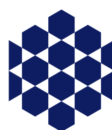

Department of
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Protect Life A SHARED VISION

The Northern Ireland Suicide Prevention Strategy and Action Plan

2006-2011

October 2006

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MINISTERIAL FOREWORD

Life is the most precious of gifts. We all share a responsibility for ensuring that it is valued and protected. At times, circumstances may lead some people to seek to end their own life. Whilst no strategy can be expected completely to remove such tragic thoughts and feelings, there is much that can be done to ensure that we reduce the likelihood of suicide and to ensure support is available for those at their most vulnerable. When faced with the reality of an increasing rate of suicide, it is essential that together, we look for and seek to address the causes behind this increase.

This Strategy recognises that suicide is on the increase in Northern Ireland. It identifies that the reduction of suicide and the tragic consequences for families is a priority for statutory, community, and voluntary sectors alike. There are no easy answers but the Strategy indicates that the only way to find solutions is to work together.

The development of this Strategy has been a long and difficult road. I want to acknowledge that we would not have reached this point if it had not been for the commitment, dedication and inspiration provided by many bereaved families and the organisations that support them. Sometimes in the past, families and loved ones have not had the support they should have had. Even so, their pain and sense of loss has galvanised their own involvement and in turn this has been an inspiration to all of us – politicians, health professionals and community organisations - to search for ways to reverse the trend.

Attitudes need to change. No longer should people feel ashamed that a death by suicide has occurred in their family - we need to bring such stigma to an end. Indeed, society has not just to allow, but actively encourage people to talk about their mental health and the support and services they need.

The publication of this Strategy is an important occasion, but it is only a start. Identifying and highlighting the problem is one thing, but dealing with it effectively is the real challenge. The successful implementation of this Strategy will take time, and must be accompanied by wider action to promote positive mental health.

I would like to take this opportunity to thank Colm Donaghy, the Suicide Prevention Taskforce and the Strategy Quality Assurance Group for their work in the development of this Strategy.

Finally, I urge everyone to play their part in helping us turn the tide, and in helping shape a future that provides hope and a greater sense of well-being for all in our society.

Paul Goggins

PAUL GOGGINS
Minister for Health, Social Services and Public Safety

KEY TERMS

Mental Health Promotion – an approach characterised by a positive view of mental health, which aims to engage with people and empower them to improve their health, rather than emphasising illness or deficits.

Self-Harm – an act of self-poisoning or self-injury irrespective of the purpose of the act.

Suicidal Behaviour – a general term to describe thoughts and acts of self-harm.

Suicide – the act of deliberately ending one's own life.

Suicide Prevention – identifying and reducing the impact of risk factors associated with suicidal behaviour, and identifying and promoting factors that protect against engaging in suicidal behaviour.

Suicide Rate – the number of suicides per 100,000 people in the population. Using the suicide rate rather than the actual number of suicides allows comparisons to be made between different geographical areas and groups within the population.

Suicide Risk – the risk of suicide in the near future, sometimes the terms refers to a person's life in general, i.e. on a lifetime basis.

CHAPTER 1 – INTRODUCTION

1.1 In the last few decades, large increases in rates of suicide have been reported across most regions of the world, particularly in New Zealand, the United States, Ireland, France, Norway, and Brazil. Worldwide, an estimated 877,000 lives were prematurely lost due to suicide in 2002, and it is the third biggest cause of "years of lives lost" after cardiovascular disease and cancer[1].

1.2 Figure 1 below compares suicide rates across several countries, and illustrates that suicide is an issue not only in Ireland, North and South, but throughout the world. It also highlights the fact that in this period Northern Ireland has more suicides per 100,000 persons than England and Wales, though less than Scotland and the Republic of Ireland.

1.3 Figure 1 also highlights the high rates of suicide recorded in the former Eastern Bloc Countries. Given the growth and transient nature of these "new populations" throughout Ireland in recent years, it may be necessary to initiate some joint research with counterparts in the Republic of Ireland into the additional risk factors faced by the "new populations" as they integrate into local communities.

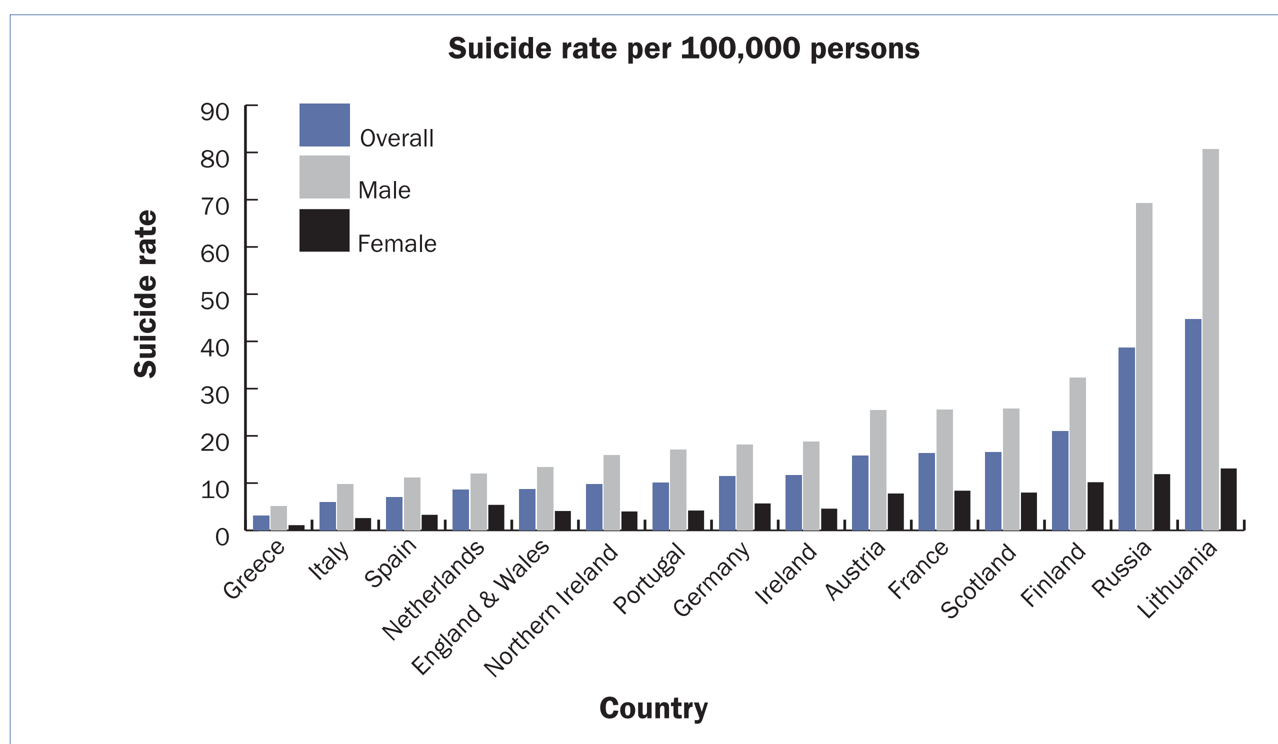

Figure 1: Suicide rate per 100,000 persons Age standardised to the European Standard Population (WHO 1999-2003)

1.4 Between 2000 and 2004, there have been approximately 150 deaths by suicide in Northern Ireland each year, and the vast majority (79%) have been male. However, 2005 witnessed a significant increase to 213 in the number of suicides recorded. Identifying the causes of such sudden rises is a major challenge.

1.5 Suicide is an emotive and sensitive subject, and there is currently little evidence as to why people take their own lives. Risk factors include depression, alcohol and drug misuse, personality disorder, hopelessness, low self-esteem, bereavement, break-up of a relationship and social isolation. While no specific intervention has been found to be universally effective, it is important that interventions address these risk factors as part of a broader approach to promoting mental health and well-being.

1.6 The term self-harm covers a wide range of behaviours including habitual self-cutting and poisoning. Northern Ireland has witnessed a substantial increase in self-harm related admissions to hospital in recent years. Self-harm involves differing degrees of risk to life and suicidal intent, and it is often considered to be a coping mechanism, or a means of helping someone deal with their life.

1.7 There are myths surrounding self-harm. One is that all of those who self-harm are seeking attention. In reality, many go to great lengths to hide their injuries. Another myth is that, in all cases, someone who self-harms is trying to take their own life. While it is true that those who self-harm are more at risk of attempting suicide, it is not true that the majority will go on to die in this manner.

PROMOTING GOOD MENTAL HEALTH

1.8 The Investing for Health Strategy[2], published in March 2002, provides the framework for the Government's approach to improving health and well-being and reducing health inequalities. It identifies the need to promote mental health and emotional well-being at individual and community level, and in particular the importance of tackling the difficult issue of suicide.

1.9 The Promoting Mental Health Strategy and Action Plan[3], published by the Department of Health, Social Services and Public Safety (the Department) in January 2003, contains 30 actions which are designed to support mental and emotional well-being.

DEVELOPMENT OF THE NORTHERN IRELAND SUICIDE PREVENTION STRATEGY

1.10 As a result of concern about an increase in the number of suicides, particularly among young people, the Department established a Taskforce in July 2005 to develop a separate suicide prevention strategy for Northern Ireland. Suicide prevention is now a priority and is included in the Department's Public Service Agreement, in the Government's "Priorities & Budget 2006 - 2008".

GUIDING PRINCIPLES

1.11 The following guiding principles were adopted during the development of the Strategy:

- **Links to Other Strategies** – to develop strong links to other relevant strategies including Investing for Health[2], Promoting Mental Health Strategy and Action Plan[3], New Strategic Direction for Alcohol and Drugs (2006-2011)[4], Neighbourhood Renewal[5], the Children's Strategy[6] and the Bamford Review of Mental Health and Learning Disability (NI).
- **Joined-Up Working** – the need for joined-up working at Government level, and between the statutory and voluntary/community sectors.
- **De-stigmatisation** – of mental health issues and to encourage help seeking behaviour.
- **Best Practice** – continuous commitment to achieving and sharing best practice.
- **Engagement** – support for, and commitment to, continued consultation with bereaved families, survivors, carers and their representatives.
- **Dual Approach** – to adopt a dual population and targeted approach when implementing the Strategy.
- **Working Together** – support for shared working with counterparts in the Republic of Ireland, Great Britain and beyond, where mutually beneficial.

1.12 At the outset, the Taskforce acknowledged the importance of taking views from interested parties and affording them the opportunity to influence the content of the new Strategy. It undertook an extensive engagement process which included:

- public consultation workshops;
- meetings with bereaved families and relevant support groups;
- meetings with political parties, local churches, coroners, the Prison Service, the Police Service and the Northern Ireland Commissioner for Children and Young People;
- consultations with health service professionals and the statutory sector;
- meetings with young people;
- a workshop for regional community and voluntary sector organisations;
- a suicide prevention conference; and
- a seminar bringing together community groups, bereaved families and relevant health service professionals.

1.13 To help in the development of the new Strategy the Taskforce also commissioned the following work:

- an analysis of the levels of suicide and self-harm in Northern Ireland;
- a review of the evidence base and identification of best practice in Northern Ireland and elsewhere; and
- a review of the implementation of the ten suicide prevention action points in the Promoting Mental Health Strategy and Action Plan[3].

1.14 The Draft Strategy and Action Plan was launched for a formal 12 week public consultation on 30 March 2006. Over 170 responses were received and these have helped to further develop the Strategy.

IMPACT ASSESSMENT

1.15 As part of the development of this Strategy, the Department used the Integrated Impact Assessment Screening Tool to determine if the Strategy had any negative economic, health, rural, environmental, social, human rights, homelessness, victims, or community safety impacts. Additional consideration was given to the Strategy's equality impacts. The Department considers that the policy should impact positively on the health and emotional wellbeing of the general population. The Department considers that the Strategy and Action Plan does not adversely impact on any of the Section 75 groups and therefore a full Equality Impact Assessment is not required.

1.16 The conclusions from this screening exercise are available online at: **http://www.investingforhealthni.gov.uk/documents/IntegratedImpactAssessmenScreening.pdf.**

CHAPTER 2 – FINDINGS

ANALYSIS OF SUICIDE AND SELF-HARM IN NORTHERN IRELAND

2.1 To help inform the Taskforce, the Department undertook an analysis of suicides and self-harm in Northern Ireland over the last five years for which data is available. Some of the key findings of this analysis are outlined in the following paragraphs.

2.2 In Northern Ireland, holding an inquest into a probable death by suicide is discretionary rather than mandatory. Where there is evidence that a death is suspected to be a suicide the coroner will often seek the views of the family as to whether they wish an inquest be held. Historically, the vast majority of those asked have requested that the death is registered without an inquest being held. The coroner will provide a summary of findings to the Registrar and the death is then coded by the General Register Office (GRO) of Northern Ireland. It is usually evident from the coroner's findings whether or not the death is considered to be suicide. However, in cases where it is unclear, GRO staff will contact the coroner for further clarification before coding the death using the International Statistical Classification of Diseases and Related Health Problems as a 'suicide' or death by 'self-inflicted injury'. In some cases a death by 'events of undetermined intent' is recorded where the intent is unclear or the coroner is not in a position to confirm that the death was a suicide. This process, particularly an inquest, can result in a considerable time delay between the actual death occurring and the date the death is registered. Given this, it is important that work is undertaken with the Coroner's Office to minimise future reporting delays, and to ensure increased sensitivity to the needs of bereaved families.

2.3 During the period 1987 to 2004 there were 2,732 registered deaths from suicide in Northern Ireland. The number of suicides registered peaked in the year 2000 with 185 deaths, while the lowest number of suicides around this time occurred in 1987 when there were 122 deaths.

2.4 The use of five year moving averages allowed the overall trend in suicide rates to be more readily identified, and in particular highlighted that the rate of male suicide in Northern Ireland has increased steadily during the late 1990's and the early 2000's. This increase has raised the male suicide rate from 14.1 per 100,000 persons to 15.3 per 100,000 persons for the period in question. During the same period the female suicide rate has remained fairly constant at 4.3 suicides per 100,000 persons. The overall suicide rates per 100,000 since 1991 are illustrated in Figure 2 overleaf.

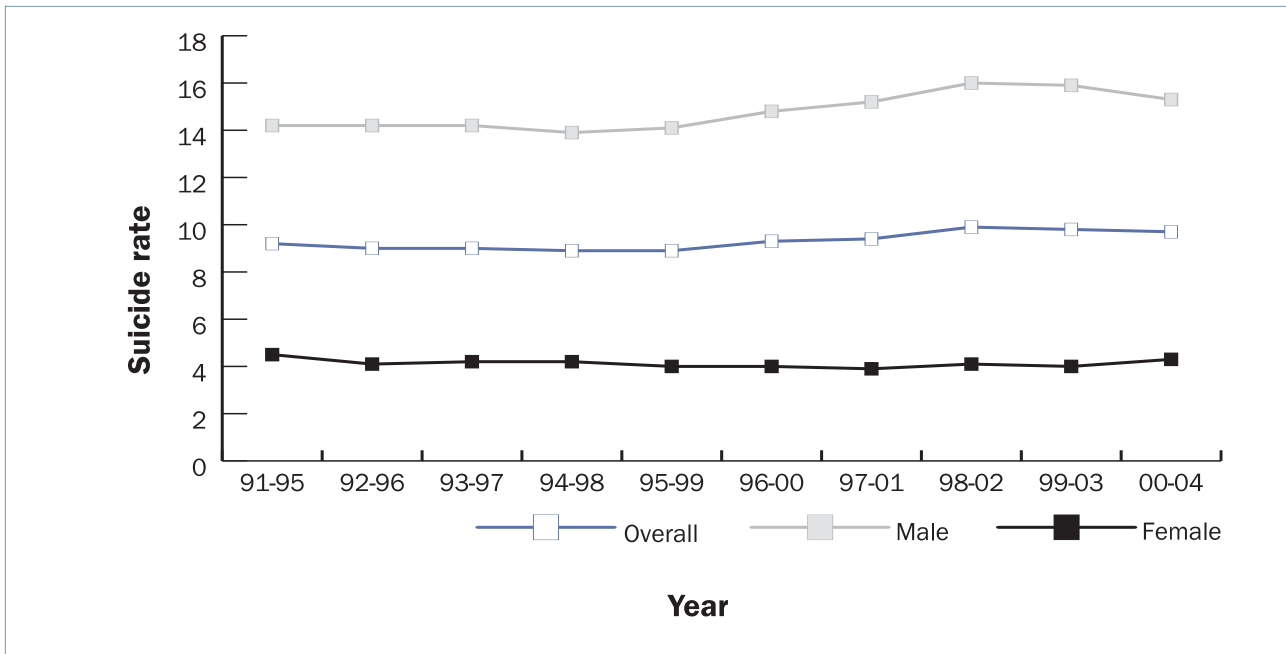

Figure 2: Age standardised suicide rate per 100,000 persons – five year moving average (1991-2004)

2.5 The identification of the 20% most deprived areas in Northern Ireland made it possible to generate suicide rate comparisons between deprived and non-deprived areas. This analysis showed that in deprived areas the age standardised suicide rate over the last five years is 14.5 per 100,000 persons compared to a rate of 8.5 per 100,000 persons in non-deprived areas. When focusing solely on economic deprivation comparisons the suicide rate gap increased even further to 16.5 per 100,000 persons in economically deprived areas as opposed to a rate of 8.1 suicides per 100,000 persons in non-economically deprived areas. While the Taskforce recognised the need to address this issue, it also recognised that economic deprivation is a wider societal issue that needs to be addressed as part of the Government's Anti-Poverty Strategy.

2.6 Figure 3 opposite also highlights that suicide rates in urban areas tended to be higher than those in rural areas. Between 2000 and 2004 there were 10.3 suicides per 100,000 persons in urban areas in Northern Ireland compared to 8.6 suicides per 100,000 persons in rural areas.

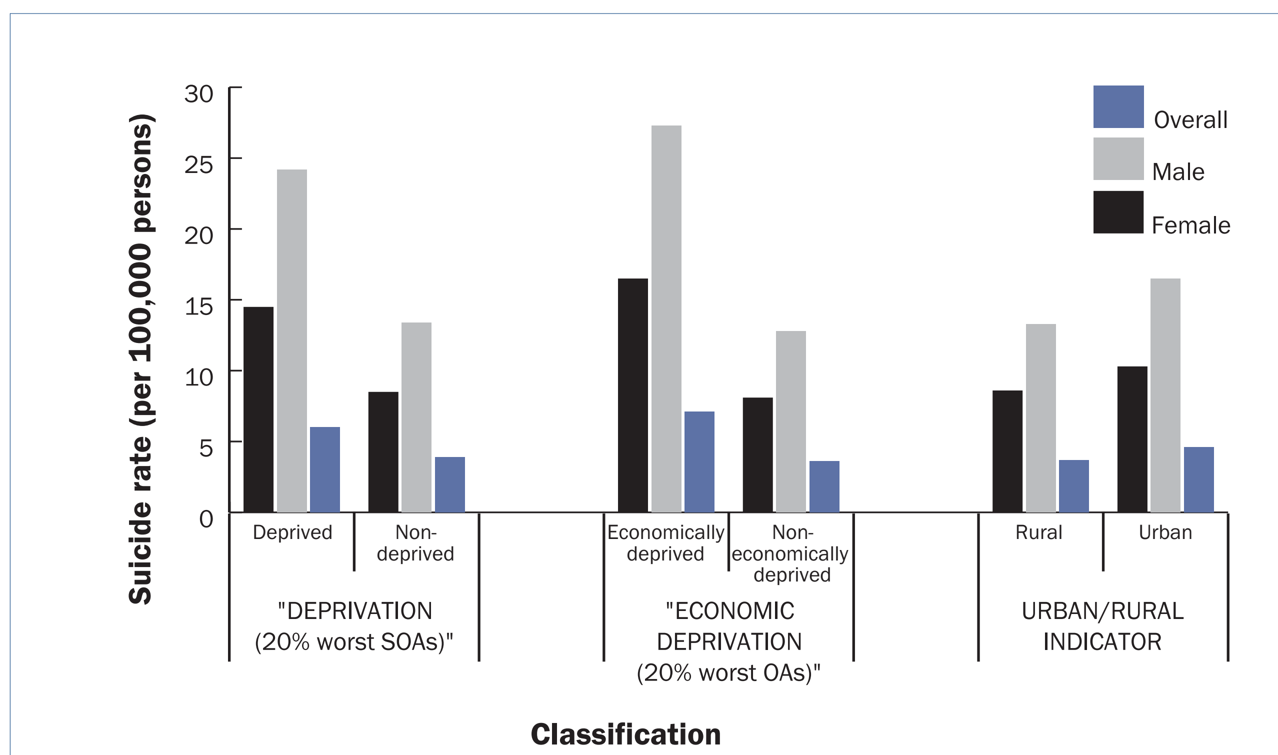

Figure 3: Age standardised suicide rate per 100,000 persons by indicators of deprivation and rurality (2000-2004)

2.7 The overall suicide rate in Northern Ireland is 9.7 per 100,000 persons, however, there are large variations across the local Parliamentary Constituencies. The North and West Belfast Parliamentary Constituencies have highest rates of 17.2 and 16.2 suicides per 100,000 persons respectively. These Constituencies have historically suffered from economic deprivation and witnessed some of the worst violence of “the troubles”, and while it is still too early to make a direct correlation between the legacy of “the troubles” and the rate of suicide, the Taskforce acknowledged the need for further research into this matter.

2.8 When analysing suicide rates by Local Government District Councils, Banbridge had the highest rate of 14.5 per 100,000 persons compared to 12.2 per 100,000 persons in Belfast. This further highlights the fact that suicide is not simply an urban issue but that it affects people throughout Northern Ireland.

2.9 Over the five year period 2000/01 to 2004/05, the number of admissions to hospital as a result of self-harm had increased by 2.7% from 4,583 to 4,705, although there had been a considerable variation in the pattern of admissions during these years. The average number of admissions to hospital each year in Northern Ireland as a result of self-harm is 280 per 100,000 persons. However, hospital admission statistics are likely to under-estimate the scale of the problem since not all incidents

of self-harm are presented for medical attention, and only a proportion of those who do attend Accident & Emergency are admitted to hospital. Available information indicates that rates of self-harm are significantly higher in Northern Ireland than in the Republic of Ireland, although the lack of an agreed recording mechanism makes it difficult to make meaningful comparisons. A mechanism for monitoring self-harm attendances at Accident & Emergency in Northern Ireland, similar to the National Registry of Deliberate Self-Harm in the Republic of Ireland, will be developed.

REVIEW OF EVIDENCE BASE

2.10 In order to inform the development of the Suicide Prevention Strategy, the Taskforce also commissioned a review of the evidence base relating to suicide and self-harm. The literature review was carried out to provide a pragmatic evidence base on which to develop the Strategy. A brief summary is outlined in the following paragraphs and the full report is available online at:
www.investingforhealthni.gov.uk/documents/reviewofbase.pdf

2.11 There is limited evidence available in relation to interventions that are effective in reducing the risk of suicide and self-harm. In many instances studies show conflicting results and in general more evidence is required before strong recommendations can be made.

2.12 It is important to note that most interventions that are assumed to prevent suicide, including some that have been widely implemented, have yet to be evaluated to determine their effectiveness. Nevertheless the following interventions have shown promising results[7]:

- GP education programmes aiming to increase detection of depression;
- restriction of access to means of suicide; and
- education of community gatekeepers e.g. school and prison staff.

2.13 There is also some evidence that the following may be effective:

- treatment of mental illness, especially depression;
- some specific psychotherapies to prevent repetition of self harm;
- follow-up after self harm; and
- responsible media reporting.

2.14 Outcomes from this review have been incorporated throughout the Strategy. Some other key issues arising from the review are set out below:

- almost 80% of those who die by suicide in Northern Ireland had seen their GP in the 6 months prior to their death (although not necessarily in relation to mental health), with 36% having seen their GP in the month prior to their death;
- of the people who died by suicide 98% over the age of 30 and 74% under the age of 30 are likely to have had a psychiatric illness;

- 7% of those who died by suicide had been discharged from psychiatric hospitals in the 3 months before their death; and
- initial research has suggested a linkage between the per capita alcohol consumption of Northern European countries and the suicide rate, particularly amongst young people.

REVIEW OF SUICIDE PREVENTION ACTIONS

2.15 As part of the review of the ten suicide prevention action points in the Promoting Mental Health Strategy and Action Plan[3], the Taskforce undertook an extensive series of meetings with relevant Government Departments, Health and Social Services Boards and Trusts, as well as interested voluntary/community organisations. In summary, the main findings of this review are:

- three of the ten action points have been met in full and six have been partially met;
- one action point, the development and delivery of a depression awareness training programme for GPs, has not yet been implemented;
- the most successful regions in delivering the action points tended to mirror those Health and Social Services Boards that have previously suffered from a spate of suicides, and that have therefore had dedicated suicide prevention resources in place for some time; and
- the main barriers highlighted as preventing achievement of the ten action points included, lack of recurrent funding and dedicated resources, lack of co-ordination and health service priority, and inability to successfully engage GPs and other health professionals on this issue.

ENGAGEMENT

2.16 The Taskforce engaged with a wide range of individuals and organisations, and the issues raised included:

IMPROVED JOINED UP WORKING

- new Strategy should contain strong linkages to other relevant Government strategies;
- inter-Departmental commitment is required, as the new Strategy will cut across several Government Departments;
- closer co-operation between local communities, voluntary/community organisations and the statutory sector; and
- better co-ordinated services must also be sensitive to the needs of those in crisis and those bereaved by suicide.

TRAINING AND DEVELOPMENT

- need to ensure improved training and development for frontline staff in health and social services particularly in A&E, and primary care, including GP's;
- provision of additional training, such as ASIST, for health professionals, clergy, people in local communities, and for occupations which regularly come into contact with those at risk of suicide; and
- introduction of social/coping skills for young people still in school.

PROMOTING GOOD MENTAL HEALTH

- the need for suicide and wider mental health matters to be recognised as a major public health issue and to be resourced accordingly;
- providing a trusting environment for young people to be able to express their feelings;
- raising suicide awareness, and reducing stigma for those seeking help should be a high priority in a range of areas including schools, prisons, youth work, local communities, universities, the armed forces and health and social services;
- need to reduce the level of stigma around mental health issues, and in particular those seeking help; and
- work with the media to ensure more sensitive reporting and portrayal of suicide.

KEY SERVICE ISSUES

- need to develop more accessible services outside normal working hours and potential alternatives to hospital admission/attendance, particularly in response to crisis in the community e.g. 24/7 community based crisis response service;
- lack of follow up for vulnerable groups, particularly those who self-harm;
- need to ensure service delivery is patient centered and services are sensitive and responsive to patient needs, especially in the transition from adolescence to adulthood; and
- need to monitor and regulate the prescribing of anti-depressants to the under 18 age group.

ECONOMIC COST OF SUICIDE AND SELF-HARM IN NORTHERN IRELAND

2.17 Suicide and self-harm have a substantial impact on Northern Ireland, both in terms of lives lost and the resulting trauma for bereaved families and the local community. Evidence also suggests that the cost of suicide and self-harm has a significant economic impact on Northern Ireland as a whole.

2.18 During 2004, there were 146 suicides recorded in Northern Ireland, equating to 4,350 potential years of life lost for that year. Associated with each suicide are the direct costs such as the post mortem and funeral costs; the indirect costs such as the value of the potential earnings lost; and the intangible costs which estimate the human costs such as suffering, grief and loss of non-market outputs such as voluntary work, housework, etc. For 2004, the total estimated cost of suicide to Northern Ireland was in the region of £202 million, which equates to £1.4 million per suicide.

2.19 Self-harm also has a significant economic impact on Northern Ireland. Over the past 5 years some 35,996 hospital admissions, or 1.46% of all admissions, were recorded as incidents of self-harm. The number of recorded cases of self-harm has increased 9.2% since 2000 with some 7,357 incidents in 2004/05 alone. These incidents are estimated to have cost the Northern Ireland economy £6.6 million in lost earnings, hospital costs, and other lost output.

2.20 The benefits of prevention of suicide and self-harm are therefore clear and quantifiable in terms of health benefits and economic costs, and these include:

- potential to save lives;
- improved quality of life;
- interruption of the cycle of self-harm and suicide experiences in some communities and families;
- reduction in the cost of hospital care associated with episodes of self-harm and poor mental health; and
- improved productivity through people's contribution to the economy.

POTENTIAL FOR NORTH/SOUTH CO-OPERATION

2.21 The development of the Strategy was greatly enhanced by a review of best practice worldwide, and in particular being able to draw on the experiences of the Republic of Ireland and Scotland.

2.22 The parallel implementation of the Republic of Ireland Suicide Prevention Strategy, "Reach Out[8]", is of particular relevance, given the potential for mutually beneficial North/South working. Obvious examples of this potential include liaison on the development of future public information campaigns and closer alignment of suicide and self-harm recording in Northern Ireland and Republic of Ireland.

CHAPTER 3 – AIMS AND OBJECTIVES OF THE STRATEGY

AIM

3.1 The overall aim of this Strategy is:

"To reduce the suicide rate in Northern Ireland"

3.2 Achieving the Strategy's aim of reducing the Northern Ireland suicide rate will be a difficult and ongoing challenge, and one that will require regular review and updating. While the **Five Year Action Plan** outlined in **Chapter 4** will play a central role in the delivery of the Strategy's key aim, it is recognised that it cannot be met by Health and Social Services alone. Therefore the onus is on all of us: communities, voluntary organisations, the media, the statutory sector including Health, Education, Employment, and society as a whole, to work together to achieve a reduction in the Northern Ireland suicide rate.

OBJECTIVES

3.3 The key objectives of the Strategy are:

- to raise awareness of mental health and well-being issues;
- to ensure early recognition of mental ill-health, and to provide appropriate follow-up action by support services;
- to develop co-ordinated, effective, accessible and timely response mechanisms for those seeking help;
- to provide appropriate training for people dealing with suicide and mental health issues;
- to enhance the support role currently carried out by the voluntary/community sectors, bereaved families and individuals who have made previous suicide attempts;
- to support the media in the development and implementation guidelines for a suitable response to suicide related matters;
- to provide support for research and evaluation of relevant suicide and self-harm issues; and
- to restrict access, where possible, to the means of carrying out suicide.

APPROACH

3.4 To meet the challenging targets set within this Strategy, it is important to set the approach within the context of the wider Investing for Health framework. The achievement of the Suicide Prevention Strategy's aim will play its part in helping to meet the existing Investing for Health targets, which include improving life expectancy, reducing health inequalities, and improving the mental health of the people of Northern Ireland.

3.5 While Investing for Health is primarily aimed at the whole population, the analysis of suicide in Northern Ireland carried out for the development of this Strategy clearly highlights that there is a direct association between suicide rates and gender, age groups, and socio-economic status. Therefore, in order to reduce the suicide rate in Northern Ireland a dual population and targeted approach will be adopted when implementing this Strategy.

3.6 The focus of this Strategy is clearly on prevention, however, it is recognised that properly resourced mental health services can have a positive impact on reducing the rate of suicide. Professor Bamford in the "Review of Mental Health and Learning Disability (NI)" has identified significant gaps in resources for mental health services. The Taskforce supported the call for these gaps to be resourced.

3.7 Government is developing a co-ordinated plan to respond to the Bamford recommendations, including resource and workforce implications, which are significant. In developing the plan, the implementation of this Strategy will be taken forward.

TARGETS

3.8 The Investing for Health Strategy set a target relating to the promotion of mental health and emotional well-being:

> to reduce the proportion of people with a potential psychiatric disorder by a tenth by 2010.

3.9 This Strategy incorporates the following targets to complement and help achieve the overarching Investing for Health target:

(i) to obtain a 10% reduction in the overall suicide rate by 2008; and
(ii) to reduce the overall suicide rate by a further 5% by 2011.

Progress towards meeting these targets will play an important part in measuring the success of the Suicide Prevention Strategy.

3.10 Paradoxically, the Strategy's success in reducing the stigma that surrounds suicide may adversely affect the ability to meet the targets set out above. In other words increased willingness on the part of families and coroners to have deaths acknowledged and officially recorded as suicide may actually create an artificial rise in the recorded suicide rate. If this occurs, it should not be interpreted as a failure of the Strategy to achieve its goals. For this reason, any evaluation of the Strategy's success will also need to consider progress towards achieving other intermediate outcomes such as:

i. changes in public attitudes towards mental health/suicide;
ii. development and rollout of suicide/depression awareness training across a range of professions;
iii. improved accuracy in suicide and self-harm data collection;
iv. a reduction in self–harm;
v. improved availability of services for people who have self-harmed in all Trusts; and
vi. the development and uptake of bereavement/community support services.

3.12 The Department, in conjunction with the Suicide Strategy Implementation Body, will need to develop suitable tools to measure these outcomes.

CHAPTER 4 – ACTION PLAN

4.1 This chapter identifies specific actions, timescales and delivery partners for each of the areas within the **population** and **targeted** approach sections of the action plan.

4.2 The population approach seeks to tackle the issue of suicide in a wider context, with actions aimed at protecting the general population of Northern Ireland. The targeted approach seeks to tackle the issue by focusing action on those who are most at risk. It is, however, important to stress that the general population approach and targeting those at an increased risk will be complementary. **Section A** of this chapter deals with the **Population Approach**, **Section B** deals with the **Targeted Approach**, and **Section C** sets out the **Overarching Actions**.

TIMESCALES

4.3 All the actions contained within this chapter have been assigned a specific timescale in which they should be taken forward, and they are:

- the Short Term (up to one year);
- the Medium Term (one to three years); and
- the Long Term (up to five years).

4.4 While it is envisaged that the targets should be met within the designated timescales, it is also recognised that some actions may require additional unforeseen work to allow for completion of specific tasks. In such circumstances, it will be for the Suicide Strategy Implementation Body and the Department to agree any revised timescales.

4.5 Depending on the prevailing conditions at the time, the Department may also need to reprioritise the delivery timescales of the identified actions, and/or add new actions to the plan.

GLOSSARY OF TERMS

DARD	**Department of Agriculture and Rural Development**
DE	**Department of Education**
DEL	**Department for Employment and Learning**
DFP	**Department of Finance and Personnel**
DETI	**Department of Enterprise, Trade and Investment**
DHSSPS	**Department of Health, Social Services and Public Safety**
DOE	**Department of the Environment**
DSD	**Department for Social Development**
GRO	**General Register Office**
HPA	**Health Promotion Agency**
HSS	**Health and Social Services**
NICS	**Northern Ireland Civil Service**
NUJ	**National Union of Journalists**
PSNI	**Police Service of Northern Ireland**
ROI	**Republic of Ireland**

SECTION A - POPULATION APPROACH

ACTION AREA: COMMUNITIES

ACTION TO BE TAKEN	TIMESCALE	DELIVERY PARTNERS
To initiate a major public information campaign that aims to de-stigmatise mental health, and promote awareness and understanding of issues relating to suicide and self-harm.	Short Term	DHSSPS, HPA, HSS, local authorities, local community and voluntary partners.
To support and encourage the development of community based suicide prevention initiatives and support mechanisms.	Short Term	DHSSPS, DSD, HSS, local authorities, local community and voluntary partners.
To encourage all statutory public bodies to carry out health impact assessments on their policies, in terms of possible adverse effect on the mental health and well-being of local communities.	Ongoing	DHSSPS, all NICS Departments and Public Bodies, HSS, local authorities, HPA, PSNI and Prison Service.
To restrict access to means and methods of suicide, including the identification of “hotspots”, the promotion of safer prescribing, a reduction in the accessibility of certain over the counter drugs, and restriction of access to firearms.	Ongoing	DHSSPS, Planning Authorities, local authorities, Health & Safety Executive, HSS, PSNI, Prison Service, DSD, DARD, DOE.

ACTION AREA: FAMILY

ACTION TO BE TAKEN	TIMESCALE	DELIVERY PARTNERS
To provide families with the opportunity to avail of non-stigmatising practical interventions to help consolidate parenting, coping and life skills.	Medium/Long Term	DHSSPS, HSS, HPA, DE, DEL, DSD, local authorities, local community and voluntary partners.
To ensure that in times of distress, families have the opportunity to access a local emotional health and well-being support network, including community/voluntary sector provision.	Medium Term	DHSSPS, DSD, HSS, DE, DEL, local authorities, local community and voluntary partners.

ACTION AREA: CHILDREN AND YOUNG PEOPLE

ACTION TO BE TAKEN	TIMESCALE	DELIVERY PARTNERS
To promote the inclusion of promoting positive mental health as a key element of the “Healthy Schools” programme and ensure that children and young people are protected from all forms of bullying.	Medium/Long Term	DHSSPS, DE, DEL, HSS, local authorities. HPA, local community and voluntary partners.
To raise awareness of and ensure availability and timely access to appropriate intervention services (e.g. Child and Adolescent Mental Health Services, mentoring schemes and other appropriate statutory and voluntary services).	Short/Medium Term	DHSSPS, DE, DEL, HSS, HPA, local authorities, local community and voluntary partners.
To make suicide awareness and positive mental health & well-being training, including how to deal sensitively with disclosure of self-harm or suicidal behaviour, a priority for teachers, youth workers, etc.	Short/Medium Term	DHSSPS, DE, DEL, HPA, HSS, local authorities, local community and voluntary partners.

ACTION AREA: CHILDREN AND YOUNG PEOPLE (Cont' d)

ACTION TO BE TAKEN	TIMESCALE	DELIVERY PARTNERS
To promote a culture of help seeking behaviour, particularly among young people.	Medium Term	DHSSPS, DE, DEL, HPA, HSS, local authorities, local community and voluntary partners.
Encourage the inclusion of coping and life skills, emotional literacy, and programmes that promote positive mental health in the school curriculum.	Medium Term	DHSSPS, DE, DEL, HPA, HSS, local authorities, local community and voluntary partners.
To develop and implement practices, protocols and referral pathways to smooth the transition from youth to adult Health and Social Services.	Medium Term	DHSSPS, DE, DEL, HSS, HPA, local community and voluntary partners.

ACTION AREA: HEALTH AND SOCIAL SERVICES

ACTION TO BE TAKEN	TIMESCALE	DELIVERY PARTNERS
To develop enhanced linkages between the Health and Social Services and the community/voluntary counselling and support network, particularly in relation to transition services and to bridge any gaps in service provision.	Medium Term	DHSSPS, HSS, HPA, local community and voluntary partners.
To make depression and suicide awareness/prevention training a priority for all frontline staff dealing with people in distress, particularly for GPs, Primary Care and A&E staff in the HSS.	Short/Medium Term	DHSSPS, HSS, HPA, DSD.
To develop clinical guidelines for all HSS staff to use when dealing with people who are at risk of suicide/self harm.	Medium Term	DHSSPS, HSS.

ACTION AREA: WORKPLACES

ACTION TO BE TAKEN	TIMESCALE	DELIVERY PARTNERS
To implement a targeted information campaign aimed at enhancing the mental health and well-being of all members of the workforce.	Short/Medium Term	DHSSPS, HPA, Health & Safety Executive, DEL, DETI, Trade Unions.
To ensure that positive mental health training is available to relevant members of the workforce including small/medium enterprise employers.	Medium Term	HPA, Health & Safety Executive, DHSSPS, DETI, DEL, Trade Unions.

ACTION AREA: POLICE AND EMERGENCY SERVICES

ACTION TO BE TAKEN	TIMESCALE	DELIVERY PARTNERS
To ensure that suicide prevention is included in all Emergency Services Public Service Agreements, and reflected in individual services annual priorities.	Short/Medium Term	DHSSPS, PSNI, Prison Service, Fire Service, Lifeboat Service.
To make suicide awareness/intervention training a priority for all frontline emergency services staff.	Short/Medium Term	DHSSPS, PSNI, Prison Service, Ambulance, Fire Service, Lifeboat Service, NICS Departments.

ACTION AREA: CHURCHES AND RELIGIOUS BODIES

ACTION TO BE TAKEN	TIMESCALE	DELIVERY PARTNERS
To support the development of enhanced links between churches/religious bodies and the local community support networks.	Short/Medium Term	DHSSPS, HSS, DSD, Churches/ Religious Bodies, local community and voluntary partners.
To make suicide/depression awareness type training available for all church/religious leaders.	Short/Medium Term	DHSSPS, HSS, Churches/ Religious Bodies, local community and voluntary partners.

ACTION AREA: MEDIA

ACTION TO BE TAKEN	TIMESCALE	DELIVERY PARTNERS
To work with the National Union of Journalists, and the Association of Editors, in relation to implementation of effective media guidelines in relation to the reporting of suicide and self-harm issues.	Short Term	DHSSPS, HPA, NUJ, Association of Editors, local community and voluntary partners.
To pro-actively work with the media to promote positive mental health and raise awareness of sources of support for individuals or families experiencing mental health problems.	Short/Medium Term	DHSSPS, HPA, NUJ, Association of Editors, local community and voluntary partners.
To develop and implement appropriate media monitoring mechanisms.	Short/Medium Term	DHSSPS, HPA, NUJ, Association of Editors, local community and voluntary partners.
To provide media volunteer training for nominated bereaved families representatives.	Short Term	DHSSPS, HPA, local community and voluntary partners, bereaved family members.

SECTION B - TARGETED APPROACH

ACTION AREA: SELF-HARM

ACTION TO BE TAKEN	TIMESCALE	DELIVERY PARTNERS
To ensure that responsive self-harm support services, including mentoring support, are in place in all Health & Social Service Trusts.	Short/Medium Term	DHSSPS, HSS, local community and voluntary partners.
To implement programmes that enhance the coping and problem solving skills of those who self-harm, and which reduce the risk of repeat self-harm.	Short/Medium Term	DHSSPS, HSS, DE, DEL, local community and voluntary partners.
To improve detection of, and access to, support services for people who engage in less serious forms of self-harm.	Medium Term	DHSSPS, HSS, local community and voluntary partners.

ACTION AREA: MENTAL ILLNESS

ACTION TO BE TAKEN	TIMESCALE	DELIVERY PARTNERS
To ensure that those in contact with mental health services are followed up at appropriate intervals, with assertive outreach where necessary, to assess suicide and self-harm risk.	Medium Term	DHSSPS, HSS, local community and voluntary partners.
To ensure that all Health & Social Service Trusts, and other relevant bodies, have pro-active suicide awareness/intervention programmes in place for staff who work with people who have mental health difficulties.	Medium Term	DHSSPS, HSS, local community and voluntary partners.

ACTION AREA: MENTAL ILLNESS (Cont' d)

ACTION TO BE TAKEN	TIMESCALE	DELIVERY PARTNERS
To provide appropriate support and information to promote awareness of suicide risk among people caring for someone with a mental illness.	Ongoing	DHSSPS, HSS, local community and voluntary partners.
To provide timely and appropriate support and follow up for patients discharged from psychiatric units.	Medium Term	DHSSPS, HSS, local community and voluntary partners.

ACTION AREA: DRUG AND ALCOHOL MISUSE

ACTION TO BE TAKEN	TIMESCALE	DELIVERY PARTNERS
To ensure that appropriate suicide awareness/intervention training is available for all frontline health services staff, police officers, and other relevant professionals who come into contact with people with alcohol and drug problems.	Short/Medium Term	DHSSPS, HSS, DSD, local community and voluntary partners, PSNI, DE.
To develop agreed protocols concerning the assessment and management of patients at risk while under the influence of drugs and/or alcohol.	Medium Term	DHSSPS, HSS, local community and voluntary partners, PSNI.

ACTION AREA: YOUNG MALES

ACTION TO BE TAKEN	TIMESCALE	DELIVERY PARTNERS
To ensure that targeted outreach programmes for young males, who may be at risk of suicide and self-harm, are available in local communities and in all Health & Social Services Trusts.	Short/Medium Term	DHSSPS, HSS, local community and voluntary partners, Youth Justice, PSNI, DSD, DEL, DE.

ACTION AREA: YOUNG MALES (Cont' d)

ACTION TO BE TAKEN	TIMESCALE	DELIVERY PARTNERS
To implement a targeted information and awareness campaign for young males, aimed at breaking down the current male culture of not discussing their problems openly.	Short/Medium Term	DHSSPS, HPA, local community and voluntary partners, DE, DEL.
To enhance the role of the community/voluntary sector concerning the provision of mentoring support for young people at risk of suicide and self-harm.	Short/Medium Term	DHSSPS, HSS, local community and voluntary partners.

ACTION AREA: BEREAVED BY SUICIDE

ACTION TO BE TAKEN	TIMESCALE	DELIVERY PARTNERS
To ensure that accessible information and timely support, both at community/voluntary and statutory level, is available to all those bereaved by suicide, and to encourage the development of support groups/networks.	Short/Medium Term	DHSSPS, HSS, HPA, local community and voluntary partners.
To work with the Coroner's Office to facilitate the provision of sensitive and timely information to those bereaved by suicide.	Short Term	DHSSPS, Coroner's Office, HPA, local community and voluntary partners.
To raise awareness among local health and education service providers, especially within Primary Care and education settings, of the increased risk of self-harm and suicide among those bereaved or affected by suicide.	Ongoing	DHSSPS, HPA, HSS, DE, DEL, local community and voluntary partners.

ACTION AREA: SURVIVORS OF SEXUAL, PHYSICAL AND EMOTIONAL ABUSE

ACTION TO BE TAKEN	TIMESCALE	DELIVERY PARTNERS
To provide an accessible support network in local communities for all survivors of abuse.	Short/Medium Term	DHSSPS, HSS, local community and voluntary partners, PSNI.
To initiate an information campaign that seeks to sensitively raise awareness of the increased risk of suicide among all survivors of abuse, and encourage survivors of abuse to seek help in times of crisis.	Short/Medium Term	DHSSPS, HSS, HPA, local community and voluntary partners, PSNI.
To make training available to support those working with survivors of abuse.	Short/Medium Term	DHSSPS, HSS, HPA, local community and voluntary partners.

ACTION AREA: MARGINALISED AND DISADVANTAGED GROUPS

ACTION TO BE TAKEN	TIMESCALE	DELIVERY PARTNERS
To ensure that appropriate support services reach out to all marginalised and disadvantaged groups, in particular lesbian, gay, bi-sexual, and transgender groups, rural communities, ethnic minorities, and those people who are economically deprived.	Short/Medium Term	DHSSPS, HSS, local community and voluntary partners.
To initiate a targeted information campaign that seeks to sensitively raise awareness of the increased risk of suicide among those groups identified as marginalised and disadvantaged, and encourages them to seek help at times of crisis.	Short/Medium Term	DHSSPS, HSS, HPA, local community and voluntary partners.

ACTION AREA: HIGH RISK OCCUPATIONS

ACTION TO BE TAKEN	TIMESCALE	DELIVERY PARTNERS
To raise awareness of high risk occupations and develop a culture of help seeking among people in occupations that have a high risk of suicide and self-harm.	Medium Term	DHSSPS, HSS, local community and voluntary partners, DEL, DETI, DARD, Health & Safety Executive, Trade Unions.
To develop a crisis plan for targeting people in high risk occupations, as and when emergency situations arise.	Short Term	DHSSPS, HSS, local community and voluntary partners, DEL, DETI, Health & Safety Executive, Trade Unions.

ACTION AREA: PRISONERS

ACTION TO BE TAKEN	TIMESCALE	DELIVERY PARTNERS
To make appropriate mental health and suicide awareness, prevention and intervention training a priority for all frontline prison and police custody staff, and where possible identified "listener" inmates.	Medium/Long Term	DHSSPS, Prison Service, PSNI local community and voluntary partners, "listener" inmates.
To ensure that the environment for those held in custody, in both prison and police stations, has been suitably adapted to reduce the possibility of suicide.	Medium Term	DHSSPS, Prison Service, PSNI.
To work with the Prison Service to provide access to appropriate services for all prisoners with mental health difficulties, including the development of appropriate "listener" groups.	Medium Term	DHSSPS, Prison Service, PSNI, HSS, local community and voluntary partners.

ACTION AREA: PRISONERS (Cont' d)

ACTION TO BE TAKEN	TIMESCALE	DELIVERY PARTNERS
To ensure that all remand and sentenced prisoners continue to receive initial and ongoing monitoring of their mental health, and assessment of their risk of suicide.	Ongoing	DHSSPS, Prison Service, PSNI, HSS.
To liaise with the prison and probation service about the provision of follow-up support for those who have been recently released from custody.	Short Term	DHSSPS, Prison Service, Probation Service, local community and voluntary partners.
To provide appropriate support in relation to the removal of stigma from those who have been released from custody without charge.	Short Term	DHSSPS, Prison Service, PSNI, local community and voluntary partners.

SECTION C - OVERARCHING ACTIONS

ACTION TO BE TAKEN	TIMESCALE	DELIVERY PARTNERS
To liaise with the Coroner's Office to minimise delays in the reporting of suicide, and to ensure increased sensitivity to the needs of bereaved families.	Short Term	DHSSPS, HPA, Coroner's Office, PSNI, GRO.
To liaise with the Coroner's Office and the General Register Office to further enhance the classification and recording arrangements for deaths by suicide.	Short/Medium Term	DHSSPS, HPA, Coroner's Office, PSNI, GRO.
To develop and pilot a self-harm register in local A&E departments.	Short/Medium Term	DHSSPS, HSS.
To develop a mechanism to allow timely access to statistics and geographical/demographic information at local level so that potential clusters of suicides/self-harm can be identified early and appropriate preventative action taken.	Medium/Long Term	DHSSPS, HSS, HPA, Coroner's Office, PSNI, GRO.
To initiate further in-depth research into the underlying causes of suicide and self-harm in Northern Ireland.	Medium Term	DHSSPS, HSS, local community and voluntary partners.
To review the suicide reduction targets highlighted in the Strategy, and in particular the baseline figures used for the establishment of these targets.	Short Term	DHSSPS, HSS, DFP.
To undertake a long-term study on the effectiveness of interventions on the general population.	Long Term	DHSSPS, HPA.
To initiate research into the additional risk factors faced by the "new populations".	Short/ Medium Term	DHSSPS, HSS, local authorities, local community and voluntary partners.
To identify areas of co-operation on a North/South basis, including research, reporting mechanisms, and public information.	Short/Medium Term	DHSSPS, HPA, Department of Health and Children (ROI), Health Service Executive (ROI).

CHAPTER 5 – MAKING IT HAPPEN

INTRODUCTION

5.1 It is widely recognised and accepted that, while the Action Plan outlined in **Chapter 4** will play a central role in delivering the Strategy's key aim, the long-term objective of reducing the level of suicide in Northern Ireland cannot be met by Health and Social Services alone. As outlined in **Chapter 3**, there is an onus on us all: communities, voluntary organisations, the media, the wider statutory sector including Education and Employment, and society as a whole, to work together to achieve a reduction in the local suicide rate. Enhanced co-ordination across Government Departments, different sectors and at community level will play a critical part in the successful implementation of the Strategy.

IMPLEMENTATION

5.2 A cross-sectoral Suicide Strategy Implementation Body has been established to oversee and drive forward the implementation of the Strategy, and it will in turn report on an annual basis to the Ministerial Group on Public Health. A Families Forum has also been established to give families bereaved by suicide a powerful voice in the implementation process.

5.3 The successful implementation of the Strategy, and the achievement of its aim, will be influenced by two other factors. Firstly, the recognition of suicide prevention as a priority by all relevant Government Departments. Secondly, implementation of the Suicide Prevention Strategy in parallel with progress being made on the delivery of the Promoting Mental Health Strategy and the Bamford Review of Mental Health and Learning Disability.

RESEARCH AND PILOT SCHEMES

5.4 It is widely recognised that there is currently little evidence as to why people take their own lives. Research and the pilot schemes will therefore play a central role in the implementation process by both filling existing gaps in our information and understanding, and by allowing people in Northern Ireland to benefit from best practice worldwide.

5.5 While some of the research will be of a localised nature, specific to particular problems, much will be similar to work also being taken forward elsewhere and will allow for shared working with counterparts in the Republic of Ireland and Scotland. Topics for initial research include:

- the effects of the "Troubles" on the mental health and emotional well-being of the people in Northern Ireland;
- a psychological profiling of deaths by suicide;
- an extensive survey into the causation of self-harm in Northern Ireland; and
- a review of the current suicide reporting/recording arrangements.

5.6 In addition to these research projects, two pilot schemes have been established to evaluate the impact of specific interventions in Northern Ireland. These are:

- a pilot mentoring project for those who self-harm in the Western Health and Social Services Board area; and
- a pilot telephone helpline within North & West Belfast in the Eastern Health and Social Services Board area.

INNOVATION

5.7 While it is crucial to learn from best practice and take account of existing evidence, it is also important to be innovative when implementing the Strategy. The Suicide Strategy Implementation Body will therefore encourage creative solutions, such as the mentoring and telephone helpline pilot scheme, to be developed where possible.

REVIEW

5.8 The implementation of the Strategy will be reviewed on an annual basis, with the first review due to take place 12 months from the date of publication of this Strategy. Responsibility for initiating the review will rest with the Suicide Strategy Implementation Body, although final ratification of any proposed changes to the Strategy will remain the responsibility of the Department. In considering the review the Implementation Body will, as outlined at paragraph 3.12, need to develop suitable tools to measure progress and outcomes.

RESOURCES

5.9 It is important to ensure that the use of all resources is maximised through partnership working at all levels. In particular, the recurrent funding identified by the Government of £1.9 million and £3 million for the implementation of the Strategy in financial years 2006/2007 and 2007/2008 respectively, needs to be invested to where it can make the most impact. Where, following evaluation, progress is not being made the funds will be re-invested in areas where it can be used more effectively.

ANNEX 1 - TASKFORCE AND QUALITY ASSURANCE GROUP MEMBERSHIP

THE SUICIDE PREVENTION TASKFORCE

- Mr. Colm Donaghy, Southern Health and Social Services Trust (Chair)

- Ms. Dorothy Angus, Department of Education
- Mr. Charlie Bamford, DHSSPS
- Mr. Martin Bell, DHSSPS
- Dr Stephen Bergin, Southern Health and Social Services Board
- Mr. John Breen, DHSSPS
- Mr. Malcolm Emery, Rural Support
- Mr. Joe Ferns, Samaritans
- Mrs. Maureen Ferris, Eastern Health and Social Services Board
- Dr. Brian Gaffney, Health Promotion Agency for Northern Ireland
- Ms. Madeline Heaney, Northern Health and Social Services Board
- Mr. Anthony Langan, Samaritans
- Mr. Gary Maxwell, DHSSPS
- Dr. Glenda Mock, DHSSPS
- Mrs. Jo Murphy, North Belfast Partnership
- Mr. Aidan McCann, DHSSPS
- Mr. Hugh McCann, Principal of St Colman's High School
- Mr. John McCavana, Department of Education
- Mr. Barry McGale, Westcare Business Services
- Dr. Philip McGarry, The Royal College of Psychiatrists
- Mr. John McGeown, North and West Belfast Health and Social Services Trust
- Mr. Shay McGovern, Department of Health & Children (ROI)
- Mr. Pat McGreevy, Down Lisburn Health and Social Services Trust
- Ms. Helen McNamee, The Rainbow Project
- Mrs. Patricia McQuillan, Lenadoon Counselling Project
- Ms. Sally Newton, Northern Ireland Prison Service
- Ms. Irene Ooi, Juvenile Justice Centre for Northern Ireland
- Mrs. Pat Osborne, DHSSPS
- Mr. Mark O'Donnell, Department for Social Development
- Dr. Denise O'Hagan, Western Health and Social Services Board
- Dr. Tracy Power, DHSSPS
- Dr. Ian Wales, Royal College of General Practitioners

THE "PROTECT LIFE – A SHARED VISION" QUALITY ASSURANCE GROUP

- Dr. Annette Beautrais, Canterbury Suicide Prevention Project, Christchurch, New Zealand
- Professor Keith Hawton, Centre for Suicide Research, Oxford University, England
- Professor Roy McClelland, Chairman, Bamford Review of Mental Health & Learning Disability, Northern Ireland
- Rory O'Connor, Suicidal Behaviour Research Group, University of Stirling, Scotland
- Dr Denise O'Hagan, Western Health and Social Services Board, Northern Ireland
- Dr. Maila Upanne, National Research and Development Centre for Welfare and Health, Finland

ANNEX 2 - REFERENCES

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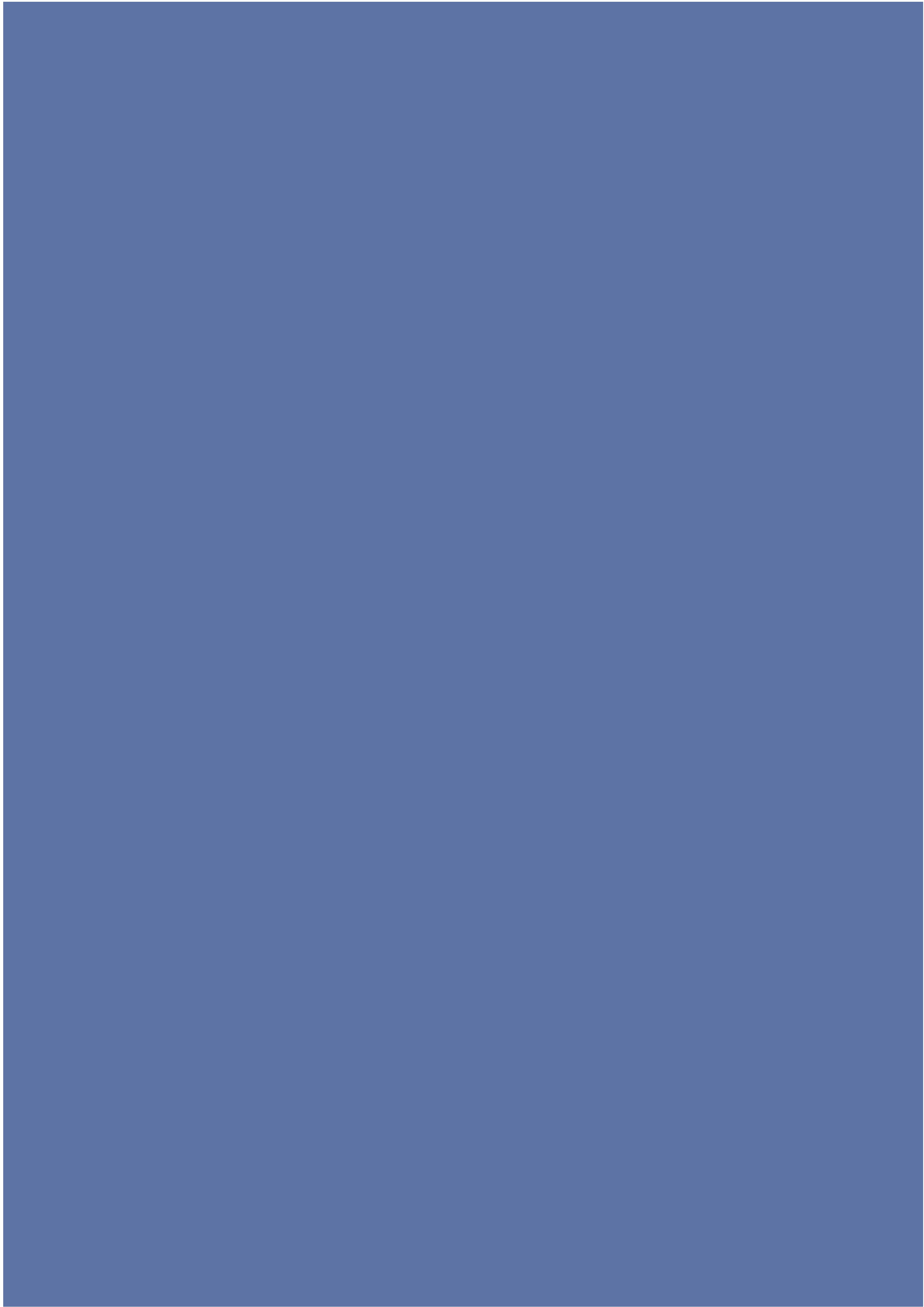
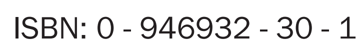
NOTES

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