the risk of suicide in the general population.[4] The *Northern Ireland Lifestyle and Coping Survey* published in 2010 indicates that 10% of 15/16 year olds in the north of Ireland have self-harmed at some stage.

The concept of a 'suicidal process' - which incorporates the development of suicidal ideas, and then non-fatal self-harm, and ending, in some cases, with suicide – has gained ground.[5] However, suicide is not inevitable. This is one of the myths about suicide that the World Health Organisation seeks to expose (see **Box 1**) in order to remove barriers to the effective prevention of suicide. The WHO "myths" and "facts" have helped inform the development of this strategy and the approach that will be taken to suicide prevention in the north of Ireland.

Box 1: WHO myths and facts about suicide[6]

Myth	Most suicides happen suddenly without warning.
Fact	The majority of suicides have been preceded by warning signs, whether verbal or behavioural. Of course there are some suicides that occur without warning. But it is important to understand what the warning signs are and look out for them.
Myth	Someone who is suicidal is determined to die.
Fact	On the contrary, suicidal people are often ambivalent about living or dying. Someone may act impulsively and die a few days later, even though they would have liked to live on. Access to emotional support at the right time can prevent suicide.
Myth	Once someone is suicidal, he or she will always remain suicidal.
Fact	Heightened suicide risk is often short-term and situation-specific. While suicidal thoughts may return, they are not permanent and an individual with previously suicidal thoughts and attempts can go on to live a long life.
Myth	Only people with mental disorders are suicidal.
Fact	Suicidal behaviour indicates deep unhappiness but not necessarily mental disorder. Many people living with mental disorders are not affected by suicidal behaviour, and not all people who take their own lives have a mental disorder.
Myth	Talking about suicide is a bad idea and can be interpreted as encouragement.
Fact	Given the widespread stigma around suicide, most people who are contemplating suicide do not know who to speak to. Rather than encouraging suicidal behaviour, talking openly can give an individual other options or the time to rethink his/her decision, thereby preventing suicide.

Suicide trends and incidences in the north of Ireland

The Northern Ireland Statistics and Research Agency (NISRA) provides data on suicide trends by age, gender, geographical area and deprivation level.

The suicide rate in the north of Ireland between 2005 and 2014 has been 15.3 deaths per 100,000 of population. The total number of deaths registered over this period is 2,738. This is over three times higher than the total number of deaths in road traffic accidents over the same period. It is estimated that for every death by suicide, six members of the immediate family are intensely affected and up to 60 other people are deeply affected. This means that over the period 2005 to 2014, around 165,000 people in our society have been directly affected by suicide.

In considering the years in which deaths actually occurred, as opposed to when they were registered as suicides, it is clear that suicide rates remained relatively stable up until the late 1990s and then increased steadily until the mid 2000s. The suicide rate

has remained relatively constant since the implementation of *Protect Life* 2006. This may be reflective of the positive contribution of the Strategy given the difficult economic situation in recent years - there is evidence that the global economic recession has had a major effect on suicide, particularly in European males.[7] Nevertheless, it is notable that the north of Ireland experienced an overall increase in suicides in the last decade; while England, Scotland and Wales had a reduction.

Figure 1: Number of Deaths Registered as Suicide 2004-2014

Male

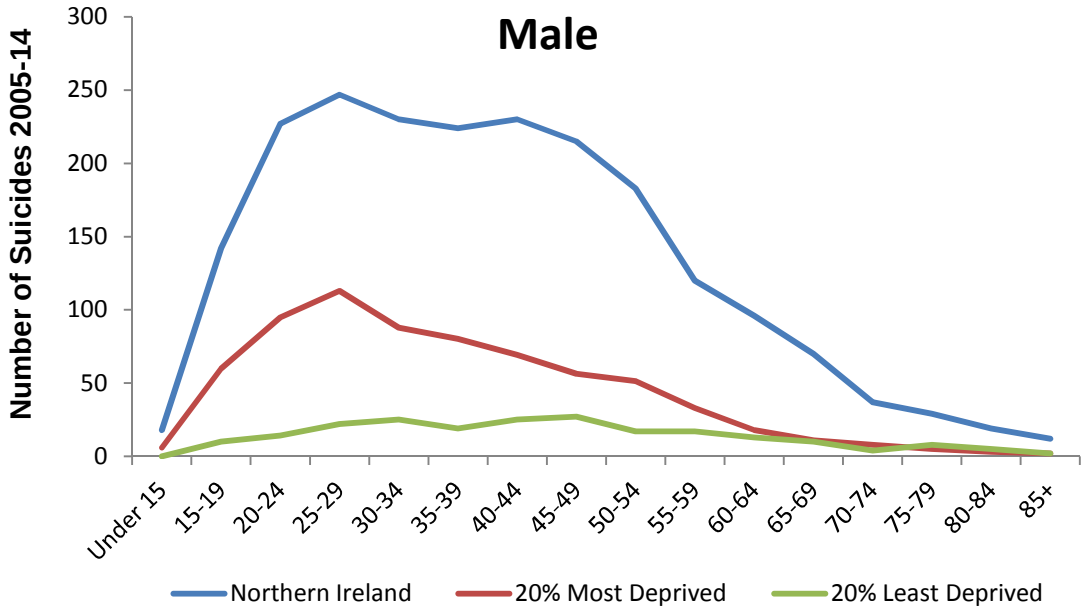
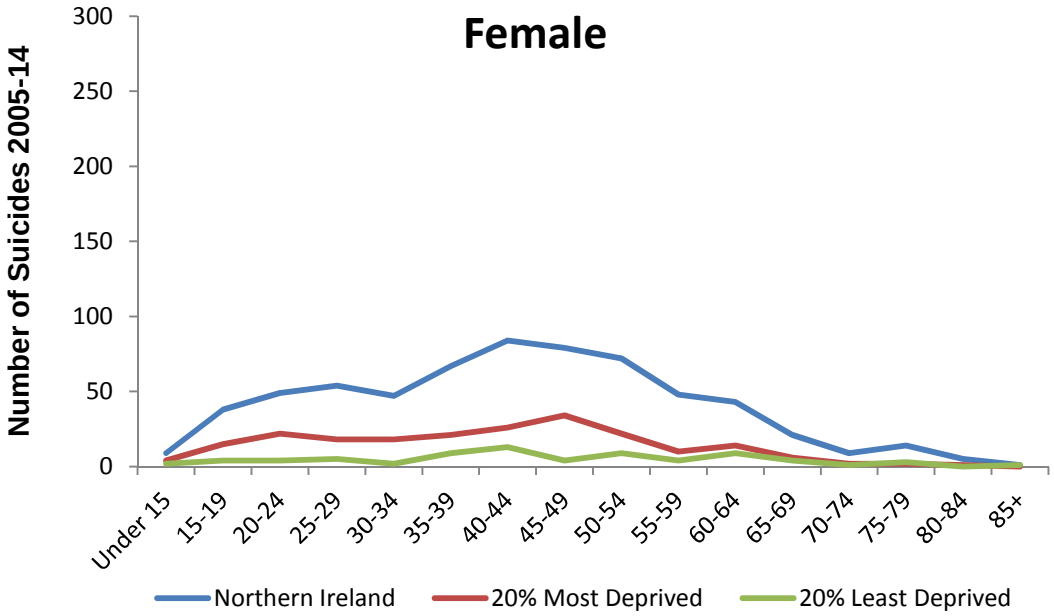


Figure 2: Number of Deaths Registered as Suicide 2004-2014

Female

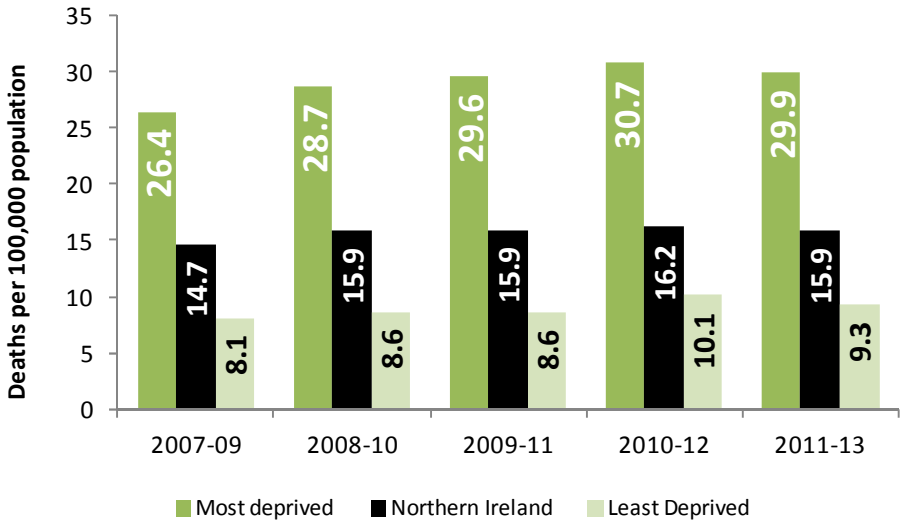


Source: Health & Social Care Inequalities Monitoring System (original deaths data from Demography & Methodology Branch, DFP).

Deprivation

There is a health inequality aspect to the burden of suicide.[8] The suicide rate in the 20% most deprived areas, at around 30 deaths per 100,000 people, is almost twice the north of Ireland average and three times the rate experienced in the 20% least deprived areas. Meanwhile, the suicide rate in rural areas is a quarter lower than the north of Ireland regional average.

Figure 3: Crude Suicide Rate: Deprivation Time Series



Source: Health & Social Care Inequalities Monitoring System

Suicide rates are quoted per 100,000 of population in order to adjust for the underlying population size. Smaller populations tend to produce rates that are less reliable as differences in the number of suicides have a proportionately bigger impact on the rate than in larger populations. For this reason, it is not common practice to use rates per 100,000 when considering suicide prevalence in specific population sub-groups in the north of Ireland, such as ethnic minorities.

When comparing trends over time it is important to consider a relatively long period. Increases and decreases for a year at a time should not be considered in isolation as there may be fluctuations year-on-year which hinder the identification of longer-term trends in suicide rates. For this reason, suicide rates quoted in this document are based on three year rolling averages.

It is clearly important to retain the goal of a substantial reduction in the north of Ireland suicide rate and the aim of reducing the differential in the rate between the most deprived areas and the least deprived. However, the difficulty in attributing outcomes or impacts to a single suicide prevention strategy is widely recognised since many other factors, such as unemployment and community violence, could exert an influence on suicide rates.[9] The Northern Ireland Audit Office has noted

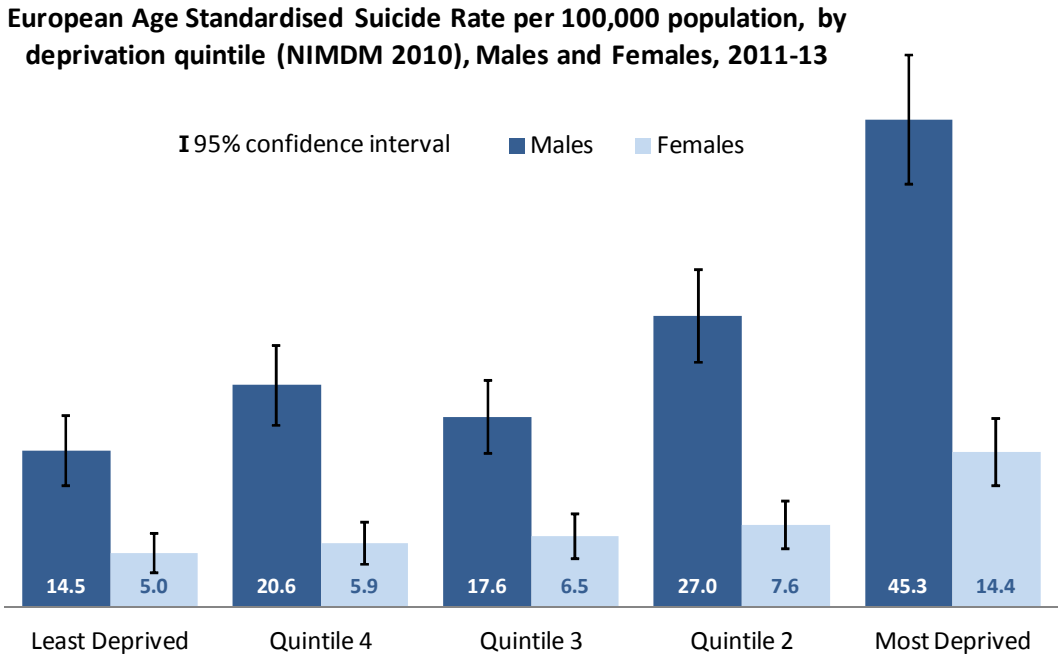
that, while the relative impact of strategies on suicide is important for planning, it is difficult to quantify.[10] In view of this, it is important to identify objectives (see Chapters 6 and 7) on which this strategy can have a measurable impact.

Gender and suicide

It is clear there is a gendered aspect to suicide in the north of Ireland with men three times more likely to die by suicide than women, and males aged 20 to 50 having the highest suicide rate. This is partly the result of differences in the methods used in terms of lethality.[11] [12] There is also evidence that long accepted cultural perceptions of masculinity - characterised by competitiveness, risk-taking and enduring hardship without displaying feelings - impact negatively upon men's help-seeking behaviour. [13] Males can be reluctant to disclose mental health concerns to their GP and often present with physical symptoms rather than mental health issues.

The "*Engaging Young Men Project*",(http://www.mhfi.org/EYMPmappingreport.pdf) cites substantial evidence that young men's inability to seek help for emotional and mental health problems is influenced by low educational attainment, low socio-economic background, and by adopting the traditional masculine ideal. It found that young males in both parts of Ireland are: more likely to turn to alcohol and drugs as coping strategies; less likely to report personal susceptibility to depression; tend not to have the same supportive friendships as young women; and are less likely to confide in family members about emotional issues.

Figure 4



The project also notes that young men use the Internet and technology as a way to seek help for mental health issues in preference to more conventional health services, and that their help-seeking intentions tend to decline as thoughts of suicide increase. This indicates a need for interventions that focus on the different means of suicide used by men and women; their different approaches in coping with psychological distress; and on their different attitudes to help-seeking. Men in particular are known to benefit from many of the broad measures relevant to suicide prevention such as action on alcohol and drugs; economic inactivity; and treatment of depression in primary care.

Urban and rural experiences

Suicide is more prevalent in urban areas, especially in large towns and cities. However, rural dwellers have experienced a unique set of circumstances and challenges in recent years including an ageing population, decline in farm incomes, changing labour markets, and depopulation/migration in some areas.

Certain factors have been identified as creating risk and stress to people living in rural areas over and above the risk factors for suicide affecting general populations. These include isolation, barriers to accessing services, a more conservative approach to help-seeking, heightened stigma associated with mental health issues,[14]

being ‘different’ (e.g. LGBT) in a rural context[15], availability of some means of suicide (firearm ownership, pesticides), and high risk occupational groups such as farmers and vets.

Stigma attached to mental illness is often seen, in rural areas in particular, as posing a substantial threat to reputation, position or role. This can lead to concealment of mental health problems and delay in seeking help until a crisis point is reached. Even at this stage, help might not be sought and the prospect of a suicide attempt becomes further heightened.

It is important that local suicide prevention plans take account of the particular circumstances in rural areas when selecting suicide prevention interventions. While it is recognised that there is a lack of evidence on what works in rural areas to prevent suicide, some useful guidance exists, such as that produced by NHS Health Scotland.[16] This guidance suggests, for example, that given the difficulties in accessing and delivering health services in rural areas, the need to train “community gatekeepers” in suicide awareness and intervention is especially relevant for these communities, as is the provision of crisis helplines.

Self-harm trends in the north of Ireland

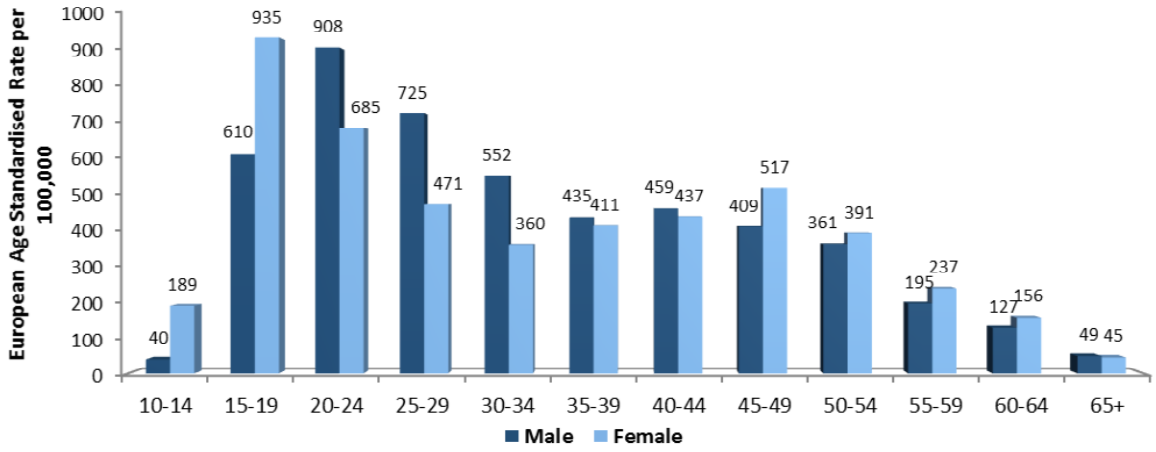
Self-harm is a manifestation of deep emotional distress. People self-harm for numerous reasons, such as (frequently undiagnosed) psychiatric disorder;[17] or as a reaction to adverse life experiences such as bullying, abuse, trauma, and victimisation. There is a clear link between self-harm and suicidal ideation.[18] People who self-harm repeatedly are much more likely to die by suicide (around half of those who die by suicide have a history of self-harm)[19], and many suffer from long-term physical effects of self-injury and self-poisoning, particularly as the intensity of self-injury tends to increase over time in the absence of any support or resolution of the source of the distress.

Self-harm is a serious public health issue in its own right. It is one of the top five reasons for medical admission in the UK. Between April 2013 and March 2014 there were 8,453 presentations at hospital emergency departments in the north of Ireland

as a result of self-harm, involving almost 6,000 people (one-fifth of whom presented on more than one occasion and would, therefore, be considered to have high risk of suicidal behaviour). An additional 3,623 cases presented with suicidal ideation, 65% of whom were male.

The Self-harm Registry Annual Report 2013/14 shows that the rate of self-harm here was 327 per 100,000 of population (64% higher than the south of Ireland), with alcohol involved in almost half of all presentations.

Figure 5: European Age-Standardised Rate per 100,000 of self-harm in the north of Ireland by age and gender, 2013/14



Source: The Northern Ireland Registry of Self-Harm Annual Report 2013/14[20]

The Registry was initially established in the Western Area in 2007 and a report[21] was published in January 2015 covering the incidence of self-harm presentation in the Western Area over the period 2007 to 2012. The main findings were that: the incidence of self-harm presentation was 14% greater in females than in males; rates were much higher among Derry City Council residents than among residents of more rural district council areas; the incidence rate tended to decrease with age; drug overdose was by far the most common method of self-harm; more lethal methods were rare but more common amongst men; almost three-quarters of the patients made only one presentation during the 6-year study period; and the number of presentations increased throughout the course of the day with alcohol involved in 60% of presentations (and even more so in those presentations occurring in the early hours).

It is noted in the study that the findings may indicate that a proportion of self-harm (necessitating hospital treatment for the injury) may be going untreated or being dealt with in primary care in rural areas. The report stresses that this would have implications for service provision and the prevention of suicidal behaviour. It also highlights the importance of deploying mental health staff at peak times to assess self-harm patients, but notes that this is also when the greatest proportion of patients are intoxicated and therefore unsuitable for assessment.

Policy context

Information on the definition and recording of suicide in the north of Ireland and on the law in relation to suicide is provided at **Appendix 1**. Key policies and activity which contribute to improved positive mental health, and which address risk factors for suicidal behaviour are set out at **Appendix 2**. Consideration will be given to achieving better integration of the delivery of these strategies and policies into suicide prevention and postvention activity e.g. bereavement support, Community Response Plan activation, and suicide data analysis.

The policy context has also been informed by NICE evidence-based guidance on the treatment of self-harm, treatment of post traumatic stress disorder and pathways to care. The Department regards this as best practice that Health and Social Care bodies must seek to implement. This guidance is also outlined at **Appendix 2**.

Recent developments – the internet, e-mental health, and the "suicide down to zero" concept

The ***Internet*** can be a powerful tool for suicide prevention, for example, in promoting awareness-raising and signposting to sources of help. Evidence shows that it is being used to access health information about stigmatising illnesses such as depression and that those who self-harm are using it for constructive purposes such as help-seeking and coping strategies.[22]

There is some evidence[23] that the internet is particularly useful for working with and accessing young men and those from minority backgrounds as the element of anonymity provides a safe space for them to explore mental health issues.

Smartphone apps have been developed locally which can provide immediate access to available support at a community level and provide potential de-escalation for users when faced with distressing situations. An app is currently being developed by Mersey Care NHS Trust that will enable clinicians to monitor digital communications by patients (on the basis of the patient's prior consent) including social media accounts, emails and phone calls. If users demonstrate a suicide risk such as visiting a suicide 'hotspot', talking about suicide or missing an appointment, the clinician is alerted by the app to contact them.

The Samaritans have linked with Facebook on a suicide prevention tool[24] that encourages users to flag and report their friends' posts that cause concern. These posts are reviewed by a team at Facebook, with help options sent to those the reviewers deem to be struggling.

The positive use of the Internet and social media in frontline suicide prevention will continue to be explored.

On the negative side, however, some social networking sites facilitate cyber bullying and the promotion of self-harm and suicide. There is also a trend towards social networking sites becoming 'memorials' following the owner's suicide, which can lead to copycat behaviour. The Health Departments in England, Scotland, Wales and here have commissioned a National Investigation into Child Suicide to examine the role of social media and internet sites in suicides amongst children and young people. The results of this study (due in 2016) will help to inform the implementation of this Strategy, as will the Technology and Wellbeing Guidelines being developed by the National Office for Suicide Prevention in the south of Ireland. Initial findings suggest that school-based mental health promotion programmes and regulation to restrict or remove suicide promoting internet sites may be the most feasible preventative measures.[25]

Locally, an e-safety strategy is currently in development by the Safeguarding Board of Northern Ireland (SBNI) to ensure the safety of children and young people when using the internet and electronic media. It will highlight best practice and ensure all children and young people can make best use of the benefits of online activity. It will

contribute to suicide prevention through the encouragement of responsible use of digital and internet technology so that children and young people have the skills to protect themselves from potential risks.

E-mental health is the use of information and communication technologies to support and improve mental health. A European Union policy paper "*Joint Action on Mental Health and Well-being*" (October 2015)[26] considered the potential for mainstreaming existing e-mental health interventions to support suicide prevention. The report highlighted the potential of e-mental health solutions for addressing barriers to help-seeking and improving access to care. Interventions include screening, self-management, e-therapy and applied games.

While acknowledging the many challenges to mainstreaming these interventions, the EU paper recommends: greater inclusion of e-mental health interventions alongside personal contact; increasing the capacity of mental health professionals to integrate e-mental health in their regular practice; and integrating e-mental health into overall e-health policies.

The Health and Social Care Board (HSCB) has published an e-Health strategy[27] and established an e-Health and Care Strategic Programme Board, supported by an e-Health team, to oversee implementation of the strategy. The HSCB works with the PHA to identify international best practice and trends in technology developments and innovation. The potential to develop projects under the strategy that focus on mental health promotion and suicide prevention will be considered.

The ***Suicide Down to Zero*** concept is gaining support among some stakeholders in the suicide prevention field. This concept and approach emerged in the USA through the work of several health care organisations that committed to suicide prevention in their care systems. Its core propositions are that suicide deaths for people in care are preventable, and that the goal of zero suicides among persons receiving care is an aspirational challenge that health systems should accept.

Suicide Down to Zero relies on a system-wide approach to improve outcomes and close care/service gaps through best practice in quality improvement and evidence-

based care. Achieving the 'zero goal' requires organisations to rigorously evaluate performance and use adverse events as opportunities to learn and enhance capacity to save lives in future. The Perfect Depression Care model[28] developed and operated by the Henry Ford Health System in Michigan includes suicide prevention as an explicit goal and has demonstrated an 80% reduction in the suicide rate among health plan members.

On the basis of these approaches, the US National Action Alliance for Suicide Prevention has identified essential dimensions of suicide prevention for health care systems and offers an evolving online toolkit[29] that includes modules and resources to address dimensions such as: leadership; risk assessment; safety planning for each individual; care pathways and treatment of suicidality; workforce development, restriction of lethal means; continuing support after acute care; increased contact and better education for families of people deemed to be at risk; and applying data-driven quality improvement to inform system changes that will lead to improved patient outcomes.

There is a case for establishing suicide prevention as a core component of health and social care services thereby improving coordinated prevention across primary care, in-patient and community mental health services, emergency departments; and linking this to community and voluntary service providers. However, as such a large percentage of suicide deaths are in people not known to mental health services, the overall impact of this approach in terms of reducing suicide rates will be partly dependent on better identification of, and service contact with, people who are suicidal.

A number of NHS Trusts in England (eg Merseycare, South West England, and East of England) are developing *Suicide Down to Zero* approaches. It is intended that this strategy will learn from their progress and consider whether and how this approach can be developed regionally for the north of Ireland.

Chapter 3: SUICIDE, SUICIDAL BEHAVIOURS AND SELF-HARM: RISK AND PROTECTIVE FACTORS

Risk factors

Suicide is the result of highly complex interactions among various risk factors and protective influences which vary from one individual to another.[30] The factors that lead to someone developing a vulnerability to suicidal behaviour (suicidal ideation, suicide planning, suicide attempt) are likely to have their roots in a chain of events and experiences that may have begun years previously, and which, in turn, were shaped by broader socioeconomic determinants. The risk factor patterns also vary across age, sex, and geographic location.

Research[31] has identified and determined the potency of risk factors for suicide and suicidal behaviours. These can be grouped into broad categories:

(a) ***socio-demographic*** characteristics - (sex, age, marital/partner status, education level, employment status, income level, and urban/rural status) that are associated with increased suicide risk in population groups.

(b) ***pre-disposing*** exposures – those which create a long-term propensity or pre-disposition for suicidal behaviour. These include genetic influences, dysfunctional family relationships, and early trauma; they increase individual risk for later vulnerability to suicide when exposed to the more direct risk factors.

(c) ***direct*** exposures – that actually precipitate suicidal behaviours. These include psychiatric disorder (the north of Ireland has a high proportion of people using psychotropic medication[32]), physical illness, alcohol intoxication, and some form of psychosocial crisis in the person's life such as a relationship breakdown.

The presence of risk does not necessarily lead to suicidal behaviour; for example, not everyone with a psychiatric disorder or chronic physical illness attempts suicide. It is the combination of powerful pre-disposing factors with triggering events and characteristics that lead to a suicide attempt. Furthermore, the likelihood of suicide

increases with an increasing number of risk factors. In view of this, society-wide awareness of the risks for suicide is an important preventative measure.

Legacy of conflict

Evidence indicates that the north of Ireland has high levels of, often untreated, post traumatic stress disorder (PTSD) and other mental health disorders as a result of almost 40 years of conflict.[33] Research[34 35] into the effects of decades of violence has indicated strong evidence that experience of the conflict is associated with poorer mental health, particularly depression and alcohol misuse.

Some researchers have suggested a possible link between the conflict in the north of Ireland and the relatively high suicide rates experienced here. The contention is that the increased rates of suicide since the peace agreements in 1998 are the result of a decline in social cohesion and social connectedness (which was characteristic of the conflict period), coupled with high levels of mental disorders (which are partly the result of previous exposure to violence). Further local research[36] found that children who grew up in the worst years of the violence in the 1970s are experiencing the highest suicide rates, indicating that they remain at risk as they grow older.

Plans are underway to establish a new comprehensive Mental Trauma Service. This will support the recovery of those who are experiencing significant mental health issues as a result of trauma, including issues arising from the conflict in the north of Ireland, as well as other causes, such as abuse, assault or accident. It is hoped that one of the outcomes of this service will be that it will form part of the overall drive against suicide.

Other local research

Research,[37] commissioned under the *Protect Life* Strategy, involving in-depth analysis of records on all suicides in the north of Ireland registered over a seven year period, provides further evidence of local suicide demographics. The findings highlight the known associative factors of mental illness, unemployment, alcohol (particularly in young people), and a history of prior suicide attempts. In addition, experience of an adverse incident prior to suicide was common. These experiences

centred on relationship difficulties but also included bereavement, financial difficulties and employment concerns, and physical illness diagnoses.

The study confirmed that the GP was the most frequently contacted healthcare professional prior to a suicide and verified the association between deprivation and incidence of suicide. It also found that, on a per capita basis, deaths in Belfast were 40% higher than the north of Ireland average. This would indicate that a population level response to suicide is required combined with targeted interventions at areas with particularly high levels of suicide and at the more vulnerable population groups.

Taking into account all this evidence, and other studies,[38] [39] together with WHO frameworks and reports[40], it is possible to state the key risk factors for suicide, see **Box 2** which indicates that risk can be addressed at individual, group, and population level. It also indicates that escalation of suicide risk tends to be on a continuum from poor mental wellbeing to suicidal behaviour. This is represented in ***figure 6*** which shows illustrative examples of escalating risk factors together with appropriate risk reduction interventions at the different stages.

Drivers for self-harm

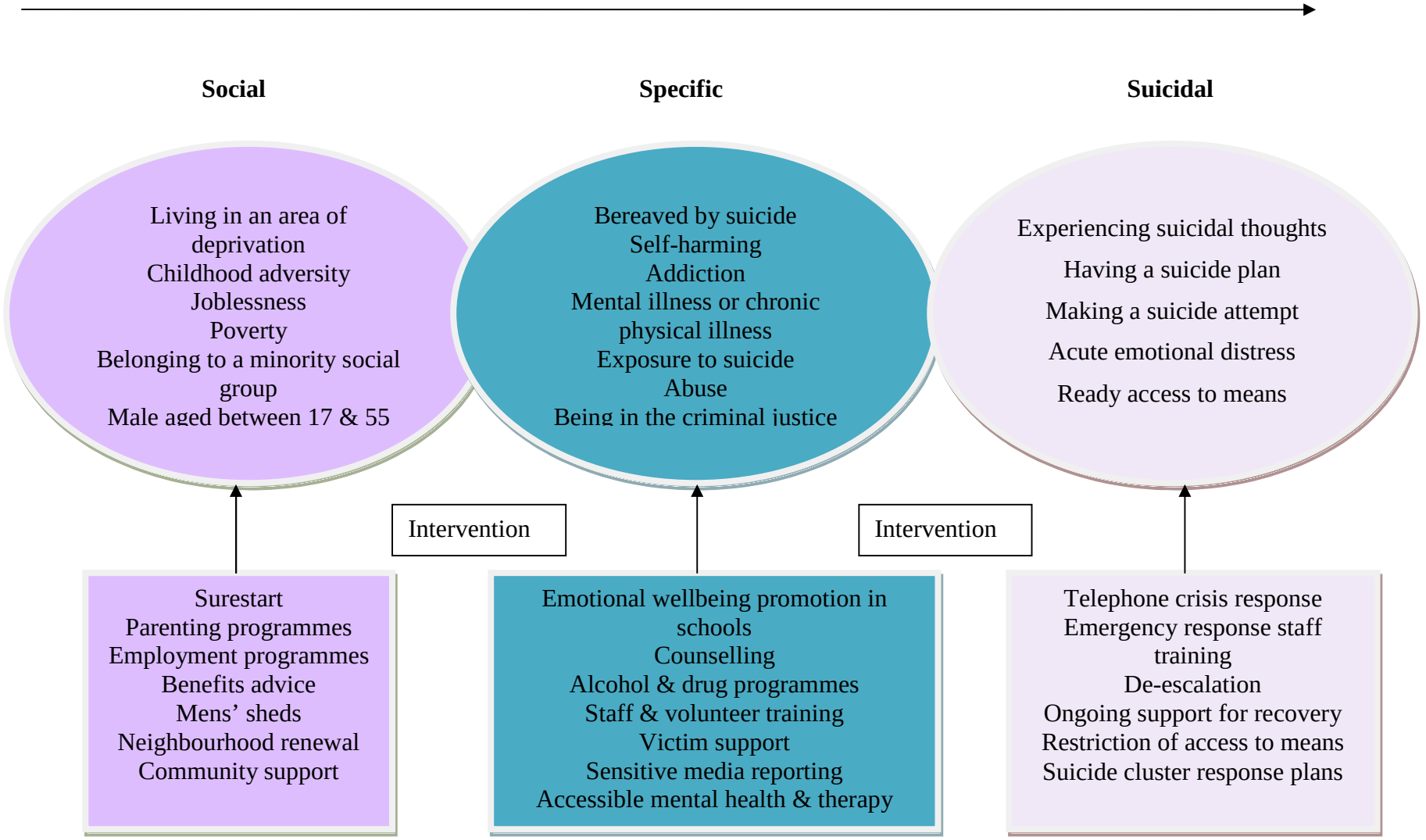
The known drivers for self-harm include depression, alcohol and substance misuse, low self-esteem, low tolerance for emotional distress, and adverse life experiences such as trauma, abuse, neglect, poor family relationships, isolation, and victimisation. In response to these issues, self-harm can be a coping or control mechanism. However, the intensity of self-injury often increases over time and, if there is no resolution of the distress and/or lack of appropriate support, this can lead to a suicidal crisis as coping and control develops into feeling out of control.[41]

Box 2: Risk Factors for Suicide

Environmental and Socio-demographic	Pre-disposing	Direct	Signs of imminent risk
Rapid changes in social structure or values. Economic turmoil. Ready access to lethal means such as firearms, pesticides, highly toxic drugs. Male gender; men have a 3-fold risk of suicide mortality relative to women. Being non-employed. Low income; living in a deprived area. Low educational attainment. Being unmarried, not living with a partner (particularly for men). Age; suicide is currently highest in the 20 to 39 age group (men) and 35 to 54 age group (women). Belonging to a minority group within the overall population. Being a combat veteran. Occupation – e.g. agricultural workers, healthcare workers and machine operatives have raised risk. Stigma associated with help-seeking behaviour for psychiatric difficulties. Poor access to mental health care.	Being in the care of mental health services. Being in contact with the criminal justice system. Experience of being in looked after childcare. Experience of abuse, trauma or violence, including sexual abuse and bullying in childhood or adolescence. Family history of suicide attempts. Lack of social support / social exclusion.	Repeated deliberate self-harm and/or previous suicide attempt(s). Presence of a psychiatric disorder including substance misuse disorder - missed appointments increase the risk. Recent discharge from in-patient psychiatric care. Being prescribed more than one type of psychotropic medication, Major physical illness / severe chronic pain. Exposure to another person's suicide or to sensationalised media account of suicide. Stressful life events/ major loss such as bereavement, divorce, redundancy, financial loss, debt, homelessness, prosecution. Intoxication. Impulsive, reckless or aggressive tendencies; impaired problem-solving. Recent discharge from in-patient psychiatric care.	Expressing suicidal thoughts and, more particularly, evidence of suicide "planning" by the individual. Expressions of hopelessness and pre-occupation with death. Acute emotional distress and/or sudden changes in mood or behaviour Acute substance misuse. Making "final" arrangements such as giving away treasured possessions. Very frequent attendance at GP surgeries, particularly for females, older people and those with a history of mental illness.

Suicide risk can be presented as being on a continuum from poor mental wellbeing to suicidal behaviour, with different interventions being relevant at the different stages.

Figure 6: Escalating suicide risk and illustrative risk reduction interventions at specific stages



Frontline prevention of suicide will focus on recognising and responding to the 'direct' risk factors and with responding to the 'markers' for suicidal behaviour together with broader awareness-raising / promotion of help-seeking behaviour and improved data collection and analysis. Where appropriate, frontline intervention will also focus on addressing the more direct risk factors for suicide, for example reducing repeat self-harming, restricting access to means, patient follow-up post discharge, and suicide bereavement support.

Caution is also needed in approaching some of the risk factors. For example, suicidal behaviour frequently has a significant psychiatric co-morbidity but certain mental disorders are relatively common, and most people suffering from them will not display suicidal behaviour. It is important to bear in mind that not everyone with anxiety, depression, or addiction issues will attempt suicide.

Priority population groups

Although suicide is not exclusive to specific population groups, the risk factors provide a clear indication that certain groups are particularly vulnerable to suicide (see **Box 3**). The reasons behind the increased risk will vary, but may include victimisation, bullying, isolation, trauma and exposure to violence, hopelessness, and access to means.

Box 3: Priority population groups for suicide prevention

LGBT people	**People who are long-term unemployed**
Migrant populations and ethnic minorities	**Certain occupations such as farming, the military (including veteran populations), dentistry, and "low status" occupations**
Homeless people	**Males aged 19 to 55, especially those who live in areas of deprivation**
Those who have experienced abuse/conflict, including sexual abuse and domestic violence	**Those in contact with the justice system**
"Looked after" children and care experienced children	**People with mental illness, including addiction disorder**
Those with PTSD as a consequence of the conflict in the north of Ireland	**Traveller community**
	Those experiencing gender identity issues

The majority of tailored interventions to address the risks that these groups experience are, or will be, delivered within the context of early intervention/resilience building through mental health promotion (a mental health promotion action plan is to be developed under the public health strategic framework *Making Life Better*) or are addressed through related strategies (see **Appendix 2**). This would include, for example, measures to strengthen social relationships for men, employment support programmes, efforts to improve the recognition of depression, services to reduce alcohol misuse, and support to help manage debt.

Other socio-demographic characteristics such as marital status, age, and gender need to be taken into account in assessing suicide risk (in line with NICE guidance) and in developing suicide prevention services that meet the needs of these groups. Many of the "pre-disposing" risk factors also need to be considered in risk assessment and provision of ongoing support for people with suicidal behaviour.

However, particularly high risk individuals requiring immediate intervention are: those who have attempted suicide; those who engage in non-suicidal repeat self-harming; people in emotional and/or social crisis; those in mental crisis; those displaying the signs of imminent risk; and people who have been bereaved by suicide.

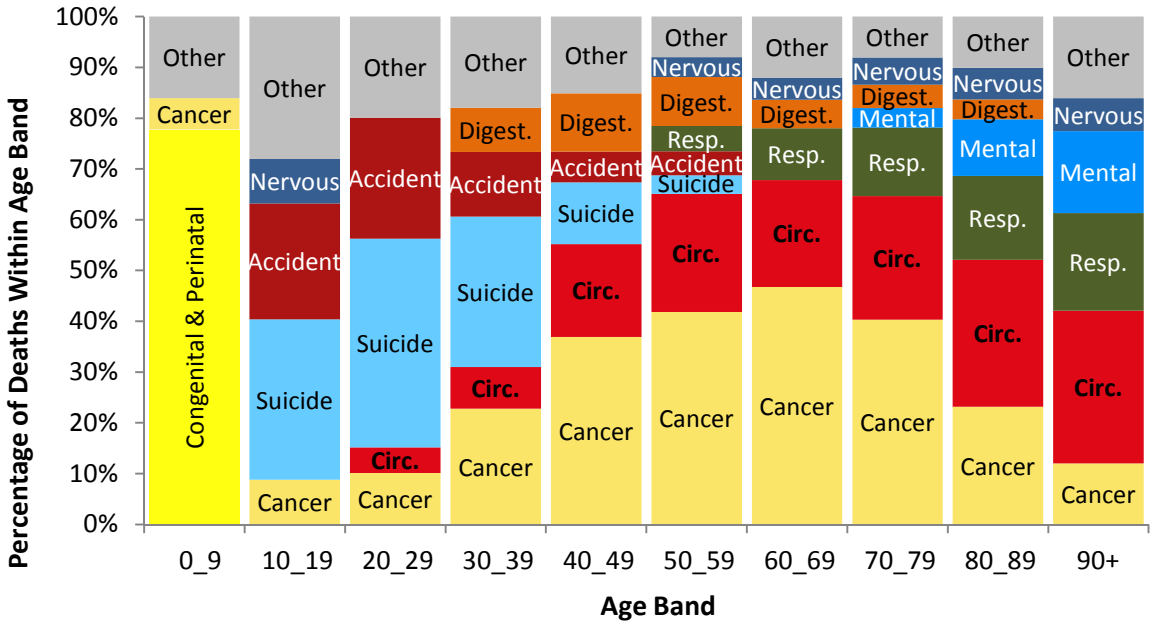
Children and older people

Children are not a specific high risk group for suicide; the rate of suicides in those aged under 18 years of age is low compared to other age groups. However, there was a significant increase in suicide in this age group, in line with that experienced by the general population, between the ten year period covering 1995 to 2004 and the subsequent ten year period 2005 to 2014.

Suicide remains rare amongst the under 15s, however, the threefold increase (from 9 deaths to 27 deaths) over the two ten year periods is a concern and suicide is one of the main causes of mortality in young people (see fig 7) in 2014. Additionally, self-harming, which is strongly associated with future suicide[42], is relatively common among adolescents and teenagers, especially females. Fifteen

to nineteen year olds accounted for 15% of all hospital emergency department self-harm presentations here in 2013/14 and this age group had the highest female rate of self-harm presentation.[43]

Figure 7: proportionate cause of death by age band (2014)



Survey results indicate that a quarter of 16 year olds in the north of Ireland have experienced serious personal, emotional, behavioural or mental health problems in the last year and that this figure increases to 43% for 16 year olds from disadvantaged background.[44] The Lifestyle and Coping Survey has shown that 10% of 15/16 year olds in the north of Ireland self-harm. Girls are also three times more likely to self-harm than boys. The study highlights the crucial role of schools in supporting the mental and emotional wellbeing of children and young people.

It is recognised that children who have suicidal thoughts and behaviours are likely to have experienced influencing factors that differ in some respects to those experienced by adults and that they have different needs in terms of support and care. There are also some important differences in the methods of suicide used by younger people compared to adults.

The *National Investigation into Suicide in Children and Young People*[45] identified the key risk factors as being bullying, academic pressures and exam stress,

concerns about sexuality, increased use of novel psychoactive substances ('legal highs'), family problems, and certain physical health conditions such as acne and asthma. The harmful effect of online social media that encourages self-harm or suicidal behaviours, the impact of cyber-bullying, and relationship breakup are also particularly important issues for children and young people.

The investigation report recommends that agencies that work with children and young people (particularly those in the health, social care, youth justice and education sectors) can contribute to suicide prevention by recognising the pattern of cumulative risks and stress that lead to a suicide attempt. Improved recognition of these features by families and children themselves, together with good access to self-harm services and CAMHS, would also enhance prevention.

ChildLine provide a key frontline intervention service – there are over 1,000 annual calls to ChildLine from children in the north of Ireland where suicide is the main reason for the call. Findings from ChildLine[46] indicate that children need to be able to talk openly about mental health in order to reduce the stigma surrounding it; they need to be listened to and have their worries taken seriously and they need to be assisted in taking control over what happens next.

As with children, older people are not a specific high risk group for suicide however the suicide rate among those aged 65 and over increased from a rate of 6.3 deaths per 100,00 in 2001-03 to a rate of 7.9 deaths per 100,000 in 2012-14.

People over the age of 65 are more likely to have physical health conditions that can lead to social isolation and depression.[47] For example, it is estimated that 10% of older people in Ireland are affected by chronic loneliness.[48] Depression affects up to 5% of over 65s at any point in time, with milder forms of mood disorder being present in a further 10 to 15%.[49] They are also more likely to experience bereavement and unmanaged depression.

Efforts to improve the management of physical illness, and the diagnosis and treatment of depression are particularly relevant to suicide prevention amongst older people. Bereavement support and efforts to strengthen social relationships

are also particularly relevant in this age group. For example, increasing awareness of depression amongst older adults in general and use of cognitive behavioural therapy (CBT) for older adults who suffer from depression have shown to be effective in reducing levels of suicide in this age group.

According to research carried out by Age UK[50], befriending schemes have proved one of the more effective services for combating both isolation and loneliness. The Good Morning scheme[51] is another example of a community support service aimed at helping older and vulnerable people remain independent in their own homes. It provides daily phone calls, alerting others if a call is not answered, thus providing service users and their families with peace of mind. In addition, the service provides telephone support, enabling users to share worries and concerns and connecting them with local community activities and services.

Victims of the conflict

Support programmes for victims of the conflict assist in developing the psychological and emotional resilience of those affected. The Public Health Agency has also supported Charter NI and the Ashton Centre Bridge of Hope through Protect Life funding which work specifically with those affected by the conflict. The Agency has also undertaken a programme looking at the emotional health needs of ex-combatants. This focus on programmes to support the needs of those affected by the conflict who may potentially have untreated PTSD will continue. Ongoing work in relation to the new Mental Trauma Service will also address these issues in future.

Protective factors

In addition to interventions geared towards reduction of the risk factors, it is important to enhance protective factors which reduce a person's vulnerability to suicidal behaviours and help them cope with difficult circumstances. Most protective factors are concerned with increasing resilience and connectedness, and include:

- the cultivation and maintenance of strong personal relationships;

- healthy lifestyle practice such as exercise, adequate sleep, moderation in alcohol intake;
- willingness to seek help for mental, emotional or social problems;
- ready access to quality care for mental and physical illness;
- a service response to those in distress that incorporates kindness, compassion, understanding, hope, and a non-judgemental listening ear;
- skills in problem solving, conflict handling, and non-violent resolution of disputes;
- positive self-esteem, religious/spiritual beliefs that support the self;
- restricted access to lethal means.

These will be covered in the future positive mental health action plan but are also important in helping those who experience suicidal behaviour to make a recovery and/or reduce the likelihood of a further attempt.

Assessing suicide risk at individual level

Suicide remains a relatively rare event, while the risk factors associated with it are common - this makes suicide very difficult to predict. However, assessing the risk of suicide in a person expressing suicidal thoughts or presenting with self-harm is crucial in preventing deaths.

There are a number of risk-predicting score systems for determining suicidal intent, however, none have good predictive ability and NICE recommends that these should not be used for assessment.[52] Instead, a comprehensive clinical/psychosocial interview should be used for assessment. NICE Clinical Guideline 133 on the long-term management of self-harm (referenced above), sets out what should be covered in the assessment interview and in the follow up care plans.

At the point at which a person attempts suicide, they are likely to be in an emotionally charged state with issues such as consumption of alcohol, fluctuating moods in mental disorders, and changing life events further narrowing their perspective. While no assessment can be entirely predictable, accurate

assessment followed by appropriate support and treatment, including the removal of access to preferred means, where possible, will save lives.

The National Confidential Inquiry into Suicide and Homicide (NCISH) Northern Ireland longitudinal study[53] noted that in 90% of mental health patient suicides, immediate risk at final contact with services had been assessed as low. The report acknowledges the difficulty in effective risk prediction and recommends that risk management needs to be improved for the majority of patients if the few who will otherwise die by suicide are to be reached. In practice, this requires comprehensive care plans addressing key clinical problems such as treatment refusal, missed contact, and substance misuse.

The Inquiry has recommended that mental health services review their risk management processes to ensure they are based on a comprehensive assessment of risk. The existing guidance on risk assessment and management contained in "*Promoting Quality care Guidance*" (DoH, May 2010)[54] has been reviewed with the intention of having new procedures in place under the regional Mental health Care Pathway "*You in Mind*" in 2017.

Conclusion

Suicide in the north of Ireland appears to be associated with high levels of mental ill-health, exposure to community conflict and the legacy of the conflict, and exposure to stress including economic deprivation. The cultural relationship with over consumption of alcohol also appears to be a contributory factor to our relatively high suicide rate.

In addressing those most at risk there must be a focus on providing accessible support and treatment for people who have suicidal thoughts. These services also need to address the diverse needs of different sub-groups in terms of age, gender, sexual orientation, social class, and locality (urban/rural).

Chapter 4: OVERVIEW OF SELF-HARM AND SUICIDE PREVENTION SERVICES

Protect Life 2006-2016

The original *Protect Life* Strategy was developed in 2005/06 in response to concerns raised by community groups based in disadvantaged areas – particularly in North and West Belfast – about significantly increased incidence of suicide in those areas. The Strategy was initially designed for a five-year period and was subsequently refreshed in 2012.

The refreshed strategy set new objectives and a target for a reduction in the differential in suicide rates between the 20% most deprived areas and the north of Ireland average, while maintaining an overall reduction in suicide as the long-term goal. Initial findings are that the gap is widening, although the gap between the most deprived and least deprived areas has reduced.

From 2006/07 to 2015/16 over £50m has been invested by DoH in the implementation of *Protect Life*. Investment in other activities across government also contributes to suicide prevention and a number of Departments have invested directly in suicide prevention initiatives. In addition, those organisations engaged in suicide prevention at community level and regional charities have allocated additional funding and resources into the drive against suicide through their own fundraising activities. The total invested in suicide prevention in recent years is, therefore, well in excess of the overall DoH funding.

This funding has supported the wide range of services outlined at **figure 8** that have been developed, refined, piloted, and explored over the duration of *Protect Life*. The approach taken is in keeping with that adopted by other national suicide prevention strategies and is in line with the common themes recommended in UN, WHO, and EU policy documents while maintaining a local perspective.

Figure 8 - Services delivered under Protect Life

Further detail on these services and initiatives is provided in **Appendix 3.**

The department has issued a set of principles to underpin the delivery of services to those at risk of self-harm and suicide who attend primary care general practice, out-of-hours GP services and hospital emergency departments.

There are a number of key suicide prevention services connected with *Protect Life* but not funded under it. These include: Samaritans which provides support to those in crisis and those who have been bereaved, provides media guidelines and collates statistics from Ireland and Britain to produce a Suicide Statistics report[55]; ChildLine which has a role in supporting and counselling children and young people with suicidal ideation; and the rural helpline[56] which can provide information and advice on a range of issues including depression, stress, loneliness, debt and addictions.

Mental health services

People with mental illness are at increased risk of suicide. This risk is heightened further for those with severe mental illness, in-patients, people recently discharged from psychiatric hospital, and those who refuse treatment in the community. Mental health services are not delivered under the umbrella of *Protect Life* but are intrinsic to suicide prevention.

The Regional Mental Health Care Pathway "*You in Mind*"[57] sets out the standards expected by all mental health and psychological therapy services. Where a person is experiencing a mental health crisis, which potentially compromises their personal safety, the pathway stipulates that mental health services will make face to face contact with the individual within two hours of receiving a referral. In other circumstances – such as when a person's psychological and emotional wellbeing is deteriorating and intervention is needed to avoid a crisis or where a person is experiencing emotional and psychological difficulties but is not in crisis - longer appointment waiting times are stipulated.

In line with Bamford recommendations, the focus over recent years in mental health service development has been on early intervention, home treatment services, the development of psychological therapy services and the establishment of Primary Care Talking Therapies. The latter provide counselling and life coaching, and will improve access to psychological care for people who are experiencing emotional difficulties.

In relation to frontline crisis intervention, mental health services include: out-of-hours; in-patient and community-based services; the psychiatric liaison service; emergency crisis resolution and home treatment teams; crisis assessment and intervention teams (CAIT) for children who present at hospital emergency departments; and the "Card Before You Leave" service based in hospital emergency departments. The new Rapid Access Interface Discharge model (RAID) in the Northern Trust area will help shape future service provision. These are all priority settings and services for suicide prevention.

Importantly, the Care Pathway also makes commitments to instil hope, enable personal recovery, involve family in supporting recovery, and to promote personal safety through a personal safety plan. Mental health services focussed on recovery include alcohol and drug addiction services, psychological and trauma therapies, drug therapies, family therapy, and Primary Care Talking Therapies Teams. Not everyone referred to these services will have a diagnosed mental illness, but most will be suffering emotional difficulties. Social support is also an important element in the recovery approach.

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NICISH)

NICISH examines and reports on all deaths by suicide in people who have been in contact with mental health services within the 12 months prior to their deaths. The aim is to improve learning, identify approaches to prevention, and help ensure that safety within mental health services is enhanced. The main findings from the Inquiry's recent annual reports[58] and its longitudinal study[59] into suicide in the north of Ireland over the period 2000 – 2008 are outlined in **Box 3**.

Box 3: Confidential Inquiry findings

- "Patient suicides" represent 28% of general population suicides in the north of Ireland, an average of 67 patient suicides per year. In-patient suicides account for an average of 3 deaths per year.
- The first three months after discharge from in-patient care, and especially the first two weeks, is a time of high suicide risk. Comprehensive care planning prior to discharge should be a key component in the management of risk.
- Inter-agency working is necessary to address adverse social issues faced by patients prior to discharge.
- Self discharge represents a high risk in the first week after discharge.
- Suicide is frequently preceded by missed appointment/contact with services; follow up after patient discharge should take place within 7 days together with assertive community outreach in response to missed appointments.
- Living alone is a common antecedent of suicide in patients under home care.
- 63% of patients who died had a history of alcohol misuse.
- A degree of pessimism exists amongst staff about the preventability of suicide.
- The serious adverse incident reporting system needs to recognise the complexities of clinical risk management.
- Increasing use of prescription opiates as a means of suicide indicates that clinicians should enquire about patients' use of opiate containing painkillers when assessing suicide risk and should limit the duration of prescription opiates as is already done with anti-depressants.

The Inquiry has also produced a checklist "Twelve points for a safer service" which provides guidance on suicide prevention for mental health services. This checklist is included at **box 4**

Box 4: National Confidential Inquiry into Suicide and Homicide by People with mental Illness: twelve points for a safer service – checklist for local services

Staff training in the management of suicide risk every 3 years

Patients with severe mental illness and a history of self-harm to receive the most intensive level of care

Individual care plans to specify action to be taken if patient is noncompliant or fails to attend

Prompt access to services for people in crisis and for their families

Assertive outreach teams to prevent loss of contact with vulnerable and high-risk patients

Atypical anti-psychotic medication to be available for all patients with severe mental illness who are non-compliant with "typical" drugs because of side-effects

Strategy for dual diagnosis covering training on the management of substance misuse, joint working with substance misuse services, and staff with specific responsibility to develop the local service

In-patient wards to remove or cover all likely ligature points, including all non-collapsible curtain rails

Follow-up within 7 days of discharge from hospital for everyone with severe mental illness or a history of self-harm in the previous 3 months

Patients with a history of self-harm in the last 3 months to receive supplies of medication covering no more than 2 weeks

Local arrangements for information-sharing with criminal justice agencies

Policy ensuring post-incident multidisciplinary case review and information to be given to families of involved patients

Adverse incident reporting on suicide and attempted suicide

Serious adverse incident reporting is a process by which the circumstances surrounding attempted suicide by, or suicide of, patients within health services are investigated in order to improve learning and develop safer services. However, the Donaldson Review; *The Right Time, The Right Place*[60] found that while data is available on serious adverse incident types (including suicide and suicide attempts), it isn't gathered in a way that facilitates identification of systemic weakness and, therefore, misses opportunities for improving patient safety.

Donaldson also found that the timescales for serious adverse incident reporting can limit the investigation into the root causes of patient suicides, thereby reducing the potential for preventing recurrences. He has identified a need for some flexibility in the mental health field where the avoidable factors in a death can be very complex and are only discernible after interviewing many people. The review places emphasis on learning from incident investigations in a way that will improve safety in mental health services across the north of Ireland rather than on focussing on actions that will only make a difference in the particular unit where the incident occurred.

As part of their review programme, the Regulation and Quality Improvement Authority (RQIA) plan to include a review of suicide prevention services in their 2018/2021 programme.

Other priority settings and services for the prevention of self-harm and suicide

In addition to mental health services, a range of service providers come into regular contact with people who self-harm or who are suicidal and with people who have been bereaved by suicide. This includes hospital emergency department and ambulance staff, police custody and prison staff, GPs and other primary care staff, social services and social care staff, fire service personnel, clergy, pastoral staff in schools and colleges, and certain community-based groups. The associated settings in which these service providers operate are important locations for frontline suicide prevention.

Given that service providers in these settings have a vital role as the first point of contact for, and care of, those with suicidal behaviours and those self-harming, it is essential that they are equipped to provide effective support and deal sympathetically with extremely distressed people. They need to have the necessary knowledge, skills and attitudes to recognise, assess, manage, and initiate appropriate follow-up for people who are at high risk of suicide. This requires appropriate training in suicide awareness and management of those who are suicidal, as well as in terms of attitudes towards people who have self-harmed or attempted suicide and their relatives/carers.

The specific self-harm and suicide prevention roles of these priority services are set out at **Appendix 3** along with the further detail on services delivered directly under *Protect Life* 2006 - 2014.

Research and data collection

Research is an ongoing strand supported under *Protect Life*. It is also acknowledged that research is commissioned by other groups involved in suicide prevention and by local universities. The focus on local research will continue and topics for new studies will be considered as part of the action plan for *Protect Life 2.*

Systematic, timely, reliable and comprehensive data collection on suicide and self-harm is essential in order to understand the factors associated with suicide in a region, and to provide responsive and effective suicide prevention services. Data gathering on suicide and self-harm here is through the mechanism of the Self-harm Registry, the Sudden Death Notification process, NCISH, and the General Register Office which highlights current trends and provides comprehensive surveillance.

However, the existing databases do not provide information on life events, prior suicidal behaviour, occupation, pharmacological profiles, etc and the quantity of information on Coroners' files – in terms of witness statements collected by police officers and medical reports – varies greatly from case to case.

Research commissioned under *Protect Life*[6162] looked at data from the Coroners' files and from GP files over specific timeframes. The former established a database of deaths by suicide for 1,671 suicides that occurred here between 2005 and 2011. These approaches provide a potential model for ongoing data collection and analysis. The Scottish Suicide Information Database (ScotSID)[63], which is a central repository for information on all suicide deaths in Scotland provides a further potential model for more connected, comprehensive data collection and analysis.

However, the collation and analysis of this type of qualitative data is expensive and time-consuming. Furthermore, the unreliability of data, particularly in relation to

adverse events, remains a major limitation until such time as this data is made more reliable.

Cross-departmental working

Other government departments are involved in suicide prevention work at operational level and through their participation in the Ministerial Co-ordination Group on Suicide Prevention. This work mostly addresses the more indirect risk factors for suicide and self-harm and is not funded under *Protect Life*. However, it constitutes an important contribution to suicide prevention and is complementary to *Protect Life*. The key initiatives and programmes are outlined at **Appendix 2**.

Chapter 5: STRATEGIC DIRECTION FOR IMPROVING SUICIDE AND SELF HARM PREVENTION

Development of this strategy

The draft strategy has been informed by a review of international research on suicide risk and suicide prevention, the evaluation of *Protect Life*, evaluation of services and programmes delivered under *Protect Life*, cross-departmental engagement, and feedback from some 20 pre-consultation engagement workshops.

Evidence of what works in suicide prevention

Frontline prevention for those at high risk and/or in crisis

A review of the evidence for *Protect Life* was undertaken by the National Suicide Research Foundation at University College Cork. Its findings are supported by the European Framework for Action on Mental Health and Wellbeing "*preventing depression and suicide work package*"[64] and other national reviews[65] [66]. Taken together they indicate substantial research evidence for the effectiveness of the interventions outlined in **Box 5**. These reviews also found some evidence of effectiveness for a wide range of specific interventions. These are outlined in **Appendix 4**.

In addition, the WHO recommends:

- Inter-sectoral collaboration.
- Comprehensive and integrated data collection for improved surveillance, plus access to 'real-time' data – which helps to identify 'at risk' groups, emerging trends in suicide, potentially emerging clusters and new means of suicide.
- Early identification, assessment, and treatment of people at risk of developing suicidal behaviour.
- Promotion of public and professional awareness about mental wellbeing, suicidal behaviours, suicide prevention, and effective crisis management.
- Research examining the effectiveness of specific interventions and population studies in selected "at risk" groups.
- Improved integration of clinical services, including substance misuse.

Box 5: Evidence-based effective interventions for suicide prevention

- Restriction of access to the means and methods of suicide - including the use of physical barriers at "hotspot" locations, the promotion of safer prescribing, a reduction in the accessibility of certain over-the-counter drugs, and continued restriction of access to firearms.
- Development of clinical guidelines for use by staff when dealing with people who are at risk of suicide or self-harm.
- Programmes (including psychological behaviour therapies) that enhance coping and problem solving skills of those who self-harm.
- Follow-up care of suicide attempters.
- Low threshold crisis intervention helplines.
- Primary care training in depression recognition, referral, and treatment.
- Multi-level community-based programmes covering training, public awareness -aising and the provision of support groups.
- Restriction of alcohol consumption.
- Media reporting guidelines and responsible reporting of suicidal events.

In relation to mental health services, a study in England and Wales found that those services which implemented recommendations from the National Confidential Inquiry into Suicide and Homicide by those with mental illness had a lower suicide rate than services which did not act on Inquiry recommendations.[67] Three recommendations in particular were associated with a lower suicide risk, namely: 24-hour crisis services; having a policy for patients with dual diagnosis (drug and alcohol problems in combination with mental illness); and multidisciplinary reviews after suicide.

The National Confidential Inquiry into Suicide and Homicide (NCISH) also recommends: prioritising the care of patients on discharge through effective care planning and risk monitoring, routine early follow-up, and provision of access to psychological services; ensuring that partner agencies address adverse social factors that add risk in male patients especially housing, debt, unemployment and

alcohol misuse; working more closely with the patient's family around discharge planning, appointments and treatment/crisis management. Following each NCISH report the HSCB and PHA draw up a combined action plan and work through the recommendations.

Postvention support

Suicide has a life-altering impact on bereaved family and friends. Those bereaved by suicide tend to feel more stigmatised, rejected, and abandoned than those bereaved in other ways.[68] They may experience erosion of social bonds and heightened anxiety of further suicides in the family. In some cases self-recrimination and feelings of guilt can also arise. These issues introduce additional stress leaving those bereaved highly vulnerable to trauma, poor mental health, emotional problems, physical ill-health and suicide.[69] [70]

It also needs to be recognised that many bereaved families have put considerable effort into seeking and negotiating help for a family member, as well as providing direct support and prompting emergency intervention when necessary. This will all have had a heavy emotional toll on the family.

Effective and timely emotional and practical support for those bereaved by suicide is essential to help the grieving process, prevent longer term emotional distress, and promote healing. This type of intervention is generally described as "postvention" and is, in many ways, a form of prevention of mental ill-health and suicide prevention.

There is very limited evidence about effective interventions for those bereaved through suicide. While some people bereaved by suicide may not respond to professional support and advice, others simply lack the understanding about what to expect, who to turn to, or have no awareness about useful coping strategies. However, while each suicide survivor and every family's circumstances are unique, there may be shared aspects of suicide and of coping with the suicide of a family member. This information needs to be made available to bereaved families.

Most studies[71] [72] have focused on the self-reported needs of those bereaved, while local research[73] has examined the impact of suicide on the bereaved and their subsequent uptake of services. Indications are that, in the immediate period following the death:

- the most valued support is that provided by family, friends and neighbours;
- formal "first responder" support (ie that provided by emergency medical service staff, police, GP, clergy, funeral home staff) is helpful as long as it is informed and compassionate;
- lack of communication and information about the death and the investigation, and inappropriate communication, contribute to greater hardship and trauma;
- documentation provided by the coroner's office is important to family members and helps in later decision-making about help seeking;
- any media reporting which distorts the facts of the death or sensationalises it causes trauma, while obtrusive media interest is a source of distress;
- active intervention from schools' staff to ensure that bereaved children are supported is important and is sometimes overlooked;
- those bereaved have mixed views to the offer of medication from their GP, some find it helpful as an initial coping mechanism whereas, for others. it delays coming to terms with the reality of the death.

In the longer-term, informal support continues to be important but many feel it necessary to seek help outside of their immediate social network. Support groups specific to suicide loss are regarded as one of the most important coping mechanisms, particularly the peer support aspect of this service. For many people, GPs and the clergy are also sources of ongoing support and help with their healing. Getting back to a routine is also important for many bereaved people, particularly for men.

Bereaved spouses generally value counselling for their children, particularly through bereavement services, such as Cruse and Barnardos, which are accessed directly or via a GP or social services referral.

Other postvention which has been reported as helpful includes: brief cognitive behaviour therapy family intervention with a psychiatric nurse; psychologist-led

group therapy for bereaved children led by psychologists; and combined health professional and volunteer group therapy intervention for adults. However, difficulty in finding and accessing this type of support is often an issue.

It is known that suicide can trigger suicidal behaviour in others within an associated group or area. It is important that potential clusters are identified at the earliest opportunity and an early intervention response is put in place as necessary. Therefore, postvention also includes surveillance of suspected suicide deaths and the activation of response plans to help communities address a number of potentially linked suicides and to prevent further deaths arising from this.

The aim of postvention is to enable those left behind to better face the challenges of suicide bereavement and restore confidence and control in their lives.

Evidence of what works in preventing self-harm

The effective assessment and management of self-harm, especially where people present in hospital emergency departments, represents a significant opportunity to reduce repetition of self-harm and future suicide risk.

Various studies have indicated the most effective approaches to the prevention of self-harm; these are outlined in **Box 5**. The report on the PHA Self-harm symposium also promotes the need to make more use of the Self-harm Registry data, in terms of translating the broad information into meaningful reports, and increasing awareness of self-harm in the primary care setting.

In 2013, NICE published a new quality standard (QS 34[74]) to improve the quality of care and support for people who self-harm. This covers the initial management of self-harm and the provision of longer-term support for people who self-harm. In addition to its clinical guideline (CG133[75]) on the longer term management of self-harm, NICE has produced a guideline (CG 16)[76] on the short term management of self-harm which covers the treatment of self-harm within the first 48 hours of the incident.

The 2010 *Lifestyle and Coping Survey*, commissioned by the Department, surveyed self-harming amongst 15 and 16 year olds. It found that 10% of respondents had self-harmed, that self-harming was more frequent amongst girls, and that boys with sexual orientation concerns had a high risk. The survey also indicated that influencing factors include the Internet, and social networking sites. There has been progress on the recommendations from the survey report, including promoting awareness among staff and pupils, development of critical incidence response plans in all schools, and promotion of responsible internet coverage of self-harm.

Box 6: Evidence-based effective interventions for the prevention of self-harm

- Early identification of people at risk of self-harm through skills training for professionals and volunteers working in the healthcare and community sectors. This includes self-harm awareness-training for hospital emergency department staff in improving knowledge, attitudes towards self-harm and suicide.[77] The report on the Public Health Agency Self-harm symposium 2015[78] emphasises the need for skilled staff in hospital emergency departments who are trained in the understanding and clinical management of self-harm.
- Uniform procedures for the assessment and aftercare of self-harm patients who present at hospitals. Psychosocial assessment following self-harm is associated with lower rates of non-fatal repetition.[79] [80]
- Screening for psychiatric symptoms in self-harming patients and appropriate phramacological treatment for any diagnosed psychiatric disorder.
- Detection and treatment of co-morbid disorders such as alcohol-related disorders (alcohol is involved in almost half of all presentations).
- Brief psychological treatment (cognitive behavioural therapy/problem solving therapy) that is specifically structured for people who self-harm,[81] and dialectical behavioural therapy for patients who repeatedly attend hospital emergency departments as a result of self-harm.[82] [83] NICE guidance on the management of self-harm also recommends psychosocial assessment following self-harm.
- Provision of a card for emergency contact.[84]

Evaluation of Protect Life

The Evaluation of *Protect Life* [85] highlighted the importance of a population approach to suicide prevention combined with selective targeting of 'gatekeepers' and high risk groups such as LGBT people and ethnic minorities. It also noted that the most effective strategies aim to improve existing services that deal with suicidal

people; address the issue of access to means; and are clear on contributions to suicide from drugs and alcohol.

In considering the position here, it indicated that waiting times and travel/transport issues were significant barriers to accessing suicide prevention services. In general, areas identified as requiring particular attention were.

- ***Service delivery*** - provision of support for families living with people at risk of suicide; greater support for people who live in rural areas; improving the hospital emergency department response; provision of tailored support for older people; and ensuring clearer pathways of support.
- ***Training and awareness-raising*** - training for GPs; awareness-raising in secondary schools.
- ***Collaboration/co-ordination*** - better joint working of frontline health and social care staff and community and voluntary sector staff and volunteers.
- ***Research*** - achieving a better understanding of why people engage in suicidal behaviour.

The evaluation report recommended.

- ***Small number of strategic actions*** - a reduced number of strategic actions to aid explicit linking from the Strategy to commissioning plans.
- ***Evaluation & reporting*** - a robust monitoring and evaluation framework and more transparent reporting on resource allocation against strategy objectives.
- ***Collaboration*** - continuation of cross-sectoral partnership working; further support for GPs and secondary care clinicians to work in partnership with the community and voluntary sectors; better connections with substance misuse services; collaborative working and sharing of learning with other jurisdictions; and the inclusion of suicide prevention actions within relevant Government Departments' business plans.

Feedback from pre-consultation engagement

Feedback from the twenty pre-consultation workshops indicated that, in general, the suicide prevention services delivered under *Protect Life* performed reasonably well and needed to be retained in the new strategy. Ongoing statutory, community and voluntary partnership was seen as vital for the delivery of effective intervention. The existing approach - in terms of working with communities of interest,

engagement in Protect Life Implementation Groups, and the person-specific and population-based interventions – were also highly valued.

A number of specific services and programmes were identified as vital to the new strategy, and a number of proposals were made for enhancing these services to address some current gaps in provision and reach. These services and proposals for enhancement are set out in **Box 7**.

Suggestions for addressing gaps and/or enhancing existing services were:

- ***Lifeline*** - increase referrals between Lifeline and the voluntary and community sector; consider enhanced use of social media for the service including the use of apps; ensure that training on the role of Lifeline is included in training packages for hospital emergency departments; explore potential for improving accessibility and awareness of the service in rural areas.

- ***Hospital emergency departments*** – provision of a quiet room where a patient's dignity is respected if in a mental health crisis; improved communication with the person accompanying individual who requires support; training courses should highlight that experience at an emergency department is often an individual's first contact and needs to be positive; compassionate and understanding staff attitude.

- ***Primary Care*** – greater recognition that GPs have a critical role in preventing suicide given that they are the main source of professional support for someone in the community seeking assistance with emotional distress; further awareness-raising of community and voluntary counselling services as potential referral services; an empathetic response for an individual in need attending primary care.

- ***Families*** – better support for families where a relative has suicidal intentions or has made a suicide attempt. Families require information regarding local support and guidance on how to access that support. (*Note: the PHA has developed a support booklet for families and carers of those who have self-harmed, attempted suicide, or had suicidal thoughts and this has been made available to all Trusts for use in hospital emergency departments*). There is concern that clinicians can be reluctant (on the basis of patient confidentiality) to inform families about aspects of risk and to open a channel of communication with the family.

- ***Sudden death notification process*** – better sharing of information, reduction in time taken to notify local Trusts, more comprehensive recording of information, suicide awareness and suicide prevention training for police officers attending bereaved families.

- ***Scene of death*** – better training for PSNI and NIAS staff relating to handling of the deceased's remains, particularly the length of time left in situ at the scene of the death.

- ***Bereaved families and friends*** – establishment of formal policies, procedures or standardised guidance for responding to suicide bereaved families in the primary care setting.

- ***Self-care*** – better support for the wide range of professionals who experience the loss to suicide of a patient or client. It was noted that a structured system of care and support for healthcare and frontline staff that provide intervention for suicidal people is in place in Ayrshire in Scotland and may provide a model for such a service.

Box 7: Feedback from pre-consultation engagement workshops

Service to be continued	***Potential enhancements***
Counselling services	Sufficient resourcing to meet demand for counselling and reduction in waiting times; improved availability of counselling services in rural areas; common standards to ensure consistency and quality.
Training programmes	Further rollout to "gatekeepers" such as clergy, undertakers, justice staff, fire service, ambulance service, counsellors, and parents; enhanced training for teachers and youth workers; regular refresher sessions.
Media campaigns and reporting	More positive use of the Internet and social media; provide training for parents and teachers on cyber-bullying; consideration of whether a direct suicide prevention campaign is now timely; explore possibility of a media campaign with bereaved family members; targeted information campaigns for high risk groups.
Sudden Death Notification	Flexibility to allow more than one family member to be involved; enhanced training for PSNI officers who interface with the bereaved.
Community Response Plans	Better learning from each occasion that plans are activated; training for those involved in implementing the plans; improved links with school critical incident plans.
Card Before You Leave	Adopt a standardised approach in all Trusts to ensure consistent implementation; address high rates of missed appointments.
Self-harm Registry	Explore potential for roll out to primary care and voluntary & community groups to help provide a more complete picture of the level of self-harm; improve stakeholder knowledge about the Registry & the useful role it can play.
Local research	Focus on bereaved families and those who have made suicide attempts; research to improve evaluation of programme impacts.
Data collection	Improved data collection & quality of information; improved sharing of information & linkages between data systems to capture and recognise trends in suicidal behaviour across the north of Ireland.
Co-ordination & collaboration	Improved co-ordination between PSNI and health; better engagement with organisations involved in relationship issues eg Relate and divorce solicitors; tangible links to be made with other influencing strategies, such as those dealing with access to therapeutic services and addressing substance; clear referral pathways; greater clarity on, and co-ordination of, bereavement support available within the voluntary sector.
Reducing access to means	No specific comments.

The need for suicide and self-harm prevention

In addition to the relatively high incidence of suicide and self-harm in the north of Ireland, as outlined above, the need for services is highlighted by the fact that there have been almost 600,000 calls to the Lifeline service since it was set up in 2008 (an average of 1,500 calls per week), over 1,000 annual calls to ChildLine from children in the north of Ireland where suicide is the main reason for the call, and 100,000 calls annually to Samaritans.

Conclusion and priority areas

People can and do recover from suicidality and self-harming behaviour. There is some robust evidence for interventions that work in preventing suicide and for interventions that reduce repeat self-harming. The evidence for reducing suicide risk and for addressing poor mental wellbeing in those bereaved by suicide is more limited.

Feedback from pre-consultation engagement indicates that most existing *Protect Life* services are valued and should be retained with some adjustments or enhancements. This feedback also highlights some areas where stakeholders consider there are gaps in current service provision, for example, in support for families with a family member at high risk of suicide and support for "self-care" in those who deliver suicide prevention services.

Taken together - the evidence, pre-consultation engagement, and learning from implementation and evaluation of *Protect Life* - indicates the need for: general population-based approaches designed to influence attitudes and behaviours; targeted intervention for groups at higher risk of suicide, such as those who self-harm, and which address the more "direct" risk factors for suicide; as well as 'indicated' intervention for those in crisis.

Population based approaches are universal interventions aimed at the whole population. Under *Protect Life 2* they will include: restriction of access to means for suicide; supporting responsible media reporting; tackling stigma; increasing public and professional awareness; and encouraging help-seeking behaviour.

Interventions delivered through associated strategies for preventing substance misuse, fostering supportive communities and schools, preventing domestic and sexual abuse, addressing poverty, and supporting victims are also relevant.

Targeted interventions are directed towards those groups known to be vulnerable to suicide and may be delivered in specific settings. They will include: efforts to improve detection and management of psychiatric disorders in primary care (especially depression and PTSD); identification and treatment of substance misuse; effective risk management within mental health services and in the follow-up of patients after hospital discharge in line with NCISH recommendations; mental health screening for people with chronic physical illness; encouraging help-seeking behaviour amongst young to middle-aged males; risk management within justice settings; promotion of guidance on crisis management and suicide/self-harm prevention in schools; and suicide bereavement support programmes.

Targeted intervention will also encompass training for front line emergency response services and "community gatekeepers" (including those who respond to the needs of "raised risk" groups identified in Chapter 3) and the promotion of self-care for the staff who deliver these services.

Indicated interventions are for individuals in circumstances that place them at a high risk of suicide and/or who are showing signs of suicidal behaviour (e.g. people who repeatedly self-harm or have previously attempted suicide, people in social/emotional crisis). They will include: suicide de-escalation services; access to psychological services; and effective self-harm and/or suicidal behaviour case management (all with a view to promoting recovery).

Underlying all of this is a need to ensure good quality *data* on suicide and self-harm which can inform improvement to prevention services. This requires systematic, comprehensive, and timely data collection and analysis. The linking of the various suicide and self-harm related datasets (together with other health datasets at some point in the future) is a priority as this will support analysis and provide enhanced information on suicide and self-harm issues and trends. Better learning from the investigation of serious adverse incidents related to suicide and suicide attempts of

people engaged with health and social care services is also a priority. Furthermore, it is intended that the learning from the activation of community response plans is incorporated into a more integrated approach to improving our understanding of suicide and self-harm in the north of Ireland.

Engaging men in suicide prevention services is a challenge, however, given the high prevalence of suicide in men aged from their late teens to late 50s, it is an area which must be addressed. Indications are that programmes which centre on sport and physical activity show promise and it is recognised that community outreach programmes into traditional male environments is a necessary step. There is potential to make greater use of the Internet and technology to engage men in addressing mental health issues. Research[86] has also highlighted the need for a focus on more appropriate terminology; men are deterred by the term 'mental health' and seem more at ease with terms such as "mind health" or 'mental fitness'.

Given that 72% of people who have died by suicide here had not been in contact with mental health services in the 12 months prior to their death, there also needs to be a focus on removing barriers to accessing suicide prevention and mental health services, and improving individual's, especially men's, willingness to use these services. This also indicates a high level of undiagnosed mental illness and highlights the importance of other health and social care services as settings for the identification of those at risk of suicide – a ScotSID 2015 report "Contact with multiple healthcare services prior to death"[87] found that 70% of people who died by suicide in Scotland had recent contact with health services.

Postvention support

It is clear that postvention services require flexibility to accommodate differences in coping styles, gender differences and situation differences. However, in general it is important to ensure that those bereaved have ready access to practical and emotional support. Support also needs to be provided to the bereaved individuals' closest network, as informal support from wider family and friends is the main source of comfort and practical help for most people and, in some cases, is the only form of support that the bereaved person requires.

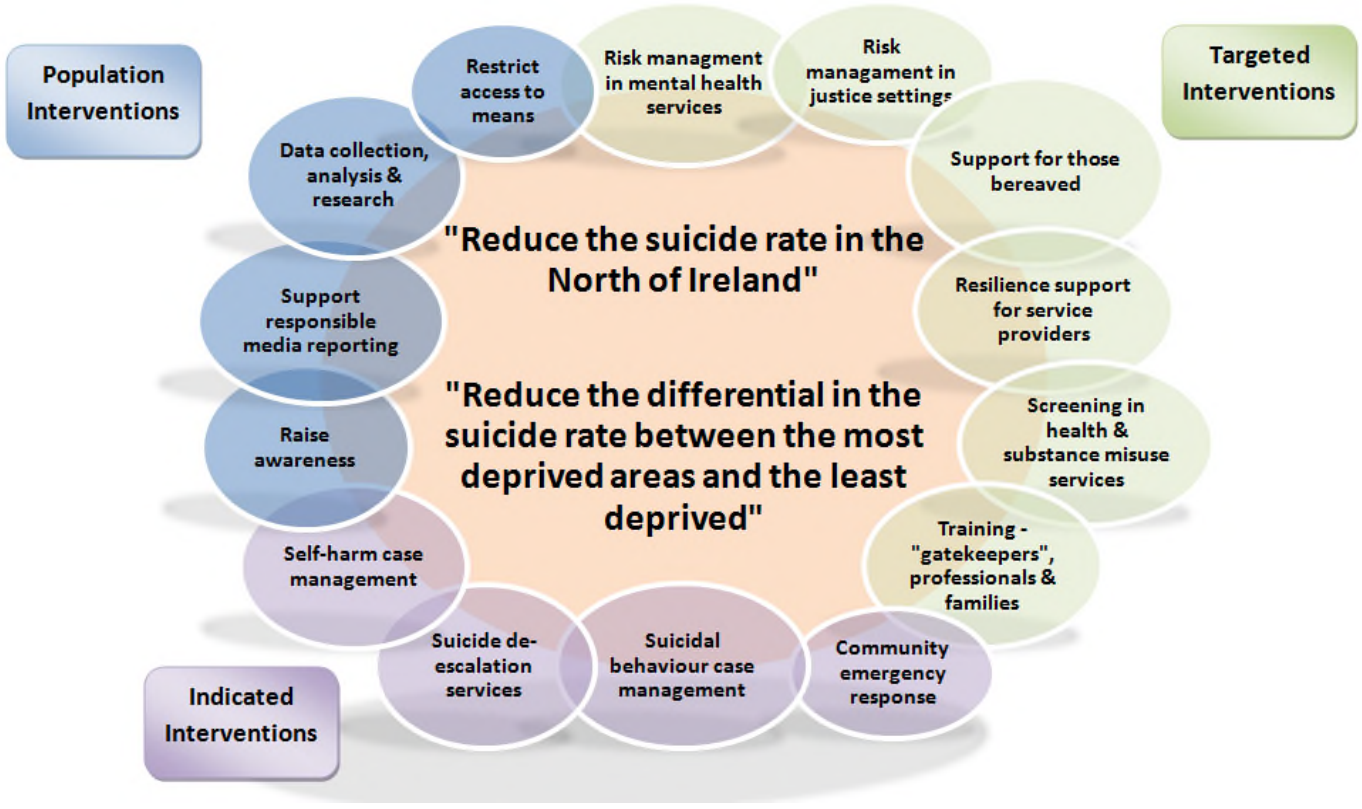
It is also true that many bereaved people look beyond family and friends for support but are often unaware of the sources of this support. Bereaved families and friends need to be made aware of these services in a way that doesn't confuse and overwhelm them and may need to try different types of support – ranging from counselling to talking therapies to peer support – at different stages before they find an approach that helps them to cope with their loss.

Postvention includes support to assist in the management of the immediate crisis and follow-up support as needs change over time. Immediate support may be provided by bereavement support workers, clergy, GPs, health professionals, voluntary and community groups and funeral directors. Longer term assistance can be provided by professional counsellors or therapists, as well as by those bereaved by suicide who have already experienced the same tragedy. Professionals who provide support in the immediate aftermath of a suicide should be appropriately trained.

Suicide can also be traumatic for communities and those who interacted with the deceased in a professional capacity such as counsellors, GPs, and psychiatrists, as well as the emergency services who attend the scene. For example, emerging findings from local research[88] commissioned under *Protect Life* indicates that the suicide of a patient tends to exact a heavy toll on the GP's wellbeing and professional confidence.

The proposed priority areas for achieving the twin aims of this strategy are set out in **Figure 9**.

Figure 9: Strategic priorities



SECTION 2

MAKING IT HAPPEN

Chapter 6: OBJECTIVES AND PRIORITIES

The proposed approach for *Protect Life 2* is to build on what has been achieved through the previous strategy whilst taking action to address those areas where gaps have been identified or where further improvement and focus have been identified as necessary. In addition, consideration will be given to the more recent developments in the field of suicide prevention in terms of how they can be incorporated into the strategic action plan.

In light of this, the objectives for the strategy are set out below. In developing these objectives consideration has been given to the priority areas identified in Chapter 5 and to the major risk factors for suicide in people who are already in emotional distress.

Objectives for frontline intervention to prevent suicide

Objective 1 – Fewer people who are in contact with mental health services, die by suicide.

28% of people who died by suicide in the north of Ireland were known to mental health services and 50% had been taking medicine for mental illness. Where people at high risk of suicide are known to services, there is an opportunity to reduce that risk and improve patient safety.

Objective 2 – Reduce the incidence of repeat self-harm presentation to hospital emergency departments.

Repeat self-harm is the major risk factor for suicide. Presentation at hospital emergency departments due to self-harm provides an opportunity to act quickly and link those at risk with services.

Objective 3 – Improve the understanding and identification of suicidal and self-harming behaviour, awareness of self-harm and suicide prevention services, and the uptake of these services by people who need them.

Stigma related to suicide remains a major obstacle to suicide prevention efforts. It isolates and may prevent people from seeking help, even though they are in

distress. Better understanding of the issues should help reduce stigma and encourage help-seeking behaviour. It should also increase the likelihood of early recognition of suicidal behaviour and suicide risk, thereby improving the chances of early intervention for more people.

Low levels of engagement with mental health services by those who have died by suicide is a cause for concern. This is particularly true for men and probably reflects a reluctance to disclose mental health difficulties. This further highlights the need to raise public awareness of mental health, address stigma around disclosure of suicidal feelings, and encourage help-seeking.

Objective 4 – Enhance the initial response to, and care and recovery of, people who are experiencing suicidal behaviour and to those who self-harm.
Those who are the first point of contact need to have the necessary knowledge, skills and attitudes to deliver compassionate and supportive care. Suicide rates in Scotland have been declining; those responsible for the Scottish *Choose Life* strategy attribute the achievement of a target of training 50% of first responders and health care staff as an important contributory factor for this outcome.

Objective 5 – Restrict access to the means of suicide, particularly for people known to be self-harming or vulnerable to suicidal thoughts.
Reducing access to the means of attempting suicide is a particularly effective prevention intervention because some people make a suicide attempt impulsively in direct response to a personal (and sometimes short term) crisis. The presence of alcohol, particularly alcohol intoxication, increases impulsivity and may create temporary depression. If lethal means are not available or if the person survives the attempt, suicidal thoughts may pass or there may be time to intervene in other ways or to seek help.

Given that most suicide attempts take place in or near the home and that the most commonly used means are easily accessible, it is recognised that the potential for restricting access to means in all cases is limited. Nevertheless, it is important to be vigilant and to restrict access to means where possible.

Restricting access to means also covers media reporting of suicide which should avoid reporting excessive detail about the methods of suicide.

Objectives for postvention support

Objective 6 – Ensure the provision of effective and timely information and support for individuals and families bereaved by suicide.

Losing a loved to suicide is one is of life's most painful experiences. The feelings of loss, sadness, and loneliness experienced after any death of a loved one are often magnified in suicide survivors by feelings of quilt, confusion, rejection, shame, anger, and the effects of stigma and trauma. Families and friends bereaved by suicide are at greater risk of depression and future suicidal behaviour and often require specific supportive measures and targeted treatment to cope with their loss.

It is estimated that around six people are intensely affected by every suicide death and a further 60 people are deeply affected. On this basis, an estimated 16,500 people in the north of Ireland have been intensely affected by suicide over the 10 year period 2005-2014 and around 165,000 have been deeply affected.

Objective 7 – Provide effective support for 'self-care' for voluntary, community, and statutory sector staff providing suicide prevention services.

Patient, client or parishioner suicide is very distressing for those who have been supporting the individual on a professional/vocational basis. It can exact a heavy toll on their personal wellbeing and professional confidence. Self-care complements suicide prevention services, and there is a need to consider mechanisms for better psychological and professional support for those who experience suicide as part of their professional or voluntary practice.

Objective 8 – Enhance responsible media reporting on suicide.

Appropriate media reporting of suicide can make a positive contribution to public understanding of suicide, and to the promotion of help-seeking behaviour and suicide prevention. Inappropriate media reporting causes considerable stress and trauma to those bereaved by suicide and can lead to 'copycat' behaviour, especially

among young people and those already at risk.

Objective 9 – Identify emerging suicide clusters and act promptly to reduce the risk of further associated suicides in the community.

There is a risk of 'copycat' suicides, particularly among young people, when a member of a community dies by suicide.

Objective 10 – Strengthen the local evidence base on suicide patterns, trends and risks, and on effective interventions to prevent suicide and self-harm.

The epidemiology of suicide and suicidal behaviour changes needs to be monitored to understand the drivers for suicide and self-harm, and to identify the most at risk groups and individuals. This in turn informs preventative measures and where/at whom these should be targeted. In essence, suicide and self-harm requires ongoing analysis and research.

CHAPTER 7 – STRATEGIC ACTION PLAN

This high level action plan sets out the strategic actions necessary for the achievement of the stated objectives of frontline intervention to prevent suicide and of postvention to support those bereaved by suicide. A more detailed, timetabled action plan with associated indicators of progress will be developed following public consultation. The Public Health Agency will lead on the process of developing the more detailed implementation plan.

As the strategy focuses on those who are in crisis, suicidal, or self-harming, most of the actions address the needs of high risk groups and individuals. However, some more broadly-based actions are included, e.g. those that are concerned with awareness raising, suicide surveillance/data gathering, and research. An underlying principle is that, where it is appropriate and feasible, the actions need to be tailored and relevant to the needs of specific high risk groups such as LGBT individuals, men aged from their twenties to late fifties, those in the criminal justice system, and those with mental illness.

OBJECTIVE 1: FEWER PEOPLE WHO ARE IN CONTACT WITH MENTAL HEALTH SERVICES, DIE BY SUICIDE	
Action	**Lead organisation**
Continue to fund north of Ireland participation in the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.	DoH
Mental health and psychological therapies service developments in line with the Programme for Government and Bamford evaluation recommendations.	DoH, HSCB.
Support improvements in areas of practice to make mental health services safer for people at risk of suicide in line with National Confidential Inquiry recommendations.	HSCB
Explore the feasibility of applying the “zero suicide” approach (initially) in mental health services.	HSCB
Improve the process for learning from suicide and self-harm related adverse incidents.	RQIA,HSCB
Implementation of clear protocols and pathways of care between mental health and other HSC services	

OBJECTIVE 2: REDUCE THE INCIDENCE OF REPEAT SELF-HARM PRESENTATION TO HOSPITAL EMERGENCY DEPARTMENTS	
Action	**Lead organisation**
Implement NICE guidance on the short and longer term management of self harm – particularly with regard to admission, psychosocial assessment, evidence based interventions and staff training.	HSCB,PHA
Evaluation of the RAID model for future roll out regionally.	HSCB
Provide self harm support and recovery services across the north of Ireland.	PHA
Use the Self Harm Registry to inform effective service provision for patients who self-harm or who present in crisis.	HSCB
OBJECTIVE 3: IMPROVE THE UNDERSTANDING AND IDENTIFICATION OF SUICIDAL AND SELF HARMING BEHAVIOUR, AWARENESS OF SELF-HARM AND SUICIDE PREVENTION SERVICES, AND THE UPTAKE OF THESE SERVICES BY PEOPLE WHO NEED THEM	
Action	**Lead organisation**
Develop, deliver & evaluate training in suicide awareness and suicide prevention targeted at “first responders” and community “gatekeepers”.	PHA, DofC, PSNI, NIPS, DoJ
Social marketing programmes to enhance public understanding of suicide & self-harm; including targeted awareness programmes for the specific higher risk groups identified in this strategy.	PHA, DofC
Increase help-seeking behaviour and awareness of services	PHA
Encourage universities, colleges and training organisations to promote, via their pastoral care arrangements, a culture of help-seeking behaviour and suicide awareness particularly among young people.	DfE
Encourage employers to create an environment that helps ensure the mental health wellbeing of their employees at work.	HSENI (DfE)
Suicide prevention co-ordinators working in community and voluntary and statutory sector	PHA, HSC Trusts
Screen (for self-harm behaviour) those patients being treated for substance misuse, acute physical health conditions, and mental health conditions.	HSCB, HSC Trusts
Develop a mental health promotion action plan with a clear focus on investment in the formative years	DoH
Strengthen cross-departmental engagement in addressing risk factors for suicide and self-harm	PHA
Promote positive use of the internet and social media in relation to suicide prevention	PHA

Provide access to services for prisoners with mental illness or at risk of suicide/ self harm	DoJ, SEHSCT
Develop and implement policies, guidance and resources for schools to include positive mental health; protecting life and the management of critical incidents	DE
OBJECTIVE 4: ENHANCE THE INITIAL RESPONSE TO, AND CARE AND RECOVERY OF PEOPLE WHO ARE EXPERIENCING SUICIDAL BEHAVIOUR AND TO THOSE WHO SELF-HARM	
Action	**Lead organisation**
Development of a comprehensive Mental Trauma Service	DoH
Provide accessible de-escalation services for people in crisis and at high risk of suicide.	PHA
Deliver targeted suicide prevention services for people who are in priority groups	PHA
Provide support to post primary schools and the post primary cohort in special schools through the Independent Counselling Service	DE
Maintain, review and further develop quality standards for the provision of mental and emotional wellbeing and suicide prevention services.	PHA
Commission and evaluate statutory, community & voluntary sector services against these standards	PHA
Provide timely, accessible and responsive suicide and self harm prevention services	PHA
Strengthen out of hours capacity to de-escalate individuals presenting in social and emotional crisis.	PHA
Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviours.	HSCB, HSC Trusts
Support families and others affected by a suicide attempt.	PHA
Establish effective links between primary care and sources of information and suicide prevention support in the community.	PHA, HSCB
Complete the roll-out of improving access to psychological therapies	HSCB
Assertively reach out to those at risk of experiencing suicidal behaviour and link them into appropriate support and care with a focus on recovery	PHA
Explore feasibility of developing a system to monitor and evaluate outcomes for individuals accessing services.	PHA
Provide farm families health checks and signpost to advice services on mental health issues	PHA, DAERA
Provide access to services for prisoners with mental illness or at risk of suicide/ self harm	DoJ
Adapt the environment for those held in custody to reduce possibility of suicide	DoJ
Development and implementation of a suicide and self-harm strategy to cover NIPS including a review of Supporting Prisoners At Risk	DoJ

OBJECTIVE 5: RESTRICT ACCESS TO THE MEANS OF SUICIDE, PARTICULARLY FOR PEOPLE KNOWN TO BE SELF-HARMING OR VULNERABLE TO SUICIDAL THOUGHTS	
Action	**Lead organisation**
Adapt the environment for those held in custody to reduce possibility of suicide	DoJ
Explore options for reducing the risk of suicide at high risk locations including the Foyle riverfront and bridges	PHA, DfI
Monitor changing behaviours or trends in suicide methods.	PHA
Work with professional groups to reduce inappropriate prescribing of medicines commonly used in intentional overdose	HSCB
Support adherence to legislation limiting access to paracetamol through awareness raising	HSCB
OBJECTVE 6: ENSURE THE PROVISION OF EFFECTIVE AND TIMELY INFORMATION AND SUPPORT FOR INDIVIDUALS AND FAMILIES BEREAVED BY SUICIDE	
Action	**Lead organisation**
Continued support for bereaved families representative groups to enable them to influence policy and service design and delivery	PHA
Provision of effective and timely services and information for those bereaved by suicide	PHA, HSC Trusts
Awareness raising with health and education providers of increased risk of suicide and self harm by those bereaved by suicide	PHA
OBJECTIVE 7: PROVIDE EFFECTIVE SUPPORT FOR “SELF CARE” IN VOLUNTARY, COMMUNITY AND STATUTORY SECTOR STAFF PROVIDING SUICIDE PREVENTION SERVICES	
Action	**Lead organisation**
Support for professionals who experience the loss of a patient or client to suicide	PHA
Provision of reflective practice for those working in field of suicide prevention	PHA
Promote Take 5 programme to enhance emotional wellbeing	PHA
Implementation of PHA standards toolkit for organisations commissioned to provide suicide prevention and mental and emotional wellbeing services	PHA
OBJECTIVE 8: ENHANCE RESPONSIBLE MEDIA REPORTING ON SUICIDE	
Action	**Lead organisation**
Promote use of media guidelines on reporting of suicide; review and update as necessary.	PHA
Monitor articles and broadcasts and report and challenge inappropriate reporting	PHA
Awareness raising with journalism students and media groups	PHA

OBJECTIVE 9: IDENTIFY EMERGING SUICIDE CLUSTERS AND ACT PROMPTLY TO REDUCE THE RISK OF FURTHER ASSOCIATED SUICIDES IN THE COMMUNITY	
Action	**Lead organisation**
Further development and evaluation of SD1 process	PHA
Further development and evaluation of Community Response Plans	PHA
OBJECTIVE 10: STRENGTHEN THE LOCAL EVIDENCE BASE ON SUICIDE PATTERNS, TRENDS AND RISKS, AND ON EFFECTIVE INTERVENTIONS TO PREVENT SUICIDE AND SELF-HARM	
Action	**Lead organisation**
Commission, publish and share local research on suicide and self-harm prevention interventions	PHA
Evaluation of Protect Life commissioned services	PHA
Longitudinal study of self harm trends in north of Ireland	PHA
Improve understanding of causes of suicide, best practice and effective interventions in suicide prevention	PHA
Support promotion and delivery of IASP 2019 Congress	PHA
Enhance North South cooperation on suicide prevention and sharing of policy and research	DoH, PHA
Ensure standardised socio-demographic monitoring to help identify gaps in service access	PHA
Improve data collection and analysis of self harm and suicide	PHA

CHAPTER 8 – IMPLEMENTATION, GOVERNANCE AND MONITORING OF PROGRESS

It is proposed that strategic oversight will continue to be led by DoH, with strategy implementation led by the PHA. DoH will continue to support the rollout of the strategy by setting suicide prevention priorities and outcomes in the relevant commissioning plans for the Health and Social Care system which are updated annually. The roles of other groups involved in the oversight and delivery of the strategy are set out in this chapter.

Managing and steering implementation

Feedback from pre-consultation engagement on the development of this draft strategy stressed the importance of retaining and clarifying the frontline suicide prevention governance structure already in place for *Protect Life*.

It is proposed that the implementation of this strategy will be managed under the direction of a newly established *Protect Life 2* Implementation Steering Group, chaired by the PHA. This was a weakness under previous governance arrangements and will now be addressed. The role of the steering group will be to monitor and report on progress of the actions in the costed implementation plan and to direct corrective action where necessary to address implementation delays. Terms of reference will be developed for the steering group and these will be representative of the make-up of the group.

The steering group may establish working groups to advise on and progress specific areas within suicide prevention such as research and evaluation, awareness raising and media reporting, training, development of standards and good practice guides, restricting access to means, collaboration with other jurisdictions, and postvention support.

Given that it is now accepted that no single government Department can hold sole responsibility for suicide prevention, it is proposed that the Ministerial Co-ordination Group on Suicide Prevention (which already has an expanded remit for mental health promotion) will continue to provide oversight, political leadership, and

impetus for cross-departmental collaboration and co-ordination on suicide prevention. Fundamental to recovery is social integration; education, training and employment.[89] Therefore, effective suicide prevention needs to be connected with services delivered through strategies for education, employment, elimination of poverty, and promotion of social inclusion.

It is proposed that the Suicide Strategy Implementation Body (SSIB) will continue to operate as the regional stakeholder representative body tasked with the remit of providing advice and strategic direction on issues relating to suicide and self-harm, as well as providing a challenge function on strategy implementation when necessary. SSIB is currently chaired by a representative from the voluntary and community sector, with secretariat support provided by DoH Population Health Directorate. This arrangement has worked well and it is proposed that this continues. The support and leadership shown by colleagues in the voluntary and community sector has been a major strength in the drive against suicide and we look forward to this continued partnership working.

The importance of the effective implementation of *Protect Life* at local level in a way that takes account of locality needs, (eg urban and rural, and areas of deprivation), capabilities and existing services cannot be overstated. It is proposed that the Protect Life Local Implementation Groups (PLIGs) continue with their role of developing local action plans (based on *Protect Life 2*), overseeing and reporting on the delivery of these action plans, and securing input from a wide range of local agencies and groups in the drive against suicide.

Effective communication between the above groups will be facilitated by sharing agenda papers and minutes of meetings between the groups (in summary as appropriate).

Representatives of bereaved families participate in SSIB and in each of the PLIGs. These representatives have an important role in giving bereaved families influence in the development of suicide prevention policy and in implementation of the strategy. It is proposed that this formal role continues to be facilitated, and that

bereaved families organisations are encouraged to continue to develop networks of bereaved families across the north of Ireland.

Collaborative working with other jurisdictions

The evaluation of *Protect Life* stressed the importance of collaborative working and sharing of learning with other jurisdictions. There will be continued focus on developing a rolling all-island action plan and links with England, Scotland and Wales will be enhanced.

Resources and resource allocation

Over recent years, resources for the implementation of the *Protect Life* Strategy have averaged around £7 million per annum from DoH with this allocation being split evenly between funding for the Lifeline service and funding for the other elements of *Protect Life*, ie training, awareness raising, community-led prevention and postvention services, research, the self-harm registry, and the employment of local suicide prevention co-ordinators.

However, it is important to emphasise that this is not the totality of funding for suicide prevention in the north of Ireland. Other government departments (DAERA, DE, DfC and DoJ) have funded suicide prevention initiatives, statutory mental health services provide suicide prevention intervention from the mental health services budget, and the community and voluntary sector brings substantial funding to the drive against suicide through the self-financing of local programmes by numerous charities and community groups. It is also important to note that the PHA combines *Protect Life* funding with its budget for mental health promotion in its thematic delivery of suicide prevention and mental health promotion services.

One of the recommendations from the evaluation of *Protect Life* and a common theme in feedback from engagement in the development of this draft document has been the need for more sustainable funding in the form of longer term funding commitments to community and voluntary sector delivery partners. This process is now underway as the PHA rolls out the new procurement of community and voluntary delivered suicide prevention services. The new contracts will commit to

three-year funding for those organisations that are successful in the tendering process.

Governance

The Ministerial Co-ordination group on suicide prevention will continue to provide oversight, leadership and impetus for cross-departmental collaboration and co-ordination. Strategic oversight will continue to be led by DoH who will also continue to support the rollout of the Strategy by setting suicide prevention priorities and outcomes in the relevant commissioning plans for the Health and Social Care system which are updated annually. It is proposed that implementation of the Strategy will be through a new Protect Life 2 Implementation Steering Group chaired by the Public Health Agency. They will be supported by the Suicide Strategy Implementation Body, and Protect Life Implementation Groups. There may be further recommendations around structure arising from the Future Search process in Belfast.

Measurement, review and evaluation

An evaluation framework will be developed prior to the launch of the strategy. This will include indicators which provide a means to measure progress towards the strategic objectives. The indicators will be classified as “process indicators” e.g.,the number of sessions of training delivered and “impact indicators” e.g. changes in knowledge and skills. The Public Health Agency will lead on developing these indicators and on the identification of the necessary data sources to monitor their progress over time.

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CHAPTER 9 – EQUALITY SCREENING AND RURAL PROOFING

Equality Screening

Section 75 of the Northern Ireland Act 1998 (the Act) requires designated public authorities to comply with two statutory duties:

Section 75 (1) - In carrying out the functions as they relate to Northern Ireland there is a requirement to have due regard to the need to promote equality of opportunity between:

- persons of different religious belief, political opinion, racial group, age, marital status, or sexual orientation;
- men and women generally;
- persons with a disability and persons without; and
- persons with dependants and persons without.

Section 75 (2) - In addition, without prejudice to the obligations above, in carrying out the functions as they relation to Northern Ireland the Department is required to have regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group.

In line with the Department's Equality Scheme the Department has completed a provisional Equality Screening and concluded that a full Equality Impact Assessment is not required. The attached consultation questionnaire seeks views on the potential impact of the policy on Equality of Opportunity, Good Relations and Human Rights. The screening decision will be reviewed in light of evidence from this consultation.

Rural Proofing

Rural proofing is the process by which all major policies and strategies are assessed to determine whether they have a differential impact on rural areas and, where appropriate, adjustments are made to take account of particular rural circumstances.

In line with government guidance from 2002, the Department has completed a rural-proofing survey and concluded that a full impact assessment is not required.

CONSULTATION

Confidentiality and access to information legislation

The Department will publish a summary of responses following completion of the consultation. Your response and all other responses to the consultation may be disclosed on request. The Department can only refuse to disclose information in exceptional circumstances. Before you submit your response please read the paragraphs below on the confidentiality of consultations and they will give you guidance on the legal position about any information given by you in response to this consultation.

The Freedom of Information Act gives the public a right of access to any information held by a public authority, namely DHSSPS in this case. This right of access to information includes information provided in response to a consultation. The Department cannot automatically consider as confidential information supplied to it in response to a consultation. However it does have the responsibility to decide whether any information provided by you in response to this consultation, including information about your identity, should be made public or be treated as confidential. If you do not wish information about your identity to be made public please include an explanation in your response. This means that information provided by you in response to the consultation is unlikely to be treated as confidential, except in very particular circumstances.

The Secretary of State for Constitutional Affairs' Code of Practice on the Freedom of Information Act provides that:

- the Department should only accept information from third parties in confidence if it is necessary to obtain that information in connection with the exercise of any of the Department's functions and it would not otherwise be provided;
- the Department should not agree to hold information received from third parties "in confidence" which is not confidential in nature, and

- acceptance by the Department of confidentiality provisions must be for good reasons, capable of being justified to the Information Commissioner.

For further information about the confidentiality of responses please contact the Information Commissioner’s Office.

Consultation Questions

The following is a list of the consultation questions. Please use the consultation booklet available online to respond; return your responses to phdconsultation@health-ni.gov.uk

Q1. Do you agree with the overall purpose of the Strategy? If not, what alternative do you suggest? (p 14)

Q2. Do you agree with the stated aims of the Strategy? If not, what alternatives do you suggest? (p 14)

Q3. Do you agree with the stated principles of the Strategy? if not, what alternatives do you suggest? (p15)

Q4. We have identified a number of priority population groups who are most at risk. Are there any other groups that are particularly at risk that have not been identified in this list? (p 34)

Q 5. We have identified a number of gaps or services that need to be enhanced. Do you agree with these? Are there any other gaps that you think need to be addresses? (p 56-58)

Q 6. Do you agree with the stated objectives of the Strategy? If not, what alternatives do you suggest (p 66-69)

Q 7. The Public Health Agency will be responsible for implementation of the action plan and will develop it in conjunction with a multi-agency implementation group. We would invite your views on the draft action plan and welcome suggestions on additional actions (p 70-74)

Q 8. Progress in delivering the Strategy will be monitored and its effectiveness will be reviewed periodically. We would welcome your views on how best to monitor and assess the impact of the Strategy over time. (p 78)

Q 9. We would welcome your views on how best to raise public awareness of suicide, suicidal ideation, suicidal behaviour and self-harm.

Q 10. Please provide any other comments or suggestions that you feel could assist with the development and delivery of the Strategy.

Q11. Are the actions set out in this draft Suicide Prevention Strategy likely to have an adverse impact on equality of opportunity on any of the nine equality groups identified under Section 75 of the Northern Ireland Act 1998?

Q12. Are you aware of any indication or evidence – qualitative or quantitative – that the actions/proposals set out in the consultation document may have an adverse impact on equality of opportunity or good relations?

Q13. Is there an opportunity for the draft Strategy to better promote equality of opportunity or good relations?

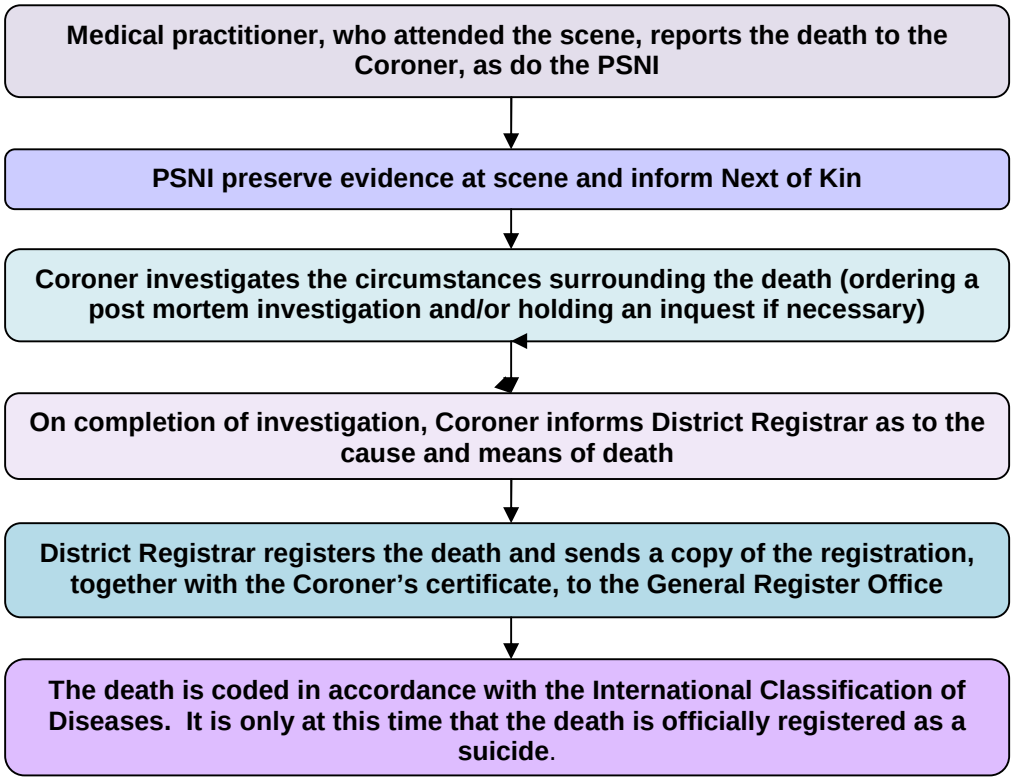
Q14. Are there any aspects of the Strategy where potential human rights violations may occur?

Appendix 1 – Policy context; definition and recording of suicide, and the law in relation to suicide

Definition and recording

Official statistics on suicide are provided by the Northern Ireland Statistics and Research Agency (NISRA) and are based on deaths where the underlying cause was of "intentional self-harm" and deaths due to "events of undetermined intent". The purpose of including deaths of "undetermined intent" is to correct for the known under-reporting of suicide. The figure below outlines the steps in the process for registering a death as suicide in the north of Ireland official statistics.

Registering a death as suicide



The registration process takes from 6 to 12 months on average, if there is no inquest. NISRA statistics relate to deaths registered (but not necessarily occurring) in a given year.

There are important differences in suicide investigation and recording across countries which makes direct comparison of suicide rates between the nations somewhat problematic. In England, Wales and the south of Ireland an inquest is held into every suspected death by suicide. This requires coroners to apply the principle of "*beyond reasonable doubt*", in reaching a verdict of suicide; whereas in the north Ireland the Coroner will normally determine the cause of death "*on the balance of probabilities*", which is a less stringent concept of proof.

One further difference is that following an inquest, coroners in England and Wales may use "*narrative verdicts*", which are narrative accounts of the circumstances surrounding a death. In coding such deaths, where the Office of National Statistics (ONS) cannot be clear from the narrative verdict that the cause of death was suicide, the death is coded as "*accidental*" rather than of "*undetermined intent*".

A key difference in recording in the south of Ireland, is that the latter does not include deaths classified as of "*undetermined intent*" in its official suicide statistics. There are even wider differences in the way that other countries investigate, classify, register, and report deaths as suicide. Consequently, international comparisons of suicide rates need to be treated with caution.

Data available from official statistics bodies on suicide is limited. It includes gender, age, means of death, marital status, and residence (to Council, HSC Trust, Parliamentary Constituency/Assembly Area level). It does not include information such as ethnicity, sexual orientation, and socio economic status.

The law in relation to suicide

Suicide was not decriminalised in north of Ireland until 1966 with the passing of the Criminal Justice Act (Northern Ireland) 1966. The 1966 Act created an offence of "*assisting, aiding or abetting suicide*". A person commits an offence if they intentionally encourage or assist the suicide or attempted suicide of another person. (who does not need be known to, or even identified by, the suspect). The suspect may commit the offence of encouragement even if a suicide attempt does not occur. The "*assisting, aiding or abetting*" offence carries a maximum penalty of 14 years' imprisonment.

The Act was amended by the Coroners and Justice Act 2009 to provide that a person who arranges for someone else to encourage or assist the suicide or attempted suicide of another person is also liable. The amendment also makes it clear that a suspect who puts pressure on the victim comes within the scope of this offence. These amendments are designed to make it clear that the offence of encouragement applies to an act undertaken via a website, such as posting to an online chat room or social networking site with the intention of encouraging another person to take their own life.

In the context of websites which promote suicide, the suspect may commit the offence if they intend that one or more of their readers will attempt suicide. A further consequence of the amendment is that it places an onus on internet service providers to act when they are notified that potentially offensive material has been posted on their websites.

The Public Prosecution Service issued policy guidance in 2010 on "*Prosecuting the Offence of Assisted Suicide*"[90] clarifying the position on evidential and public interest factors relevant for and against prosecution in cases of encouraging and assisting suicide.

Place of safety

A "*place of safety*" is somewhere a person – who is considered to be suffering from a mental disorder and, as a consequence, is at risk of serious physical harm - is brought under the Mental Health (Northern Ireland) Order 1986. This can be any hospital, any police station, or other suitable place the occupier of which is willing temporarily to receive the person while other arrangements are made for their care.

A police station should only be used in exceptional circumstances, when no other suitable place is available, and for the minimum length of time necessary. In practice, the PSNI (if they are involved) will normally bring such a person to the nearest hospital emergency department – particularly where the person is also highly distressed and displaying suicidal behaviour. At the "*place of safety*", the person is examined by a medical practitioner and interviewed by a social worker specially trained in mental health. Where the person has consumed alcohol or drugs, the mental health assessment may be delayed until they are deemed fit to be assessed.

Work has been ongoing between the HSCB and the PSNI to develop and agree protocols for the handover of a person in these circumstances, including where the person is intoxicated and/or exhibiting signs of drug taking. The detailed pathway flowcharts for various scenarios under the Mental Health (NI) Order 1986 which are set out in GAIN Guidelines[91] on the use of the Order assist greatly with this work.

Appendix 2 – Detailed policy context; strategies, programmes and national guidance relevant to suicide prevention and postvention

Protect Life 2 is being introduced within a policy environment that will impact on the delivery of policy aims for the prevention of suicide and self-harm. The table below provides an overview of national and international policy guidance, national best practice guidance, and north of Ireland strategies and programmes which have the potential to impact on, and contribute to, the prevention of suicide and self-harm.

The wider social determinants of mental health and wellbeing are largely addressed in associated strategies such as the Public Health Strategic Framework "*Making Life Better*" and cross-departmental strategies on poverty, children and young people, community safety, neighbourhood renewal, and social inclusion.

International policy guidance	Overview	Lead agency
Preventing Suicide: a global imperative WHO (2014)	These set out guiding principles for the development and implementation of national strategies. They cover population level interventions, approaches to vulnerable sub-populations at risk, and individual intervention.	World Health Organisation

Risk factor	Relevant policy, action or intervention	Lead agency
Deprivation	Improving Children's Life Chances: the Child Poverty Strategy (2011) The aims of the strategy are to: reduce the number of children in poverty; and reduce the impact living in poverty on children (their lives and life chances).	The Executive Office
	Pathways to Success: A Strategy for those young people Not in Education, Employment or Training (NEETs) Establishing an initial broad strategic direction and supporting cross-Departmental actions to reduce the number of young people most at risk of remaining outside of education, employment or training.	Department for the Economy
	Strategy for Children and Young People (2006-16) The aim of this strategy is to ensure that by 2016 all our children and young people are fulfilling their potential.	The Executive Office
Unemployment	Steps to Success programme to build	Department for

	skills and experience to find a job Disability employment services to support people with health conditions and disabilities Support Equality Through Inclusive Employment - An Employment Strategy for People with Disabilities The strategy contains proposals that will help the Department, working in partnership with others, to address the difficulties and inequalities that people with significant disabilities are attempting to overcome in employment	Communities Department for Communities Department for Communities
Substance misuse	The New Strategic Direction for Alcohol and Drugs Phase 2 (2011-16) a framework for reducing alcohol and drug related harm in The north of Ireland Hidden Harm Action Plan. Responding to the needs of children born to and living with parental alcohol and drug misuse in The north of Ireland	Department of Health Department of Health
Mental and emotional wellbeing	Making Life Better – Strategic Framework for Public Health (2013) Designed to provide direction for policies and actions to improve the health and well being of people in the north of Ireland and to reduce health inequalities. NI Service Framework for Mental Health and Wellbeing (2011) Aims to improve the mental health and wellbeing of the population of the north of Ireland, reduce inequalities and improve the quality of health and social care in relation to mental health. Infant Mental Health Framework (2016) This Infant Mental Health Framework represents a commitment by the Public Health Agency, Health and Social Care Board and Trusts, as well as academic, research, voluntary and community organisations across the north of	Department of Health Department of Health Public Health Agency

	Ireland, to improve interventions from the ante-natal period through to children aged three years old. ProMenPol – Promoting and Protecting Mental Health Aims to support the practices and policies of mental health promotion in three settings: schools, workplaces and older people's residences. Improving Dementia Services in The north of Ireland – A Regional Strategy The strategy makes recommendations aimed at improving the services and support arrangements currently available for people with dementia, their families and their carers. Tackling Rural Poverty and Social Isolation – A New Framework Aims to tackle poverty and social isolation in rural areas through organisations working in partnership to design and implement measures which target the needs of vulnerable people.	The European Network for Mental Health Promotion Department of Health Department of Agriculture, Environment & Rural Affairs
Mental health	A Strategy for the Development of Psychological Therapy Services (2010) This strategy has the overarching aim of improving the health and social wellbeing of the population of the north of Ireland by improving access to psychological therapies and by being more responsive to service user's needs. Personality Disorder: A Diagnosis for Inclusion. NI Personality Disorder Strategy (2010) Mental Capacity Bill which fuses mental health and mental capacity law into a single piece of legislation Delivering excellence, supporting recovery: Professional Framework for	Department of Health Department of Health Department of Health

	Mental Health Nursing in NI (2011-2016) To provide a framework that will enable the achievement of a world class mental health nursing service, that is designed to meet the vision and aspirations of Bamford, and by doing so, will provide safe and optimum nursing care that achieves for service users and their carers the best possible experiences and outcomes. Bamford Action Plan (2012-15) to support the Bamford review of mental health and learning disability Reports from the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness The Inquiry produces a wide range of national reports, projects and papers – providing health professionals, policymakers, and service managers with the evidence and practical suggestions they need to effectively implement change.	Department of Health University of Manchester, Centre for Mental Health & Safety
Domestic abuse Housing and homelessness	Stopping Domestic and Sexual Violence and Abuse Strategy (2016) The vision of the Strategy is to have a society in the north of Ireland in which domestic and sexual violence is not tolerated in any form, effective tailored preventative and responsive services are provided, all victims are supported, and perpetrators are held to account. Homelessness strategy (2012-17) The aim of this homelessness strategy is that long term homelessness and rough sleeping is eliminated across the north of Ireland by 2020.	Department of Health Northern Ireland Housing Executive
Offending	Strategic Framework for Reducing Offending (2013) The Strategic Framework seeks to promote more effective use of resources attached to current and future strategies and programmes of all	Department of Justice

	criminal justice organisations, and across Government and other sectors, to reduce offending.	
Legacy of the conflict	Strategy for Victims and Survivors (2009) This strategy is designed to provide the outline of a coherent and comprehensive approach for taking forward work on a range of issues relating to victims and survivors.	The Executive Office
Low educational attainment	Every School a Good School: A Policy for School Improvement (2009) This policy aims to support schools and teachers in their work to raise standards and overcome barriers to learning some pupils may face. Generating our Success: The The north of Ireland Strategy for Youth Training (2015) This strategy outlines the future direction for youth training in The north of Ireland and sets out the new policy commitments and an implementation plan to ensure their delivery. Success through Skills: Transforming Futures This ten year strategy looks at the current skills base, examines the skills we will need in future to grow the The north of Ireland economy and highlights areas for action.	Department of Education Department for the Economy Department for the Economy
Raised risk groups	Draft Sexual Orientation Strategy – under development by OFMdFM Caring for Carers: Recognising, Valuing and supporting the Caring Role It addresses, in a practical way, the support that carers want, and need, to allow them to continue caring, and to give them as much access as possible to the same opportunities that the rest of us enjoy. Care Matters in The north of Ireland – a Bridge to a Better Future Strategy (2009)	 Department of Health Department of Health

	The document looks at how best we can invest in a range of preventative services designed to help children and their families stay together. For those who need to come into care, we want to strengthen kinship care and more flexible forms of foster care. Living with Long-term Conditions – A Policy Framework A strategic driver for the reform and modernisation of services for adults in the north of Ireland living with long term conditions irrespective of condition or care setting.	Department of Health

Relevant NICE guidance	
Clinical guideline on Post Traumatic Stress Disorder (CG26)	Although published in March 2005, DoHdecided to review it in April 2012 for applicability to the health and social care sector in the north of Ireland. A Cochrane review on psychological therapies for PTSD in children was published in 2012. The findings are in line with NICE clinical guideline 26 in supporting the use of psychological therapies, particularly CBT.
Clinical guideline on Self-harm: short-term treatment & management (CG16)	Evidence-based clinical guideline for professionals involved in the management of people who self-harm within the first 48 hours of an incident. It recommends that risk assessment tool and scales should not be used to predict future suicide or repetition of self-harm, or to determine who should be offered further treatment & who should be discharged. It supports offering integrated & comprehensive psychosocial assessment of needs & risks, taking account of the fact that each person self-harms for individual reasons.
Clinical guideline on Self-harm: longer-term management (CG133)	Deals with the longer-term psychological treatment & management of both single & recurrent episodes of self-harm. Based on the clinical guidelines, NICE quality standards identify the key markers of high-quality self-harm services.
Clinical guideline on Common mental health disorders: Identification and pathways to care (CG123)	Guideline for primary and secondary care clinicians, managers and commissioners. Notes that depression is the most common disorder contributing to suicide. Recommends that people with a common mental health disorder are always asked directly about suicidal ideation and intent. Where there is a risk of self-harm or suicide, assessment should include whether the person has adequate social support and is aware of sources of help. Intervention should

	include arranging help appropriate to the level of risk. Where the person presents a high risk of suicide, manage the immediate problem first and then refer to specialist services and, where appropriate inform families and carers. Where the suicide risk is considerable & immediate risk, refer them urgently to the emergency services or specialist mental health services. Assessment should take into account toxicity in overdose, if a drug is prescribed, and potential interaction with other prescribed medication and, if necessary, limit the amount of drug(s) available, consider increasing the level of support, such as more frequent direct or telephone contacts.
Clinical guideline on Depression in children and young people: Identification and management in primary, community and secondary care (CG28)	Recommends that in the assessment of a child or young person with depression, healthcare professionals should always ask the patient and their parent(s) or carer(s) directly about the child or young person's alcohol and drug use, any experience of being bullied or abused, self-harm and ideas about suicide. High recurrent risk of self-harm or suicide should be used by healthcare professionals as criteria for referral to tier 4 services: Inpatient treatment should be considered for those who present with a high risk of suicide or of serious self-harm.

Appendix 3 – Current programmes and priority settings/services for preventing self-harm and suicide

A wide range of programmes, initiatives, and services have been developed and delivered under *Protect Life* over the past eight years. These are described below and include some initiatives that have been explored and/or piloted but not yet fully developed.

Lifeline – 0808 808 8000
Free-to-call confidential telephone helpline for people who are experiencing emotional crisis and who are at risk of suicide. Aims to: de-escalate clients at risk of self-harm or suicide; provide an immediate response proportionate to the client's assessed risk; deliver short term rapid response community based counselling; and refer clients for on-going support, as appropriate. Public Health Agency has undertaken a consultation on proposals for a new Lifeline crisis response service.
Training
Suicide and self-harm prevention training courses have been delivered covering: mental health awareness and support (Mental Health First Aid and primary care training on depression awareness); suicide & self-harm awareness (Suicide Talk, safeTALK, & Introduction to Self-harm); and suicide/self-harm intervention (ASIST – Applied Suicide Intervention Skills Training, Storm – Skills-based Training on Risk Management, Understanding Self-Harm). Training has been targeted at frontline staff such as those working in hospital emergency departments, primary care, mental health services, ambulance service, third sector organisations engaged in suicide prevention, prison staff, and the police. Other 'community gatekeepers' such as youth workers, sports coaches, and clergy have also been actively involved. The PHA introduced a regional training programme in November 2012 to help ensure that organisations providing suicide prevention/mental health training meet set standards and that consistent, high quality training is provided.
Community support
A wide range of community and voluntary group led services have been made available under *Protect Life*. These include counselling, therapy support services, locality-based prevention, crisis intervention, and bereavement support initiatives. These services are procured and delivered against "*Quality Standards for Services Promoting Mental Health and Emotional Wellbeing and Suicide Prevention*" developed by the PHA. The standards cover corporate governance and clinical service delivery, and promote safe and effective practice of services for the patient/client. A process of re-procurement of community-based services against these standards was undertaken. Re-procurement was also designed to introduce longer term contracts in order to assist providers to undertake longer term planning and enhance the stability of service provision. Capacity building support has also been provided (through a small grants scheme) to help local community organisations develop the knowledge and skills to introduce suicide prevention services in their localities.
Self-harm prevention
A Regional Self-Harm Steering Group oversees the delivery of data gathering on self-harm & a range of self-harm intervention services. *The Self-harm Registry* Following a successful pilot, launched in the Western Area in 2007, the Self-harm

Registry was implemented in all hospital emergency departments from April 2012. It records data on presentations at hospital emergency departments as a result of self inflicted injury or poisoning and presentations due to severe emotional distress. The data provides a unique opportunity for comparative analysis on the extent and complexity of self-harm in our society, helps in identifying trends, and informs the design of support services. Published reports based on this data highlight challenges for emergency departments in terms of training staff, understanding the issues relating to self-harm, and ensuring effective interfaces between acute and mental health services.

Self-harm intervention services

Two pilot self-harm specific services were supported in the Western Trust area, (i) a community-based counselling service known as the Self-Harm Interagency Network which was integrated into the referral pathways of statutory services, and (ii) the resourcing of additional staff within the Trust's mental health services to address the issue of self-harm. These pilots have informed the development of the Self-Harm Intervention Programme (SHIP), in operation regionally and the training of emergency department staff – a training programme has been developed (in line with the NICE guidance on the management of self-harm) and is currently being rolled out. SHIP is delivered by community and voluntary sector organisations. It provides counselling to help improve coping skills, and offers education and support to carers/families to help them better understand and cope with the issue. Access to the service is through GPs.

A Dialectical Behaviour Therapy Service is currently being delivered in the SEHSCT through its Mental Health and Psychological Therapy services. This service, which is recommended by NICE, is a recovery focussed psychological treatment designed primarily for high suicidal and self-harming people that works intensively with the individual to help them enhance their skills in regulating emotional arousal and in tolerating emotional distress.

Card Before You Leave service (CBYL)

Provides patients, who present at hospital emergency departments as a result of self-harm and/or in emotional distress, with access to ongoing care in the community following their discharge. Patients assessed as being of no immediate risk to themselves and who might require future care from mental health services, are discharged with a card giving details of a fixed-time appointment to attend community mental health services the following day and contact numbers for support. (Patients considered to be at high risk of suicide are usually offered an urgent health assessment in the emergency department or on the ward.) In some circumstances clinicians may decide that a follow-up phone-call is more appropriate. The card also gives details of contact numbers for support. The new Rapid Access Interface Discharge model (RAID) in the Northern Trust area will help shape future service provision and evaluation of this pilot may reduce the need for a next day appointment card to be issued.

Media reporting

Updated Samaritans and Irish Association of Suicidology media guidelines for the responsible reporting of suicide and self-harm were issued in 2014. A dedicated resource in this area through the Public Health Agency and also proactive engagement by HSC Trusts has helped to ensure these guidelines are adhered to and that media reporting is responsible and proportionate. The media are generally receptive to feedback and training has been provided to journalists.

Reducing access to means

Custody Settings

Protect Life sought to ensure the environment for those held in custody had been suitably adapted to reduce the possibility of suicide. All The north of Ireland Prison

Service new build residential accommodation is designed to reduce ligature points, including use of lower risk cell furniture and anti-ligature fittings, observational cells with CCTV monitoring, and direct phone contact with helpline services in place for those prisoners identified to be of immediate risk of suicide or self-harm.
All PSNI custody facilities are ligature free. There are clear policies and guidelines regarding detained persons and when detained persons are not in cells there is constant observation.

Mental health settings

Minimising potential ligature points within inpatient mental health settings has been an NCISH recommendation for some years. Staff in mental health units carry out risk assessments of accommodation and, where possible, take steps to reduce or eliminate ligature points.

Other high risk locations

High bridges have a global association with suicide attempts. The Foyle Bridge is one such site. Suicide risk can be reduced by limiting access to these sites and making them safer. However, previous work to consider structural changes to Foyle Bridge to provide a suicide barrier highlighted difficulties in both cost and technical adaptation. The PHA is now exploring a health and wellbeing initiative at the Bridge and riverfront to engage users, promote positive messages and facilitate physical activity in order to reduce associations and perceptions of the bridge as a means of suicide.

Introduction of legislation to limit the size of packs of paracetamol, salicyates and their compounds sold over the counter, supported by guidance on best practice in the sale of pain relief medication has reduced access to medications associated with suicide attempts.

Existing strict rules on gun control also contribute to access restriction.

Place of safety

A Place of Safety is defined in legislation as any hospital, any police station or other place (such as a residential or nursing home) where the occupier is willing to keep the individual. They are places where police officers can take an individual, who they believe is suffering from a mental disorder and is in immediate need of care and control, for the purpose of having them medically examined and, if necessary, assessed by an approved social worker. Within the HSC, hospital emergency departments are designated as “Places of Safety”. This ensures: 24 / 7 access to medical examination; access to medical treatment if required; access to urgent mental health assessment; and ease of access to psychiatric ward.

Joint working protocols have been developed between PSNI, NI Ambulance Service and HSC Trusts to improve processes and working relationships, to reduce the time police officers have to remain, and to clarify the most appropriate “Place of Safety” in any given circumstances. There has also been additional investment to improve the mental health response in emergency departments with the objective to provide a two hour urgent response time on a 24/7 basis.

A number of options are available for people with serious mental illness for care, post mental health assessment. These include: inpatient admission (24/7), Crisis resolution (24/7), Home Treatment (7/365), Community and Voluntary sector services. A relatively new 6 bedded Home Treatment House is available in the Belfast HSC Trust area. This service is available to patients for short term treatment of up to 2 weeks who do not require acute admission to hospital but cannot stay at home.

Safe place

During the implementation of Protect Life, there have been repeated requests for a "Safe Place" service to be made available. This is seen as somewhere that a person experiencing a social or emotional crisis could have time out for crisis resolution for them and their families. It is also seen as facilitating access to Tier 1 prevention and early intervention services, and supporting clients to avail of these services to address underlying social or emotional issues. Similar services exist in Dublin (Pieta House), Manchester (The Sanctuary), and Leeds (Dial House).

Consideration by the Belfast HSC Trust was inconclusive regarding the need for this service (the estimated annual cost for such a service was significant at around £450k per facility). A PHA audit of Protect Life service providers in 2013/14 showed that 60% included crisis de-escalation as part of the contract. However, a gap in service provision was identified out-of-hours. The Self-harm Registry indicates that 75% of attendances are out of hours.

Further work is required to explore the concept of a safe place and its feasibility and service specification if funding is available. An options appraisal will be developed by the PHA and HSCB to determine the requirement for the service and optimal delivery on either a regional or local basis. This will include consideration of virtual pop up safe places; accommodation safe place; reprofiling of existing Protect Life service provision.

Public information / awareness raising

Public information and education campaigns

A wide range of media has been used to deliver positive mental health messages and to raise awareness of suicide and self-harm prevention. To date the campaigns have focused on reducing the stigma associated with mental health, encouraging help-seeking behaviour, raising awareness of early warning signs of mental health problems, promoting recovery, and raising awareness of sources of help. This focus reflects the available evidence base which suggests that a normalisation of mental health issues broadly, and a de-stigmatisation of mental and emotional health and mental illness and encouraging a help-seeking approach is the most effective approach. Feedback on recent mental health and wellbeing awareness campaigns such as '*The Boxer*', '*Under the Surface*', and "*The Fog*" have been positive. These campaigns were designed to reach all of those most at risk of attempting suicide or self-harm, and particularly males in the most deprived areas.

PHA qualitative research has highlighted a potential risk that tackling suicide awareness directly may further increase public perception of the frequency of suicide here, thereby helping to normalise it and possibly engendering suicide imitation.

The promotion of Lifeline, mental health promotion and public awareness programmes on have also contributed to raising awareness of suicide, self-harm and their prevention.

Minding Your Head

The Minding Your Head website, www.mindingyourhead.info/, is a central resource for information on protecting mental and emotional wellbeing. The website also provides a signposting function to a list of local services which can provide support for those in need.

North/South collaboration

Protect Life and the previous south of Ireland suicide prevention strategy, *Reach Out*, have been implemented in parallel. The new suicide prevention strategy for the south, *Connecting for Life,* was issued in 2015. A review of evidence commissioned to inform the development of *Connecting for Life* was shared with this Department and has informed the development of the draft *Protect Life 2*. Close parallel working will continue aided by further development of the All Island Action Plan in suicide prevention. 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.

Flourish!

Churches and suicide prevention

The Clergy's role within society inevitability means a requirement to support people who are vulnerable and experiencing an emotional crisis in their lives. The PHA - working with the Churches' Community Work Alliance NI, Lighthouse Ireland, and clergy from the four main Christian churches in Ireland - has developed the *Flourish!* Initiative to support the clergy in this role. Under *Flourish! s*uicide awareness guidelines[92] have been developed for the clergy and pastoral teams to provide support for people bereaved/affected by suicide and to promote positive mental health. Training has been developed on "Faith and Mental Health" and "Pastoral Care for the Suicidal Person and for the Bereaved Family". This training has been accepted by the four main All-Island theological colleges for their student-clergy training programmes. A handbook which provides advice on speaking about mental health and suicide during a religious service has also been distributed together with advice on dealing with the media. A self-care toolkit has also been developed in light recognition of the stressful nature of the work undertaken by the clergy in this regard.

Flourish! www.wewillflourish.com is being delivered on an All-Island basis.

Sudden death notification

SD1 process

The responsibility of the first police officer at the scene of a sudden death is to summon a doctor to pronounce death, maintain the scene, establish the facts and circumstances surrounding the death and ensure the death has been reported to the Coroner. The family of the deceased is also spoken to as a priority in order to obtain vital information surrounding the death. The Sudden Death Notification form (SD1) is used by the PSNI to notify relevant statutory agencies about a sudden death and whether the death was probably a suicide. Prompt notification helps to ensure that timely support is offered to grieving families and friends.

A surveillance process is in place in that SD1 forms are sent to the local Trust and the PHA who both monitor the information. Each Trust area has a system in place to follow up with next of kin (if they have given consent) and provide access to support services. An arrangement is also in place by which the Coroner's Office provides the PHA with monthly anonymised data - date of birth, gender, locality and known methodology - on cases it deals with. This information is used by the PHA to cross reference the SD1 data.

Real time surveillance is necessary to identify emerging clusters of suicide and activate the existing community response plans to prevent further suicide attempts. It also helps to identify new methods of suicide, commonly used locations, or associated factors (such as intake of a specific drug) early on. In this regard, the SD1 process contributes to action on restriction of means of suicide. The system is regularly refined and it will be possible in future to reconcile SD1 data with NISRA suicide statistics to ensure accuracy and consistency.

PSNI training and guidance

In cases of suspected suicide, police officers are bound by the "*Service Procedure on Police Investigations into Unexpected, Unexplained or Suspicious Deaths*" which provides guidance on how they should proceed in the investigation of those deaths where the cause of the death is not immediately known. The need for potential forensic examination presents a challenging set of competing needs for the police in terms of

securing the scene whilst acting with sensitivity and care for the relatives. Additional training has been developed for officers to ensure accurate completion of the "Sudden Death Notification Forms" in a sensitive manner. They also complete Mental Health First Aid and ASIST training.

Suicide surveillance and emergency community response plans

In the context of potentially linked suicides, plans are in place (*Community Response Plans*) in all Health Trust and can be activated at short notice to generate a co-ordinated multi-agency response to prevent further deaths. Activation of this response is linked to ongoing surveillance to identify emerging suicide "clusters" through the Sudden Death Notification process. Community response plans have been activated on numerous occasions over the past few years. Following de-activation a de-briefing is conducted to draw out learning from both the event and the response to it.

Data Collection

The National Confidential Inquiry into Suicide and Homicide (NCISH) by People with Mental Illness

NCISH is part of the Clinical Outcome Review Programme and is commissioned by the four Health Departments in England, Scotland, Wales and the north of Ireland to provide definitive figures on suicide, homicide, and sudden unexplained death in patients under mental healthcare. The Inquiry collects information on all general population suicides in from the NI Statistics and Research Agency. This data is submitted to HSC Trust mental health services in order to identify those with a history of mental health service contact in the 12 months before death. Detailed clinical data are then obtained for these individuals. The aim is to identify factors associated with suicide, assess the quality of mental health care and, make recommendations to stimulate improvement in safety and effectiveness.

The Inquiry also: undertakes complementary projects, such as analysis of contact with primary care services of those who later died by suicide; produces annual reports; and produces specific themed reports, such as its ten year longitudinal study on suicide amongst those known to mental health services in the north of Ireland. It has also examined the quality of the process of risk assessment to gain an understanding of why many suicides occur in people who have been deemed to be at low risk by the clinicians. The NCISH "*Twelve points for a safer service – checklist for local services*" is set out at Box 4, p 45. There has been some progress in local mental health services in implementing these recommendations.

The Northern Ireland Statistics and Research Agency (NISRA) suicide statistics

NISRA produces mortality statistics for the north of Ireland. In relation to deaths by suicide this information includes; sex and age; area; multiple deprivation measure; registration and occurrence data. This is useful for identifying trends but does not allow for more detailed analysis.

The Self-harm Registry

Role is set out earlier in this table.

Research

Local research is an integral part of suicide and self-harm prevention policy. It contributes to a better understanding of the drivers for suicide and self-harm, and helps to inform data collection, the identification of at risk groups and individuals, and effective prevention approaches. Significant research projects have been commissioned and published under *Protect Life*. Research has also been commissioned and/or undertaken by local suicide prevention organisations, charities, and universities.

Postvention support/intervention

A range of suicide postvention services and resources provided by statutory services and within the voluntary and community sector to assist those bereaved by suicide. These include:

Health Trust Bereavement Support Workers/Family Suicide Liaison Officers whose role is to work with local community organisations to increase awareness of existing suicide bereavement support services. Some of the Trusts have produced 'Bereaved by Suicide' booklets.

Information
PHA has produced a booklet 'Bereaved by Suicide' which provides local information on the availability of bereavement support services.

The prevention roles of a number of the other priority services not delivered directly under Protect Life 2006-2016 are outlined at **table 1**.

Table 1: Priority services and settings for the prevention of suicide and self-harm

Priority service / priority setting	Intervention / service	Comments
Hospital emergency departments and ambulance services	Risk assessment. Referral to self-harm prevention intervention. Referral to suicide prevention services. Initiation of the self-harm care pathway in line with NICE guidelines on the management of self-harm in primary and secondary care..	A significant proportion of people who die by suicide have had relatively recent contact with a hospital emergency department and those contacts frequently related to a mental health crisis. Following up with these individuals is a vital means of suicide prevention. Non-judgemental treatment of self-harm and presentation with suicidal ideation in emergency departments encourages future help-seeking and engagement with services. In light of this, a programme of training has been initiated for emergency department staff to enhance the skills and support the attitudes necessary to recognise, assess, signpost and initiate follow up for those who present in distress.
Primary care	Management of mental illness. Identification and assessment of suicide risk. Referral to appropriate support, eg crisis de-escalation, mental health services, psychological therapy, mental health services. Bereavement support and access to local bereavement support services.	The majority of mental health problems are managed within primary care and a high percentage of problems presented in primary care are psycho-social. Around 30% of all consultations concern some form of psychiatric problem.[93] Primary care is one of the most common services used in the months prior to suicide and offers a significant opportunity for suicide prevention intervention.[94] However, recognition of risk and referral to specialist mental health services tends to be low[95]. Programmes have been delivered to primary care in relation to depression awareness and suicide prevention training.

Justice services, prisons and custody suites		The Bradley Report (2009)[96] on people with mental health conditions or learning disabilities in the Criminal Justice System indicated that the prevalence, among suspects and offenders, of mental disorders and learning disabilities is very high – with one survey showing that over 90% of prisoners had a psychiatric disorder (this definition included hazardous drinking and drug dependence). The Report also noted that rates of neurotic disorder in prisoners were higher for women than in men and highlighted the particular difficulties faced by women in the criminal justice system. There is also evidence that people who die by suicide may be at least as likely to have been in contact with police as mental health services in the months before death.[97] People in the criminal justice system are at increased risk of self-harm and suicide; prisons and police custody suites are therefore priority places for focussing suicide prevention efforts. The Welsh Government has issued policy implementation guidance: *Mental Health Services for Prisoners in Wales* designed to help prison and healthcare staff to adopt measures which are designed to identify need, risk and potential of those admitted to custody to take their own life. The emphasis is placed on reception screening and immediate follow-up of risk indications. In the north of Ireland there has been joint working between DoJ and Health to implement the Bradley Review recommendations, other reviews such as Criminal Justice Inspectorate Report '*Mental Health not a marginal issue'*, and the criminal justice-based actions in the *Protect Life Action Plan*. In relation to self-harm and suicide prevention, this has included: training for prison officers, probation staff, and police custody staff in suicide awareness and prevention; and improving the reception screen process for mental health conditions and suicide risk. Other criminal justice based services in place include: - the Samaritans prisoner *Listener* scheme (a peer support scheme where prisoners are trained and supported by Samaritans to listen in confidence to fellow inmates). - Promotion of ligature free custody settings - Mental health, suicide prevention and self-harm awareness training for frontline prison and custody staff.

		- NI Prison Service Supporting Prisoners At Risk (SPAR) procedures. Going forward, DoJ and DHSSPS will develop discrete criminal justice suicide and self-harm prevention actions as part of the new strategy and as an integral part of the new Healthcare in Criminal Justice Strategy. **Prisons and custody settings** There has been significant progress made in providing suicide prevention training for frontline prison and police custody staff. This remains a priority and will continue. PSNI requires all custody officers to be as a minimum Suicide Alertness for Everyone (safeTALK) trained. There are a significant number of custody officers who are Applied Suicide Intervention Skills Training (ASIST) trained. This training requirement will be regularly reviewed and delivered. For the Prison Service, significant numbers of operational staff who work and engage directly with prisoners have been trained in the Supporting Prisoners at Risk (SPAR) procedures. A similar number of staff have received training in ASIST. All recruits to the custody prison officer and prison custody officer roles have completed training programmes which includes identifying and supporting prisoners at risk and challenging anti-social behaviour and bullying, with a focus on embedding a culture of care and support. The probation board has also been delivering mental health training to its staff. Those in prisons or PSNI custody are provided with access to appropriate services form mental health needs or if at risk of suicide or self-harm. Where there are any medical concerns or where a detained person is under the influence or alcohol or drugs PSNI ensures that a detainee will be assessed by a Healthcare Professional. Where a detained person is seriously ill they are conveyed to hospital via ambulance. Within the NI Prison Service the medical needs for all vulnerable offenders including those identified as having mental health and/or addiction diagnosis are provided by the South Eastern Health and Social Care Trust. All prisoners have access to the Samaritans helpline and Lifeline crisis response helpline 24 hours per day.
Community-led suicide and self-harm prevention	Awareness raising on suicide prevention. Suicide and mental	Community and voluntary sector service providers are often the first point of contact for individuals in emotional despair and their families. Community groups have a key role in delivering frontline suicide prevention support, reducing stigma associated with help-

	awareness training, suicide prevention training. Crisis intervention/de-escalation. Signposting & referral to specialist services. Recovery support through counselling, complementary therapies, & self-help support groups. Bereavement support (children & adults). Self-harm intervention. Research.	seeking for suicidal thoughts and behaviour, and raising awareness and local capacity for suicide prevention. The Community Support Package has been in place since the inception of *Protect Life*. The Public Health Agency continues to procure a range of suicide prevention and self-harm intervention services from the community and voluntary sector. Self-funding by the sector is an important additional contributor to the drive against suicide. Community and voluntary sector resources and supports include organisations (local, regional and national) that provide bereavement support and specialist bereavement support for children. The Families Voices Forum is a regional group of those bereaved by suicide in the north of Ireland and has helped in shaping suicide postvention policy and programmes. The Forum also strives to address the issue of stigma which surrounds suicide.
Schools, further and higher education	Guidance on managing critical incidents in order to minimise the impact and reduce risk of "copycat" behaviour. Protect Life in Schools. Anti-bullying policies and a whole school approach to the promotion of positive mental health and wellbeing. Schools counselling service.	These are priority settings for suicide and self-harm prevention in children and young people. However, apart from evidence that training for teachers increases their confidence in recognising those who may be at risk of suicide and referring them appropriately for help, there is no evidence that school-based suicide prevention programmes have a long-term impact on suicidal behaviour and help-seeking in the longer term. Indications are that school-based intervention needs to be broadly based (as it currently is) on a whole school approach to the promotion of positive mental health and emotional resilience. On a practical basis, the Department of Education (working with Health) has produced comprehensive guidance on *Managing Critical Incidents in Schools* which covers the postvention response in the school setting. This provides a detailed process for schools to follow when an incident, including a suicide that is in any way linked to the school community, has occurred. It includes advice on supporting peers in class and students who are distressed, advice on memorials and commemorations, advice on home visits and for briefing staff and pupils on how best to support individuals returning to school, and longer term follow-up for the school community.

		Broader guidance on suicide and self-harm prevention has also been developed for schools as part of the Department of Education "iMatter" programme. The "*Protecting Life in Schools*" document was launched in March 2016. A schools-based counselling for the post primary sector has also been funded. It is designed to support children and young people with emotional and behavioural difficulties and, potentially, contributes to suicide and self-harm prevention efforts, being suitably placed and accessible to children and young people in crisis. Further and higher education colleges have a range of support services available for students.
Coroners Service for The north of Ireland	Provision of information to bereaved relatives.	***Coroners Liaison Officers*** who are designated to families following a bereavement to help explain the preliminary cause of death; provide information on the post-mortem process, and explain the Coroner's investigation. The Coroner's Service Charter sets out the standards of service that bereaved family members can expect from the Coroners Service and is available at: https://www.courtsni.gov.uk/en-GB/Publications/UsefulInformationLeaflets/Documents/p_uil_Coroners_Charter/Coroners-Service-Charter.pdf

Appendix 4 - Suicide and self-harm interventions for which there is moderate to low evidence of effectiveness

- Evidence indicates that antidepressants may be beneficial[1] especially in elderly people, and that lithium reduces suicide risk.[1]
- Increased awareness of depression and suicidal behaviour amongst older adults
- CBT oriented interventions for older adults who suffer from depression
- Self-harm and suicide awareness training for hospital emergency department staff.[1]
- Screening and improved understanding of clinical, psychological, sociological and biological risk to help identify high risk individuals in health care settings, and subsequent management of risk.[1]
- Immediate de-escalation crisis helplines, both for the wider population and targeted at certain vulnerable groups (with peer support) have been successful in engaging seriously suicidal individuals and in reducing immediate risk.[1]
- Addressing suicidal behaviour - safety planning (working collaboratively with the individual to develop an action plan for times of crises); specific forms of intensive psychotherapy
- Multi-level community-based suicide prevention programmes and access to a local emotional health and wellbeing support network for families in times of distress..
- Psychological, pharmacological, or nueromodulatory treatment of mental disorders.
- Public information campaigns to de-stigmatise mental illness, encourage a culture of help-seeking for mental health concerns, and increase awareness of suicide prevention.
- Physical adaptation of custody and prison environments, eg to eliminate ligature points and training for prison and police custody staff.
- Screening of prisoners for mental health issues, and improved access to mental health services and emotional wellbeing support for prisoners.
- Provision of support and information to promote awareness of suicide risk among people caring for someone with a mental illness.
- Provision of accessible support networks in local communities for survivors of abuse.
- Provision of accessible support services for marginalised and disadvantaged groups such as LGBT people, ethnic minorities, rural communities and people who experience economic deprivation.
- Programmes to reduce domestic violence and bullying.
- Support for the establishment of protective social networks.

Appendix 5 – Glossary

Adverse Incident/Serious Adverse Incident	The Donaldson Review[xcviii] defines an adverse incident as any event that could have or did lead to harm to people (80k to 90k are reported annually in NI) & a serious adverse incident as one which involved the serious injury or unexpected death of a service user, an unexpected risk to a service user, or serious self-harm including by any person in the community who has been in receipt of mental health services within the previous 12 months.
Attempted suicide	A potentially self injurious action with a non-fatal outcome for which there is evidence, either explicit or implicit, that the individual intended to kill himself or herself.
Common mental disorders	Anxiety and depressive disorders are often called "common mental disorder" and are largely treated by primary care (GPs).
Depressive disorder	Depressive disorder (Depression) is a common mental health condition. It includes being sad or unhappy but is much more than this. A person with depressive disorder may experience intense emotions of anxiety and hopelessness. They may be unable to experience pleasure, lose interest or motivation, and have very negative views about themselves and the future with feelings of guilt, worthlessness. These problems interfere with the way a person is able to function in their relationships or at work, and may become prolonged or recurrent. The symptoms of depression are seen as occurring on a continuum of severity and persistence from mild depression to major depression. The condition is often accompanied by anxiety.
Emotional resilience	Relates to how people feel about themselves, their interpretation of events, and ability to cope with adverse circumstances. This differs in individuals and therefore people have different vulnerability to the adverse effects of negative environments. Emotional resilience is the capacity that allows individuals to adapt and overcome adverse circumstances and events, and thrive despite adversity and stress in their lives. This ability to cope in the face of environmental adversities, is the result of a complex interplay of many factors contributing to an individual's level of emotional resilience.
First Responders	Police officers, ambulance and hospital emergency department staff, prison officers, social care workers, and fire-fighters.
Gatekeepers	Typically include: primary health care providers; mental health care providers; those providing addiction services; teachers; human resources staff; community leaders; spiritual and religious leaders; sports organisations; and youth offending services providers.
Health inequalities	Have been defined as 'the systematic and avoidable differences in health outcomes between social groups such that poorer and / or more disadvantaged people are more likely to have illnesses and disabilities and shorter lives than those who are more affluent'.
Mental health	Refers to the successful performance of mental functions in terms of thought, mood, and behaviour.
Mental health condition / mental health needs	Generally refers to symptoms that meet the criteria for clinical diagnosis of mental illness, or symptoms at a sub-clinical threshold which interfere with emotional, cognitive or social

	function thereby affecting how we go about our everyday lives. Describes all mental disorders or illnesses including common conditions, such as depression and anxiety, as well far less common and enduring conditions such as schizophrenia or bipolar disorder.
Mental illness	The term that refers collectively to all diagnosable mental disorders that affect the person's cognitive functioning.. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behaviour (or some combination thereof) associated with distress and/or impaired functioning. Covers a broad spectrum of mental health problems including Depression, Anxiety and Panic disorders, Post Traumatic Stress Disorders, Obsessive Compulsive Disorder, Addictions, Eating Disorders, Schizophrenia, Bipolar and Personality Related Disorders.
National Confidential Inquiry into Suicide and Homicide by People With Mental Illness (NCISH)	NCISH collects data on all suicides and homicides by people in contact with psychiatric services (in the year prior to death) in the UK. It monitors trends and collects detailed clinical information. Data are published along with recommendations for changes to clinical practice and policy aimed at reducing the risk of suicide and homicide. In addition to core work, the Inquiry carries out time limited specific studies. NCISH is based in the Centre for Suicide Prevention, part of the Psychiatry Research Group in the School of Medicine at Manchester University. DHSSPS contributes to the cost of the work of the Inquiry in The north of Ireland.
NICE	The National Institute for Health and Clinical Excellence. The Institute provides guidance and advice to improve health and social care. Guidance published by NICE since June 2006 is considered locally for its application to the north of Ireland and, where appropriate, is endorsed by the Chief Medical Officer for implementation in the Health and Social Care Sector.
Prevention	Primary prevention – promoting population mental health and wellbeing. Secondary prevention – interventions targeting high risk groups.
Recovery	It is not easy to define 'recovery' from a mental health condition. Traditionally the term recovery has implied being free from symptoms. However, the recovery model is about personal control over one's life and experiencing a good quality of life whether there are symptoms or not. In this sense work can be part of recovery. The National Institute for Mental Health in England describes recovery as something that people experience as they become empowered to achieve fulfilling, meaningful lives and both contribute and belong to their communities.
SCIE	The Social Care Institute for Excellence aims to improve the lives of people who use care services by sharing knowledge about what works.
ScotSID	The Scottish Suicide Information Database – a dataset linking records on all probable suicide deaths in Scotland with the individuals' demographic details and previous contact with particular healthcare services. The aim of maintaining the database is support research, policy-making, and preventive activity. Specific reports can be produced such as a summary

	of the broad characteristics and circumstances of those who died by suicide or an examination of the contact by the deceased with specific healthcare services prior to death compared to the general population.
Self-harm	Self-harm refers to a wide range of behaviours including self-poisoning with or without suicidal intent, and self-injury.
Stigma	Causes an individual to be classified by others in an undesirable, rejected stereotype rather than in an accepted, normal one.
Suicidal Ideation	The existence of current wishes to die by suicide or of taking action to end one's own life.

Endnote References

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