Department of Health
An Roinn Sláinte
Männystrie O Poustie
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Protect Life 2

A Strategy for Preventing Suicide and Self Harm in Northern Ireland 2019-2024

CONTENTS

FOREWORD

Permanent Secretary of the Department of Health

Suicide is preventable, it is not inevitable yet almost every day in Northern Ireland a person takes their own life. Every life lost to suicide represents someone's partner, relative, friend or colleague. Each of these deaths is an individual tragedy and a life changing experience for those who were close to the person.

It is important that we acknowledge that suicide is a major problem in our society and, also, that it is preventable. The feelings that drive suicide are often temporary. With the right help, people can get through a suicidal crisis and recover.

Protect Life 2 2019-24 sets out what we will do to prevent suicide over the next five years. The Strategy is based on feedback and learning from the 2016 consultation report. I would like to thank all those who have contributed to the extensive consultations which have informed the new *Protect Life 2* Strategy.

Protect Life 2 sets ambitions which will only be achieved by working together across government departments and with stakeholders from all sectors of society. Effective prevention is a collective responsibility. It requires a sustained collaborative and co-ordinated response across government, statutory and community services, and the various sectors of society at regional and local level. Achieving that response is the primary purpose of this strategy.

Under the original *Protect Life* strategy suicide rates here have remained relatively stable over the last decade but, unquestionably, at a level that is unacceptably high. The challenge for *Protect Life 2* will be to sustainably reduce those rates. This Strategy sets a target to reduce the rate of suicide by 10% by 2024 in line with WHO advice. This target will be supported by continuation of existing initiatives and the introduction of a wide range of new measures.

Many initiatives which have been advocated in recent years are already underway through additional investment from the transformation programme. This includes a Towards Zero Suicide regional initiative; a crisis de-escalation pilot in Belfast and crisis intervention service pilot in Derry; and a Multi Agency Triage Team pilot.

Protect Life 2 also has a particular focus on those who have been bereaved by suicide. Those who have lived through this most traumatic of experiences have much to offer in policy design, service delivery and advice. They also should be offered additional support. It is widely recognised that suicide prevention is a challenging area for professionals to work in, so the principle of self-care will also be promoted to support those professionals in caring for others.

Suicide and self-harm affect all ages and walks of life but are also amongst the starkest indicators of inequality here. Suicide rates in our most deprived areas are three times higher than in the least deprived areas. For self-harm the differential is four times higher. This differential has reduced slightly in recent years and targeted resourcing will aim to see that trend continue.

As Permanent Secretary it is my expectation that this Strategy will bring hope, support and clear direction for all involved in suicide prevention in Northern Ireland.

Richard Pengelly

Permanent Secretary, Department of Health

September 2019

Chair of Suicide Strategy Implementation Body

It has been a personal and professional privilege and honour for me as Chair of the Suicide Strategy Implementation Body (SSIB) to have been part of the development of *Protect Life 2*, our next step in addressing the trauma of suicide and self-harm.

As a therapist with Zest: Healing the Hurt, for the past 21 years, my colleagues and I have talked with several thousand young, middle-aged and older people who have experienced these behaviours. In some cases, there were underlying clinical conditions, however in most cases, the service users were feeling very bad because bad things had happened in their lives. Many came from disadvantaged areas, experiencing poverty, unemployment, substance misuse, family problems, gender problems, sexual orientation. Many had experienced adverse childhoods indicating the fundamental importance of a nurturing early childhood and positive parenting as a protective factor against later suicide. I was delighted to see the PHA Infant Mental Health action plan and new Department of Education, Department of Health, Public Health Agency and Education Authority for Northern Ireland framework being developed to promote emotional resilience in children and young people. This is particularly important for young boys and men to help develop healthy emotional expression and behaviour, without which we see the unacceptable levels of suicide in young males of working age.

The statistic that 5 people die by suicide every week here (or almost 1 a day) are the people who feel trapped and do not see any other viable option for addressing the emotional pain that they feel. In many cases alcohol can become the medicine that anaesthetises the pain leading eventually to a more vulnerable disposition to suicide and self-harm. We also have addressed the issue of repeat self-harm with a very specific focus in this Strategy. We have identified these vulnerable groups from the Self-Harm Registry statistics.

The importance of enhancing protective factors in the general population that prevent people becoming suicidal at a later date can never be under-stated. This includes the importance of developing family and community connectedness, that sense of ‘belonging’ which many who are suicidal or self-harming lack in their lives. We can give this sense of belonging through a more compassionate and empathic approach to those who are struggling. It is compassion and kindness that give us ‘hope’ for the future.

However, in order to give this to others, we must, in the first instance, give it to ourselves. The importance of self-care is highlighted in the strategy and it applies to all of us. We have to take responsibility for our lives physically, emotionally, psychologically, socially and spiritually (that means the reason we give to our existence). The after effects of a suicide reach into every community and have a devastating impact on families, friends, colleagues and others such as first responders and health and social care professionals. They are traumatic events that need high levels of self-care and self-compassion.

I have heard so many times in recent years, after a suicide, that “there are no services”. In my experience there have never been as many services as we have now. *Protect Life 2* ensures these services are available but the one thing we can’t ensure is getting the person to come for help. Parents/siblings often ask me “how do I get him/her to go for help, they are refusing?” My answer is always “If the worst were to happen what would you regret not having done?” and the answer comes immediately. So many times the suicidal/self-harming person is not in a position to think or see clearly what they need to do, so we must make the decisions for them. Please encourage, support and if necessary make decisions for those you see or know are struggling because the services are there to help them. *Protect Life 2* ensures that.

Finally, a huge word of thanks to the Department of Health staff who supported, guided and consulted with me over the past 4 years and to all the SSIB members both Statutory and Community & Voluntary who contributed selflessly and from a place of genuine commitment to addressing the issues of self-harm and suicide. I look forward to our future involvement under the new governance structures of *Protect Life 2.* I would also like to thank my colleagues and Board at Zest: healing the hurt Ltd, for their support and understanding of my role as Chair. It is our collective knowledge and experience that I brought with me to this role.

Conor McCafferty M.Sc. Reg. MBACP (accred)

Chair of Suicide Strategy Implementation Body

EXECUTIVE SUMMARY

Protect Life 2 2019-24 is a long-term strategy for reducing suicides and the incidence of self-harm with action delivered across a range of Government departments, agencies, and sectors. It recognises that no single organisation or service is able to influence all the complex interacting factors that lead someone to harming themeselves or, ultimately, to taking their own life.

It stresses the importance of services, communities, families and society working together to help prevent suicides. In practice this means, for example: that community and voluntary organisations are supported to deliver suicide prevention services; that sports clubs and faith groups are trained in suicide awareness and intervention; that justice services develop and implement self-harm and suicide prevention action plans; that primary health care is skilled and proactive in identifying and intervening with patients showing signs of suicidal behaviour; that there is closer working with addiction services; that schools know how to respond when a pupil is in emotional distress; and that those delivering public services to potentially vulnerable people are trained in suicide awareness.

The strategy encompasses:

- General ***population-based*** approaches designed to influence attitudes and behaviours such as help-seeking behaviour, restricting access to means of suicide, raising awareness and supporting responsible media reporting.

- ***Targeted intervention*** such as training for health and social care staff and people working in the community, self-harm referral from emergency departments, self harm case management, improving risk management within mental health services, screening in health and substance misuse services, and supporting recovery in those who have made suicide attempts.

- ***Crisis de-escalation*** and case management to prevent attempted suicide by people in mental health crisis and/or emotional or social crisis.

- ***Postvention support*** for those bereaved or otherwise affected by suicide, and improving data collection and analysis in relation to suicide in order to inform service improvement.

The layout of *Protect Life 2* is summarised below.

Chapter 1 highlights some myths and facts about suicide.

Chapter 2 sets out the purpose of this strategy, its twin aims for a reduction in suicide and for suicide prevention services and support to be delivered in areas of deprivation where suicide is most prevalent. It also sets out the agreed principles for achieving these aims, defines the scope of the strategy and the key objectives. The rationale for each of the objectives is given in **Appendix 1.**

Chapter 3 provides background context to suicide and self-harm in Northern Ireland in terms of trends, area inequalities and gender inequalities, urban and rural experiences, and the prevalence of suicide and self-harm amongst children and young people.

Chapter 4 considers the risk and protective factors for suicide and self-harm emphasizing the complex societal nature of these phenomena and the multi-varied, interlinking influences on suicide and self-harm. In, particular the need for building the psychological resilience of victims of the Northern Ireland conflict and its legacy.

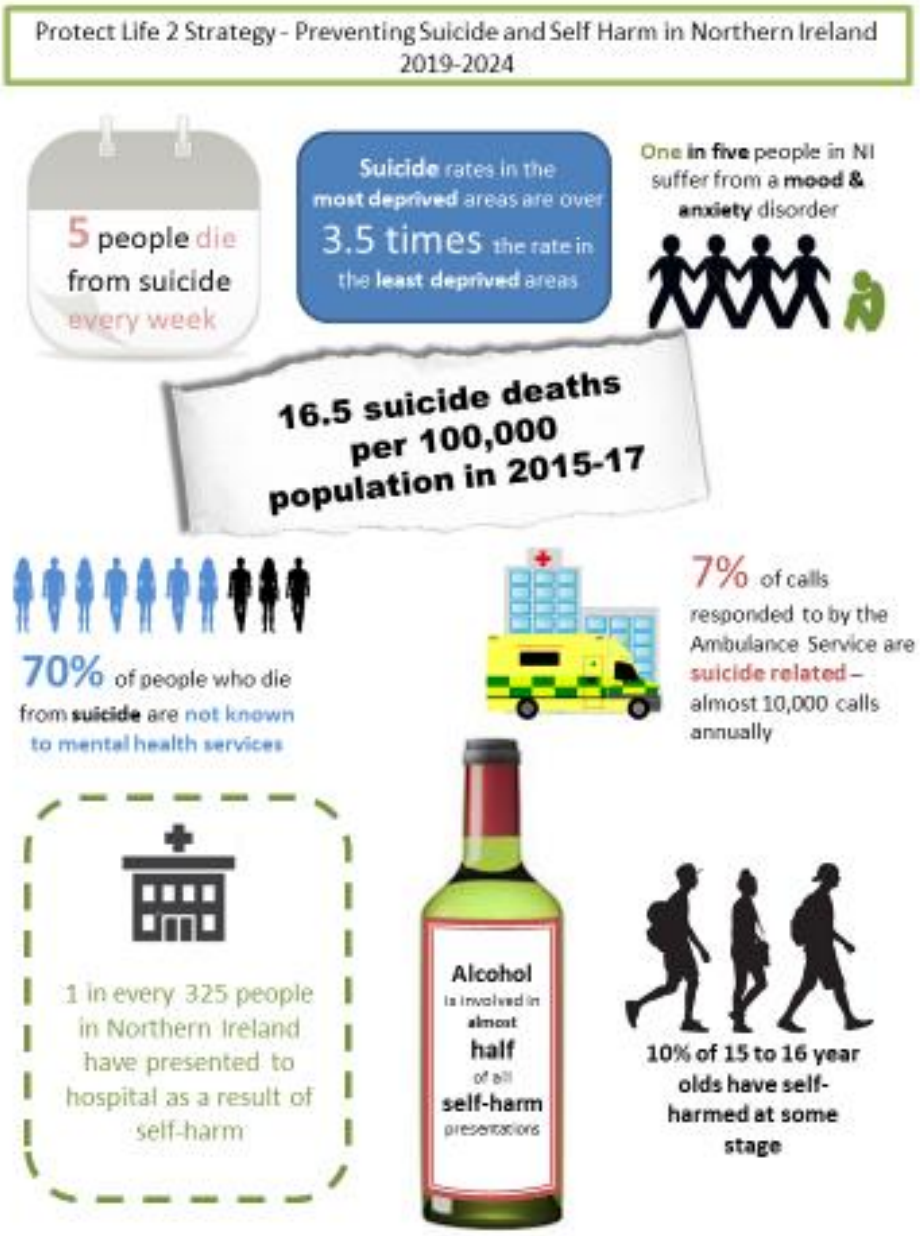
Chapter 5 outlines the current suicide and self-harm prevention funding and services delivered in Northern Ireland and the areas where consultation feedback on the draft strategy indicated that enhancement is required or where there is a gap in services.

Chapter 6 includes some recent developments in suicide prevention including the towards zero suicide movement and technological innovations.

Chapter 7 highlights a range of areas for service enhancement and service development. This includes safer mental health services; multi-sectoral training for frontline staff; support for those not known to mental health services; linkages with substance misuse; crisis de-escalation and crisis intervention service pilots; and a Multi Agency Triage Team pilot.

Chapter 8 provides a high level action plan with key actions under each of the 10 objectives outlined in Chapter 2.

Chapter 9 explains how the strategy will be implemented and sets out the governance structures and progress reporting arrangements.


Protect Life 2 Strategy - Preventing Suicide and Self Harm in Northern Ireland 2019-2024
5 people die from suicide every week
Suicide rates in the most deprived areas are over 3.5 times the rate in the least deprived areas
One in five people in NI suffer from a mood & anxiety disorder
16.5 suicide deaths per 100,000 population in 2015-17
70% of people who die from suicide are not known to mental health services
7% of calls responded to by the Ambulance Service are suicide related – almost 10,000 calls annually
1 in every 325 people in Northern Ireland have presented to hospital as a result of self-harm
Alcohol is involved in almost half of all self-harm presentations
10% of 15 to 16 year olds have self-harmed at some stage

CHAPTER 1: MYTHS AND FACTS ABOUT SUICIDE

Suicide and self-harm are highly complex societal and personal issues that result from unique interaction between personal circumstances, wider societal issues, emotional resilience, adverse life events and biology which vary from one individual to another.

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. The belief is that suicide results from the frustration of psychological needs leading to psychological pain culminating in an overwhelming sense of burdensomeness, hopelessness, entrapment, and lack of belonging. In this state, it is theorised that suicide becomes possible when the person also acquires the ability to enact lethal self-injury (Joiner, 2005) often through acts of non-fatal repeat self-harm which habituate the person to the fear and pain associated with suicide.

Impulsivity (often associated with alcohol consumption), access to means, and exposure to suicide by others (including through the media) are also associated with suicide attempts.

However, suicide is not inevitable. This is one of the myths about suicide that the World Health Organisation seeks to expose (see Box 1 below) 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 Northern Ireland.

Box 1: WHO myths and facts about suicide

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.

Source: Preventing suicide: a global imperative. World Health Organization 2014

CHAPTER 2: STRATEGY AIMS, PRINCIPLES, SCOPE AND OBJECTIVES

Protect Life 2 seeks to build on the achievements of *Protect Life* since it was originally published in 2006 and takes action to address gaps and improve services where necessary. This strategy has been informed through extensive consultation in late 2016 and analysis of consultation responses.

Purpose

The purpose of this strategy is to set the priorities and define the key actions for reducing the prevalence of suicide and self-harm over the period 2019 – 2024.

Aims

- Reduce the suicide rate in Northern Ireland by 10% by 2024.
- Ensure suicide prevention services and support are delivered appropriately in deprived areas where suicide and self-harm rates are highest.

The 10% reduction target is based on the 3 year rolling average annual rate of suicide for the period 2015/17 (16.5 deaths per 100,000 of population). This will equate to a target of 14.9 deaths per 100,000. This will be measured for the period 2021/23 (although this will not account for the full 5 year impact of the strategy). It is important, however, to acknowledge that full attribution of the impact of the strategy on suicide rates is not possible due to the many and varied societal factors that influence suicidal behaviour and the impact of a wide range of other policies and programmes that impact on these factors.

Principles

In striving to achieve these aims, suicide prevention actions will be informed by a set of agreed principles. These are set out below:

- Be evidence-based where possible, achieve measurable outcomes and be fully evaluated.
- Be collaborative with public / private sector organisations, academia, professional bodies, service users, carers, voluntary & community agencies, and groups representing bereaved families.
- Be co-ordinated across government.
- Be informed through engagement and learning from suicide prevention approaches in other jurisdictions, especially those that have achieved reduction in suicide rates.
- Contribute to reducing inequalities.
- Be person centred and informed by those with lived experience of suicide and self-harm.
- Where appropriate, action will be tailored to the diverse needs of different sub-populations at greater risk of suicide in terms of age, gender, ethnicity, social class, sexual orientation, location, physical and mental health, and occupation.
- Promote sustainable funding for suicide prevention.
- Be aware that measures to address the wider determinants of mental health and wellbeing also contribute to reducing suicide.
- Build on existing strengths such as strong community engagement.

Scope

National suicide prevention strategies that have achieved reductions in suicide rates have encompassed both universal and targeted interventions. This approach was also highlighted in feedback in the Protect Life 2 consultation report[1] in 2017. The strategy therefore contains population-wide approaches and interventions focussed on groups and individuals who are at increased risk.

The broader population approaches include:

- increasing awareness of suicide prevention;
- reducing stigma associated with suicidal behaviour and mental illness;
- promoting help-seeking behaviour, especially in males;
- training those who interact regularly with vulnerable or at risk people so that they can pick up early signs of acute distress and mental ill health;
- improving data collection and analysis to inform service improvement; and
- restricting access to the means of suicide, where possible.

Targeted interventions focus primarily on:

- those who self-harm and their families;
- those who are in emotional crisis or who are already suicidal, and their families;
- those who are bereaved by suicide and those who are exposed to suicidal behaviour in others; and
- reducing suicide risk among those in contact with mental health and substance misuse services.

72% of people who die by suicide in Northern Ireland had not been under the care of statutory mental health services in the 12 months prior to death. A focus is therefore required on promoting help-seeking; detection of risk in primary care; removing barriers to accessing suicide prevention services and mental health services where these are needed; and access to other appropriate services to meet identified needs.

[1] Protect Life 2 Consultation Report https://www.health-ni.gov.uk/publications/protect-life-2-draft-strategy-suicide-prevention-north-ireland-consultation-analysis-report

It is also recognised that suicide and suicidal risk varies across the life-course, and that age and gender appropriate interventions are important. Furthermore, most interventions for people in emotional distress or suicidal crisis are relevant to vulnerable sub-populations known to be at increased risk of suicide. This includes LGBT population, ethnic minorities, migrants, and those in contact with criminal justice. We have not, therefore, developed specific high level actions for these "at risk" population groups. Instead, the emphasis is on ensuring that risk assessment and frontline intervention are inclusive, non-stigmatising, and tailored to the needs and experiences of people from these population groups.

Furthermore, a consistent theme arising from consultation on *Protect Life 2* was concern at over emphasis on population groups at greater risk of suicide – consultees felt strongly that everyone can be at risk of suicide.

Public Health Agency standards for commissioned services for suicide prevention specify that service providers ensure that services are open, culturally aware, welcoming, and accessible to all communities and sections of society. Providers are also required to demonstrate how these principles are applied within the context of the service they deliver.

Suicide will not be addressed through frontline crisis intervention services and health sector interventions alone. Action is needed to address the wider determinants of mental health and wellbeing at societal, community, family and individual level including issues of socio-economic disadvantage and inequality that are associated with suicide. A wide range of existing policies are relevant. This includes strategies designed to reduce poverty and unemployment, improve family support and enhance child development, restrict harmful use of alcohol, improve educational attainment, reduce crime and antisocial behaviour, promote social inclusion, reduce domestic and sexual violence, address the legacy of "the troubles", and improve mental health. Successful outcomes in these areas are vital for achieving a sustained reduction in suicide prevalence.

It is also recognised that early intervention to promote positive mental health and emotional resilience in vulnerable people before adverse life events push them

towards suicidal behaviour is necessary for effective population-wide suicide prevention. The wider social determinants of mental health and wellbeing are addressed in the Programme for Government Outcomes Delivery Plan and through the Public Health Strategic Framework "*Making Life Better*". *Protect Life 2* therefore sits within the wider context of these policy frameworks, and in the context of the range of policies that aim to reduce socio-economic disparity and improve quality of life.

Objectives

The objectives for *Protect Life 2* are set out below and full rationale for these are described in **Appendix 1.**

AIMS

1. Reduce the suicide rate in Northern Ireland by 10% by 2024.
2. Ensure suicide prevention services and support are delivered appropriately in deprived areas where suicide and self-harm rates are highest.

OBJECTIVES

1. Ensure a collaborative, co-ordinated cross departmental approach to suicide prevention.
2. Improve awareness of suicide prevention and associated services.
3. Enhance responsible media reporting on suicide.
4. Enhance community capacity to prevent and respond to suicidal behaviour within local communities.
5. Reduce incidence of suicide amongst people under the care of mental health services.
6. Restrict access to the means of suicide.
7. Enhance the initial response to, and care and recovery of people who are suicidal.
8. Enhance services for people who self-harm, particularly for those who do so repeatedly.
9. Ensure the provision of effective support for those who are exposed to suicide or suicidal behaviour.
10. Strengthen the local evidence on suicide patterns, trends and risk, and on effective interventions to prevent suicide and self-harm.

CHAPTER 3: THE NORTHERN IRELAND CONTEXT

Suicide trends and incidences

Over the past ten years (2008 – 2017), 2913 deaths by suicide were registered. Many more are affected by suicidal thoughts at some point in their life and there were over 8700 presentations at hospital emergency departments annually as a result of self-harm.

Northern Ireland continues to have the highest suicide rate in the UK averaging 15.8 deaths per 100,000 over the last decade. In 2017 the overall rate in the rest of the UK was 10.1 deaths per 100,000. In 2017 Scotland reported the lowest suicide rate for females since 1981 (6.3 deaths per 100,000). In England, the 2017 male suicide rate was the second lowest since 1981 at 14.0 deaths per 100,000.

Key facts

- Three times as many people die by suicide here each year than are killed in road traffic collisions.
- An estimated 219,000 people have been directly affected by suicide since 2005 through close association with the deceased.
- Over 70% of people who die by suicide are not known to mental health services, yet research indicates that most people who die by suicide have a mental disorder at the time of death.
- 7% of calls responded to by the Ambulance Service are suicide-related – almost 10,000 calls annually.
- 10% of 15/16 year olds have self-harmed at some stage.
- Over 20 people are treated daily at hospital due to self-harm; the risk of suicide in the first year after self-harm is over 60 times the risk in the general population.
- Suicide rates in the most deprived areas are over 3.5 times the rate in the least deprived areas; self-harm admissions rates are also 3.5 times higher than in the least deprived areas.
- Men are more than three times more likely than women to die by suicide.

Data sources

The primary source of data on suicides is the General Registrar Office (compiled from coronial records). The NI Statistics and Research Agency uses this information to provide data on suicide trends by age, means of death, gender, marital status, geographic area (including associated area deprivation quintiles). The National Confidential Inquiry into Suicide and Homicide by people with mental Illness provides further information on suicide by those known to mental health services, while the NI Registry of Self-harm provides data on presentations at all hospital emergency departments as a result of self-harm and/or emotional crisis.

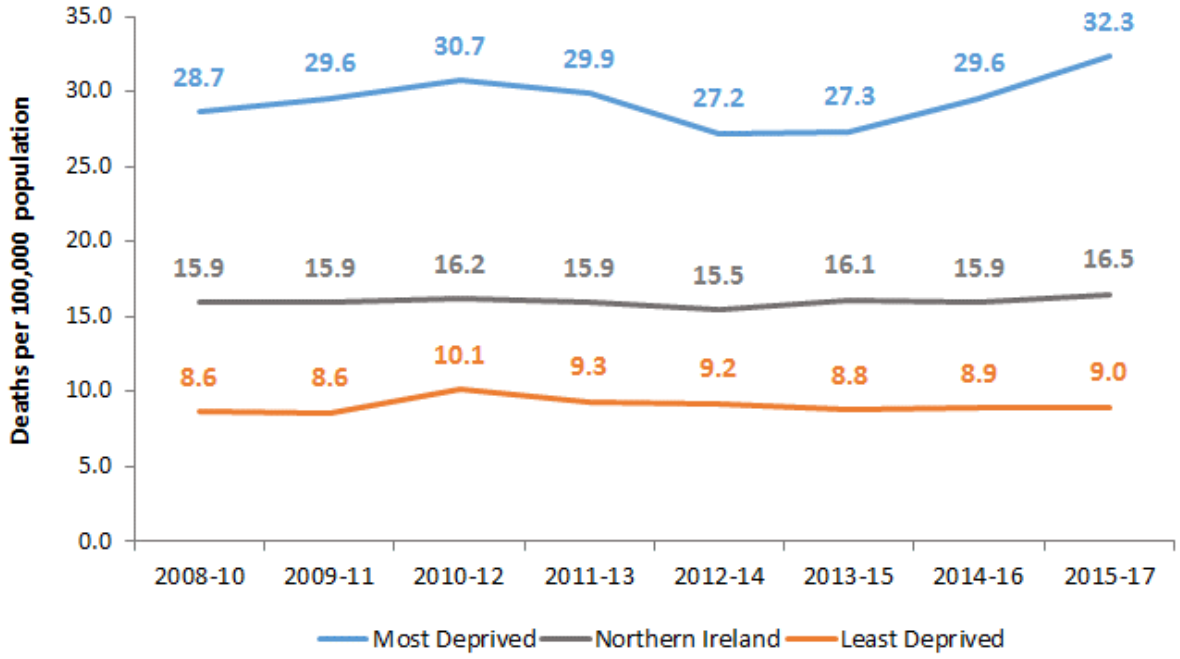
Suicide rates are quoted per 100,000 of population and, when comparing trends over time, rates are generally based on 3 year or 5 year rolling averages there can be fluctuations year-on-year which hinder the identification of longer term trends.

Deprivation

There is a strong health inequality aspect to suicide incidence (***see figure 1***). The suicide rate in the 20% most deprived areas is almost twice the Northern Ireland average and 3.5 times the rate experienced in the 20% least deprived areas. (Almost 28% of adults living in the most deprived areas of Northern Ireland are on prescription medication for mood and anxiety conditions).

Addressing this differential in suicide rates is retained as a focus in in *Protect Life 2*.

Figure 1: Crude suicide rate: Deprivation Time Series

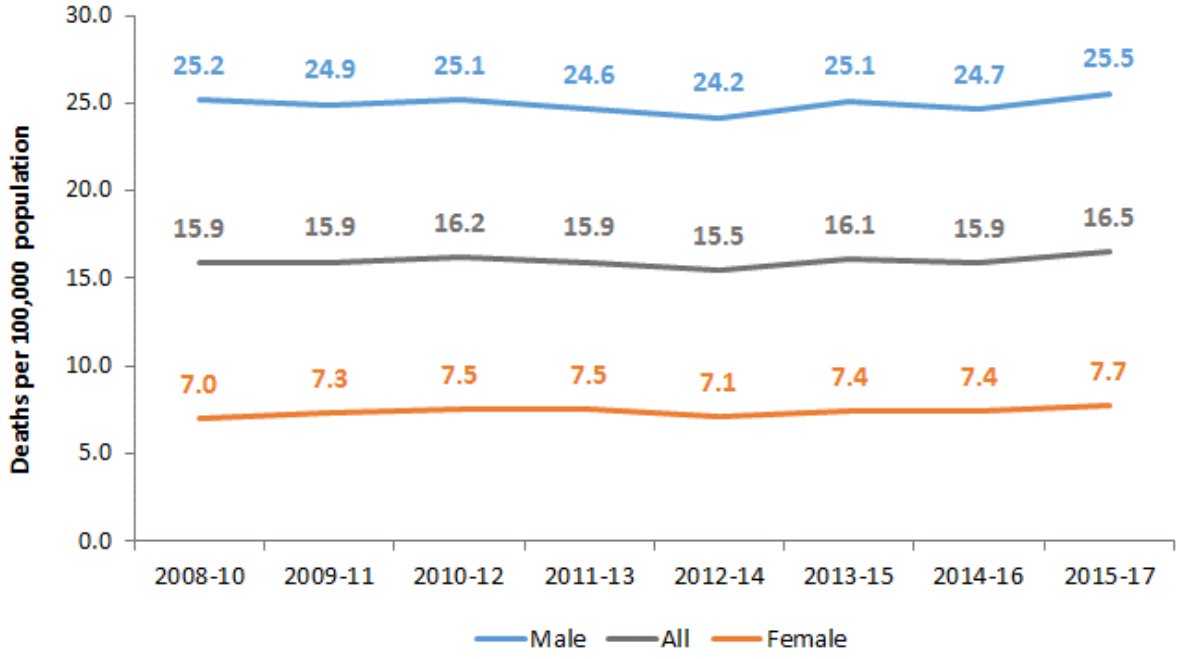


Gender and suicide

There is a gendered aspect to suicide here with men more than three times more likely to die by suicide than women. This is partly the result of differences in the lethality of methods used. There is also evidence that cultural perceptions of masculinity impact negatively upon men's help-seeking behaviour. Psychological distress is perceived by many men as a weakness and as representing a loss of control, whilst seeking support equates to an acknowledgement of vulnerability.

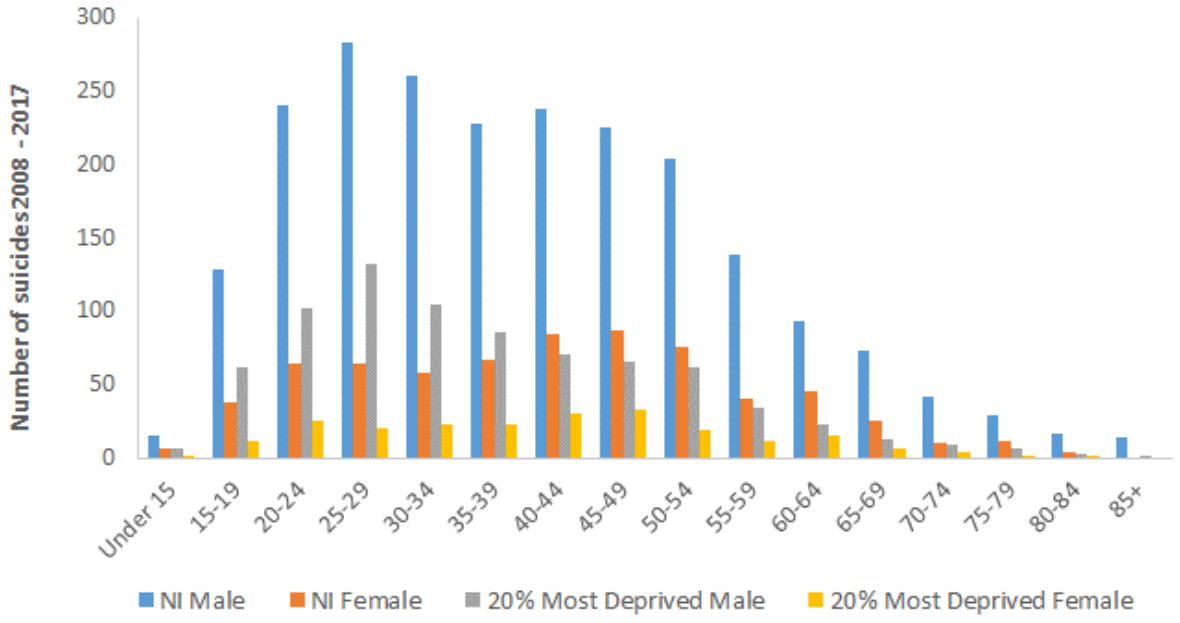
Males can be reluctant to disclose mental health concerns to their GP and often present with physical symptoms even when there are underlying mental health issues. Some men turn to problematic "coping strategies" such as alcohol use, repression of feelings, and social withdrawal as a means of responding to psychological distress. The most commonly reported trigger to seeking support for many men is when they have reached crisis point in terms of psychological distress.

Figure 2: Male and female crude suicide rate per 100,000 population



Evidence indicates that to effectively engage men with their mental and emotional health, it is necessary to build trust and rapport, work in informal non-medicalised environments, consider the use of technology, and adopt a strengths-based approach involving a focus on hope, optimism and solutions.

Figure 3: Number of deaths registered as suicide 2008-2017



Age related trends

In the period from 2004 to 2017, suicide accounted for 1.8% of all deaths in Northern Ireland. This is shown in ***figure 4*** below by age group.

Figure 4: Percentage of all suicide deaths in Northern Ireland by age group

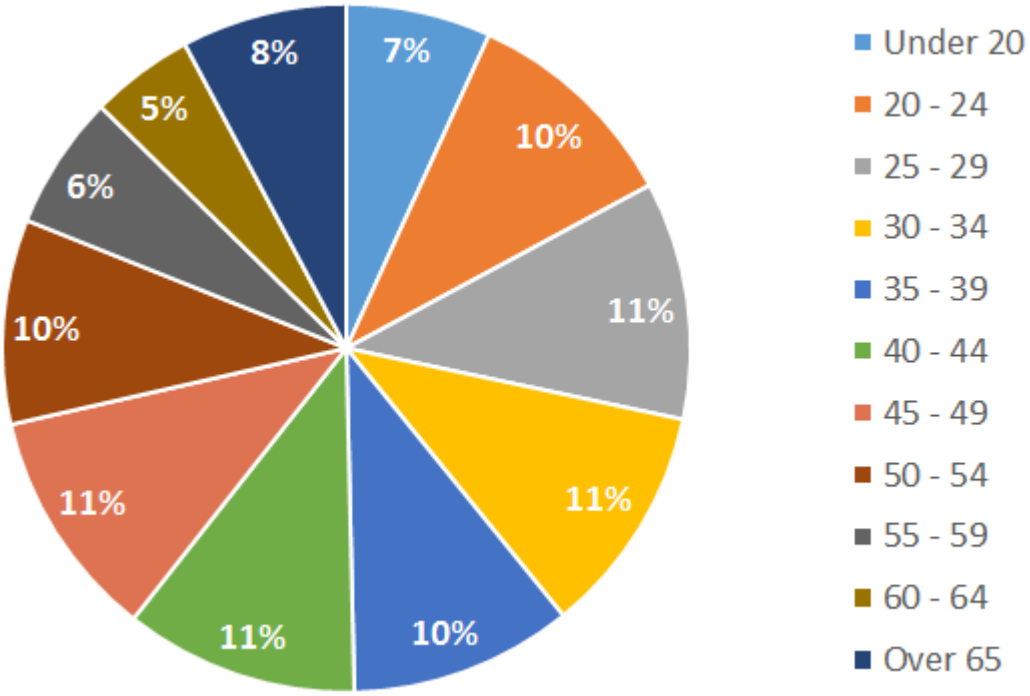


Figure 5: Suicide deaths as a percentage of all deaths in each age group

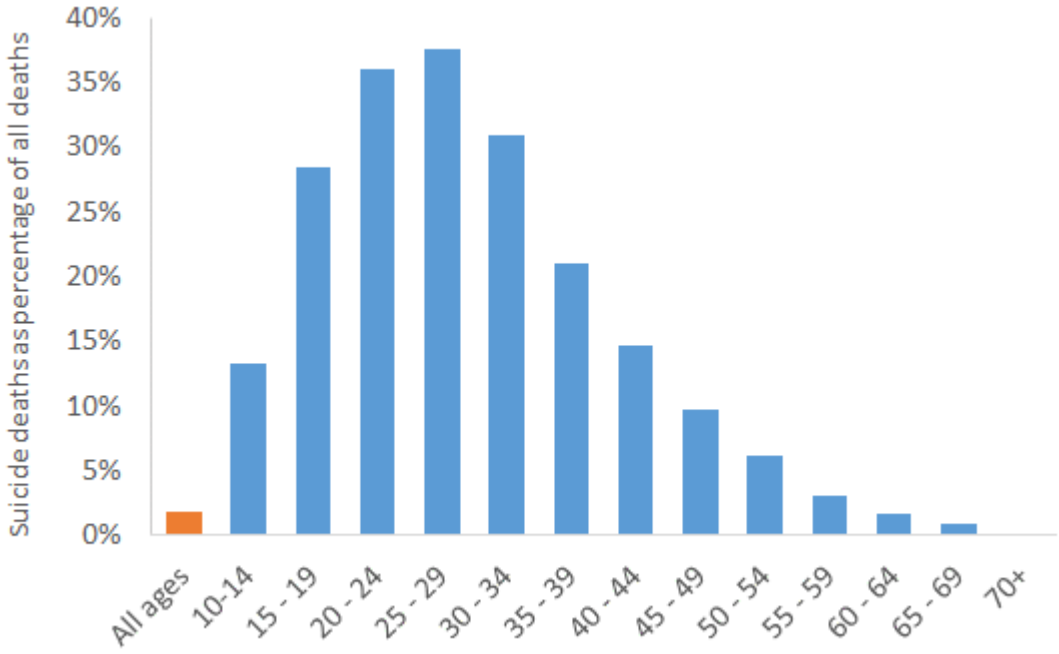
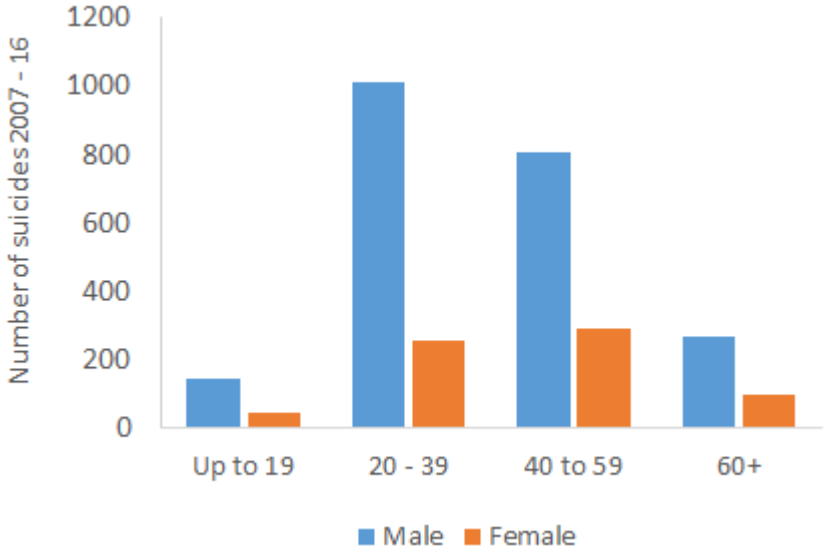


Figure 6: Number of male and female suicides by age group 2008-17



Men in their late teens to mid-50s are the most at risk group in society and the risks increase further for men who are single, unemployed, and living in socio-economic disadvantage.

The rate of suicides in those aged under 18 is low compared to other age groups and suicide remains rare amongst the under 15s. However, suicide is one of the main causes of mortality in young people (***see figure 5***). Local surveys indicate that a quarter of 16 year olds have experienced serious personal, emotional, behavioural or mental health problems, with this figure increasing to over 40% for those from a disadvantaged background.

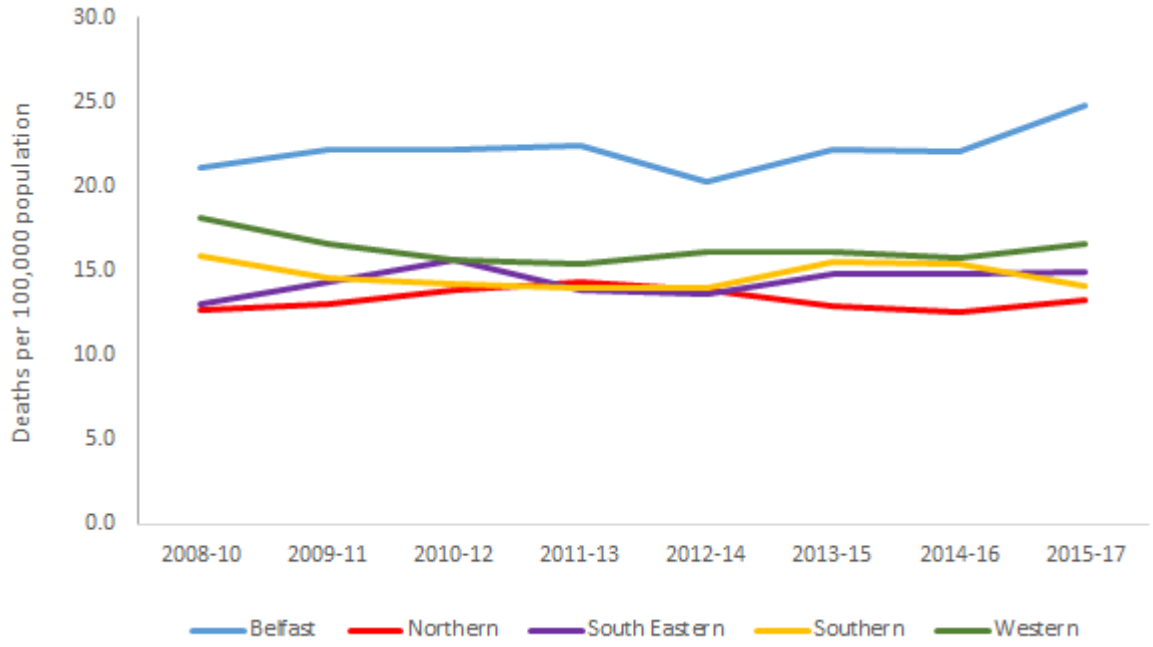
Urban and rural experiences

Suicide is more prevalent in urban areas, especially in large towns and cities with Belfast, in particular, experiencing higher rates of suicide. However, rural dwellers have experienced particular 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,

being ‘different’ (eg LGBT) in a rural context, availability of some means of suicide (firearm ownership, pesticides), and higher risk occupational groups such as farmers and veterinarians.

Figure 7: Crude suicide rate per 100,000 population by Health & Social Care Trust



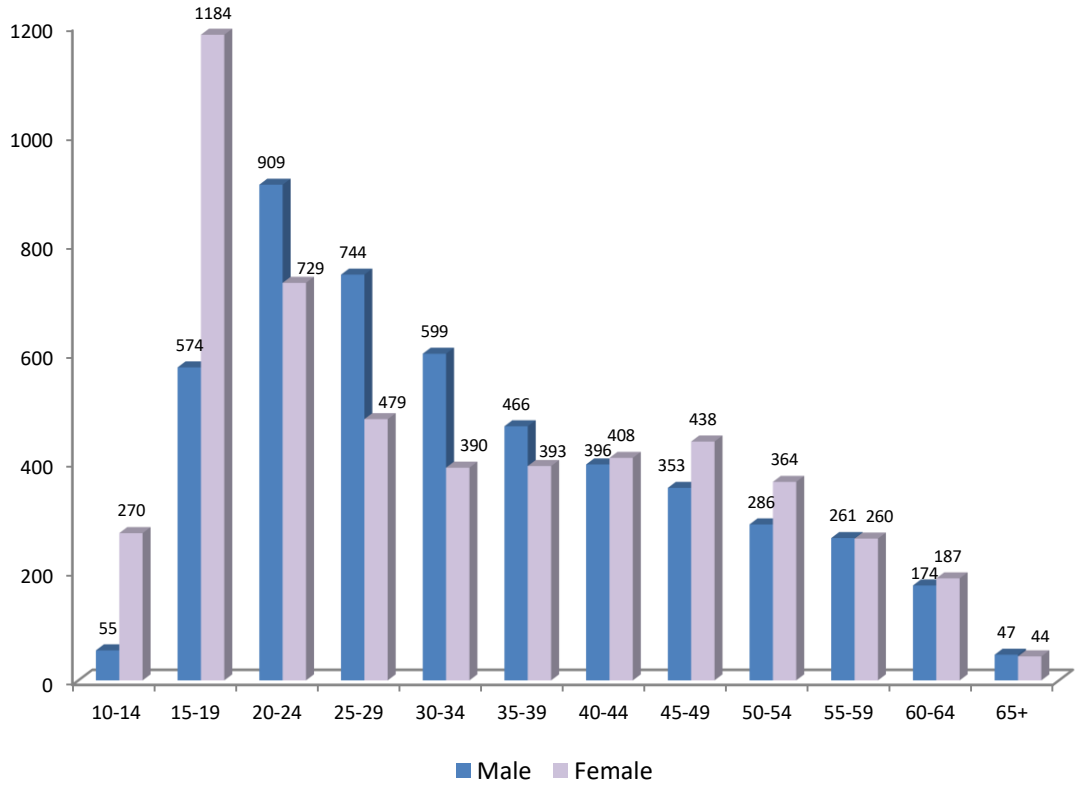
It is important that local suicide prevention plans take account of the particular circumstances in rural areas when selecting interventions. Arrangements in the Northern Area, where suicide prevention officers are based in rural community networks, provides a potential template for helping to address suicide in rural areas.

Self-harm trends and key facts

While females are slightly more susceptible to self-harm than males, there is not the same degree of gender imbalance as there is in suicide (***see Figure 8***).

Presentation to hospital emergency departments as a result of self-harm represents a relatively small proportion of overall self-harming activity. It is, for example, known that self-harming is relatively common among adolescents and teenagers, especially females. The Lifestyle and Coping Survey has shown that 10% of 15/16 year olds in Northern Ireland self-harm.

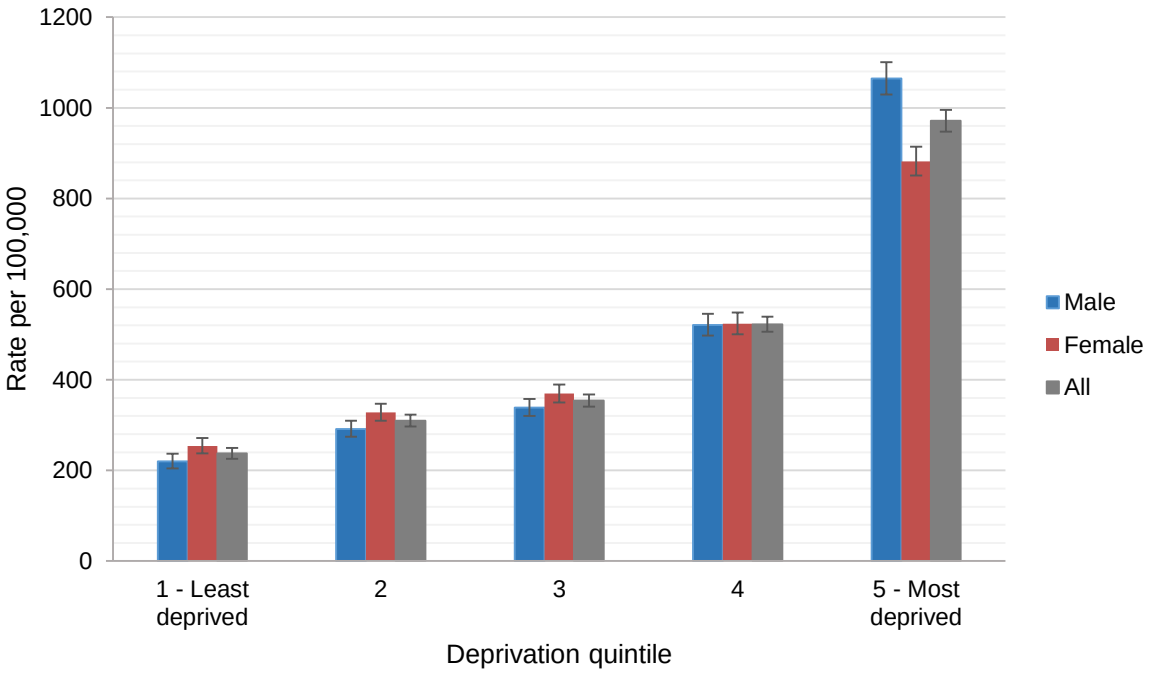
Figure 8: Incidence rate of self-harm per 100,000 in Northern Ireland by age and gender, 2017/18



Source: Northern Ireland Registry of Self-Harm

As with suicide, there is inequality in the experience of self-harm with the incidence being considerably more prevalent amongst those who lives in more deprived areas. Hospital admissions data indicates that over 3.5 times as many people from the most deprived areas are admitted due to self-harm compared to admissions from the least deprived areas. ***Figure 9*** shows the stark inequality regarding self-harm presentations in Northern Ireland.

Figure 9: Rates of self-harm presentations per 100,000 among 16-64 year-olds, according to deprivation quintile (2012-2015).



Self-harm key facts

- 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.
- 1 in every 325 people in Northern Ireland have presented to hospital as a result of self-harm.
- In 2015/16 there were 9,110 self-harm presentations to Emergency Departments by 6,137 people.
- Rates are highest among young people in the 15-24 age range; 70% of under 18 year olds presenting to Emergency Departments are female.
- The rate of presentations to emergency departments as a result of self-harm is consistently highest for those living in the Belfast Trust.
- Alcohol is involved in almost half of all self-harm presentations.
- Around 1 in 5 people who attend Emergency Departments with self-harm will re-attend with self-harm within one year.
- Repeat self-harm is a major risk factor for suicide, around half the people who die by suicide have a previous history of self-harm.
- Rates of suicide in the year after an episode of self-harm are over 50 times the general population rate.
- In 2015/16 there were 3,920 presentations to Emergency Departments for suicidal or self-harm ideation by 2,729 people.

CHAPTER 4: RISK FACTORS AND PROTECTIVE FACTORS

Risk factors - suicide

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 socio-economic determinants such as deprivation, community conflict, marginalisation and discrimination.

Childhood adversity (neglect and/or abuse) is a contributory factor and a genetic pre-disposition to depression is also thought to be an important influence. There is strong evidence for preventative action and investment in the formative years to address and avoid adversity as a means to reduce vulnerability to suicide in later life.

Those with an increased risk of suicide include broad swathes of the population such as: working-age men (particularly if they are single, divorced/separated, unemployed and/or living in an area of socio-economic disadvantage); those who identify as LGBT; ethnic minorities; those who are care experienced; people who have experienced trauma and conflict; those with a family history of suicide; people with mental health problems; and people in contact with the criminal justice system.

Furthermore, risk factor patterns for suicide vary across age, gender, geographic location, employment status, physical health status, occupation, and level of education. Occupations which are known to have a higher risk of suicide include farmers and agricultural workers, health service professionals, carers, veterinarians, members of the armed forces, and males in unskilled occupations and trades (with job features such as low pay, employment insecurity, and lack of job control).

With this in mind, particularly high risk individuals have been identified as those who:

- have attempted suicide
- self-harm (particularly on a repeat basis)
- have certain chronic and painful physical illnesses
- are going through divorce/separation

- have been bereaved by suicide
- have mental illness
- misuse drugs and/or alcohol
- are incarcerated in the criminal justice system (the majority have mental health or substance misuse problems and have experienced adverse life events)

As suicide rates are a consequence of many factors, (***see table 1***), identifying the means of best intervention is difficult. However, early identification and effective management of self-harm, mental ill health, and substance misuse are important in suicide prevention as is action in specific settings – such as prisons, and primary/secondary healthcare – and postvention support.

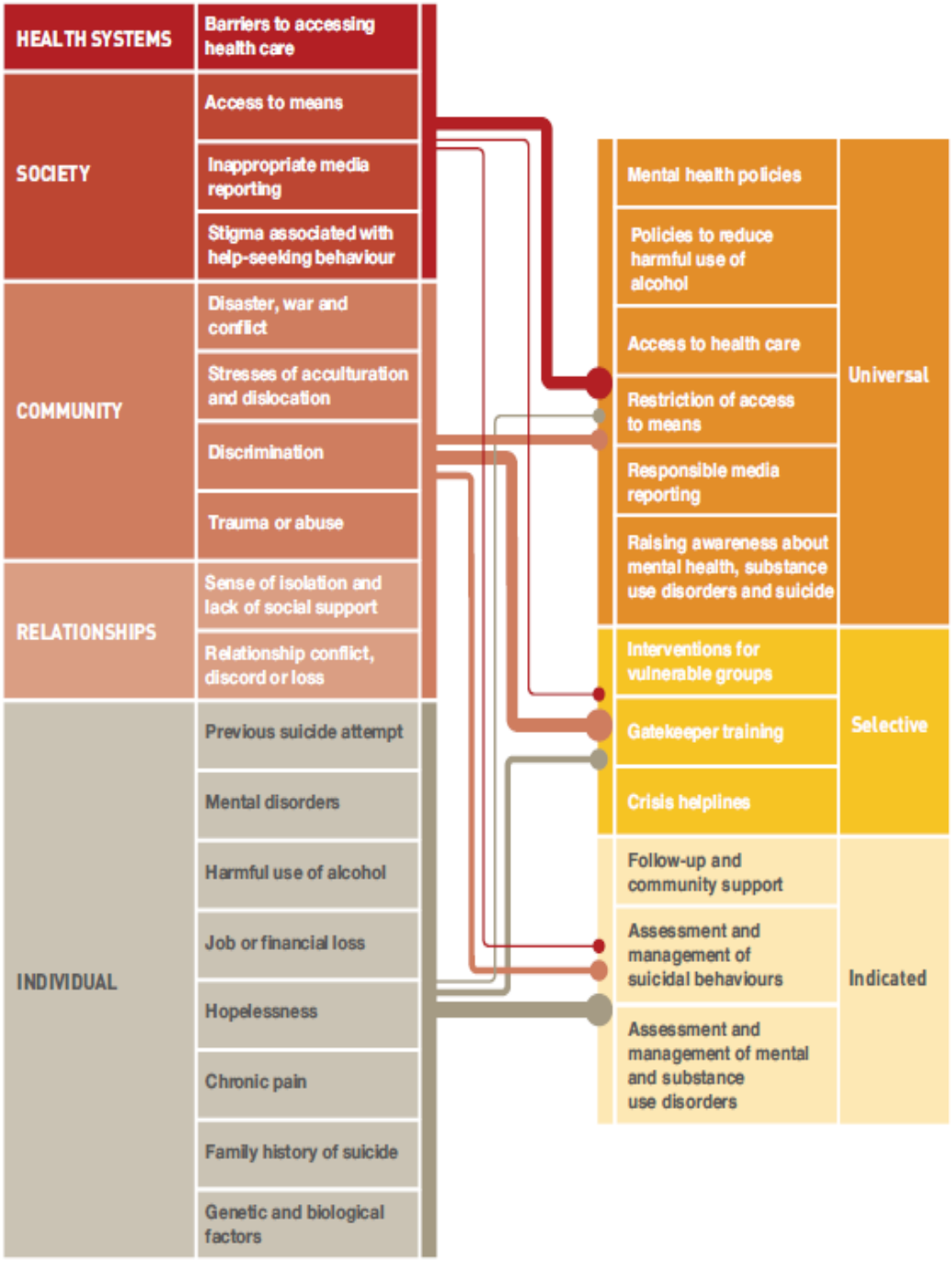
The presence of risk does not necessarily lead to suicidal behaviour, for example, psychiatric disorder and chronic physical illness are risk factors but relatively few people with these conditions attempt suicide. The World Health Organisation (WHO) has defined common suicide risk factors at four primary levels of influence: individual, relationship, community, and society and health systems (WHO, 2014). ***Table 1*** presents an adapted summary of these risk factors.

Table 1: Suicide Risk Factors

Individual Level	Relationship Level	Community Level	Society and Health Systems Level
• **Previous suicide attempt** • **Family history of suicide** • **Chronic pain, debilitating physical illness** • **Physical and sensory disability** • **Mental disorders** • **Alcohol and substance misuse** • **Hopelessness** • **Unemployment, job or financial loss, unmanageable debt, poverty**	• **Sense of isolation and lack of social supports** • **Relationship conflict, discord or loss** • **Unstable / unsupportive parent – child relationships** • **Bereavement**	• **Disaster, war and conflict** • **Stresses of cultural assimilation for migrant or ethnic groups** • **Being LGBT** • **Discrimination** • **Trauma, abuse or bullying** • **Incarceration (particularly in the early stages)**	• **Access to means** • **Inappropriate media reporting** • **Stigma associated with help-seeking behaviour**

Key risk factors for suicide ***aligned with relevant interventions*** have also been identified by WHO and are reproduced at ***figure 10*** below.

Figure 10: Key risk factors for suicide aligned with relevant interventions
(Lines reflect the relative importance of interventions at different levels for different areas of risk factors)



Source: WHO - Preventing Suicide: A Global Imperative

Local research

Research, commissioned under the *Protect Life* Strategy, involving in-depth analysis of records on almost 1,600 deaths by suicide, highlights the known associative factors of mental illness (almost 60% of those who died had been diagnosed with a mental health condition; a substantial proportion of the rest would likely have had an undiagnosed mental disorder), 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 and family discord 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. It also found that, on a per capita basis, deaths in Belfast were 40% higher than the Northern Ireland average and highlighted the likely impact of 40 years of civil conflict in terms of very high levels of (often untreated) post-traumatic stress disorder and other mental health disorders as a legacy of conflict.

Recent research has also pointed to trans-generational trauma where children born after the conflict ended experience poor mental health associated with conflict related trauma and ongoing violence or threat of violence. In this respect, programmes, such as the developing *Regional Mental Trauma Network, to* assist in building the psychological resilience of victims are important for suicide prevention.

Risk factors for children and young people

Increasing numbers of children and young people who contact Childline and growing numbers of younger children are feeling suicidal. Childline also reports that, like adult counterparts, boys are less likely than girls to seek help if they are feeling suicidal. Childline advise suicide is the 3rd most common reason for girls to contact the organisation and 5th most common for boys. Mental health issues, family relationships and self-harm were the most common concerns expressed during Childline suicide counselling services.

Many of the antecedents for later suicidal behaviour are laid down in childhood through experience of adversity and poor relationships. It is difficult to overstate the importance of the early years, in terms of protecting the individual from suicidal behaviour when faced with challenges in later life.

Influencing factors for suicidal behaviour in children differ in some respects to those experienced by adults and children have different needs in terms of support and care. At the request of the UK Health Departments, the National Investigation into Suicide in Children and Young People examined the antecedents of suicide in children and young people, and made recommendations to strengthen suicide prevention for this age group. Its main findings and key messages are set out below.

COMMON THEMES & RISKS

Family factors such as mental illness, substance misuse, & instability.

Abuse (emotional, physical & sexual), neglect, & witnessing domestic violence.

Academic pressures, especially related to exams.

Bullying.

Bereavement, especially through suicide.

Previous self-harming.

Suicide-related internet use.

Being in care / looked after.

Being LGBT or having concerns about sexuality.

Social isolation or withdrawal.

Physical health conditions that have a social impact, eg asthma, acne.

Alcohol & illicit drug use.

Mental ill-health.

Relationship breakup.

KEY MESSAGES

Suicide in young people is rarely caused by one thing; it usually follows a combination of previous vulnerability & adversity, high risk behaviours in adolescence, & recent adverse events.

The stresses prior to suicide are common in young people; most come through them without harm.

Suicide prevention should address family factors, childhood abuse, bullying, physical health, social isolation, mental ill-health, & substance misuse.

Specific actions are needed for young people who are bereaved, mental health support in colleges & universities, housing & mental health care for looked after children, mental health support for LGBT young people.

Further efforts are needed to promote universal mental health in schools & encourage online safety.

Services which respond to self-harm are key to suicide prevention in children & young people, & should work with services for drug & alcohol misuse.

The National Confidential Inquiry into Suicide and Homicide (NCISH) also 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 would also enhance suicide prevention.

Risk factors – self-harm

Self-harm is also a multi-faceted and complex behaviour, and a manifestation of deep emotional distress. People self-harm for numerous reasons, including (frequently undiagnosed) psychiatric disorder, alcohol and substance misuse, low self-esteem, and low tolerance for emotional distress. Adverse life experiences are also drivers for self-harm. These include bullying, abuse, trauma, victimisation, neglect, poor family relationships, and isolation.

In response to these issues, self-harm can be a means of communicating distress and repetition of self-harm episodes is relatively common. The intensity of self-injury may increase over time and repetition may lead to the acquired capability for suicide attempts. If there is no resolution of the distress this can lead to a suicidal crisis. Furthermore, those who self-harm may suffer from long-term physical effects of self-injury and self-poisoning.

Protective factors – suicide and self-harm

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

Protective Factors

- Maintaining strong personal relationships and positive family relationships which provide sources of emotional and social support.
- The development of sound emotional resilience in infancy and childhood through experiencing positive, nurturing parenting.
- A healthy active lifestyle.
- Willingness to seek help for mental, emotional or social problems.
- Ready access to quality care for mental and physical illness.
- Service response to those in distress that incorporates kindness, compassion, understanding, hope and non-judgemental listening.
- Skills in problem solving, conflict-handling, and non-violent resolution of disputes and distressing life events.
- Positive self-esteem.
- Supportive school environments.
- Employment – particularly in supportive workplace environments.
- Religious/spiritual beliefs that support self-preservation and offer social supports and encourage altruism.
- Restricted access to lethal means of suicide.
- Sensitive, non-sensationalist, non-stigmatising reporting of suicide.

Conclusion

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

CHAPTER 5: SUICIDE PREVENTION FUNDING AND SERVICES

This chapter outlines current investment in suicide prevention and the services which are already delivered under the *Protect Life* Strategy.

Funding

£8.7m is currently invested annually in suicide prevention by the Department of Health through the Public Health Agency which, in turn, supports community led suicide prevention services and funds Health and Social Care Trusts to provide local suicide prevention co-ordinators, family liaison officers (who work with bereaved families), training officers (suicide prevention and mental health promotion), and self-harm resources. A range of suicide prevention and emotional health and wellbeing programmes have also been funded separately under the transformation programme.

Mental health services in general, which receive separate funding, are intrinsic to suicide prevention and a significant element of funding for these services and for social services contributes towards the aim of reducing suicide and self-harm. The regional Mental Health Care Pathway "*You in Mind*" stipulates that where a person is experiencing a mental health crisis, which risks their personal safety, services will provide an emergency response within two hours. The pathway also commits to taking a recovery approach, which involves the family in supporting a person's recovery, and to promote safety through a personal safety plan.

Investment in other activities across government also contribute through integration of suicide prevention services into broader service provision for marginalised groups such as homeless people, care leavers, people with addictions, victims of abuse and LGBT people. In addition, a number of government departments have directly funded suicide prevention initiatives such as the Education Authority's Facilitating Life And Resilience Education (FLARE) initiative. Organisations engaged in suicide prevention at community level and regional charities have also allocated additional funding and resources to 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.

Services

Existing services delivered under *Protect Life* are outlined at ***Figure 11***.

Figure 11

Within this context the Public Health Agency provides gender-focussed services; and programmes working with marginalised / high risk population groups such as older people experiencing isolation, carers, young people in aftercare, people with chronic illness, and the LGBT community.

The PHA provide funding to the NI Helplines network to support better co-ordination of services and support. There are also a number of other important 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.
- ***Childline*** – which has a role in supporting and counselling children and young people with suicidal ideation.
- ***The Rural Support Helpline*** – which provides information on issues such as depression, stress, loneliness, debt, and addictions.
- ***Mental health services*** – particularly in relation to crisis intervention, including out-of-hours, in-patient and community-based services, the psychiatric liaison service, emergency crisis resolution and home treatment teams, psychological therapies for those with suicidal ideation, and crisis assessment and intervention teams for children.

Services for Children and Young People

It is important to retain a focus on children and young people in order to prevent future suicidality. A number of actions under *Protect Life* are targeted at younger age groups. These include suicide prevention training for teachers, youth workers and sports coaches; emotional resilience building and responding to critical incidents in schools (iMatter programme); the schools counselling service; the Facilitating Life and Resilience Education (FLARE) project; child-focussed bereavement support services; and developments within Child and Adolescent Mental Health Services.

Evidence indicates that an approach which emphasises broader positive mental health and incorporates training in coping skills is most effective for the school setting. In this regard, suicide prevention in schools is focussed on strengthening

pupils' self-esteem and emotional resilience, preventing bullying, raising understanding of the importance of positive mental health, provision of an independent counselling service, and (where an incident has occurred) ensuring that appropriate crisis response plans are activated and skilled staff in place.

Childline provides support to thousands of children and young people under 18 across the UK who are at points of crises in their lives and/or who have experienced bereavement through suicide. Through this service trained counsellors engage with suicidal and self-harming young people. Advice and peer support in respect of self-harm and suicidal feelings is also available on the Childline website.

It is recognised that the response to children who self-harm, who are in emotional crisis and at risk of suicide, or who have been bereaved by suicide, has to be tailored to their particular circumstances and may not be the same as the response for adults.

The Department of Education, the Department of Health, the Public Health Agency and the Education Authority have commenced work on developing a joined up framework across government for supporting the emotional health and wellbeing of children and young people. This work will include further consideration of child and youth focussed interventions, building on what is already in place through the "*iMatter*" programme.

Child protection procedures drawn up by the Safeguarding Board NI address the issue of suicidal intent. They require that any child or young person who expresses thoughts about suicide must be taken seriously and appropriate help offered at the earliest point. The guidance also provides practitioners involved in the care of children with advice on the signs of distress, how to discuss the issue with the child, sources of support, and consent to share information with parents and family. Where schools have a concern about risk of suicide, an urgent referral should be made to children's social care.

CHAPTER 6: RECENT DEVELOPMENTS IN SUICIDE PREVENTION

There have also been several recent developments which contribute to reducing suicide. These are detailed below.

Internet, social media, and e-health

The internet can be a powerful tool in suicide prevention, for example in promoting awareness-raising and signposting to sources of help. Evidence shows that it is being used for constructive purposes to access health information about illnesses such as depression and for coping strategies to avoid self-harm. However, there is also concern over social networking sites that 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 imitative behaviour by others.

There is evidence that the internet and E-health interventions are particularly useful and cost-effective means for reaching and working with adolescents, young men, and those from minority backgrounds as the element of anonymity provides a safe space for them to explore mental health issues.

Technology and Mental health good practice guidelines have also been published by the National Office for Suicide Prevention in the South of Ireland (*https://ie.reachout.com/guidelines*).

Smartphone apps have been developed locally which can provide immediate access to available support at a community level and provide 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) where users demonstrate a suicide risk - such as visiting a known suicide 'hotspot', talking about suicide or missing an appointment - the clinician is alerted by the app to contact them.

Samaritans have been exploring the potential for online suicide prevention and offer 24/7 emotional support through text and email as well as via their helpline. They have also linked with Facebook on a suicide prevention tool which provides advice, resources and support to people who may be struggling with suicidal thoughts and their concerned friends and family members.

Business in the Community has partnered with Public Health England to produce online toolkits to help organisations support the mental health of their employees. This includes a toolkit designed to assist employers in their response to the suicide of an employee and to reduce the risk of further suicides.

Childline reports indicate that children and young people who contact its service about suicide and self-harm tend to prefer getting in touch online and that they are also receiving help and emotional support through other websites, particularly through joining with suicide and self-harm discussion forums.

The four UK Chief Medical Officers have published their independent systematic map of evidence on screen and social media use in children and young people, and recommended next steps and advice for parents and carers. They have concluded that the published scientific research is currently insufficient to support evidence-based guidelines on screen time, but there is enough basis to warrant a precautionary approach and action by schools, government and technology companies.

The Health and Social Care Board has published an *e-health strategy* and works with the Public Health Agency to identify international best practice and trends in technology developments and innovation. The potential to develop projects that focus on mental health promotion and suicide prevention will be considered in the implementation of the *e-health strategy*.

An online Harms White Paper was published in April 2019 and sets out a programme of action to tackle content or activity that harms individual users, particularly children. Locally, an *e-safety strategy* is in development by the Safeguarding Board of

Northern Ireland to ensure the safety of children and young people when using the internet and electronic media. This will contribute to suicide prevention through the encouragement of responsible use of digital and internet technology so that children and young people in particular have the skills to protect themselves from potential risks.

The positive use of the internet, social media, and E-health will continue to be explored through *Protect Life 2*.

Towards Zero Suicide

The USA 2012 *National Strategy for Suicide Prevention* includes an objective to promote the adoption of "zero suicide" as an aspirational goal by healthcare and community support systems. The core propositions of this approach 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.

The zero suicide model relies on organisational leadership and a system-wide approach to improve risk assessment, safety planning, workforce development and adverse incident learning to inform system and culture change. It also seeks to enhance care pathways for suicidality in order to close gaps in service provision and improve co-ordination across settings (primary care, secondary care, emergency departments, mental health services, and third sector services) – including continued support after acute care.

Further information on the local Towards Zero Suicide initiative is contained in Chapter 7.

Crisis Response – Mental Health Liaison

Mental Health Liaison is a system developed in Birmingham and trialled in the Northern HSC Trust whereby physical and mental health staff work together in emergency departments to ensure that vulnerable patients are detected and offered prompt, compassionate assessment and care by a mental health professional prior

to leaving the hospital (removing the need for some patients to return for assessment the next day as is currently the case with the *Card Before You Leave* protocol). The aim is to reduce the likelihood of patients leaving the emergency department without being seen by mental health staff. The initiative is now being phased in regionally.

Dealing with the legacy of the conflict

A new *Mental Trauma Network* Is being established by the Department of Health and the Executive Office. 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 Northern Ireland such as untreated Post-traumatic Stress Disorder, as well as other causes. This service will, therefore, contribute to suicide prevention efforts.

CHAPTER 7: AREAS FOR ENHANCEMENT AND SERVICE DEVELOPMENT

Following the 2016 consultation report a number of areas for service enhancement and service development have been identified. While the existing £8.7m budget is fully committed on current services, a number of service gaps were identified in the consultation exercise. It is the intention to address these gaps in *Protect Life 2.* Some action in these areas may be subject to the availability of additional funding. These are highlighted below under three key headings and are detailed further in Chapter 8:

a) Areas for enhancement in pre-crisis intervention
b) Areas for enhancement in crisis intervention
c) Areas for enhancement in postvention services

Areas for enhancement in pre-crisis intervention

The following areas have been identified as requiring service enhancement and development and will be actioned under the Strategy.

1. Safer mental health services (Actions 5.1, 5.2 and 5.3)

Effective assessment, diagnosis and treatment of mental illness can reduce suicidal behaviour. Where people at risk of suicide are known to services, there is an opportunity to reduce that risk and improve patient safety.

NCISH recommendations

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) identified the period following discharge from in-patient care as a time of high suicide risk and notes that suicide is frequently preceded by missed appointment/contact with services. Consultation on *Protect Life 2* highlighted support for assertive outreach in mental health services.

NCISH recommends comprehensive care planning prior to discharge, routine follow up together with assertive community outreach in response to missed appointments, and addressing adverse life and social circumstance (such as housing and debt) through inter-agency working prior to discharge. The Inquiry has produced a checklist *"Twelve points for a safer service*" which provides guidance on suicide prevention in mental health services.

Implementation of NICISH recommendations has been shown to improve patient safety and contribute to an overall reduction in suicide.

The 2018 NCISH Report also noted that a history of alcohol and/or drug misuse by children and young people was significantly more likely in Northern Ireland compared to the rest of the UK.

Towards Zero Suicide

Local HSC Trusts, working in partnership with service users and carers have formed a Regional Towards Zero Suicide Mental Health Collaborative Programme. This will focus on patient safety to reduce suicides within Adult mental Health Services. This will be supported through *Protect Life 2*. A regional Collaborative Board will drive the work at a strategic level.

Trust implementation groups will support a learning climate and roll-out revised practice and processes and measure impact at a local level, engaging with staff, supporting learning and spreading identified good practice across partner providers in the community and voluntary sector. The South Eastern Trust is working in Partnership with the Northern Ireland Prison Service to implement within the prison environment.

The structure is supported by a partnership with Mersey Care NHS Trust who will perform a 'confirm and challenge' function to the programme, and share their experience of implementation of the Zero Suicide Model which is reporting early positive outcomes.

Learning from adverse incidents

Serious adverse incident reporting is a process by which the circumstances surrounding patient/client suicide or attempted suicide are investigated and reported in order to identify learning and develop safer services. This procedure was reviewed and revised by the Health and Social Care Board in 2016 to improve regional learning and to support preventative measures. Serious Adverse Incident processes in relation to suicide are also being examined under the Towards Zero Suicide initiative.

Perinatal mental health

Mental health support for new or expectant mothers is provided in the community through general mental health services in line with the 2017 *Integrated Perinatal Mental Health Care Pathway* which provides regional guidance for all health care professionals who come into contact with pregnant women, to ensure that any mental health problems are identified early and women are directed to the appropriate mental health services.

Currently only the Belfast Trust has specialist perinatal mental health practitioners providing care and where inpatient care is required, this is provided within existing general adult mental health facilities, as there is no specialist Mother and Baby Unit in Northern Ireland. The voluntary and community sector also continue to provide a range of excellent support to women suffering from mental ill health in the perinatal period.

To further the development of specialist services a regional perinatal mental health group, led by the Public Health Agency in partnership with the Health and Social Care Board, has been set up to co-produce an updated service model, including comprehensive community-based services.

2. Additional training across sectors for front line staff (Action 4.3)

Consultation has highlighted the view that there needs to be a more coordinated and consistent approach to depression awareness, suicide prevention and safety planning training of health care staff. People, particularly females, who die by

suicide tend to have quite extensive contact with health and social care services (outside of mental health services). This underscores the importance of awareness and intervention skills training for staff, particularly in emergency departments, social care and primary care (GPs are the most frequently used source of professional support for someone in the community seeking assistance with emotional distress).

The National Confidential Inquiry into Suicide in Primary Care in England has noted that suicide risk increases with increasing numbers of patient consultations with GPs. The Report also found that 37% of those who died by suicide did not have a mental health diagnosis recorded.

The Royal College of General Practitioners provides online mental health toolkits to support GPs in suicide prevention and risk assessment. The General Medical Council and the Royal College are also working to ensure that medical students, GP trainees, and GPs receive training in assessing and managing depression, self-harm, and suicide risk.

There is also strong support for suicide prevention training across a range of sectors which interact with vulnerable people as many people who are suicidal do not have contact with health care professionals - over 70% of people who die by suicide in Northern Ireland are not known to mental health services. A comprehensive multi-sectoral training programme will be developed under the new Strategy and will staff working in areas such as education, justice, social security, and sport and culture.

Training and awareness raising will take place at three distinct levels:

- ***Population-wide awareness raising*** to improve understanding of the issues that impact on mental health, address stigma, and improve awareness of the signs of distress;
- ***Carer knowledge and skills development*** to improve their ability to intervene and offer support, and to enhance awareness of support services and means of referral;

- ***Specialist intervention*** encompassing risk assessment, clinical interventions, counselling and therapeutic interventions, specialist bereavement support, child interventions, and referral pathways.

3. Support for those not known to mental health services / engaging men in suicide prevention (Actions 1.5, 2.1, 4.4, 4.5 and 7.1)

There is a need to improve the identification and early diagnosis of mental ill health, and access to appropriate treatment, and to expand prevention efforts beyond traditional health settings. This will entail promoting workplace stress management programmes, supporting crisis management services such as Lifeline, Childline, Samaritans, out-of-hours de-escalation services.

The vast majority of the people who die by suicide but who are not known to mental health services are males aged from their late teens to late 50s. Engaging men in suicide prevention is a challenge but there are indications that programmes which centre on sport and physical activity show some promise. It is also recognised that community outreach programmes into non-health settings where males traditionally gather is a necessary step. Suicide prevention in those not in mental health services or not attending a GP requires reliance on agencies such as sporting bodies, addiction services, social welfare services, family, schools and colleges to identify the suicide behaviour and intervene to help encourage help-seeking.

4. Linkages with substance misuse services (Action 7.4)

There is a clear association between suicidal behaviour and alcohol use, abuse and intoxication. The 2018 NCISH Report highlights that 63% of patients in Northern Ireland who died by suicide between 2006 and 2016 had a history of alcohol misuse. 43% of patients had a history of drug misuse. This underlines the need for close linkages between implementation of *Protect Life 2* and the Drug and Alcohol Strategy, and the continued roll-out of programmes aimed at early intervention and prevention of alcohol and drug misuse.

A high proportion of those in treatment for alcohol use conditions and in drug treatment programmes have co-existing mental health problems (dual diagnosis). NICE guidance on dual diagnosis recommends building capacity in care mental

health teams and community addiction services. It is anticipated the Mental Health Liaison model will also contribute to future learning for dual diagnosis presentations.

There is potential for greater co-ordination in commissioning and developing drug and alcohol and suicide prevention services in future.

5. Colleges and universities (Action 1.4 and 4.5)

A number of studies have identified that students in third level education are experiencing increasing levels of stress, anxiety, mental illness, and suicidal behaviour. The need for more preventative action has been recognised in terms of identifying early warning signs, providing peer-to-peer support, signposting to sources of help, and provision of welfare and counselling services.

There is growing appreciation of the need for a whole university / college approach to mental health and wellbeing within further and higher education, for example, through the efforts of the UK Healthy Universities Network. The development of a new University Mental Health Charter was announced in June 2018 with the aim of driving up standards in promoting student and staff mental health and wellbeing. The Charter is being developed by Student Minds, a UK student mental health charity.

6. Safer custody (Action 1.6)

The Northern Ireland Prison Service together with the South Eastern HSC Trust has agreed and implemented a Joint Suicide and Self Harm Risk Management Strategy. A review of the Supporting Prisoners At Risk process has been completed and a new person-centred approach “Supporting People at Risk (SPAR) Evolution” has been agreed with the Trust and implemented within prisons and prison escort & court custody service. Other initiatives developed include: suicide prevention training for prison and police custody staff; adaptation of custody environment to reduce the possibility of suicide; and the provision of support services for prisoners at risk of suicide and self-harm.

Areas for enhancement in crisis intervention

A range of initiatives have been identified to support people in crisis. Several of these initiatives are being funded in 2018/19 and 2019/20 through the transformation programme and are in addition to the existing *Protect Life* budget. It is also essential to provide greater support to families who are caring for a loved one who may be at risk of suicide.

1. Out-of-hours crisis de-escalation and "safe places"

The need has been highlighted for a service or facility which would enable people who present in social and/or emotional crisis to access a service which provides them with an opportunity to de-escalate from that crisis in a safe manner and receive referral to appropriate support. Crisis de-escalation is provided by a number of organisations but a gap in out-of-hours provision has been identified.

A crisis de-escalation pilot based in Belfast was piloted between March and July 2019. The model included out-of-hours service provision for people in social/emotional crisis. A Derry Crisis Intervention Service pilot has also been established by Derry and Strabane Council and commenced in early 2019.

A Multi Agency Triage Team in the Belfast and South Eastern Areas has been established to meet the needs of people facing emotional and social crisis, and their families. This model involves health professionals working with PSNI officers in responding to suspected mental health incidents in both public and residential places. The aim is to support access to appropriate crisis care avoiding the Emergency Department unless necessary, provide timely access to health and social care or third sector services, and reduce the use of police cells as places of safety.

2. Self-harm services

Full implementation of NICE guidance on the short-term and long-term management of self-harm is also a priority. The introduction of the Mental Health Liaison service will ensure that all people presenting to Emergency Departments in crisis are offered

a psychosocial assessment prior to leaving the hospital in line with NICE recommendations.

There is evidence that follow-up care and engagement with people who self-harm reduces the incidence of repeat self-harm. NICE guidelines on the management of self-harm recommend that multi-disciplinary care plans (incorporating a risk and crisis management plan) are developed with the person who self-harms and, provided the person agrees, with the family, GP and significant others.

Follow-up care for self-harm is provided by the HSC Trusts for people with associated mental health problems. For people that do not require input from statutory mental health services the *Self Harm Improvement Programme* (SHIP) provided by the Community and Voluntary sector offers short term psychological intervention and support. It aims to improve coping skills. It also offers education and support to carers and families to help them better understand and cope with self-harm.

3. Support for families of suicidal individuals

There are two elements to this:

- families have described their distress and sense of isolation at having responsibility for looking after a suicidal relative but lacking the skills and knowledge to do so effectively; and
- bereaved families have highlighted a need to improve the provision of information and support for families concerned about a relative who may be at risk of suicide and/or who has demonstrated suicidal behaviour. This would involve increased contact and better education for families of people deemed to be at risk.

A recurrent concern raised by families is the perception that healthcare professionals exclude them from the healthcare management of their relative by excessive adherence to patient confidentiality. While a patient's right to confidentiality is paramount, there are instances where professionals sharing information – with

consent – with a person's trusted family or friends may assist in determining appropriate healthcare and safety management.

In conjunction with the Royal Colleges, the Department of Health (England) published the *Information Sharing and Suicide Prevention Consensus Statement* in 2014 to encourage health professionals to share information about someone at risk of suicide with family and/or friends. Work is ongoing in England to consider means of improving awareness of the *Consensus Statement* within the professions and improving health professionals' confidence in applying the guidance given their concerns about breaching patient confidentiality.

Areas for enhancement in post-vention services

When someone dies by suicide, the shock is profound and widely felt by families, friends, colleagues, and professionals. The term "postvention" describes support for people who have been affected by a suicide. It also encompasses action taken in response to a potentially emerging cluster of linked suicides, and the gathering of data on suicide in order to identify trends, patterns and potential causes.

1. Sudden death notification and bereavement support

When the police attend a sudden death that is a suspected suicide, they record basic information about the deceased in the Sudden Death Notification (SD1) form which is then shared with the local Health Trust and the Public Health Agency. Where family members have provided their consent to be contacted by support services, the SD1 process is used to target postvention support. It is also used as a means of real time surveillance to identify emerging clusters of linked suicides and to activate pre-existing multi-agency *Community Response Plans* to prevent further suicides and to support communities that are impacted by the deaths.

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. However, it is important to ensure that those bereaved have ready access to practical and emotional support from other sources.

Immediate support may be provided by bereavement support workers, clergy, GPs, health professionals, social security staff, Lifeline, Childline, Coroner's Office (Family Liaison Service), police, schools, voluntary and community groups, and funeral directors. As support needs change over time, 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.

The Public Health Agency has developed quality standards for service provision of mental and emotional wellbeing and suicide prevention to ensure consistency of approach. These standards reflect that the needs of people bereaved by suicide are many and can be quite complex, often necessitating support from a variety of sources.

During the development of this strategy, the following areas for improvement in postvention support were identified:

- Training for police and emergency service staff relating to handling the scene of a suicide in ways that minimise the trauma for those bereaved;
- Better co-ordination of the provision of information to the bereaved and closest network of the sources of support that are available, in a way that doesn't confuse and overwhelm them;
- A follow up offer of bereavement support regardless of the information contained in the *SD1*. The form includes an indication of whether the family wishes to be referred to support services. There is a high rate (50%) of refusal, possible because the question is posed at a time of extreme shock and trauma for the family;
- Better regional learning from each occasion that *community response plans* are activated;
- Age appropriate services should be available for children and young people;
- Support for those who had engaged with the deceased in a professional capacity, eg counsellors, GPs, and psychiatrists, as well as the emergency services who attend the scene;

- Establishment of a referral process for family members where death by suicide was not immediate but occurred later in hospital; and
- Development of formal procedures or standardised guidance for responding to suicide bereaved families in the primary care setting.

2. Self Care

Exposure to distress and the responsibility of providing support can have a substantial impact on the service provider / carer. Self-care complements suicide prevention services and there is a need to enhance mechanisms for better psychological and professional support for those who experience suicide as part of their professional or voluntary practice, and for informal carers of someone who is suicidal.

It is also recognised that those bereaved by suicide are often passionate about suicide prevention; however, care needs to be taken to avoid encouraging them to volunteer until they have taken the time they need to grieve their own loss.

Suicide can be traumatic for those who interacted with the deceased in a professional capacity either within the statutory sector or the community sector. It can exact a toll on their personal wellbeing and professional confidence.

Support is also required for those caring for people who are suicidal. This includes families. Given the nature of the most common means of suicide in Northern Ireland, the need for vigilance, information and support for informal carers is vital.

3. Guidelines on memorials/ public gatherings/ social media postings

Given the profound impact of bereavement through suicide there is a need for balance between helping those left behind to grieve their loss and the need to ensure that public expressions of their grief are safe and do not put vulnerable people at risk of suicide.

Remembering the deceased is a normal part of grieving and public memorials are sometimes used following a suicide death. However, memorials carry the risk of normalising or romanticising suicidal behaviour and there is a need to ensure they

cause no harm in this regard. PHA and Samaritans have published guidelines in relation to memorials, public gatherings and social media postings.

4. Research, and data collection / analysis (achieving a better understanding of suicide)

Comprehensive data on suicide and self-harm is essential in order to understand the factors associated with suicide, and to provide responsive prevention services. Data gathering on suicide and self-harm is through the mechanisms of the Self-Harm Registry, the Sudden Death Notification process, National Confidential Inquiry, the Serious Adverse Incident process, and the General Register Office – these data systems are not linked at present.

On a wider basis, a range of organisations hold intelligence that is relevant to understanding the context and patterns of suicide. They include general practice, mental health services, ambulance services, social services, police services, housing, education, probation, and many others.

Research has commenced by Queen's University to link some of these data sources and this should provide very useful information to guide suicide prevention initiatives in the coming years. It is hoped that it may be possible to identify particular sub-groups that are at higher risk and inform preventative services e.g. identifying which people who self-harm are more likely to die by suicide.

The Scottish Suicide Information Database (ScotSID) and the Northern Ireland Suicide database (established temporarily to inform research commissioned under *Protect Life*) provide potential models for improved data collection and linking of data sources encompassing information on medical records, contact with addiction services, emergency department attendances, contact with justice services, as well as demographic data. The Public Health England Suicide Prevention Profile provides another potential model.

In relation to research, it is intended that the focus on local research will continue and new topics will be considered as part of the action plan. Potential areas that

have been suggested include a focus on those who have made suicide attempts, bereaved families, the characteristics of those not known to core services (mental health and primary care), links between self-harm presentation at hospital and later suicide, and research to improve the evaluation of programme impacts.

Conclusion

Consultation, reviews of evidence and the work undertaken elsewhere have shown a substantial number of areas where there is significant scope for further development in suicide prevention. These areas are being considered but it should be emphasised that not all can be taken forward simultaneously due to resource constraints and a phased approach is likely to be necessary.

CHAPTER 8: HIGH LEVEL ACTION PLAN

Protect Life 2 builds upon what has been achieved through the previous strategy whilst taking action to address those areas where further improvement and focus have been identified as necessary. In addition, consideration has been given to recent developments in suicide prevention in terms of how they can be incorporated into the strategic action plan for trialling and evaluation.

The need for a relatively small number of grouped actions was a recurring theme in consultation on development of the strategy. In keeping with this, the action plan sets out the strategic actions necessary for the achievement of each objective (see ***figure 12***). A more detailed, timetabled implementation plan with associated indicators of progress will be developed by the Public Health Agency working with the newly formed *Protect Life 2* Strategy Steering Group, and will be used to monitor progress in implementation of the strategy.

Implementation of some areas of the action plan will be dependent on additional investment over the next 5 years. It will be necessary to phase implementation in light of the availability of resources and it is not expected that all of the actions will be implemented in each of the five years of the Strategy.

Figure 12 - Protect Life 2 Action Grid

Cross Government collaboration

Objective 1 Ensure co-ordinated cross government approach to suicide prevention.

- Resources for schools / emotional wellbeing framework.
- Wellbeing & arts programme.
- Safer custody initiatives.
- Ministerial Group on Suicide Prevention.

Awareness raising & media reporting

Objective 2 Improve awareness of suicide prevention and services.

- Public information campaigns.
- Stigma reduction initiatives.

Objective 3 Enhance responsible media reporting.

- Media monitoring / Guidelines on memorials / promote online safety.

Community support

Objective 4 Enhance community capacity.

- Commission community-led services / Integrate with community planning.
- Workplace initiatives.

Safer mental health services

Objective 5 Reduce suicide among people under care of mental health services.

- Implement SAI learning & NCISH recommendations.
- Test the Toward Zero Suicide approach.

Access to means

Objective 6 Restrict access to means.

- Safety plans for high risk locations.
- Safer prescribing and medication review for those at risk of suicide.

Crisis response, care & recovery

Objective 7 Enhance initial response, care and recovery of people who are suicidal.

- HSC Staff training. • De-escalation services.
- Regional Care Pathway / Follow up Care.

Self-harm

Objective 8 Enhance services for people who self-harm, particularly for those who do so repeatedly.

- People who repeatedly self-harm are identified for additional support.
- Self-harm registry.

Support for those bereaved or exposed to suicidal behaviour

Objective 9 Effective support for those exposed to suicidal behaviour.

- Bereavement support services / Self care for service providers.
- Support families & informal carers, & encourage involvement.
- Refine SD1 process & Community Response Plans.

Research & data collection

Objective 10 Strengthen NI evidence on suicide & effective interventions.

- Commission local research.
- Improve integrated data collection & analysis.

Action Plan

The following action plan outlines the key objectives and associated strategic actions underpinning the *Protect Life 2* strategy. Actions new to this strategy are highlighted. Other actions were taken forward under the former strategy and are ongoing.

Objective	Actions	Delivery Lead
1. Ensure a collaborative, co-ordinated cross-departmental approach to suicide prevention	1.1 Support the Ministerial Co-ordination Group on Suicide Prevention to link suicide and self-harm risk prevention to strategic activity across Government.	DoH
	1.2 Work with the All Party Group on Suicide Prevention to build further societal commitment to reduce suicide and self-harm.(***new action***)	DoH / All Party Group
	1.3 Promote UK-wide & North / South co-operation on suicide prevention.	DoH
	1.4 Develop a joined up framework across government to support the wellbeing of children and young people in educational settings and beyond. This will include the development and implementation of policies and guidance which promote emotional resilience in educational settings.(***new action***)	DE / DoH / PHA / Education Authority
	1.5 Promote mental health & wellbeing through arts, culture, leisure, libraries and sport.	DfC
	1.6 Implement suicide prevention and self-harm elements of the Improving Health within Criminal Justice Strategy.	DoH/ DoJ / NI Prison Service / SE Trust
2. Improve awareness of suicide prevention and associated services	2.1 Develop and deliver public education programmes: to increase awareness of the signs and symptoms of emotional distress and of the appropriate response; to reduce stigma around mental illness; and to encourage help-seeking behaviour.	PHA
	2.2 Promote awareness of available support, including de-escalation and bereavement services.	PHA, C&V sector
	2.3 Promote positive use of the internet & social media in relation to suicide prevention & self-harm reduction. (***new action***)	PHA
3. Enhance responsible media reporting on suicide	3.1 Promote use of, and compliance with, media guidelines on the reporting of suicide; review & update guidelines as necessary.	PHA

Objective	Actions	Delivery Lead
	3.2 Monitor media reporting and challenge inappropriate reporting.	PHA
	3.3 Promote best practice guidelines on memorials/ public gatherings/ social media postings. (***new action***)	PHA / Samaritans
	3.4 Ensure that Northern Ireland is part of the UK-wide arrangements to promote & encourage sensitive reporting of suicide online and in social media, and for making the internet safer for those who are vulnerable to suicide. (***new action***)	DoH, PHA
4. Enhance community capacity to prevent and respond to suicidal behaviour within local communities	4.1 Support, encourage and procure community-based suicide prevention services.	PHA, C&V sector
	4.2 Ensure effective co-ordination with Council community planning on suicide prevention by embedding suicide prevention in all District Council "Community Plans". (***new action***)	PHA / District Councils
	4.3 Deliver a multi-sectoral training framework in suicide intervention for people working in the community.(***new action***)	PHA/ Agencies/ C&V sector
	4.4 Provide practical support to employers on mentally healthy workplaces and supporting employees experiencing emotional crisis.	PHA / HSENI / private sector companies/ Chamber of Commerce
	4.5 Encourage universities, colleges, schools and training organisations to promote a culture of help-seeking behaviour and suicide prevention awareness among their students and trainees. (***new action***)	DfE / DE / PHA / Education Authority / NIMDTA
5. Reduce the incidence of suicide amongst people under the care of mental health services	5.1 To establish a regional mental health collaborative across HSC Trusts using a Towards Zero Suicide approach and concepts for adult mental health to improve patient safety and to reduce levels of suicide. (***new action***)	HSC Trusts
	5.2 Continue participation in the National Confidential Inquiry on Suicide (NCISH) & support practice improvement in line with NCISH recommendations.	DoH / HSC Trusts
	5.3 Improve the process for learning from suicide & self-harm related adverse incidents. (***new action***)	HSC Trusts

Objective	Actions	Delivery Lead
6. Restrict access to the means of suicide	6.1 Reduce risk of suicide at high risk locations, engaging with local stakeholders and developing plans for enhancing safety at those locations. (***new action***)	Multi Agency
	6.2 Work with professional groups to encourage safer prescribing and develop policy proposals where restricted access to certain medications demonstrates positive outcomes in terms of reductions in this means of suicide.	DoH/ HSCB
	6.3 Ensure safe custody in relation to suicide prevention.	DoJ / NI Prison Service/ PSNI/ NI Court Service
7. Enhance the initial response to, and care and recovery of people who are suicidal	7.1 Provide timely, accessible de-escalation services for those in emotional crisis or despair. (***new action***)	HSC Trusts / PHA / C&V sector / PSNI
	7.2 Develop and implement a regional training framework which will include suicide awareness and suicide intervention for HSC staff with a view to achieving 50% staff trained (concentrating on those working in primary care, emergency services, & mental health / addiction services) by 2022. (***new action***)	HSC Trusts / PHA
	7.3 Encourage health and social care professionals, & others, who provide services to people at risk of suicide to (as a matter of course) seek patient / client permission to engage trusted family or friends in their safety planning for that person. (***new action***)	HSC Trusts
	7.4 Embed suicide prevention in drug and alcohol policy and services. (***new action***)	PHA, HSC Trusts
8. Enhance services for people who self-harm, particularly for those who do so repeatedly	8.1 Improve access to, and uptake of, a range of therapies and interventions for those who self-harm in line with NICE guidance on the management of self-harm and relevant guidance on other associated conditions.	PHA, HSCB, HSC Trusts
	8.2 Maintain the NI Self-harm Registry to determine trends over time, inform service provision, & improve understanding of self-harming behaviour.	PHA

Objective	Actions	Delivery Lead
	8.3 Embed psychological support in the new mental health liaison service. (***new action***)	HSCB / Trusts
	8.4 Ensure all people who attend the ED with self-harm are offered a psychosocial assessment by the new mental health liaison service.	HSCB/ Trusts
9. Ensure the provision of effective support for those who are exposed to suicide or suicidal behaviour	9.1 Provide a consistent, compassionate approach to supporting those bereaved/affected by suicide, including family and social circle. (***new action***)	PHA / HSC Trusts / C&V sector
	9.2 Facilitate support networks for people bereaved by suicide and their role in influencing policy and service delivery.	PHA HSC Trusts
	9.3 Provide support and reflective practice for professionals who experience loss of patient or client to suicide and their work on suicide prevention. (***new action***)	PHA, C &V Sector, HSC Trusts
	9.4 Support families and other informal carers in caring for suicidal individuals to help them manage suicidal behaviours and emotional distress; and to look after their own mental wellbeing. (***new action***)	PHA, Trusts
	9.5 Ensure collation of accurate real time information on probable suicides through the Sudden Death Notification process.	PHA / PSNI
	9.6 Identify emerging suicide clusters and act promptly to reduce the risk of further suicides in the community through proportionate activation of multi-agency Community Response Plans.	PHA, PSNI, Trusts, NIPS
	9.7 Implement recommendations of the PHA review of the Sudden Deaths Notification process and the Community Response Plan process. (***new action***)	PHA, HSC Sector, PSNI
	9.8 Ensure contracted organisations adhere to PHA Quality Standards of Services promoting mental and emotional wellbeing and suicide prevention. (***new action***)	PHA, C&V sector
	9.9 Support for school staff to help them provide effective support to children & young people affected by suicide or suicidal behaviours at	DE

Objective	Actions	Delivery Lead
	home. (***new action***)	
10. Strengthen the local evidence on suicide patterns, trends and risk, and on effective interventions to prevent suicide and self-harm	10.1 Identify priorities for local research into suicide, self-harm & their prevention including data linkage; promote, encourage and commission local research.	PHA / DoH
	10.2 Support promotion and delivery of the 2019 International Association for Suicide Prevention Congress. (***new action***)	PHA
	10.3 Conduct ongoing surveillance to monitor changing behaviours or trends in suicide and self-harm means to inform preventative action, particularly where new methods emerge.(***new action***)	PHA

CHAPTER 9: GOVERNANCE AND PROGRESS MONITORING

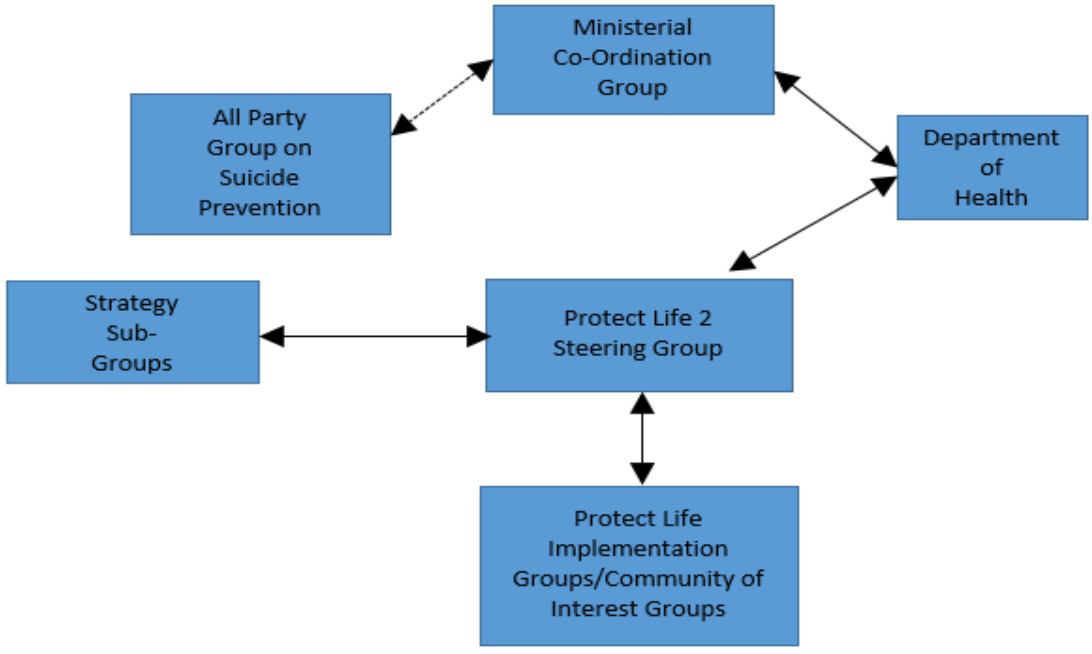
Protect Life 2 will be underpinned by a more detailed implementation plan, developed by the PHA, and by robust governance and monitoring arrangements. The new *Protect Life* 2 Steering Group and its sub-groups will have broad-based representation, with direct responsibility for strategy delivery. In light of this the previous Suicide Strategy Implementation Body and Bamford *Protect Life* groups will be discontinued.

There were extensive comments during consultation that there is a need to streamline working groups. It was also felt that there was considerable overlap between SSIB and a range of other lobbying and information sharing groups. The new Governance structures seek to address these points.

Governance

A structure for the governance arrangements for the *Protect Life 2* Strategy is set out at ***Figure 13***.

Figure 13: *Protect Life 2* Structure and oversight



The Ministerial Co-ordination Group on Suicide Prevention

This Group will continue to provide oversight, leadership and impetus for cross-departmental collaboration and co-ordination. It will consider priority issues of escalation and provide opportunities for Ministers to consider new programmes and means of joined up working. The Department of Health will provide the secretariat for the Group.

Department of Health

The Department will provide strategic oversight and will continue to support the roll out 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 and in Programme for Government Delivery Plans.

Protect Life 2 Steering Group

Implementation of the Strategy will be through a new *Protect Life 2* Steering Group chaired by the Public Health Agency which is the lead organisation with responsibility for co-ordinating implementation of the Strategy. The Steering Group will drive the delivery of the strategy through a more detailed implementation plan. It will also track and monitor implementation, and report on progress in delivering the implementation plan. Part of its role will be to identify factors that may be hindering the achievement of specific milestones necessary for the delivery of the strategic actions.

An additional function will be to agree annual action plans and milestones for delivery of those actions and reporting. 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 which will have cross-sectoral membership.

The Steering Group may establish working groups or sub-groups to advise on and progress specific areas within suicide prevention such as data collection, analysis and research, postvention support, training and awareness raising. It may be practical for some of the existing groups to become sub-groups under the *Protect*

Life 2 Steering Group, such as the Regional Self-Harm Steering Group or Lifeline Steering Group. Other subject areas for consideration by sub groups may include:

- Self-harm
- Regional training
- Media and awareness raising
- Primary care
- Safer mental health services
- Developing community capacity
- Data and research – “knowledge into action”
- Justice services
- Strategy evaluation

Any sub-groups set up by the Steering Group will need a terms of reference and a well-defined role.

Local Protect Life Implementation Group and Communities of Interest

The *Protect Life 2* Steering Group will continue to be supported by *Protect Life* Implementation Groups and Community of Interest Groups across Northern Ireland. These groups will help ensure effective implementation of the strategy at local level in a way that takes account of local needs and assets. They will develop local action plans based on the *Protect Life 2* action plan, and oversee delivery of these plans.

The hosting of networking events for providers of services such as mental health, substance misuse, homelessness, debt advice, and suicide prevention is an important role of the *Protect Life* Implementation Groups. This helps in improving referral and signposting, joint working and peer support.

Representatives of bereaved families participate in each of the *Protect Life* Implementation Groups. These representatives have an important role in giving bereaved families influence in the development of suicide prevention policy and in

implementation of the strategy. This formal role will continue to be facilitated and bereaved families encouraged to continue to develop networks.

Progress monitoring and reporting

Performance reports will be published by DoH setting out a narrative summary of performance against each of the actions in the action plan.

Measurement, review and evaluation

The World Health Organisation has advised that reductions in mortality should not be the only outcome measure for a suicide prevention strategy – primarily because it is exceptionally difficult to evaluate a national suicide prevention strategy as a whole in terms of its contribution to achieving the aim of achieving a sustained reduction in the number of suicides. Concerns were also expressed, in response to the public consultation on the draft strategy, that this single primary measure of progress would not adequately inform the contributions of the various organisations involved in delivering *Protect Life 2.*

An evaluation framework will therefore be developed under the Protect Life 2 Steering Group to critically examine the outcome and impact of interventions and programmes against the strategy objectives. Measureable "outcome indicators and process indicators" will be linked to each objective to help assess progress towards that objective. Further work will be taken forward by the Steering Group to develop appropriate performance indicators and to identify or establish the necessary data sources to monitor their progress over time. Potential examples of these indicators are also set out in **Appendix 2**. This includes examples suggested through public consultation.

APPENDIX 1: RATIONALE FOR PROTECT LIFE 2 OBJECTIVES

Objective 1: Ensure a collaborative, co-ordinated cross-departmental approach to suicide prevention

Suicide is a societal issue that requires a cross-government response to address the wider risks of suicide and self-harm. The Ministerial co-ordination group will continue to provide strategic leadership and build political commitment to reduce suicide and self-harm and ensure sustained allocation of resources to suicide prevention from across Departments. Suicide prevention also requires work across a range of settings and services. As such, the combined knowledge, expertise and resources of organisations across public, private and voluntary/community sectors is essential.

Objective 2: Improve awareness of suicide prevention and associated services

Men in particular often seek to conceal psychological distress but exhibit signs in other unspoken ways, such as becoming withdrawn. Awareness raising is essential to promote helping others and signposting to sources of support. People need to know about the causes of suicidal behaviour, recognise the signs of such behaviour, know to ask the right questions, deal with difficult conversations that may follow, and know what suicide prevention services exist, and how to access those services.

Low levels of engagement with mental health services by those who have died by suicide is concerning and highlights the need for greater public awareness about mental health, addressing stigma around disclosure of suicidal feelings, and encouraging help-seeking.

There is no solid evidence that public information campaigns that focus overtly on suicide and its prevention help to increase help-seeking or reduce suicide prevalence. Hence, the focus to date has been on promoting broader positive mental health, addressing stigma, and promoting help-seeking for those experiencing emotional or psychological difficulty.

Objective 3: Enhance responsible media reporting on suicide

Media influences on suicidal behaviour are well established. The risk of media reporting influencing imitational suicidal behaviour significantly increases if details of suicidal methods are reported, if the story is placed prominently, and if coverage is sensationalised and/or extensive. Insensitive, sensationalist, and graphic reporting

of suicide can contribute to the imitation of the act by others and causes great distress in those bereaved. On the other hand, media reporting can break down taboos, challenge stigma, identify sources of support, and encourage help-seeking.

Objective 4: Enhance community capacity to prevent and respond to suicidal behaviour within local communities

Communities have a critical role in suicide prevention through the provision of social support to vulnerable people, engaging in follow up care and implementing suicide prevention programmes. Facilitating community engagement in suicide prevention is a key task and a range of initiatives are already supported within the community sector that focus on empowering, building resilience and promoting positive mental health and wellbeing. PHA also fund Suicide Prevention Officer posts which focus on awareness raising and education; capacity building and resilience; partnership working and information management.

Objective 5: Reduce incidence of suicide amongst people under the care of mental health services

People with mental illness are at increased risk of suicide. Effective assessment, diagnosis and treatment of mental disorders can reduce suicidal behaviour. Safe mental health services are also key - almost 30% of the people who die by suicide in Northern Ireland are known to mental health services. There has been improvement within in-patient safety over recent years and there is now substantial scope for action in community mental health services to reduce the number of patients who take their own lives. Furthermore, the enhanced focus on the “recovery” approach within broader mental health service delivery has clear links with suicide prevention policy. Where people at high risk of suicide are known to services, there is an opportunity to reduce that risk and improve patient safety.

Objective 6: Restrict access to the means of suicide

Restricting access to the means of suicide such as ligature points, high places, firearms, pesticides, and medicines is a proven method of reducing suicide; particularly for people known to be self-harming or vulnerable to suicidal thoughts. While it is challenging to identify effective approaches to reduce the incidence of suicide by hanging, there is potential for reducing certain means of suicide. Given that location is often important in suicide attempts, restriction of access to means can

include restriction on media reporting in regard to means and location of individual suicides.

Objective 7: Enhance the initial response to, and care and recovery of people who are suicidal

Crisis intervention and de-escalation for people in distress or despair saves lives. This needs to be supported by follow-up care and safety planning across primary care, community care, secondary care, and 3rd sector services in order to prevent further suicide attempts - the chance of repetition after attempted suicide is very high. There is evidence for a range of follow-up interventions. These may include: establishing a suicide prevention care plan; treating underlying mental health problems; counselling; psychosocial treatment (such as cognitive behaviour therapy and dialectical behaviour therapy); increasing emotional resilience; fostering problem solving and interpersonal skills; addressing social isolation (especially in older people); and provision of supportive ongoing contact. The appropriate intervention depends on the individual's needs and circumstances.

There is also evidence that professional and non-professional gatekeeper training, and effective risk assessment, reduces suicide rates by improving early identification of suicidal behaviour and ensuring appropriate intervention and signposting. GP training is particularly important as primary care is the most commonly accessed health service in the month prior to suicide.

Exploration of new ways of responding to the needs of people in emotional crisis is necessary in order to reach more people at risk of taking their own lives. Samaritans have, for example, developed online capacity for the provision of emotional support.

Objective 8: Enhance services for people who self-harm, particularly for those who do so repeatedly

Self-harm is an expression of distress increasing the risk of suicide. Repeat self-harm in particular is a significant risk factor for suicide as well as being a public health issue in its own right. Early identification of people who self-harm and provision of support to help them come to terms with the underlying problems is important in reducing suicide.

Presentation at hospital emergency departments due to self-harm or emotional crisis provides an opportunity to intervene and connect those at risk with appropriate services. There is substantial evidence for the effectiveness of psychological therapy

interventions that enhance the coping and problem solving skills of those who self-harm.

Objective 9: Ensure the provision of effective support for those who are exposed to suicide or suicidal behaviour

This objective relates to those bereaved by suicide, those (whether in a professional or voluntary capacity) who have been supporting someone who was suicidal, and those caring for a relative or friend who is suicidal.

Bereavement through suicide has a life-altering and potentially destructive impact on bereaved family and friends leaving them highly vulnerable to trauma, risk of family breakdown, poor mental health, emotional problems and suicidal behaviours. Up to half of those bereaved through suicide experience moderate to chronic trauma in the initial years. Support is often essential to help the grieving process, prevent longer term emotional distress, and promote healing. It also serves as a vehicle to reduce risk of further suicide. The type of support and how long it will be needed for varies from person to person. Active intervention from schools is necessary to ensure that bereaved children are fully supported.

It is also 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. Identification requires surveillance of suspected suicide deaths; intervention requires the activation of multi-agency response plans to help communities address a number of potentially linked suicides and to prevent further deaths arising from this.

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

In order to accurately monitor trends in suicide and self-harm, improve insight into risk factors, and enhance understanding of interventions that prevent suicide and self-harm, it is essential to have good quality information obtained through systematic data collection. Improved recognition and understanding of clinical, psychological, sociological, and biological influences on suicidal behaviour can help in the detection of high risk individuals and in treatment selection. Research provides the evidence base for effective interventions.

There are a number of sources for accessing information on suicide and self-harm. These include the Self Harm Registry, NISRA / General Registry Office death

statistics, Sudden Death Notification process, National Confidential Inquiry, Child Death Inquiry, Coroner's records, and the HSC adverse incident report system. There is a need to collect and interpret data on deaths by suicide in a more systematic and integrated way to enhance our understanding of suicide and suicide prevention in Northern Ireland.

APPENDIX 2: EVALUATION FRAMEWORK / PERFORMANCE INDICATORS

The *Protect Life 2* Strategy Steering Group will develop a list of indicators to assess Strategy performance and progress. The list below is an example of potential indicators which may assist the Steering Group.

Objective	Indicator / Outcome
1. Ensure a collaborative, co-ordinated cross departmental approach to suicide prevention	Self-harm in all custody settings. Provision of safe custody settings. Publication of a children and young people's Emotional Health and Wellbeing Framework.
2. Improve awareness of suicide prevention and associated services	Evaluation of public information campaigns. Numbers availing of suicide prevention and self-harm services. Reduced mental health stigma from Change Your Mind campaign. Regional mental health trends in NI health Survey. SHIP referrals. Lifeline referrals.
3. Enhance responsible media reporting on suicide	Sustained reduction in the number of inappropriate articles.
4. Enhance community capacity to prevent and respond to suicidal behaviour within local communities	Number of people working in the community trained in suicide awareness / prevention. Suicide prevention is embedded in, and an active part of, all District Council Community Plans. Audit of C&V sector suicide and self-harm services against the set quality standards.
5. Reduce incidence of suicide amongst people under the care of mental health services	Number of people in contact with mental health services who die by suicide (expected decrease). [Data source: NCISH] Towards Zero Suicide approach within mental health services trialled and evaluated in all Trusts. Reported progress on the implementation of

	NCISH recommendations. [Data source: HSC Trust reporting] Number of self-harm and suicide related serious adverse incidents within mental health services. [Data source: HSC serious adverse incident reporting system]
6. Restrict access to the means of suicide	Reduction in the numbers of people who die by suicide in high risk settings. [Data source: NISRA, Sudden Death Notification process, SAI reporting system] Reduction in recorded suicide and self-harm incidents involving prescription medication. [Data sources: NISRA, Self-harm Registry, NCISH, Serious Adverse Incident reporting system]
7. Enhance the initial response to, and care and recovery of people who are suicidal	50% of frontline HSC staff trained in suicide awareness and prevention. Testing and evaluation of at least three new initiatives designed to improve the efficiency of responses to people in emotional/ psychological crisis. [Data source: evaluation reports] Waiting time targets met for access to psychological therapies.
8. Enhance services for people who self-harm, particularly for those who do so repeatedly	Year on year reductions in the number of repeat self-harm presentations to hospital emergency departments .[Data source: NI Self-Harm Registry] Evidence of service re-design as informed by analysis of the NI Self-harm Registry. Full implementation of NICE guidance on the management of self-harm. [Data source: HSC progress reports] Number and percentage of SHIP clients who achieved a reliable improvement in CORE measures. [Data source: SHIP]
9. Ensure the provision of effective support for those who are exposed to suicide or suicidal behaviour	Development of a regional “reflective practice” programme for those working in the field of suicide prevention. Provision of a range of support services available to people bereaved by suicide or exposed to suicidal behaviour.

	Annual reporting on learning and assessment of activation of community emergency response plans for preventing linked clusters of suicides. [Data source: PHA]
10. Strengthen the local evidence on suicide patterns, trends and risk, and on effective interventions to prevent suicide and self-harm	Research studies. 2019 Conference Report. SD1 Reports.

APPENDIX 3: EQUALITY SCREENING AND RURAL NEEDS

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 relate 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 an Equality Screening and updated this following consultation. The Department has concluded that a full Equality Impact Assessment is not required.

Rural Needs

The Rural Needs Act (NI) 2016 (the Act) provides a statutory duty on public authorities to have due regard to rural needs when developing, adopting, implementing, or revising policies, strategies and plans, and when designing and delivering public services. Accordingly the Department of Health has completed a Rural Needs Impact Assessment Template which has been published with this Strategy.

APPENDIX 4: GLOSSARY OF TERMS

Care Pathways

Structured, multi-disciplinary care plans which detail how patients or clients should expect to receive treatment and care for a specific issue.

Community Planning

In 2015, local councils were given the responsibility of leading the community planning process for their area. Community plans identify long-term priorities for improving the social, economic and environmental well-being of the local area and the people who live there. Community Planning Partnerships are in place comprising the council, statutory bodies, agencies and the wider community. Each partnership includes a sub-group with a focus on health and wellbeing. This provides an opportunity to work collaboratively to develop the health and wellbeing of local people, and develop local assets to improve mental health.

Emotional resilience

The capacity that allows individuals to adapt and overcome adverse circumstances and events. This ability is the result of a complex interplay of numerous factors, many of which stem from early years and childhood experiences. Individual levels of emotional resilience differ, consequently people have different vulnerability to the adverse effects of negative environments.

Frontline health & social care staff

This includes: GPs and primary care staff; hospital emergency health care providers; ambulance staff & paramedics; social workers; mental health care providers.

National Confidential Inquiry into Suicide and Homicide by people with mental Illness (NCISH)

NCISH is a UK-wide study of people who have been in contact with statutory mental health services in the 12 months before their death by suicide. NCISH publishes data along with recommendations for changes to clinical practice and policy aimed at reducing the risk of suicide.

National Institute for Health and Clinical Excellence (NICE)

NICE produces guidance evidence-based guidance for effective intervention, treatment and care management to improve health and wellbeing and prevent ill-health and poor wellbeing. Guidance published by NICE is considered locally for its

application to Northern Ireland and, where appropriate, is endorsed by the Chief Medical Officer for implementation in the Health and Social Care sector.

People working in the community

Those likely to be in contact with vulnerable individuals. Includes: relatives; community workers; police officers; teachers & school staff; clergy; social welfare staff; prison & custody staff; college & university staff; youth workers; sports coaches; fire service personnel; funeral directors; veterinarians; military welfare staff; workplace managers & personnel staff; pharmacists; those working with people with mental health conditions & addiction issues; taxi drivers; hairdressers.

Postvention

Activities developed by, with, or for people bereaved by suicide or exposed to suicide. The aim of these activities is to support recovery and prevent adverse outcomes, including further suicide and / or poor mental health and wellbeing.

Psychotherapies

These are evidence-based treatments for depression. They include: Cognitive Behaviour Therapy; Dialectical Behaviour Therapy; Inter-personal Psychotherapy; mindfulness-based cognitive therapies.

SD1

In the event of a suspected suicide, a Sudden Death Notification (SD1) form is completed by the PSNI and recorded on a secure email system which allows for the notification to be shared with a limited number of Health and Social Care representatives.

Self-harm

The term self-harm is used to refer to any act of self-poisoning or self-injury carried out by a person, irrespective of their motivation.

Serious Adverse Incident (SAI) reporting system

A protocol designed to provide a system-wide perspective on serious adverse incidents (including suicide & suicide attempts) within the Health & Social Care sector & within those services provided on behalf of the Health & Social Care sector. A serious adverse incident is one which involved the serious injury or unexpected death of a service user, or an unexpected risk to a service user.

Suicidal behaviour

Encompasses expressions of desire to end one's life, suicide planning and suicide attempts.

Suicidal ideation
Thoughts about wanting to be dead or about taking action to end one's own life (including identifying a method, having a plan, or intent to act).

Suicide

A fatal self-injurious act with some evidence of intent to die.

Suicide attempt

A potentially self-injurious behaviour, with a non-fatal outcome, associated with some intention to die. However, it is recognised that the main motivation of some people who attempt suicide is not to die but to escape emotional pain and / or a perceived intolerable situation.

Zero Suicide Approach

A number of models, initially originating with healthcare services in the USA, based on the concept that suicides within health & behavioural care settings are not inevitable. It sets an aspiration for zero suicides within those settings through leadership, training, culture changes, and a data-focussed quality improvement approach to inform systems changes.