Department of Health
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PROTECT LIFE 2:

a draft strategy for suicide prevention in the north of Ireland

Consultation Analysis Report

February 2017

CONTENTS

SECTION 1: INTRODUCTION

1.1 The Department of Health (DoH) has developed and consulted on *Protect Life 2,* a draft suicide prevention strategy for the north of Ireland.

1.2 Formal public consultation was launched on 9 September 2016 with over 800 letters and emails distributed to a wide range of stakeholders including statutory, independent, voluntary and community sector organisations and political representatives. A press release was issued to all media outlets on 9 September to coincide with the consultation launch. Consultation awareness-raising and discussion took place at several events and working group meetings including the Ministerial Coordination Group on Suicide Prevention, the Suicide Strategy Implementation Body, the All Party Group on Suicide Prevention, the Bamford Protect Life and Emotional Health and Wellbeing Group and with the Royal College of Psychiatrists. A range of stakeholder engagement events were also facilitated by the VSB Foundation. In addition, many organisations held their own workshops in order to coordinate joint responses.

1.3 In total there were 104 responses received, several of which were composite responses from multiple organisations. Appendix A shows the list of respondents to the consultation exercise

1.4 This report summarises the responses to the consultation and sets out the Department's response and next steps.

SECTION 2: SUMMARY OF CONSULTATION

2.1 104 consultation responses were received from a broad range of stakeholders including voluntary community/third sector bodies, professional bodies, and public/statutory bodies. 85 of the responses used the standard template provided. Not all respondents chose to respond to every question.

2.2 The consultation responses have very clearly articulated that suicide prevention should be a responsibility for all Executive Departments, not just Health. Given the complex and multi-factorial nature of the drivers for suicide, the future success of *Protect Life* depends upon the success of a range of other Executive Strategies which tackle: equality; debt; homelessness; domestic and sexual violence; victims and survivors of the conflict; impact of crime; drugs and alcohol misuse; prison reform; rehabilitation following psychiatric and prison release; employability; and education and training.

2.3 The *Protect Life 2* consultation focused specifically on crisis intervention and postvention. The Department fully recognises the importance of early intervention to enhance the emotional resilience for people who are at risk of poor mental wellbeing which can increase a person's vulnerability to suicidal behaviour in the face of adverse life events. Accordingly, a positive mental health action plan is under development as a priority and likely to issue at the same time as *Protect Life 2* or shortly after depending on Ministerial views and level of consultation required.

2.4 A number of respondents suggested that the strategy should focus on self-harm as well as suicide prevention

2.5 The Department greatly appreciates the time respondents have taken to reflect considered and very detailed views and acknowledges the genuine willingness across all sectors to work together to tackle suicide. The assessment of responses gives a number of clear suggestions for further development and refinement of the Strategy. In the main those who responded agreed:

- final document should be concise and more reader-friendly;
- greatly decrease the number of actions;

- increase funding;
- set target in line with WHO 10% reduction in the suicide rate;
- more measurable strategy needed to assist with implementation and evaluation;
- training plan needed across all sectors with focus on frontline staff and gatekeepers;
- more focus on the 72% of people not known to mental health services;
- more focus on children and young people required;
- more emphasis on the impact of alcohol and drugs required.

2.6 Many respondents wished for more detail on proposed actions with specific targets and dates for completion. There is a commitment to complete the stated actions within the lifetime of the strategy subject to available funding. Exact timeframes and measurement will be dependent on more detailed scoping as work progresses on the final Strategy. It was widely felt there were too many actions. The Department will give consideration as to how best to link the actions to the objectives and to strike the challenging balance between providing the right level of detail and being overly prescriptive. The actions will require further discussion and significant rewriting.

2.7 Throughout the consultation many comments were made that various sections would have been enhanced by the inclusion of upstream intervention and early intervention work. A Ministerial decision was taken to develop a separate mental health promotion action plan following concerns raised by families about the potential dilution of focus from suicide prevention work and the breadth of the Strategy. This will be discussed again with the Health Minister before writing the final Strategy. Given the very strong view that there are already too many actions in *Protect Life 2,* this would seem to support the decision to separate. There were several comments in this consultation that if the two are separated then they should run concurrently. The Department would be supportive of this position and would endeavour to publish any mental health promotion action plan at the same time or shortly after *Protect Life 2* depending on the level of consultation required.

SECTION 3: SUMMARY OF CONSULTATION RESPONSES TO EACH QUESTION AND DEPARTMENTAL RESPONSE

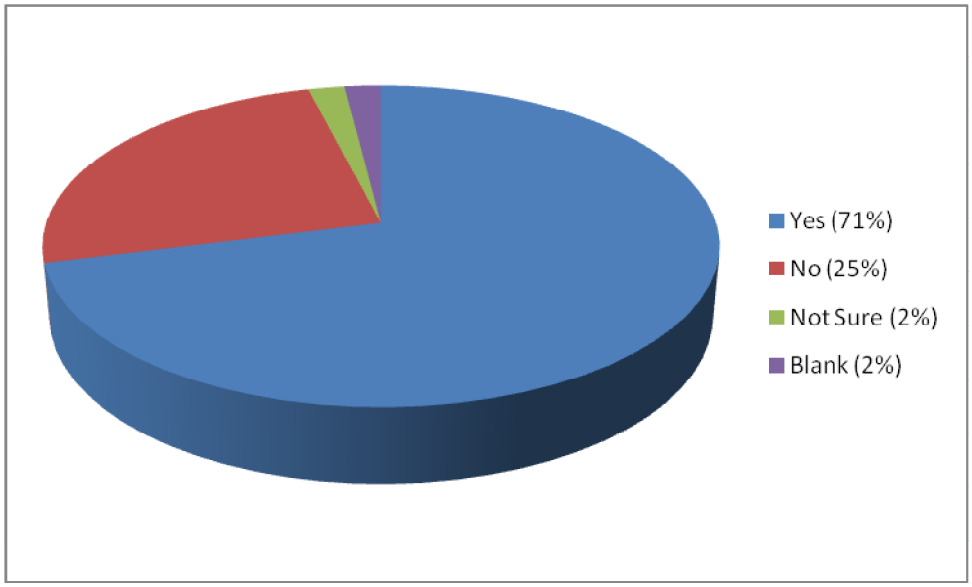
Strategy Purpose

The consultation asked:

Do you agree with the overall purpose of the Strategy? If not, what alternative do you suggest?

The consultation document proposed the following twin purpose:

- Reduce the suicide rate in the north of Ireland
- Reduce the differential in the suicide rate between the most deprived areas and the least deprived areas.



Summary of comments

3.1 There was widespread agreement on the first element, *to reduce the suicide rate in the north of Ireland*. A small number of respondents felt that the stated purpose should be more ambitious and seek to prevent suicide altogether with some suggesting an aspirational target of zero suicide. Still others felt that zero suicide was an unrealistic target and this is elaborated upon on page 6 and page 43. There were several requests for a target to be included to reduce suicide with suggestions for a target in line with the World Health Organization (WHO) recommendation to reduce suicide rate by 10% by 2020. Two responses were received suggesting the rate in most deprived areas

deserved special attention and a separate target should be made to reduce the rate there by 20%.

3.2 There were concerns raised around the second element of the purpose, *to reduce the differential in the suicide rate between the most deprived and the least deprived areas*. Consultees were strongly in favour of the need to focus resources on the most deprived areas given rates are three times higher there than the least deprived areas. However, there was a feeling that the wording was open to different interpretations and could be met by the rate in least deprived areas increasing without any reduction in the most deprived areas. Many respondents preferred a sole purpose of reducing the overall rate of suicide and suggested that a focused reduction in deprived areas should be one of the Strategy's aims. There was also support for a target to reduce the rate of self harm.

3.3 The majority of respondents from a wide range of different organisations expressed strongly that they disliked the crisis focus of the strategy and that prevention and early intervention should be included in the purpose and scope. Of those who expressed this, most noted the intention to develop a separate mental health promotion action plan.

Below are some examples of comments made:
To make the purpose 'to reduce the differential' looks like an attempt by lobbyists to ensure that more funding is focused in the most deprived areas. Worst case it looks like suicides are ok so long as the rate is more equally balanced. If there are more suicides in the least deprived areas to reduce the differential then it will have been achieved – is this acceptable?

The reference to reducing the differential in the suicide rate between the most deprived and the least deprived is potentially misleading because if the suicide rate increases in the non-deprived areas the differential will have been reduced. The target will have been achieved although the suicide rate will have increased. Clearly this is not what the Strategy set out to achieve.

*Overall Purpose **second aspect** - to focus interventions in areas of deprivation: The health inequality in suicide rates persists and is alarming for everyone, especially those working in areas of significant health and life inequalities. Currently the suicide rate in the most deprived areas here is 3 times higher than the rate in the least deprived areas. In relation to self-harm the rate is 4 times higher. It is right that this draft Strategy notes how complex a task this trend would be to reverse (page 19) especially considering issues such as unemployment and community violence*.

Departmental response

3.4 Consideration will be given as to whether to include a target in line with the WHO recommendation of a 10% reduction in the rate of suicide during the lifetime of the Strategy. Consideration will also be given to how best to reflect the desire to reduce the suicide rate in deprived areas which is currently three times greater than in the least deprived and is double the north of Ireland average; and whether a specific target for up to a 20% reduction in the most deprived areas should be set. It should be noted that this would be a very ambitious aim and one which cannot be achieved solely through the *Protect Life 2 Strategy.* The NI Audit Office have previously advised that the suicide rate is heavily dependent upon other Executive Strategies tackling the wide range of factors which impact on the north of Ireland suicide rate including unemployment; legacy of the conflict; low educational attainment; mental health; and drug and alcohol misuse.

3.5 Setting an overall target of zero suicide for the Strategy is considered unrealistic. This may be a practical and obtainable option in a closed healthcare setting but is not appropriate for an overall strategy when only 28% of those that have completed suicide have been known to mental health services in the preceding 12 months.

3.6 Consideration will be given as to whether the overall purpose of the Strategy should include self-harm.

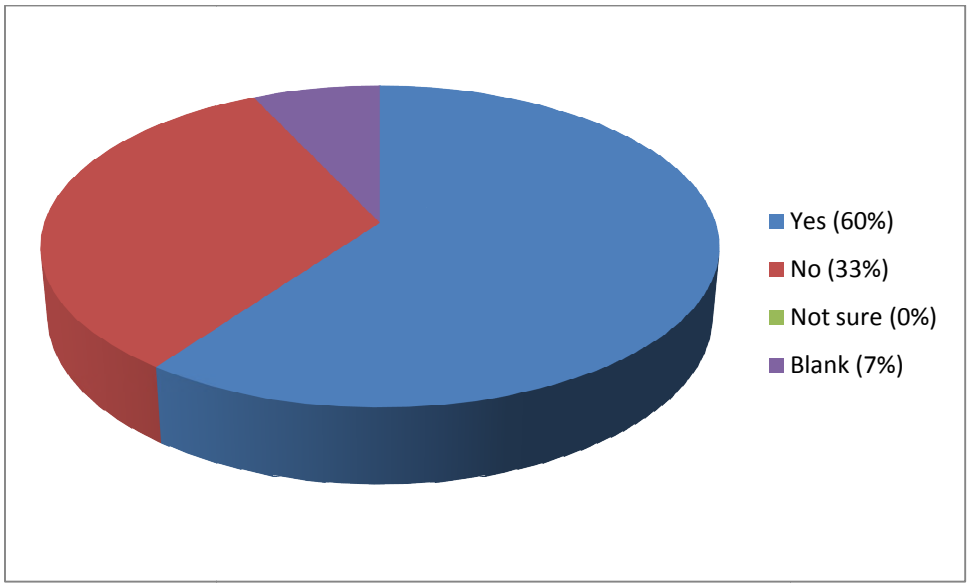
Strategy Aims

The consultation asked:

Do you agree with the stated aims of the Strategy? If not, what alternative do you suggest?

The consultation document proposed the following aims:

- Gain a better understanding of suicidal behaviour in the north of Ireland
- Improve the identification of and response to suicidal behaviour
- Prevent suicide by people in crisis
- Support recovery from suicidal behaviour and repeat self-harming; and
- Support those bereaved by suicide.



Summary of comments

4.1 While there was broad support for the aims set out in the consultation document, there were a number of constructive and well-informed suggestions to enhance this section. Some people felt the aims could be condensed and simplified with the detail included in the objectives. A single aim of reducing suicide and self harm was suggested. There was a strong view expressed that more measurable aims would be welcomed.

4.2 Other views suggested enhancements and supplementary aims. There was a strong view expressed that the purpose of reducing the suicide rate in deprived areas needs to be reflected in the aims. Some felt that the aim should be prevention of suicide by people at risk rather than just those in crisis. Among the additional aims suggested were:

- Promote understanding and reduce incidence of repeat self harming behaviour.
- Build resilience and self esteem, reduce stigma and increase help-seeking behaviours and connectedness.
- Strengthen collaborative and multiagency working across sectors.
- Reduce rate in deprived areas by 20% by 2021.
- Include young people.

4.3 There were a significant number of comments in favour of aims around early intervention and upstream prevention. Many wanted to see more of a focus on families, community and on sectors outside Health such as Education and local government.

Below are some examples of comments made:

Suicide is a family health and community health issue. If this strategy is about prevention it needs to address these issues, otherwise it is simply about reaction, avoiding the truth about family life, community life and the society we live in and placing all the blame on the suicidal person.

This strategy is aimed at intervening when people are in mental distress and suicidal crisis. Its overall aim is too narrow and is not tackling these issues from a much earlier stage, where protective factors could be built to mitigate the risk of crisis behaviour in later life.

The strategic aims must state how the policy will identify, address and mitigate for the impact of the socio-economic differential in suicide rates.

There should be a single aim – to reduce the suicide rates in Northern Ireland.

Attempts to cover a range of issues linked with this provides a lack of clarity and focus and points currently made under aims should be put elsewhere in the document.

Aims of Strategy should focus at reducing the potential impact of suicide. The implementation/objectives will make the difference.

Departmental response

4.4 While 60% of respondents agreed with the aims as drafted, several of the suggestions made would enhance this section. Consideration will be given in redrafting the Strategy to both condensing the aims and setting more measurable targets to inform future evaluation. Reducing inequalities is fundamental to the work of the Department and we agree with comments about the aims needing to better capture the focus on most deprived areas. While this occurs routinely in our suicide prevention work, it is important to reflect and reemphasise this in the Strategy.

4.5 The Department agrees that the aim should include a deep embedded approach towards suicide prevention that involves all nine Executive Departments and the community and voluntary sector. The Department will aim to have a greater focus on children and young people in the final Strategy.

4.6 It is intended to develop a separate positive mental health promotion action plan; this would include specific aims around building resilience, prevention and early intervention.

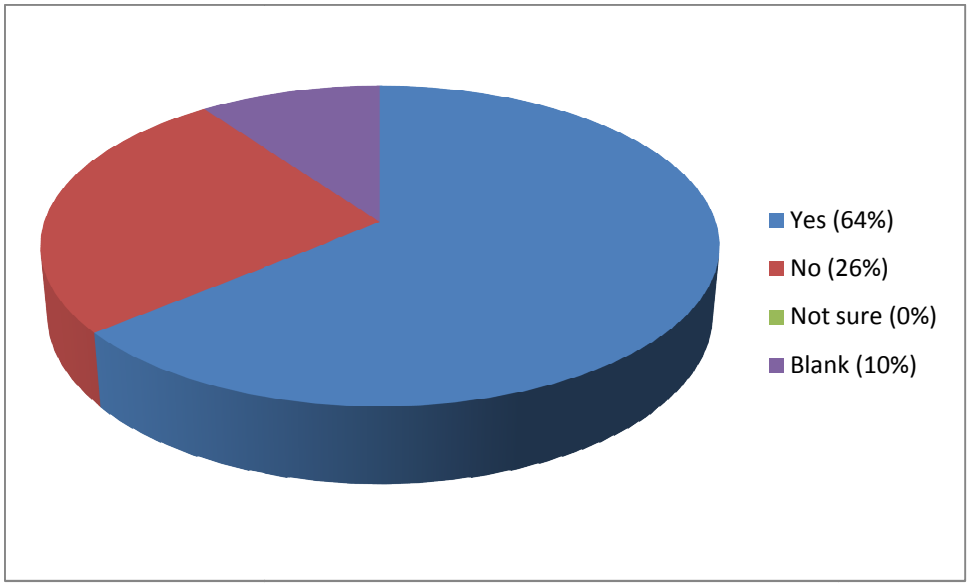
Principles

The consultation asked:

Do you agree with the stated principles of the Strategy? If not, what alternatives would you suggest?

The consultation document proposed the following principles to underline the Strategy:

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



Summary of comments

5.1 There was criticism in relation to the fourth principle about the use of the term 'burden of suicide'. Respondents felt strongly this was an inappropriate term and should be removed.

5.2 There were a number of very helpful suggestions to strengthen the wording and promote ownership and effective partnership and collaboration across Departments and the third sector. Several respondents wished to see robust evaluation of interventions and a solid rationale provided for where evidence was limited.

5.3 A strong view was expressed that the principles should reflect the 72% of people who die by suicide and are not connected to mental health services. Strong preferences were also expressed around the promotion of a person centred approach and one which is informed by lived experience. Several responses requested greater recognition for the community planning role now played by Councils in suicide prevention work. A clear need to fully resource programmes across the lifetime of the Strategy was expressed. A number of alternative principles were also suggested for consideration and are detailed below:

- principles should reflect openness, transparency, honesty and integrity;
- promote help-seeking action;
- include sustainable funding;
- challenge a growing culture of suicide and self harm;
- highlight that prevention of suicide is everyone's responsibility;
- promote person-centred approach;
- effective collaboration between public/private and community and voluntary sectors;
- accountability with clear governance structures and transparency;
- responsive suicide prevention services;
- community involvement and awareness-raising in local communities;
- early prevention.

Below are some examples of comments made:
The principles do not reflect the full enormity of death by suicide to the wider community who are not known to mental health services or who have left the mental health service.

There should be a principle promoting a person centred approach to suicide prevention which recognizes the uniqueness of every individual.

A principle to reflect values of openness and transparency and a principle to reflect values of honesty and integrity.

We would like to reinforce the message about the need for more sustainable funding in the form of longer term funding commitments to the community and voluntary sector delivery partners.

It is important to acknowledge that many people in distress do present in non-health related agencies. Attempts to prevent suicide by people in crisis will require appropriate training for frontline staff in many statutory agency offices.

Challenge a growing culture of suicide and self harm and an acceptance by some that suicide is a valid coping strategy.

Departmental response

5.4 The Department wishes to stress that there was no defamatory intent in using the phrase '*burden of suicide'*. This wording will be removed to avoid further ambiguity. While 64% of respondents agreed with the principles as drafted, several of the suggestions made will be used to enhance this section. The wording will be strengthened to highlight the Department's commitment to strategy delivery. The Department agrees that there is a need to reflect sustainable funding and financial commitment to the Strategy in the principles. The Strategy will also benefit from the promotion and service delivery of a person-centred approach and this will be reflected in the final version. Further consideration will be given as to how best to enhance the focus on the 72% of people not known to mental health services.

5.5 The Department agrees that robust data collection is critical to informing the evidence base and will reflect this in the principles. The Department will reflect on the language used and consider whether this needs to be strengthened.

Priority Groups

The consultation asked:

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

The consultation document proposed the following priority groups:

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

Summary of comments

6.1 A large number of respondents felt that specifying priority groups was unhelpful, stating that suicide is not exclusive to specific population groups and that everyone can be at risk of suicide. There was concern that focussing on particular groups might result in 'lower risk' people being brushed off or overlooked.

6.2 In addition, there was confusion about reference to those with PTSD with some respondents seeking clarification as to whether this referred only to those with a clinical diagnosis.

6.3 While many respondents preferred priority groups not to be included, very many suggested additional groups including:

- those who engage in alcohol or substance misuse;
- those bereaved by suicide;
- children and young people;
- those who self harm;
- those with long term, chronic or terminal illness;
- carers;
- those with physical disability;
- those experiencing relationship break up;
- Black or Minority Ethnic people;
- those with a dual diagnosis;
- those experiencing financial hardship;
- people with eating disorders;
- students especially those geographically relocating;
- ex-prisoners.

Below are some examples of comments made:
EVERYONE is vulnerable to suicide – suicide knows no boundaries and does not discriminate. Labels send wrong messages but boxes send out messages too ie if you are not in this box you are not in the higher risk groups and you may be missed, dismissed or avoided because you are not in the tick box.

Several reports show that patients/service users identified as low risk go on to take their lives – for this reason, the identification of certain people or groups as high risk is not necessarily useful because our understanding and assessment of risk is flawed.

We would prefer no priority groups but recognise that these are needed to streamline resources.

Groups at risk of suicide can change over time and therefore this aspect of the strategy should be kept under review.

There is no group of people regardless of age, gender locality etc exempt from suicide. There is a risk in defining groups in that individuals not belonging to one of those groups will not be considered as at risk of suicide.

Producing a list of priority population groups for suicide prevention can exclude other high risk groups.

WHO recognised the need to identify relevant risk and protective factors and develop strategies at both general populations level and for vulnerable sub-populations and to achieve political commitment to do this.

Whilst we appreciate it is important to start with groupings that are evidently high in risk, we understand that suicide knows no boundaries and can affect many people below the public radar. This is supported by the fact that 72% of those who died by suicide were not known to services.

NICE guidance, NCISH and WHO guidance conclusively advise, based ont he international research evidence, that a comprehensive assessment must include evaluation of the social, psychological and motivational factors indicative of current suicidal intent and hopelessness, as well as full mental health social needs assessment. Furthermore, assessment of risk should not be determined solely on the basis of having self-harmed/ suicide attempt and neither should it be used to predict suicide or self-harm.

Anyone with feelings of hopelessness, frustration, anger etc can be at risk of suicide and may act on thoughts of not wanting to live any more.

Departmental response

6.4 WHO guidance and many suicide prevention strategies identify certain vulnerable groups that evidence has deemed as being at higher risk of suicide. The consultation document was drafted in line with this approach and

attempted to supplement the identified groups with those that are specific to the north of Ireland. Very strong views have been expressed in the consultation and the equality screening document that this was unhelpful and could lead to others at risk not being prioritised. The Department acknowledges that anyone can be vulnerable to suicide. It is also acknowledged that risk factors do not necessarily occur in isolation but can be complex and overlapping. In light of the strong feedback, the Department will redraft this section to highlight that everyone may be at risk of suicide and there are multiple contributing factors and causal pathways to suicide with a range of options for prevention. The final Strategy will reflect Figure 7 in the WHO document *Preventing suicide: A global imperative*[1] which shows the key risk factors for suicide aligned with relevant interventions.

[1] http://apps.who.int/iris/bitstream/10665/131056/1/9789241564779_eng.pdf?ua=1&ua=1

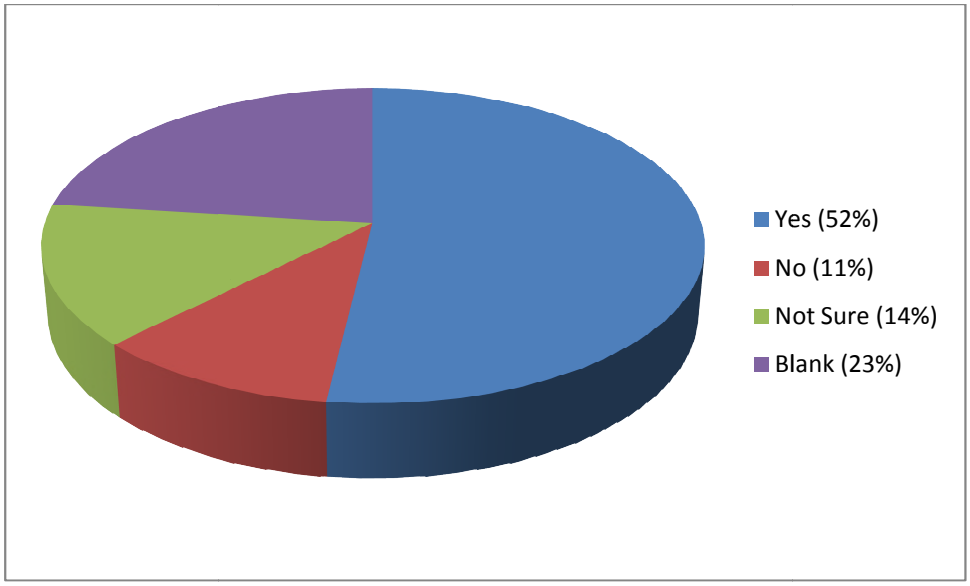
Service Gaps

The consultation asked:

We have identified a number of gaps or services that need to be enhanced. Do you agree with these? Are there any other gaps that you think need to be addressed?

The consultation document proposed suggestions for addressing gaps and/ or enhancing existing services in relation to:

- Lifeline
- Hospital Emergency Departments
- Primary Care
- Support for bereaved families and friends
- Sudden Death Notification Process
- Scene of death
- Self-care



Summary of comments

7.1 Many of the comments in relation to this section closely mirrored or built on those identified in the consultation document.

7.2 There was strong support for a safe place to be piloted that could de-escalate clients presenting in social or emotional crisis, particularly out of hours. The preference expressed was for such a service to run on a 24/7 basis.

7.3 There were a great number of comments advocating for greater primary care suicide prevention training and in particular for this to be made mandatory for GPs. There was a suggestion that all members of primary care should receive training including receptionists and practice nurses.

7.4 Many comments were received in relation to the Sudden Death Notification process. In particular was a preference for these to operate on an opt-out rather than opt-in process for follow-up support. There was a preference for these to capture the contact details of the person who found the deceased if not the next of kin. Respondents wished to see a process set up for revisiting the offer of support at a later time when a family may be more aware of their needs. There was also support for a process for instances where deaths occur outside the north of Ireland but families live here, as these are not currently picked up in the process. Some respondents asked for cognisance of the fact that people in certain areas do not have a good relationship with the police.

7.5 A large number of comments were received in relation to Lifeline calls not being free and associated roaming charges for those living in border areas phoning the service on a mobile. There was strong support for more referrals to take place between Lifeline service and other community and voluntary groups. A small number of respondents wished to see the Lifeline number reduced to 3 digits similar to other emergency services.

7.6 There were several comments in relation to shifting away from a blame culture and improving the system for learning from Serious Adverse Incidents (SAIs) following deaths of people known to mental health services.

7.7 Strong support was reflected in relation to improving self care; making greater use of social media; improved referral pathways so there is no gap in service provision; and a standardised long-term approach to family support.

7.8 Several responses raised issues relating to mental health services, in particular the transition from Child and Adolescent Mental Health Services (CAMHS) to adult mental health services; requests for appointment of a mental health champion; increased availability of psychological therapies; and requests for further information on the proposed Mental Trauma Service.

Below are some examples of comments made:
Provision of crisis houses so that people have an alternative to attending hospital emergency departments.

Through awareness raising we have an ethical obligation to ensure that when we create awareness which creates a demand, its like advertising, this needs to be matched by accessible services.

The lack of any increase in funding to support subsequent service provision at the voluntary and community sector level creates a very real concern for the voluntary and community sector organisations in having the capacity to respond in a timely manner to support the needs of individuals who are at risk of suicide.

An honest review of people's perceptions of services is needed because often when signposting to services we find that it is not stigma which acts as a barrier to people seeking help but rather it is a lack of confidence in services based on previous experience or hearsay.

Departmental response

Safe Place

7.9 There has been considerable support for a crisis intervention centre/ safe place in various parts of the north of Ireland. The consultation document committed to strengthening out of hours capacity to de-escalate individuals presenting in social and emotional crisis. One option is to pilot a safe place. This could tie into current discussions ongoing about the possibility of street triage where there is a joint mental health service and policing approach to crisis care. It would be essential that such a service closely connects to and has effective referral pathways into a de-escalation service such as a safe place.

Progression of a safe place pilot is dependent upon additional resources to implement this service development.

Training

7.10 Recent research supports the consultation comments that primary care is an essential area to target for suicide prevention training. The GP is usually the most recent point of health service contact prior to death by suicide. While a range of primary care training options have been made available through the PHA, uptake has been lower than hoped for in this sector. Further consideration will be given to strengthening training in this sector and the possibility of making training mandatory can be explored with the Royal College of GPs.

Sudden Death Notification Process

7.11 A review is ongoing into the Sudden Death Notification process. Comments received for future development of this initiative have been forwarded to the PHA.

Lifeline

7.12 The issue of roaming charges around border areas is recognised and it is hoped that EU decisions to end roaming charges altogether from 15 June will resolve the issue. The rationale for amending the Lifeline helpline to a more memorable 3 digit number is appreciated, however, this would require considerable rebranding and expense. The risks associated with changing a helpline number for vulnerable people would need to be considered. This is an issue which can be addressed once a decision is taken on the future model of the Lifeline service.

Serious Adverse Incidents

7.13 The Department agrees with the comments around improving the learning from SAIs. Following the Donaldson Review, the Department asked the Regulation and Quality Improvement Authority (RQIA) to undertake a review of SAIs relating to suicide and homicide. This review is expected to report in the very near future and a number of learning points are anticipated for future implementation.

Services

7.14 Comments on mental health services are being addressed by Mental Health and Capacity Unit in the Department (which has policy responsibility for these areas) in line with work to improve mental health services under the draft Programme for Government.

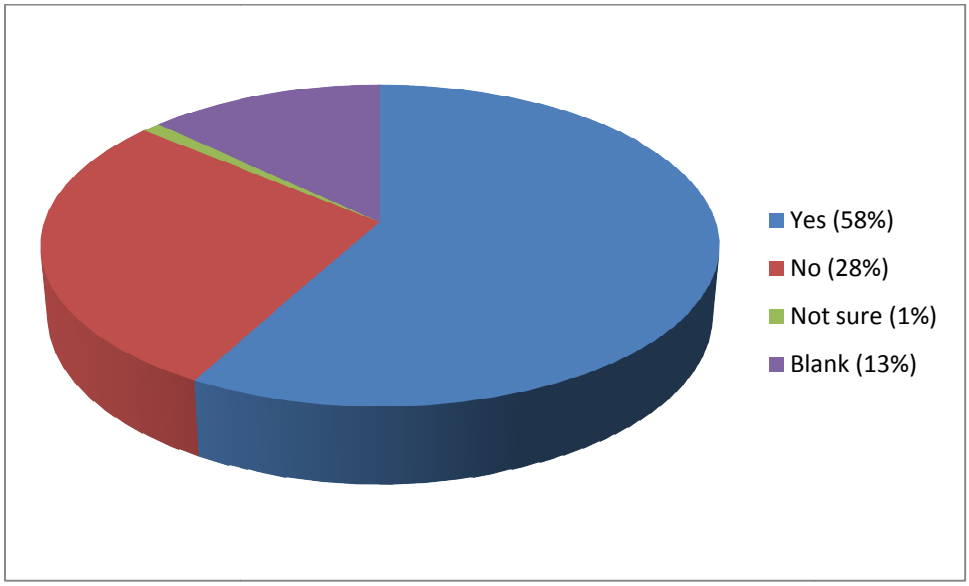
Strategy objectives

The consultation asked:

Do you agree with the stated objectives of the Strategy? If not, what alternatives do you suggest?

The consultation document identified 10 objectives:

1. Fewer people who are in contact with mental health services, die by suicide
2. Reduce the incidence of repeat self harm presentation to hospital emergency departments
3. Improve the understanding and identification of suicide and self-harming behaviour, awareness of self-harm and suicide prevention services, and the uptake of these services by the people who need them
4. Enhance the initial response to, and care and recovery of people who are experiencing suicidal behaviour and to those who self harm
5. Restrict the access to the means of suicide, particularly for people known to be self-harming or vulnerable to suicidal thoughts.
6. Ensure the provision of effective and timely information and support for individuals and families bereaved by suicide
7. Provide effective support for “self care” in voluntary, community, and statutory sector staff providing suicide prevention services
8. Enhance responsible media reporting on suicide
9. Identify emerging suicide clusters and act promptly to reduce the risk of further associated suicides in the community
10. Strengthen the local evidence base on suicide patterns, trends and risks, and on effective interventions to prevent suicide and self-harm



Summary of comments

8.1 While the majority agreed with the objectives as drafted, there were a large number of comments and suggested improvements in relation to objectives 1-5. Respondents broadly agreed with postvention objectives 6-10 with a few suggestions for enhancement.

Objective 1: *Fewer people who are in mental health services die by suicide.*
There was a preference to avoid the use of the term 'fewer' and set a target for reduction. A preference was also expressed for this objective to be set wider than mental health services which only covers 28% of those who die by suicide each year in the north of Ireland. Several views were expressed that it was more important to focus on the 72% not known to mental health services in the initial objective.

Objective 2: *Reduce the incidence of repeat self-harm presentation to hospital emergency departments*.
Several respondents urged caution with the wording of this objective. There was concern that the objective could be achieved if people go on to die by suicide rather than repeating self harm. There was also concern that EDs could discourage those in need from returning to reduce repeat attendance. Respondents felt that a more positive message needed to be conveyed relating to assessment and subsequent support. It was generally felt better to focus on outcomes for the patient rather than

numbers of hospital presentations. Alternative wording was suggested to ensure people have access to assessment and evidence-based interventions to reduce or prevent repeated self harm.

Objective 3: *Improve the understanding and identification of suicidal and self-harming behaviour, awareness of self-harm and suicide prevention services and the uptake of those services by people who need them.*
It was generally felt this objective was overly wordy and should focus on addressing stigma and encouraging help seeking behaviour. A further suggestion was made by several respondents to focus on improving the quality and awareness of self-harm and suicide prevention services and the uptake of these by the people who need them.

Objective 4: *Enhance the initial response to, and care and recovery of, people who are experiencing suicidal behaviour and to those who self-harm*.
Strong support was expressed that this objective should include a target for staff training. Several respondents suggested that a regional training strategy was required to support this objective. A suggestion was made to expand the objective to a commitment to deliver training that is based on the evidence regarding the type of training that works and the training that creates a meaningful change in behaviour and care delivery. Strong support was expressed for additional funding to support the implementation and realisation of this objective.

Objective 5: *Restrict access to the means of suicide, particularly for people known to be self-harming or vulnerable to suicidal thoughts.*
There were a large number of comments in relation to the difficulty in achieving this objective with many expressing a view that it is not achievable. There were several comments about the need for safer prescribing as well as further consideration of availability of over the counter medications. There were comments about the need to better reflect the impact of misuse of drugs and alcohol in this objective.

Objective 6: *Ensure the provision of effective and timely information and support for individuals and families bereaved by suicide*.
There was strong support for this objective. Respondents were keen to see wider recognition that bereavement support may be required in the longer term and not just

in the immediate aftermath. There was also support for suicide bereavement counselling for school personnel.

Objective 7: *Provide effective support for self-care for voluntary, community and statutory sector staff providing suicide prevention services.*
There was very strong support for this objective. Respondents were keen to see this implemented with additional resources for the community and voluntary sector who may find it difficult to provide self care opportunities for employees and volunteers.

Objective 8*: Enhance responsible media reporting on suicide.*
There was very strong support for this objective. There is a need to attain a balance between what is newsworthy and what is safe to publish. Respondents were keen to see social media covered in the media guidelines in future. Several views were expressed that the media guidelines should be made compulsory for media outlets to adhere to.

Objective 9: *Identify emerging suicide clusters and act promptly to reduce the risk of further associated suicides in the community.*
There was strong support for this objective.

Objective 10: *Strengthen the local evidence base on suicide patterns, trends and risks, and on effective interventions to prevent suicide and self-harm.*
There was strong support for this objective. A view was noted from several respondents that future research should not just be academic in nature as so much knowledge and experience has been developed at a community level; qualitative as well as quantitative research would be valuable.

8.2 A few suggestions were also made for additional objectives. In particular was a preference for one around positive mental health; and one on clear pathways for movement of clients between points of support with improved communication between all agencies to improve outcomes.

8.3 Several comments were received that consideration should be given to making the objectives in the final strategy more strategic. Views were also expressed that the objectives need to better reflect the purpose of the strategy and focus

on deprived areas. There was also a common view that the objectives needed to be more SMART with measurable timescales and outcomes.

Below are some examples of comments made:

The first statement: "Fewer people who are in contact with mental health services, die by suicide" this accounts for 28% of the people who die by suicide. We believe the first objective should be aimed at the 72% of people who die by suicide and who are NOT known the mental health services, as this is primarily what the Protect Life strategy was set up to address."

We feel there should be higher level strategic objectives.

These objectives are focused on what others can do to prevent suicide which we believe fails to recognise the point of suicide being a decision of the individual. A crucial objective should be developing resilience, coping strategies and normalising help-seeking behaviours within the population – especially at the pre-crisis level. The Strategy is therefore missing the opportunity to 'help individuals to help themselves and give them control over their own lives.

Restrict access to the means of suicide particularly for people known to be self-harming or vulnerable to suicide thoughts is a formable objective, but we are unsure if it is a realistic objective.

Many of the objectives outlined place the responsibility for the reduction in suicide firmly within the remit of Health and Social Care. This is detrimental to the success of the strategy as it reinforces the notion that suicide prevention is solely a Health and Social Care issue.

The objectives refer to suicidal behaviour, however we know that suicidal thoughts are often a precursor to behaviour and that we can pretext suicide by asking about suicidal thoughts in primary care, and in other contexts. Therefore people with suicidal thoughts should also be a target of the strategy.

Departmental Response

8.4 While respondents were broadly in agreement with the objectives, a number of very helpful suggestions have been made to enhance this section. In particular, the Department will reflect on the many suggestions made to the first five objectives.

6.5 Objective 1: the Department will consider setting a target for reduction and widening the focus beyond the 28% of people known to mental health services.

8.6 Objective 2: a rationale for tackling repeat self harm specifically was due to the high numbers in this category. However, the Department agrees with many of the comments received there is a risk of misinterpretation of this objective and not enough focus on those who only self harm once. This will be redrafted to focus more specifically on service provision and patient outcome.

8.7 Objective 3: will be redrafted with a greater focus more specifically on planned anti-stigma work and on improving quality and awareness of suicide prevention and self harm services.

8.8 Objective 4: the Department agrees with the comments made. A baseline target will be set in the 2017 Commissioning Plan Direction for the HSC in relation to suicide prevention training. This will be increased each year to redouble efforts to promote HSC staff training. The Department is in agreement with the need for a wider regional training strategy for suicide prevention and recognises that funding is required across sectors to support this.

8.9 Objective 5: Restricting access to means has one of the strongest evidence bases for success in suicide prevention globally. The Department recognises that in many instances it is very difficult to achieve, particularly where suicides occur close to home or involve easily obtainable medications or substances. A significant amount of work has been undertaken to date to meet this objective where possible in relation to safer custody settings and through legislation relating to paracetamol. It is also important to keep under regular review the methods used in recent suicides in case action can be taken to restrict access where there are novel or unusual methods being employed. The Department

prefers to retain this objective, recognising the considerable difficulty in implementation in many situations, and will seek to reflect the points made in the final strategy.

8.10 The minor changes suggested for objectives 6-10 will be made. As the Samaritans currently produce the media guidelines, the Department will discuss with them in the first instance how best to achieve commitment to adherence to the media guidelines.

Action Plan

The consultation asked:

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

Summary of comments

9.1 There was a very clear view expressed that there are too many actions specified in the action plan. Several respondents wished to see the action plan drafted at a higher, more strategic level to accomplish a reduction. There was a preference for the redrafted action plan to have more explicit targets and measurement to assist with strategy evaluation. A clear view was conveyed that the action plan should include all partner organisations and not just the identified lead or commissioning lead. In particular, was a wish to see greater visibility for the third sector and District Councils in partner organisations.

9.2 It was noted widely that there was a shortage of actions relating to other Departments which gave the Strategy an overly health focused feel. While several respondents wished to see more actions relating to early intervention it was noted that a positive mental health promotion action plan was a specific action. A view was expressed that the revised strategy should include a comprehensive reference at the beginning to the importance of early years and how this can in turn lead to self harming and suicidal behaviour. A strong view was noted generally for more reference to children throughout the action plan. There was also a strong preference for resourcing commitments to be articulated in the final action plan.

9.3 Some key points are noted below which received considerable support in the consultation:

- greater focus on the 72% who are not known to mental health services;
- self harm actions should be wider than just Emergency Departments;

- action needed to promote uptake of recovery programmes;
- better articulation of future Mental Trauma Service;
- focus for counselling support in schools should not just be on post-primary;
- remove references to Foyle Bridge;
- more actions around social media;
- support for data linkage studies;
- include international research as well as local.

Below are some examples of comments made:
The number of actions related to the objectives (65) is considered excessive and may detract from the focus on the local multiagency Protect Life Implementation groups. A number of actions could be set, with others flexible enough to reflect local needs. Each local PLIG should be able to take the objectives and a number of actions (12-15 max) and translate those into local plans based on the needs of local communities.

Protect Life 2 should be a higher level strategic document containing a key aim, clear objectives and expected outcomes. The development of a subsequent action plan should be the responsibility of local PLIG groups taking a multi-agency approach that takes into account ongoing work in response to other strategic drivers and commissioning processes. The current action plan within the document contains many actions that are difficult to measure and there is an absence of performance indicators.

There is little reference to the role of 3rd sector organisations that have played a vital role to date in suicide prevention in Northern Ireland. We feel this is a grave oversight and will have a detrimental effect in moving forward into the next phase of Protect Life.

The principles for the strategy imply a level of cross sectoral and cross departmental collaboration which is not reflected in the action plan.

The actions are very health focused with only 7 out of 63 not including a health service body as lead organisation.

Departmental Response

9.4 There is a challenging balance to strike between providing the right level of detail and being overly prescriptive. While many people wished to see more detail around financial commitment and timescales in relation to the actions outlined, the very strong view from the consultation was that the number of actions should be reduced. There are a number of ways in which we will consider achieving this. One way would be to include a series of commitments similar to that outlined in the Scottish Strategy and leave the detailed action plans to be developed by the PHA and local Protect Life Implementation Groups (PLIGs). Another way would be to raise the actions to a more strategic level with much of the detail taken out. Further consideration will be given to this.

9.5 The Department recognises that there was insufficient appreciation of the vital role of the third sector in delivering the community led suicide prevention strategy. This arose from a decision to only name the lead organisation which in many cases was the commissioner. The role of all partner organisations will be reflected more fully in the final strategy.

9.6 The actions section will require significant rewriting. The Department agrees that the draft was overly health focused and will again engage with other Departments to seek commitment to greater cross-government delivery and investment in the Strategy.

9.7 The proposal to have a central steering group to oversee the Strategy was widely welcomed to enhance governance and delivery however, there were a number of comments that this group should be chaired independently to avoid any conflict of interest. The PHA commissions *Protect Life* services and it is normal practice for that organisation to retain governance and accountability responsibility. The challenges involved in managing demand-led services within a set budget underline the need for future robust governance arrangements through a steering group.

9.8 The Department accepts that resourcing commitments should be articulated in the final action plan. The Department currently invests £7m annually in suicide prevention services. Funding sources for new actions will need to be identified. The pace at which actions can be progressed will be determined by the availability of finance and the approval of business cases

Monitoring and evaluation

The consultation asked:

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

Summary of comments

10.1 There was very strong support for either a strategy with outcomes based accountability or alternatively SMART targets which can be used to evaluate the success of the strategy. A target which would help to achieve a 10% overall reduction in the suicide rate was strongly supported. Wide support was also noted for close read across to Programme for Government suicide prevention indicators. It was also highlighted that these need to reflect the focus on deprived areas and final agreed purpose of the strategy. A wide range of potential indicators were suggested for consideration including:

- reduction in numbers of suicides/ suicide rate;
- reduction in self harming;
- increase in number of quality support services available;
- work achieved against high level action plans;
- numbers trained;
- beneficiary satisfaction levels;
- numbers offered/ accessing services;
- evaluation of services offered;
- reduction in stigma;
- PLIG reports on implementation;
- reports on services provided or effectiveness of services.

10.2 There was strong support for regular published reviews of Strategy implementation.

10.3 There were several comments in relation to the need for a separate independent monitoring body which would assist with evaluation. The

Regulation and Quality Improvement Authority advised they would be keen to be involved in monitoring the Strategy.

Below are some examples of comments made:
We would ask that evaluation takes place at the macro level. The fundamental question that needs to be considered is 'Is the Strategy working?' if there is no distinct reduction in deaths – and there should be inclusion of a target such as the 10% (WHO target) or 20% (Scottish Government) – then we would conclude that the strategy is failing to deliver the stated aim.

An evidence based accountability approach to the monitoring and progress development of the strategy would be welcomed. It will be important for those working in this field to be clear on who has overall responsibility for ensuring the monitoring and effectiveness of the strategy.

It is essential that the oversight of the strategy is deemed independent from the governing body which as discussed at consultation and as stated in the plan, it currently is not.

Having an independent monitoring and evaluation agency should be considered as a key component of the strategy.

Match a set of clear, concise and measurable objectives to the aims of the strategy.

Measurement, review and evaluation must be outcome-focused and should embrace the engagement of service users and potential service users, service accessibility and uptake, the professional engagement of health and social care staff, service quality and patient experience, together, most importantly, with a quantifiable and sustainable reduction in suicide and related episodes.

Departmental Response

10.4 The Department greatly appreciates the wide variety of suggestions made to enhance future monitoring and evaluation of the Strategy. While *Protect Life* was evaluated in 2012 it is felt that monitoring and evaluation was a relatively

weak component of the original strategy and that this could be strengthened considerably in *Protect Life 2*.

10.5 To produce a strategy based in full accordance with an *Outcomes Based Accountability* (OBA) approach would require a fresh start and fresh engagement as OBA requires that the desired outcomes are agreed first and that indicators for measuring progress against these outcomes are then agreed (assuming the data are available) and developing a thorough common understanding of what is driving the indicators i.e. “the story behind the baseline” – which, at present, is not well known in relation to suicide. In practical and resource terms it is not feasible to start afresh and develop a new strategy using the OBA approach.

10.6 The Department agrees that there should be regular published reviews of strategy implementation. Discussion will take place with the PHA as to how best to deliver this.

10.7 The Department recognises the need to have an independent monitoring body to scrutinise and provide external recommendations and assurance. RQIA reviews provide assurance to the public about the quality, safety and availability of HSC services in the north of Ireland. The Department will therefore ask RQIA to review the implementation of the *Protect Life 2* Strategy and provide this independent monitoring function.

Awareness Raising

The consultation asked:

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

Summary of comments

11.1 Some concern was expressed that the question posed was poorly worded and focused on advertising negative perceptions to already at-risk individuals. Some felt that raising awareness of suicide risked encouraging "copycat" behaviours.

11.2 Several respondents proposed an advertising campaign with a bereaved family speaking openly about suicide and of their devastation at the loss of a loved one while also encouraging helpseeking. It was recognised that such an approach would take a very courageous family member who had reached an advanced stage of their own personal healing. One respondent suggested a public campaign focus on the WHO report *Preventing Suicide, a global imperative: Myths*[2] highlighted in the consultation document. One respondent suggested there was a need to tackle the cultural issue of acceptability versus the finality of suicide to counter the growing mythology of suicide as a means to address short term problems.

11.3 There was overwhelming support for the PHA-run mental health adverts of recent years and for the recently launched anti-stigma campaign. Several respondents wished to see increased focus on building resilience in individuals and communities, lifeskills, relationships, activity, occupation and leading meaningful lives in future positive mental health awareness raising. There was strong support for existing work by PHA on awareness-raising with a range of community groups including sports clubs, young farmers, churches, and youth clubs. Several respondents wished to see a communications plan developed under the next strategy

[2] http://www.who.int/mental_health/suicide-prevention/myths.pdf?ua=1

11.4 Several respondents highlighted the need for caution in awareness-raising activity if services are not immediately available and there are waiting lists. This underlined the need for clear pathways and investment to ensure existing services are operating effectively.

11.5 The importance of training in raising awareness was consistently raised. In particular was the need for training for frontline staff in the HSC; teaching staff; and the range of community gatekeepers. Many positive comments were received in relation to PHA and Samaritans work with media and journalism courses to train people to report responsibly.

11.6 There was widespread support for more awareness-raising to take place in the school setting to build resilience and promote mental and emotional health and wellbeing. It was recognised that Department of Education and the Education Authority would have a lead role in driving this forward. It was widely felt that there would be considerable long term benefits in targeting children through awareness-raising. There was recognition that communications need to include a wide variety of media such as social media, apps and live webchats especially for children and young people.

11.7 There was strong support for greater use of high profile patrons or well respected individuals to deliver messages and raise awareness. It was also felt that such individuals could help people to focus on their potential and to encourage them to access services.

11.8 Many respondents highlighted the benefits of greater awareness-raising with captive audiences for example in bus stations, trains, cinemas, primary care, opticians and pharmacies.

11.9 Greater integration with Councils through their community planning function was also noted as contributing to awareness-raising and should be given prominence in the final Strategy.

11.10 There was support for targeted awareness-raising for specific communities of interest such as LGBT and Black and Minority Ethnic Groups (BME).

11.11 It was suggested that a training and accreditation system for organisations working in this area will help promote suicide prevention and communicate about suicide in an appropriate manner.

Below are some examples of comments made:

There is no better way to raise awareness than through schools, but this has to be more than awareness raising. Effective education involves developing understanding, pupil agency, coping skills, resilience, reporting, peer support etc.

We are all aware of the effectiveness of the road traffic accident advertisements on our TVs in the reduction of deaths due to road traffic collisions. We would propose a softer approach to advertisement, for example, a mother, father, brother, or sister speaking on the devastation on the loss of their loved one to suicide, encouraging people to seek help. The only reference to suicide is the word; there is no need to state methods or anything personal to the family.

Consideration should be given to changing the emphasis to enhance resilience and life-skills rather than focusing on suicide in itself.

We need to cut back on awareness raising as we are putting people at risk. The barriers faces by clients and the community services before they can even be seen is putting people at risk. Why raise awareness to basically disappoint people seeking help.

We believe suicide reduction initiatives should be focused on the benefits of help seeking behaviour and the ease of finding services appropriate to an individual's need, encouraging people that they can access support to help them cope/take control of their lives again.

Venues where captive audiences meet should be considered as they could also run educational videos such as bus stations, GP surgeries, dentists, opticians, trains etc

Raising awareness about suicide, suicide ideation, suicide behaviour and self-harm

should take a more targeted approach focusing on high risk groups more vulnerable to suicide. A population approach focusing on positive mental health, how to keep well and help seeking behaviour may be a more appropriate approach in general.

Education to address...cultural issue of acceptability versus the finality of suicide as a life choice need to be addressed in a hard hitting manner to counter the growing mythology of suicide as a means to address short term problems.

Departmental Response

11.12 The approach to date on awareness-raising around suicide prevention has always been in line with the evidence available. It is essential that all public campaigns and planned awareness-raising is rigorously tested and evaluated to avoid any unintended messages or outcomes. The Department will keep the evidence under review and the PHA will consider the possibility of a future campaign along the lines suggested with a bereaved family.

11.13 Further discussion will take place with the Department of Education around the possibility of future investment and development of both training and awareness-raising in the school setting, recognising the importance of having young people give their opinion on what works best for them

11.14 A large number of very helpful comments have been received in relation to potential areas for targeting and enhancing communications in the next strategy and we would support the call for a robust communications strategy in implementing *Protect Life 2.*

11.15 It is anticipated that the quality standards developed by PHA will go some way to addressing concerns raised around standardisation and appropriate promotion and communication on suicide prevention issues.

Other issues raised

The consultation asked:

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

12.1 There were a number of recurring themes which were highlighted under this section which are covered below.

Self Harm Intervention Project (SHIP)

12.2 Many respondents advised they did not feel this service was working optimally and there was significant room for improvement. Considerable frustration was expressed at the many changes to the referral criteria since the service was initiated. There was a strong view that the supporting family was largely excluded from the process and given insufficient consideration. Several respondents felt that the criteria should be amended to allow providers to work with individuals and families rather than wait until they present with self-harm. Several respondents advised there was a gap in relation to suicidal ideation. There was support expressed for community and voluntary groups funded through *Protect Life* to be able to refer to SHIP services. There was also support expressed for self referral to SHIP. Several respondents referred to relatively low uptake of SHIP services in their area and the need to remind unscheduled care teams of the service. Concerns were expressed about clients who decline SHIP service and how these instances are followed up.

Departmental Response

12.3 These comments have been passed to the Public Health Agency who commission the service. This is an essential service which has great potential to improve the response to self harm in the north of Ireland and the Department is keen to see it working to potential.

Funding

12.4 Several comments were made that the £7m budget is insufficient to meet the service enhancements suggested within the consultation document. There was also concern expressed about the pressure that community and voluntary groups were under to meet existing service demand. Other comments focused on the requirement for longer term sustainable funding.

Departmental Response

12.5 The Department currently invests £7m annually in suicide prevention services. Funding sources for new actions will need to be identified. The pace at which actions can be progressed will be determined by the availability of finance and the approval of business cases

Streamlining working groups

12.6 A large number of comments were received that there are too many similar working groups on suicide prevention and these should be streamlined. A recurrent comment was: "*Isn't it just all the same people sitting around a different table discussing the same things?"* Respondents were keen to see structures revised to provide transparency and clarity.

Department Response

12.7 The Department agrees with the need to streamline the *Protect Life* groups. There is an opportunity under the new Strategy steering group to link all stakeholders together through collaborative approaches and to develop a series of working groups which could consider specific areas of work needing development. In particular, data linkages, communications, zero suicide, and training would be possibilities to consider. One suggestion was made that SSIB should instead become the steering group, however, the Department considers that the commissioner, in their position as the accountable budget holder, needs to maintain this role.

Zero suicide

12.8 There were mixed comments in relation to this initiative. Two HSC Trusts indicated support for implementing zero suicide as a pilot in the mental health setting. Some comments suggested agreement with the overall initiative however concern about the public perception and understanding of the title. There were several comments expressing concern with the notion that driving suicides to zero in the north of Ireland was a realistic ambition. One response noted the need to fully support staff who are already working under considerable pressure if this model is implemented.

Departmental response

12.9 Discussion will take place with mental health leads in the Department about establishing and funding a zero suicide pilot in at least one HSC Trust. The Department acknowledges there is considerable learning to be gained from existing pilots and is keen to build on this in local settings. The Department appreciates there is some concern around the term ‘zero suicide’ and this will be reflected on going forward. However, a goal of zero suicides in mental health settings seems ambitious but reasonable and achievable. The Department recognises the benefits of closer linkages to other regions, such as the Merseyside Care NHS Trust, where similar initiatives are currently being implemented, and from a potential change in mindset that suicide is preventable.

Legislation

12.10 There were three issues raised under proposed suicide prevention legislation: mandatory training; patient client confidentiality; and the duty to cooperate across HSC and Justice sector.

12.11 There were several responses asking for suicide prevention training to be made mandatory particularly for teachers, and frontline HSC staff.

12.12 A number of responses alluded to patient confidentiality precluding clinicians from sharing vital information with families. Several respondents felt that better and more timely communication needed to be made between clinicians and families to make them aware of suicidal thoughts of loved ones.

12.13 One response pressed for legislation in relation to a duty to cooperate across all HSC and Justice sector provision.

Departmental response

12.14 As outlined earlier in the document, the Department agrees that frontline and gatekeeper training is a priority and targets will be set in the Commissioning Plan Direction and raised annually for frontline HSC staff. Engagement will take place across the Executive to develop a widespread training programme on suicide prevention and promoting mental health. Laws were passed in some States in the USA making suicide prevention training mandatory for teachers. This was in response to a number of specific instances on suicide amongst school children.

12.15 The issue of patient confidentiality is not unique to suicide prevention nor is it unique to the north of Ireland. Similar concerns were raised with Department of Health in England resulting in the Information Sharing and Suicide Prevention consensus statement: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/271792/Consensus_statement_on_information_sharing.pdf

The consensus statement says: *"We want to emphasise to practitioners that, in dealing with a suicidal person, if they are satisfied that the person lacks capacity to make a decision whether to share information about their suicide risk,* ***they should use their professional judgement to determine what is in the person's best interest."***

The Department is not in favour of legislating on this issue however would be content to engage with the relevant professional bodies to develop something similar in the north of Ireland to bring clarity to this issue.

12.17 The feasibility for a legislative duty to cooperate will be discussed further with the HSC and Justice sector however the Department could not find any evidence of the impact of this legislation on suicide rates. Policy work has commenced to establish a statutory duty of candour for the HSC.

Proposal for The Executive Office to lead Suicide Prevention Strategy

12.18 Two responses were received supporting the future Strategy to be led by the Executive Office rather than the Department of Health, the rationale for this proposed change being the many factors which influence the suicide rate and are beyond the scope of *Protect Life*; and that it would bring a more co-ordinated approach to cross government working and a move away from suicide being perceived as a Health issue.

Departmental response

12.19 The Department appreciates the rationale for this suggestion which was discussed at the inception of the original *Protect Life* Strategy. This proposal will be tabled for discussion at the next Ministerial Group on Suicide Prevention.

Misuse of Drugs and Alcohol

12.20 Several respondents referred to the importance of close linkages with drug and alcohol strategies. The use of drugs or alcohol is strongly associated with suicide and self harm in the general population. Dual diagnosis (co-morbidity of drug and alcohol misuse and mental ill health) is associated with increased risk of suicide and suicide attempts.

Departmental Response

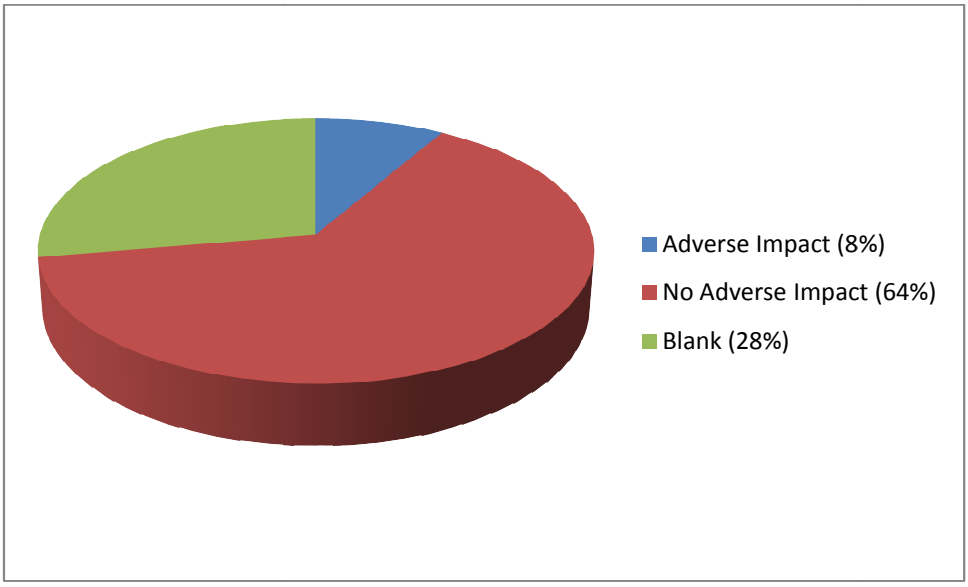
12.21 The *New Strategic Direction on Alcohol and Drugs Phase 2* recognises this association and sets out the framework for reducing alcohol and drug related harm. The Department will ensure this work continues to be built on in policy development, implementation and commissioning.

SECTION 4: EQUALITY IMPLICATIONS

Equality Question 1

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

If Yes, please state the group or groups and provide comment on what you think should be added or removed to alleviate the adverse impact.



13.1 83 respondents answered the question in their consultation response. 8% (7 respondents) felt there would be an adverse impact. 64% (53 respondents) felt there would not be an adverse impact. 28% (23 respondents) of responses were left blank.

13.2 Some respondents highlighted that using priority groups could potentially miss those most vulnerable and advocated for an inclusive approach instead. There was also a tension in relation to the focus on higher male suicide rate which could create an adverse impact on females. The focus on males aged 19-55 was also felt that it could create an adverse impact on children. Several respondents advocated for specific actions to cover the highlighted priority

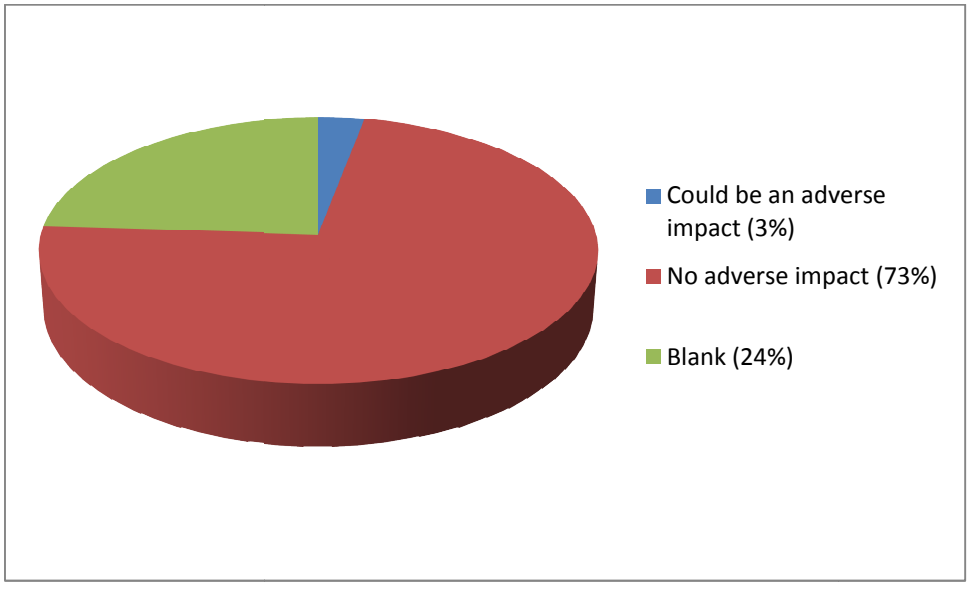
groups. It was also highlighted that specific services need to be in place for minority groups especially those whose first language is not English.

Equality Question 2

Are you aware of any indication or evidence – qualitative or quantitative – that the actions/proposals set out in this consultation document may have an adverse impact on equality of opportunity or on good relations? If yes, please give details and comment on what you think should be added or removed to alleviate the adverse impact.

13.3 82 respondents answered the question in their consultation response. 3% (2 respondents) felt there could be an adverse impact on equality of opportunity or good relations. 73% (60 respondents) felt there would not be an adverse impact on equality of opportunity or good relations. 24% (20 respondents) of responses were left blank.

13.4 Respondents asked the Department to ensure that the Human Rights in Emergency Departments report is referenced and the associated actions highlighted or addressed. It was felt that greater reflection of the key role of the community and voluntary sector as partner organisations needs to be made in both the screening document and Strategy. It was also felt the issue of language barrier, particularly for people whose first language is not English needs to be reflected in the Strategy and screening document.



Equality Question 3

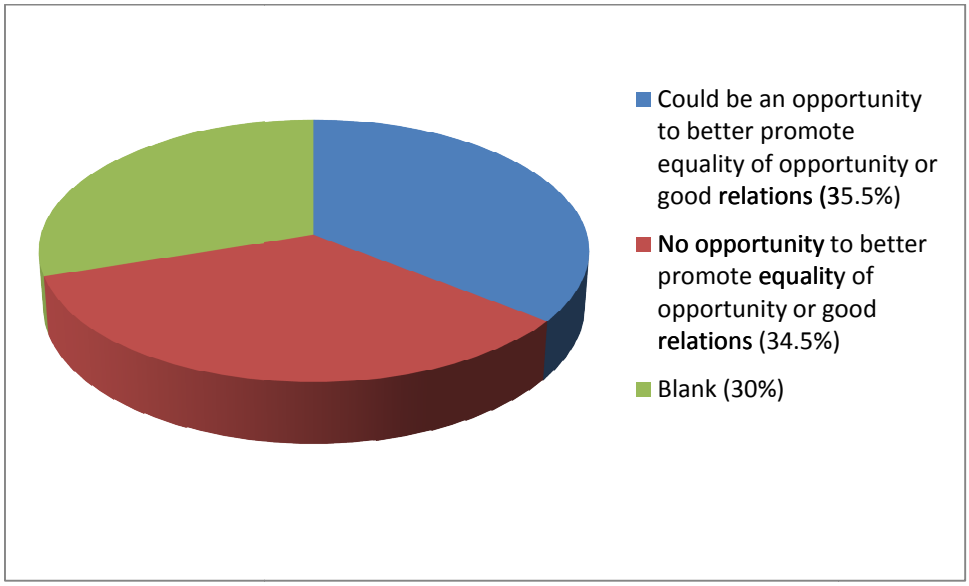
Is there an opportunity for the draft Strategy to better promote equality of opportunity or good relations?

If you answered yes to this question, please give details as to how.

13.5 79 respondents answered the question in their consultation response. 35.5% (28 respondents) felt there was an opportunity to better promote equality of opportunity or good relations. 34.5% (27 respondents) did not feel there was not an opportunity to better promote equality of opportunity or good relations. 30% (24 respondents) of responses were left blank.

13.6 Several respondents felt the Strategy was overly HSC focused and needed to highlight the role of Council community planning and the Community and Voluntary sector to promote good relations. There were a number of issues in relation to mental health services that were raised including an improved care pathway from CAMHS to adult mental health services; appointment of a mental health champion; and development of a 10 year mental health strategy.

13.7 Several respondents highlighted that services targeting specific higher risk groups would promote equality of opportunity and in particular the LGBT population. It was felt that providing greater clarity around cross-departmental actions and cross-sectoral and cross community working would also promote good relations and equality of opportunity. One respondent referred to the need to engage the least deprived who face different challenges such as exam stress, pressure to attend university and to maintain a particular lifestyle.



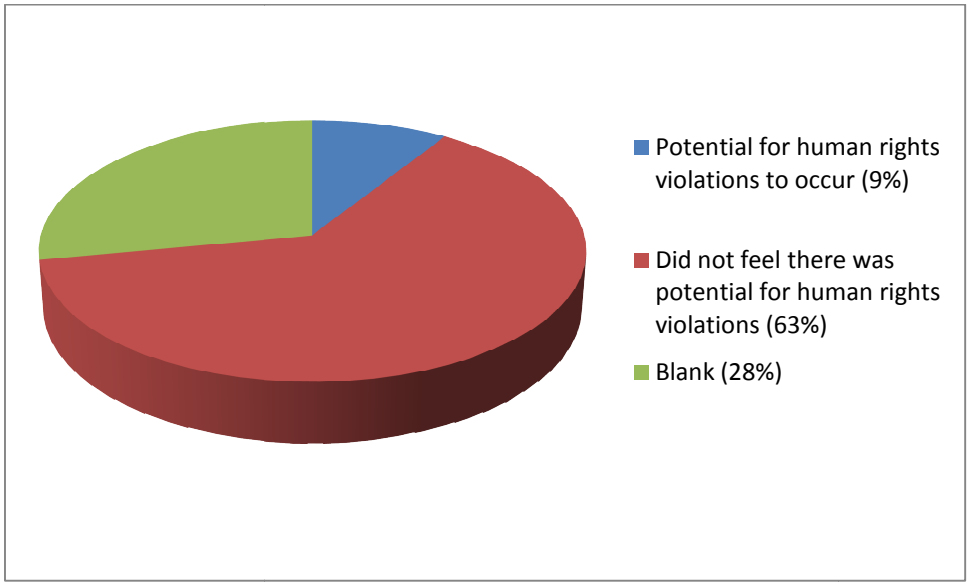
Equality Question 4

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

If you answered yes to this question, please give details as to how.

13.8 80 respondents answered the question in their consultation response. 9% (7 respondents) felt that there was potential for human rights violations to occur. 63% (50 respondents) did not feel there was potential for human rights violations. 28% (23 respondents) of responses were left blank.

13.9 Some respondents felt potential existed for human rights violations in relation to media reporting and there was an inherent tension with privacy rights. Several respondents felt there could not be a neutral impact in respect of the liberty and security of a person. In particular instances where an individual may be detained under the terms of mental health legislation may result in a restriction of their right to liberty were highlighted. One respondent highlighted that failure to provide services within appropriate timescales could also create potential for human rights violations. One respondent asked that the Department consider amending the strategy to include explicit references to its human rights obligations.



Departmental Response

13.10 The Department will review the screening document and amend accordingly to take into account the various points raised. Following this, the Department will review whether a full Equality Impact Assessment needs to be undertaken in relation to the Protect Life 2 Strategy. Various case law was referenced in some responses and the Department will also wish to review the learning from these to inform screening decisions.

SECTION 5: CONCLUSION, NEXT STEPS AND WAY FORWARD

14.1 Having considered the responses received, the Department will now consider the necessary amendments to the final Protect Life 2 Strategy. Ministerial decisions will be taken on some of the key points arising from the consultation around: a separate positive mental health action plan; future funding; safe place pilot; zero suicide pilot; and future targets.

14.2 The final Strategy and Action Plan will be submitted for Executive approval by the Minister for Health.

14.3 We would like to thank all of those who have contributed to the development of this strategy and action plan. The views shared have been extremely useful and we hope that this engagement will continue as we embark on the next phase of this important area of work.

Appendix A

List of Respondents to Consultation

No	RECEIVED FROM
1	NICCY
2	Stamp Out Suicide
3	Garvagh response (various)
4	East Belfast Community Development Agency
5	Various North and West Belfast clubs
6	Zest NI
7	Suicide Down to Zero
8	Network Rail
9	Stranmillis University College
10	Niamh Louise Foundation
11	Health and social Care Board, Mental Health Director
12	Police Rehabilitation and Training Trust
13	Community Wellbeing Alliance
14	Dungannon Youth Resource Centre
15	Institute of Public Health
16	Ards and North Down Borough Council
17	PIPs Newry and Mourne
18	Newlife Counselling
19	NIPEC
20	Armagh, Banbridge and Craigavon Borough Council
21	Beakthru, Dungannon
22	Mental Health Foundation
23	NICCY
24	PIPS Upper Bann
25	Belfast City Council
26	Dept. for Infrastructure
27	Nexus NI
28	Diana King

29	Shankill Suicide and Self harm Reference Groups
30	RCPsych
31	COSTA Rural Support Network
32	EBCDA
33	Zest NI
34	South Belfast Sure Start
35	College of Occupational Therapists
36	Zest NI
37	Rural Support Network
38	HFT Community Counselling
39	Mindwise
40	Alva Cudden, Outreach Counsellor
41	Reverend Andrew Balding
42	Cruse Bereavement Care
43	BACP
44	Lighthouse
45	Samaritans
46	Belfast Health and Social Care Trust
47	RQIA
48	Chinese Welfare Association
49	Health and Social Care Board
50	Inner South Belfast, Shaftesbury Recreation Centre
51	National Childrens Bureau
52	NIASW
53	RCPCH
54	CUNAMH
55	Relate NI
56	Barnardos
57	Families Voices Forum
58	AWARE NI
59	Belfast Alliance
60	Autism NI
61	Newry Rainbow Community
62	Southern Area PL Voluntary and Community Forum
63	Southern Trust
64	CLEAR Project
65	Arts Council of NI

66	Action Mental Health
67	NI Youth Forum
68	Together for you
69	Royal College of Nursing
70	Start 360
71	VOYPIC
72	Belfast Healthy City
73	Victims and Survivors Service
74	MACS Supporting Children
75	Extern
76	NIPSA
77	Western Health and Social Care Trust
78	Northern Health and Social Care Trust
79	Contact NI
80	Participation and Practice of Rights (PPR)
81	Confederation of Community Groups
82	Colette Ramsey, Professional Practitioner
83	Womens Aid NI
84	CAMHS
85	HURT NI
86	Aisling Centre
87	CAUSE for mental Health
88	New life Counselling
89	Train To Be Smart Programme
90	University of Ulster
91	BHSCT
92	NUS-USI
93	Mid-Ulster District Council, Environmental Health
94	Rainbow Project
95	Royal College of GPs NI
96	Newry and Mourne Down district council
97	SEHSCT
98	WHSCT
99	NSPCC
100	Sinn Féin
101	Commission for Victims and Survivors

102	Childrens Law Centre
103	Derry and Strabane District Council
104	Northern Ireland Human Rights Commission