

**Section 75 analysis of
Suicide and Self-harm
in Northern Ireland
(2000-2005)**

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Introduction

Of the various causes of death in Northern Ireland, suicide is regarded as being one of the most tragic and difficult to understand. It is now one of the major causes of death in young adults, particularly young males and various studies have indicated that it is on the rise. Incidents of self-harm are also seen to be on the increase. While this is not the same as attempted suicide those who self-harm are more likely to go on to commit suicide and level of self-harm may thus be a helpful indicator in identifying those persons more at risk¹. This paper presents an analysis of data held by the General Register Office (GRO) and the Hospital Inpatients System (HIS) regarding deaths due to suicide and incidents of self-harm over the last five years in Northern Ireland, examining its impact on the various Section 75 equality groups.

Recording suicide in Northern Ireland (1999-2003)

When a death is suspected to be a suicide, the death is referred to a coroner and goes through a formal inquest. Upon completion the coroner will provide a summary of findings to the Registrar and the death is coded by the General Register Office (GRO) of Northern Ireland. It is usually evident from the coroner's finding whether or not the death is a suicide. 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 (ICD)², 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 reluctant to say that the death was a suicide.

This process, particularly the inquest, results in a time delay between the actual death occurring and the date the death is registered, which can be up to several years. Based upon GRO data from the last five available years (1999-2003) and including deaths due to undetermined events only 24.3% of suicides are registered within six months of the actual death occurring, 69.4% are registered within a year and 2.9% take two years or more. This means a long period of time can pass before a complete picture of the total number of suicides occurring in a given year is available.

¹ Source: Hospital Inpatients System and Samaritans Information Sheet on Self-Harm and Suicide (www.samaritans.org/know/information sheets/selfharm/selfharm_sheet.shtm).

² This classification is revised periodically to reflect changing mortality patterns and since 1979 deaths have been classified using version 9 up to 2000 and version 10 since 2001. Slight discontinuities in the data may be introduced by revisions to the ICD but these are generally small in their effect.

With the exception of 2002 and 2003 in which deaths have probably occurred but have not yet been registered, the figures from 1990 onwards are quite close when comparing occurrences and registrations, with the increasing trend in suicides being present in both sets of figures. These differences however are variable with no direct relationship between the two existing.

Comparing deaths data with registrations data shows only a small disparity between the figures. Given the closeness of the figures and the time delay in obtaining a full years set of suicide figures the approach of reporting suicides by year of registration will be used (this is consistent with the way death statistics are reported by NISRA³ and ONS⁴). This is particularly important when looking at the most recent data available as the registrations will give a more accurate impression of the trends in recent years, whereas the death figures give a false impression of falling rates.

Deaths from undetermined intent

In reporting statistics on suicide, it is conventional to combine cases where the cause of death is classified as 'suicide and self-inflicted injury' with cases where the cause of death is classified as an 'event of undetermined intent'⁵. Both NISRA and ONS quote the combined figures whenever producing statistics on suicide but are clear that they include deaths due to events of undetermined intent. Traditionally however, DHSSPS has quoted figures solely using the 'suicide and self-inflicted injury' category. This report adopts the more general approach of combining the two sets of figures and the term 'suicide' will cover both sets of deaths.

Suicide rates in Northern Ireland

During the period 1991 to 2003 there were 1,979 registered deaths from suicide in Northern Ireland. The number of suicides registered peaked in 2000 with 185 suicides while the lowest number of suicides in this time period occurred in 1992 when there were 128 cases. Table 1 illustrates the increasing trend in suicide registrations but also

³ Northern Ireland Statistics and Research Agency (which includes GRO).

⁴ Office of National Statistics – the NISRA equivalent in England and Wales.

⁵ ICD codes used in classifying 'suicide and self inflicted injury' using ICD10 are X60 to X84 and Y87.0. The equivalent codes using ICD9 are E950 to E959. In coding 'events of undetermined intent' the ICD10 codes are Y10 to Y34 and Y87.2 and using ICD9 they are E980 to E989. See Annex 2 for a complete list of ICD10 codes used in this analysis.

highlight the considerable variation each year in the number of cases. Consistent trends are not immediately apparent. For instance, the 21.3% decrease from 183 incidents of registered suicides in 2002 to 144 incidents in 2003 is not necessarily an indication of a change in the trend.

Table 1: Number of suicides (1987-2003)

Year	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
All	148	128	151	151	146	143	138	150	154	185	158	183	144
Male	105	103	120	117	105	114	108	113	127	140	132	142	112
Female	43	25	31	34	41	29	30	37	27	45	26	41	32

Suicide rates, which have been age standardised⁶ to adjust for differences in the age structure of the population in the year the suicides are registered and the age structure of the population at the middle of 2003⁷, are given in Table 2 and are plotted in Figure 1 for each available year since 1991. The 144 suicides which were registered in 2003 equates to a rate of 8.5 suicides per 100,000 persons in the general population. Breaking this down by sex demonstrates significant differences between the male and female populations with 13.4 suicides per 100,000 males compared to 3.7 suicides per 100,000 females.

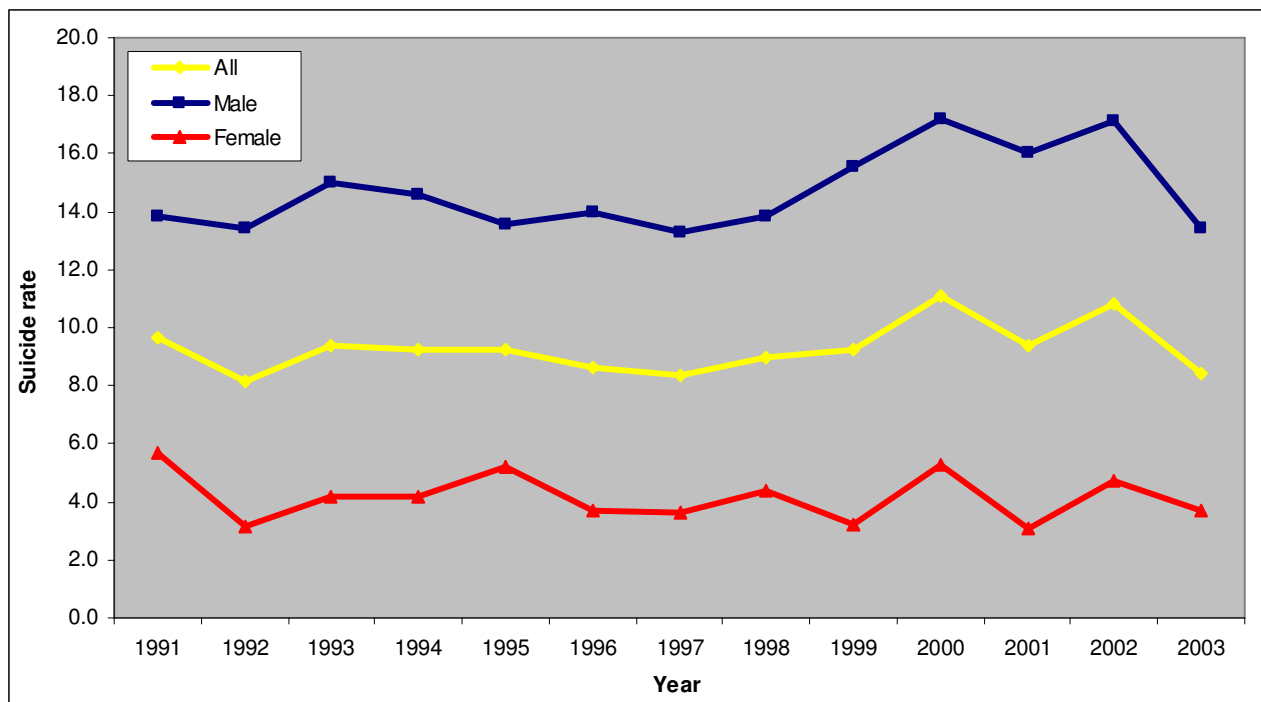
Table 2: Age standardised suicide rate per 100,000 persons (1991-2003)

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
All	9.7	8.2	9.4	9.3	9.3	8.6	8.4	9.0	9.2	11.1	9.4	10.8	8.5
Male	13.9	13.5	15.0	14.6	13.5	14.0	13.3	13.9	15.6	17.2	16.0	17.1	13.4
Female	5.7	3.2	4.1	4.1	5.2	3.7	3.7	4.4	3.2	5.3	3.1	4.7	3.7

Figure 1: Age standardised suicide rate per 100,000 persons (1991-2003)

⁶ Age standardisation facilitates comparisons across either time periods or geographical areas by controlling for differences in the age structure of these time periods or areas. There are two methods of age standardisation: direct and indirect. For suicide rates direct standardisation is used. The directly age standardised rate is the number of suicides that would occur in a standard population (per 100,000) if that population had the age-specific rates at a given period of time or for a given area. The reference population used in this report is the Northern Ireland 2003 mid-year estimate produced by NISRA.

⁷ Based upon results reported from the 1991 and 2001 Censuses; between 1991 and 2001 the age structure of the population continued to become older. In 1991 children aged 16 years of age represented 26% of the population but in 2001 they accounted for 24%. Compared to 1991, there were 5% fewer children aged less than 16 years of age.



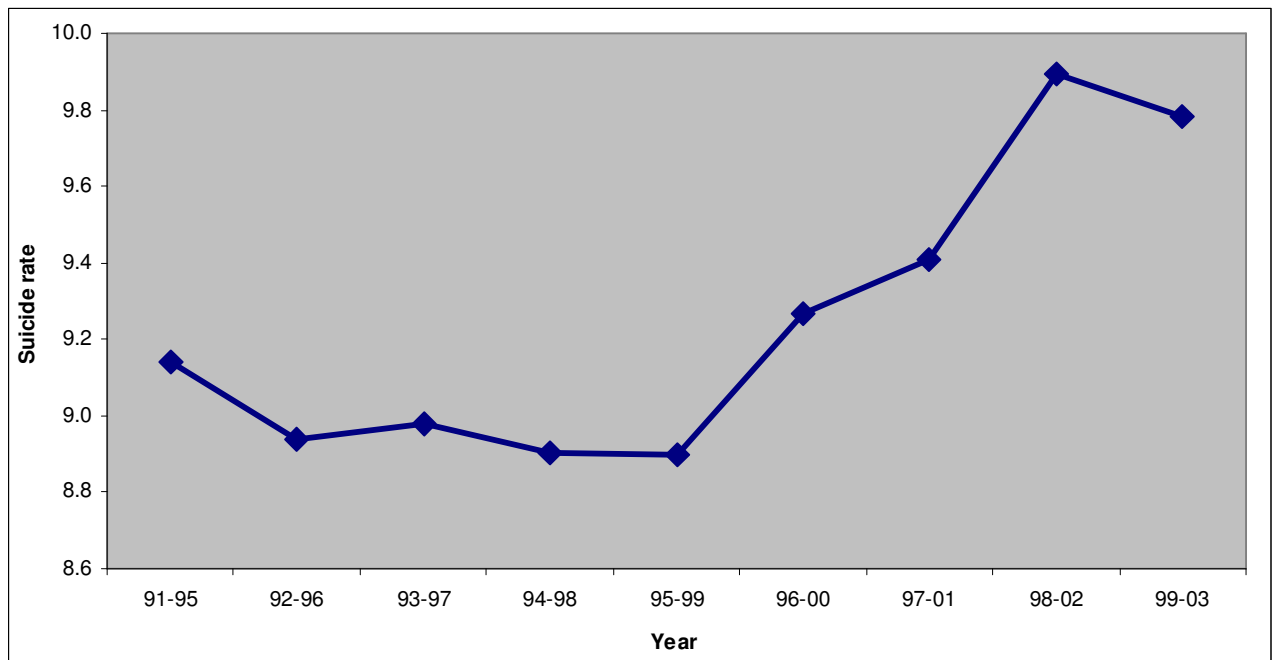
The suicide rates are seen to vary considerably year on year with the rate peaking in 2000 with 11.1 deaths per 100,000 of the population. The suicide rate in 2003 was at its lowest level since 1997 with 8.5 suicides per 100,000 persons.

Over the last five years in Northern Ireland (1999-2003), the suicide rate averaged 9.8 per 100,000 persons. Five year moving averages allow the overall trend in suicides to be more readily identified as they smooth the annual variations. The rates since 1991 are presented in Table 3 and plotted in Figure 6. The rate of suicide in males has been increasing since the period 1995-1999 to 1999-2003. The increase has taken the male suicide rate from 14.1 per 100,000 persons to 15.9 per 100,000 persons in only five years. The female suicide rate however has remained fairly constant during the same period at around 4 suicides per 100,000 females.

Table 3: Age standardised suicide rate per 100,000 persons – five year moving average (1991-2003)

	1991 to 1995	1992 to 1996	1993 to 1997	1994 to 1998	1995 to 1999	1996 to 2000	1997 to 2001	1998 to 2002	1999 to 2003
All	9.1	8.9	9.0	8.9	8.9	9.3	9.4	9.9	9.8
Male	14.1	14.1	14.1	13.9	14.1	14.8	15.2	15.9	15.9
Female	4.5	4.1	4.2	4.2	4.0	4.0	3.9	4.1	4.0

Figure 2: Age standardised suicide rate per 100,000 persons – five year moving average (1991-2003)



Suicide levels in Northern Ireland

There are approximately 15,000 deaths in Northern Ireland each year with 74,127 recorded in total in the five year period from 1999 to 2003. Over this period, suicide represented 1.1% of these deaths. For the purpose of this analysis we will refer to such a percentage (i.e. the percentage of deaths which have suicide attributed as the cause) as the suicide level.

Equality Groups

Suicide information is taken from information on deaths recorded by the General Register Office, which does not record data on all nine equality groups outlined in the Northern Ireland Act (1998). Information is only readily available for sex, age and marital status. However the full postcode is recorded which allows various geographical comparisons to be made.

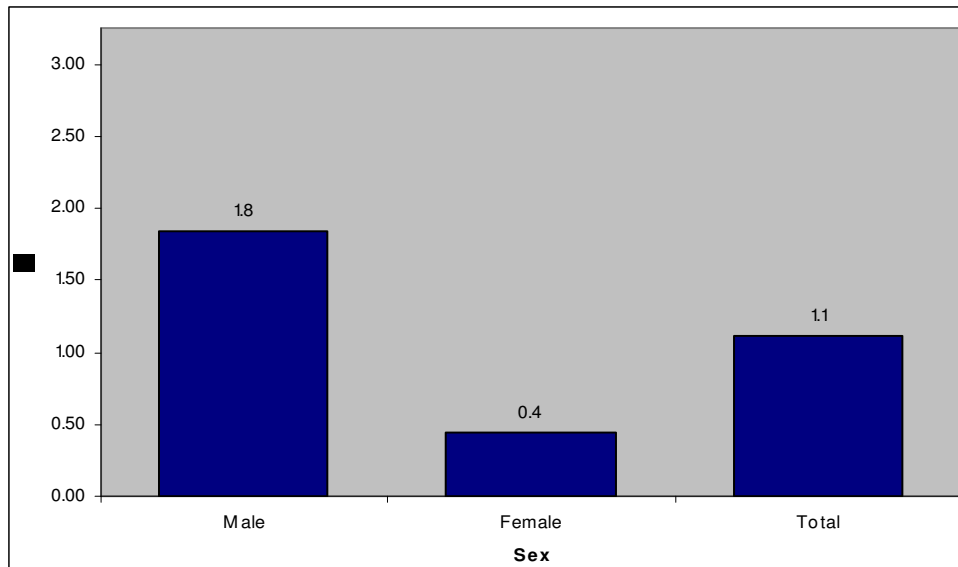
This analysis will mostly examine the impacts of suicide on equality groups in two ways. Firstly, the suicide level across each group will be compared and contrasted (i.e. the proportion of deaths attributable to suicide that occurred during 1999 and 2003). A limitation of this approach is that all deaths are understandably dominated by older persons whose characteristics can differ from younger persons (e.g. marital status). The second method compares the average number of suicides each year for each equality

group expressed as a proportion of the total population within each group (2001 Census of Population). As the numbers tend to be quite small, the average suicide rate will be expressed as a ratio of each 100,000 persons in the population. Both methods will be used in conjunction to attempt to ascertain differential impact.

Sex

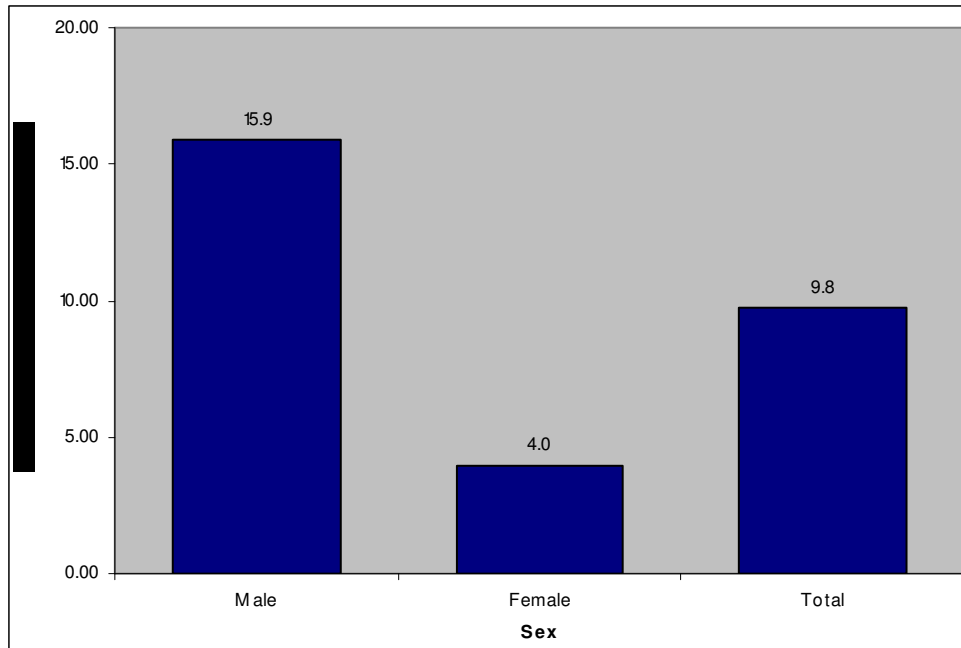
Overall males accounted for almost four-fifths of the 824 suicides (79.2%) that occurred in Northern Ireland between 1999 and 2003.

Figure 3: Proportion of all deaths due to suicide by sex



Overall the suicide level for males (1.8%) was considerably higher than that of females (0.4%). This shows that there is differential impact acting against males.

Figure 4: Average suicide rate per 100,000 persons by sex



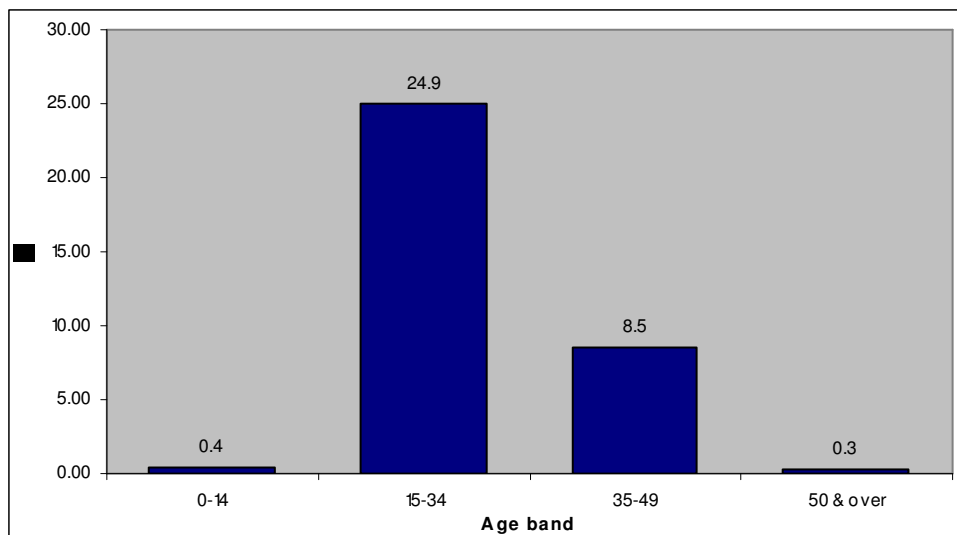
On average there were 15.9 male suicides per 100,000 persons, which compares with 4.0 female suicides. This provides further strong evidence of differential impact acting against males.

Age

Nearly half of all suicides in NI that occurred during 1999 and 2003 were carried out by persons in the 15 to 34 age group. A further 30.6% of suicides were carried out by those in the 35 to 49 age group. The median⁸ age for those committing suicide was 35 years of age, while the median age for males is 34 years old and 40 years old for females.

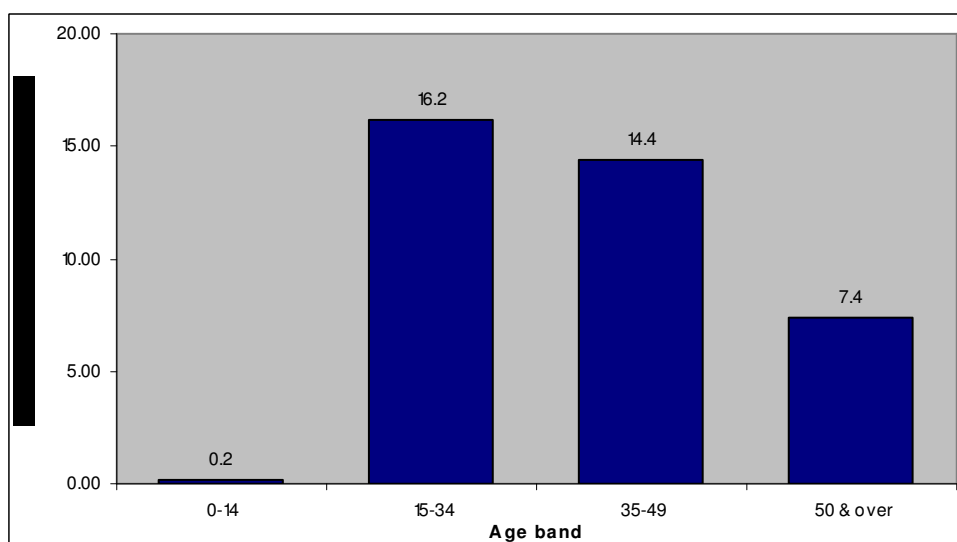
Figure 5: Proportion of all deaths due to suicide by age band

⁸ A quantity, term, or value that is the midpoint of a set of values, such that the variable has an equal probability of falling above or below it, i.e. the middle term of a series of values arranged in order of magnitude (or, if there is no middle term, the mean of the middle two terms).



Nearly a quarter of all deaths (24.9%) of persons aged between 15 and 34 years of age between 1999 and 2003 were attributable to suicide. This compares with 8.5% of those aged 35 to 49 years of age. Suicides accounted for proportionately few of the deaths of those aged 14 years and under and those aged 50 years and above. Therefore it would appear that there may be potential differential impact against the 15 to 34 age group.

Figure 6: Average suicide rate per 100,000 persons by age band



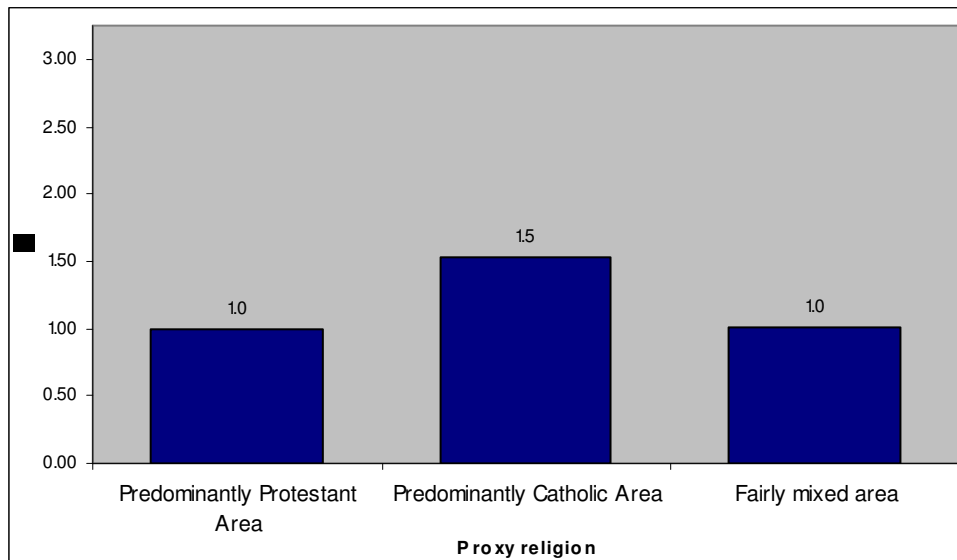
Comparing the numbers of suicides with the 2001 Census population shows that the 15 to 34 age group has the highest numbers of suicides per 10,000 persons (16.2). However the disparity, outlined in figure 5 with other age groups (especially the 35 to 49 age group) is greatly reduced.

Religion

The information recorded by GRO for deaths does not include the religion of the deceased person. However by using the full postcode, which is recorded, it is possible to assign a proxy for religion. Using information from the 2001 Census of Population, the religious composition of each Census Output Area (COA) can be determined. The postcode allows each death (and therefore incidence of suicide) to be assigned to a COA. For the purposes of this analysis, an area that has 80% or more of its resident population being Protestant is deemed to be a predominantly Protestant Area. Similarly an area with a population that is 80% or more Roman Catholic has been deemed a predominantly Catholic Area. All other areas are assumed to be of mixed composition.

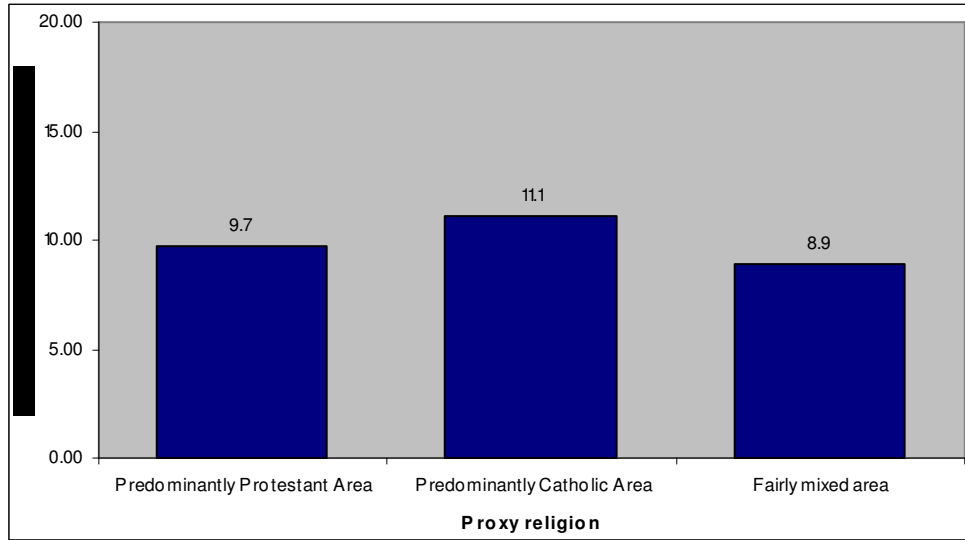
Overall, 35.4% of the population were living in predominantly Protestant Areas, 26.3% in predominantly Catholic Areas and 38.3% in fairly mixed Areas. Within all the areas deemed Protestant, 89.3% of the population were Protestant. Within all the areas deemed mostly Catholic, 93.8% of the population were Roman Catholic. Within the “Fairly Mixed Areas” 52.4% of the population were Protestant and 43.8% were Catholic.

Figure 7: Proportion of all deaths due to suicide by proxy religion



As can be seen from figure 7, suicides account for a higher proportion of deaths in predominantly Catholic areas (1.5%) than in Protestant areas (1.0%) or mixed areas (1.0%). This might suggest that there is differential impact acting against Roman Catholics. However a firm conclusion on whether differential impact exists cannot be reached due to the fact that there will be a substantial proportion of Catholics living in mixed areas. The observed effect could in fact be an area effect, in that it is due to the relative affluence/deprivation or rurality present in each area.

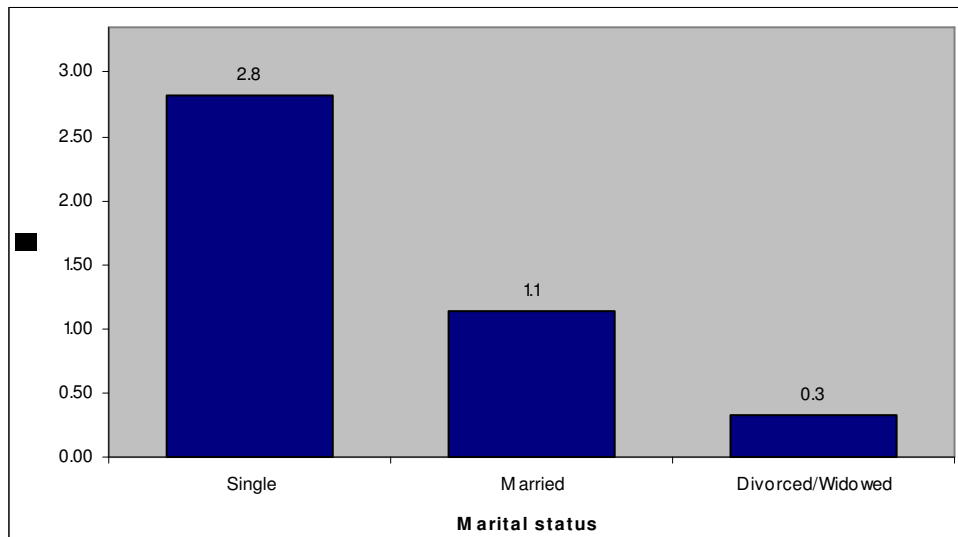
Figure 8: Average suicide rate per 100,000 persons by proxy religion



Comparing the average suicide rate between 1999 and 2003 with the composition of wider population, shows that a higher suicide rate per 100,000 persons occurred in predominantly Catholic areas (11.1) than in Protestant (9.7) and mixed areas (8.9).

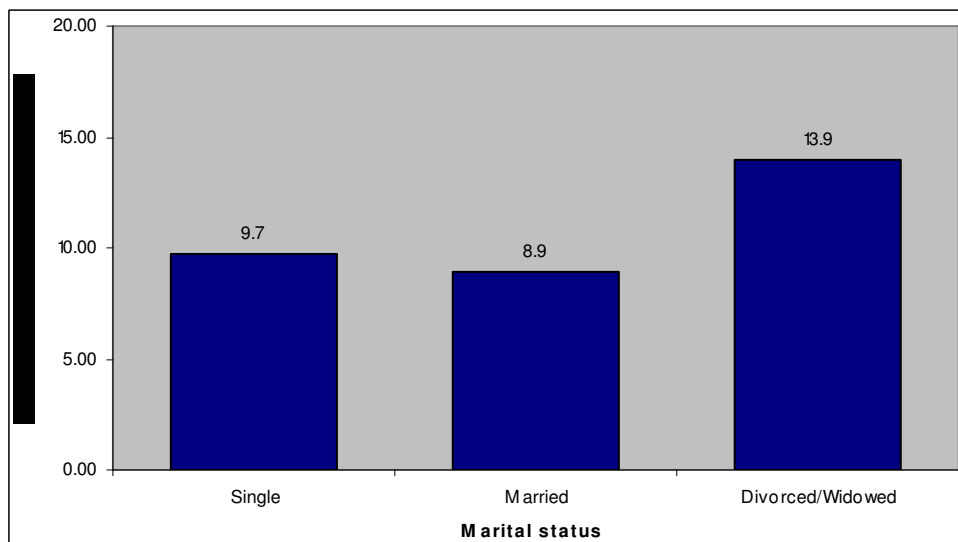
Marital status

Figure 9: Proportion of all deaths due to suicide by marital status



The suicide level amongst the single marital status group (2.8%) was considerably higher than in the other groups. This would suggest that there is differential impact against the single group. Although the lower suicide levels among the married and divorced/widowed groups may be due to some extent to the age distribution of deaths (a large proportion of deaths occur in the older population).

Figure 10: Average suicide rate per 100,000 persons by marital status



However when comparing the average suicide rate per 100,000 persons, the single marital status group was broadly similar to the married group and lower than in the divorced/widowed group. It is not possible to reach a firm conclusion whether this constitutes differential impact as the numbers in the population that are either divorced or

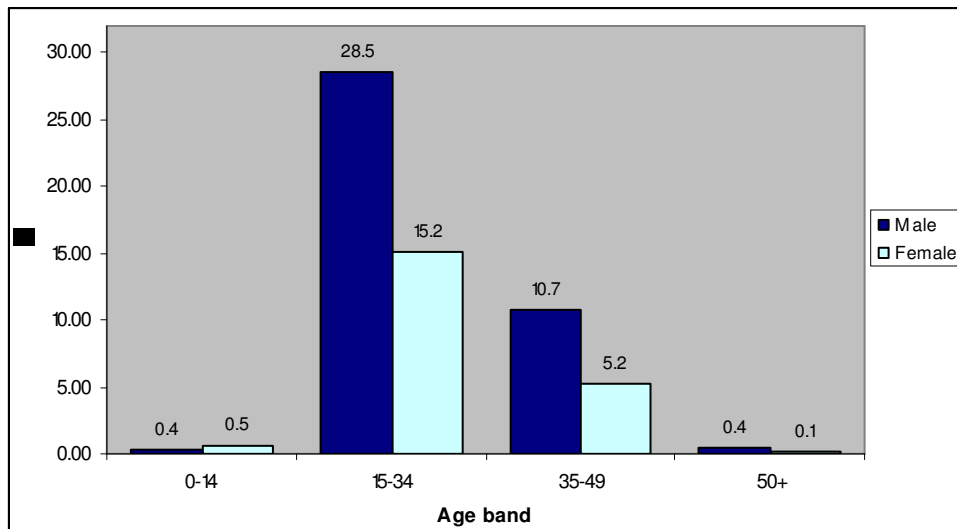
widowed are relatively small compared with the other groups. This analysis would cast doubt on whether there is differential impact acting against any marital status group.

Further disaggregations

Further analysis is required to establish whether the observed effects actually constitute actual differential impact and that they do not occur due to interactions with other variables.

Gender and age

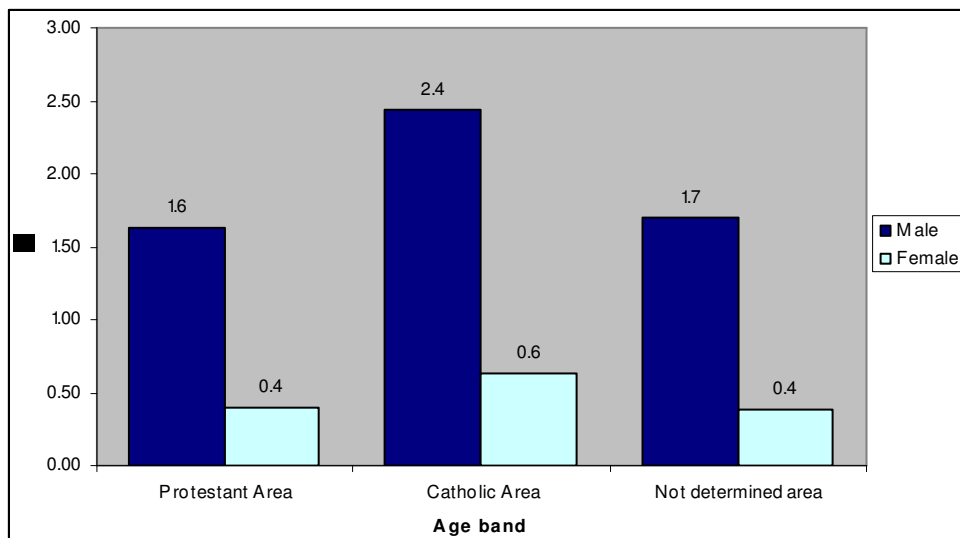
Figure 11: Proportion of all deaths due to suicide by sex and age band



Generally, the suicide level for males was higher than for females across each age band. In both the 15-34 and the 35-49 age bands, the male suicide level was approximately twice that for females. Therefore age does not provide an explanation of the overall gender difference. As with males, suicide within the 15-34 age band accounts for the largest proportion of females deaths. This would suggest that there is also an age effect present.

Gender and religion

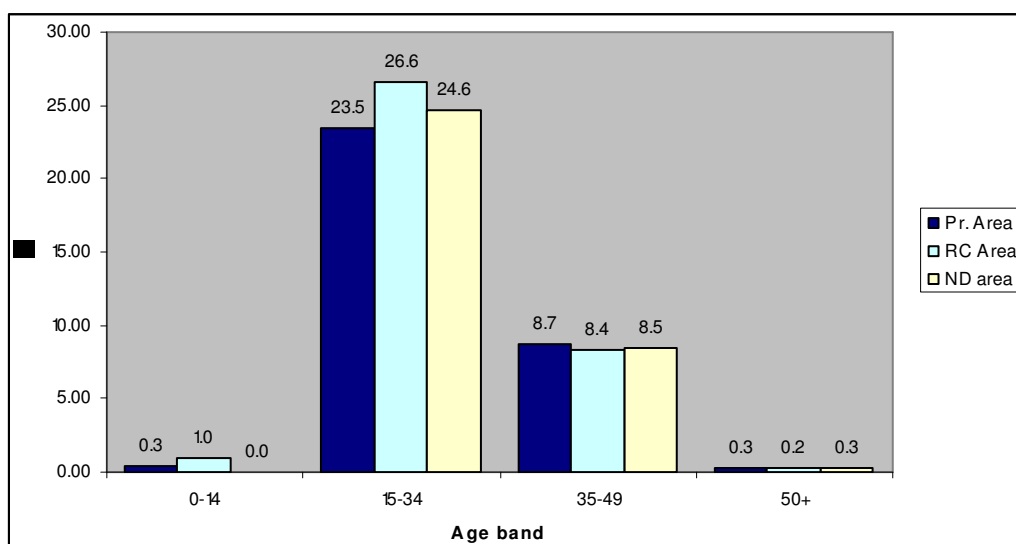
Figure 12: Proportion of all deaths due to suicide by sex and age band



Suicides account for four times the proportion of all male deaths than female deaths across each category. The male and female figures show a similar trend to the overall figures (see fig 7) with suicides in predominantly Catholic areas accounting for one and a half times the proportion of deaths within the other areas. Therefore it can be concluded that the slight religion or area effect cannot be explained by differences in gender composition.

Age and religion

Figure 13: Proportion of all deaths due to suicide by proxy religion and age band

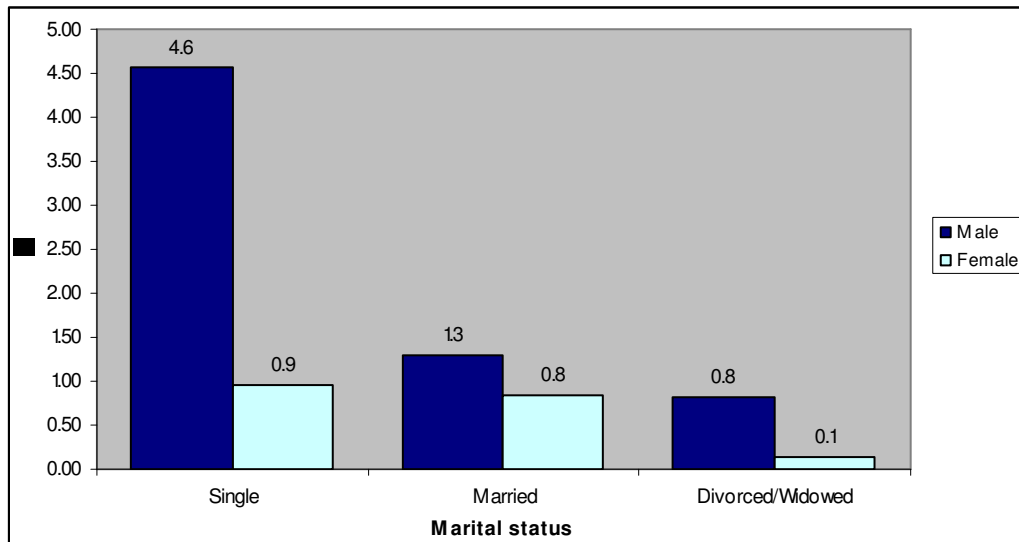


Suicide levels by age band are broadly similar across all categories although the 15-34 proportion is slightly higher in predominantly Catholic areas than in Protestant and mixed areas. Comparing with the overall population shows that on average, a higher suicide rate

per 100,000 persons among the 15-34 age group in predominantly Catholic areas (21.1) than in predominantly Protestant areas (15.5) and in mixed areas (13.5). This would suggest that the slight religion or area effect is not explained entirely by differences in the age profile within each area type.

Marital status and gender

Figure 14: Proportion of all deaths due to suicide by marital status and sex



Although the proportion of deaths that can be attributed to suicide was higher for males than females across each marital status group, the obvious disparity with the proportion of single males with all other groups would indicate differential impact acting against single males. As the average suicide rate per 100,000 persons for divorced/widowed males (35.5) was more than twice that of single males (15.6) and married males (13.8), this suggests differential impact against the divorced/widowed group. This cannot be firmly concluded as the divorced/widowed group is relatively small in size compared with the other groups.

Marital status and age

Figure 15: Proportion of all deaths due to suicide by marital status and age band

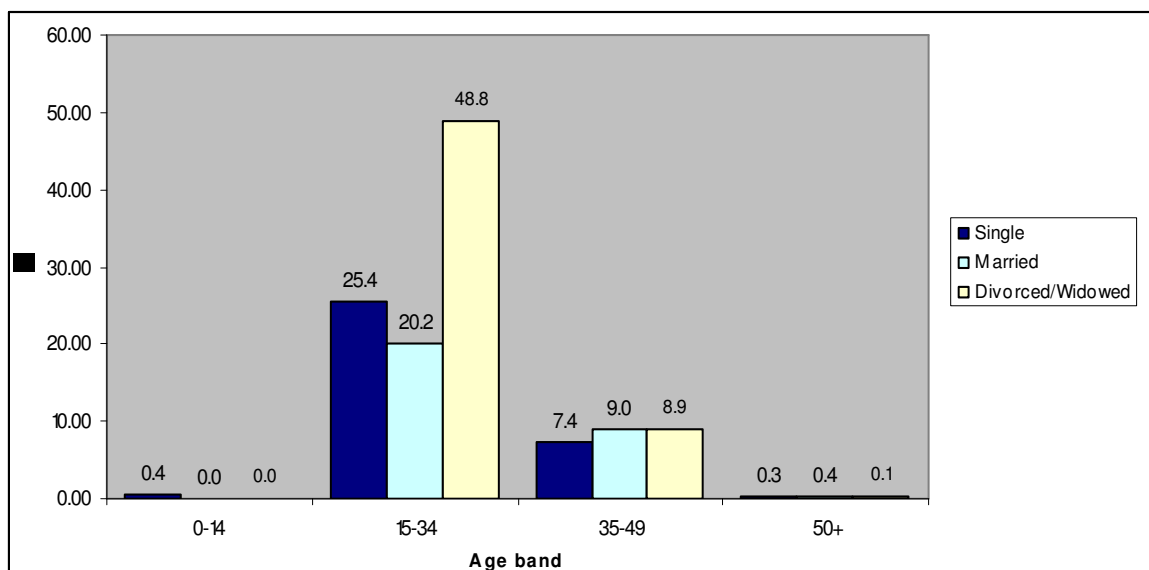


Figure 15 shows a clear age effect with the highest proportions of all deaths due to suicides occurring within the 15-34 age band. Within the 15-34 age group, the highest suicide level occurs within the widowed/divorced, however as this is based on relatively small numbers. The proportion of suicides within the single marital status group aged 15 to 34 (25.4%) is higher than that in the married group (20.2%). The difference between the two groups disappears however when just males aged 15 to 34 years of age are analysed (27.8% of single males aged 15-34 compared with 27.5% of married males). Therefore it can be concluded that the apparent differential impact on the single marital status group can mostly be explained by differences in age and sex composition.

Conclusion – Equality groups

From the analysis, there is evidence of a strong differential impact against males and also the 15-34 age group. There also seems to be a lesser differential impact against 'predominantly Catholic areas' which cannot be explained by differences in sex and age. However due to the fact that a large proportion of all Roman Catholics actually live in mixed areas, no firm conclusion can be reached on whether there was real differential impact. The apparent differential impact in predominantly Catholic areas may actually be due to the deprivation/rurality of these areas. Any apparent differential impact on the single marital status group can be explained by differences in the sex and age composition of the group.

Rurality

Overall, approximately a third of the population in Northern Ireland (33.5%) lived in rural areas. A slightly higher proportion of the population in rural areas (50.6%) were male than in urban areas (47.8%). Broadly similar proportions of the population in rural (50.9%) and urban (50.4%) areas were aged 34 years or less.

Fig 16: Proportion of all deaths due to suicide by rurality

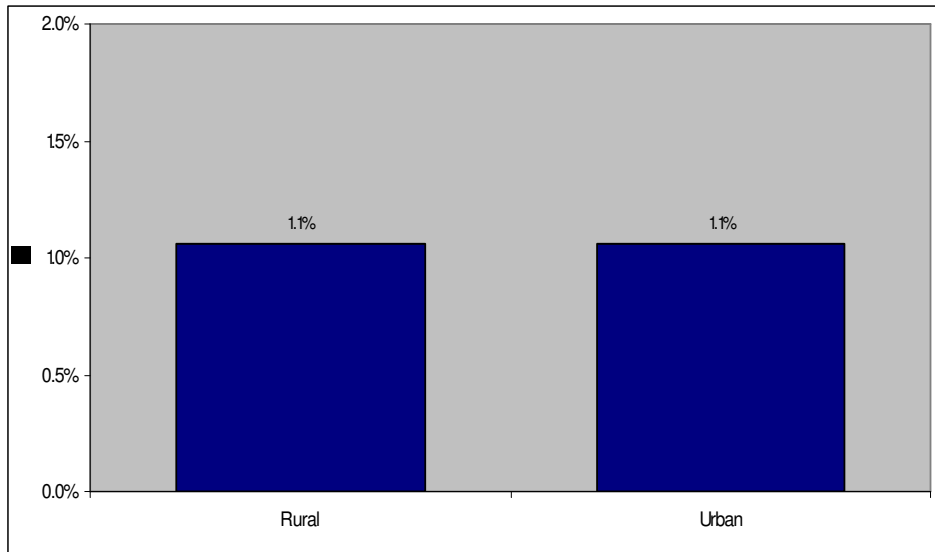
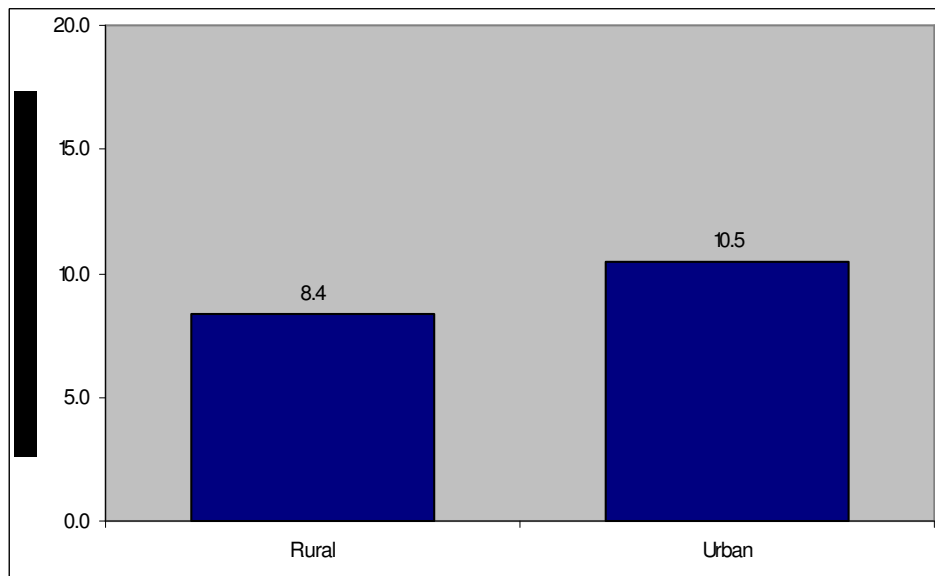


Figure 17: Average suicide rate per 100,000 persons by rurality



Overall suicides accounted for 1.1% of all deaths in both rural and urban areas (see figure 16). However, there was a higher average number of suicides per 100,000 persons in urban areas (10.5) than in rural areas (8.4).

Rurality by sex

Fig 18: Proportion of all deaths due to suicide by rurality and sex

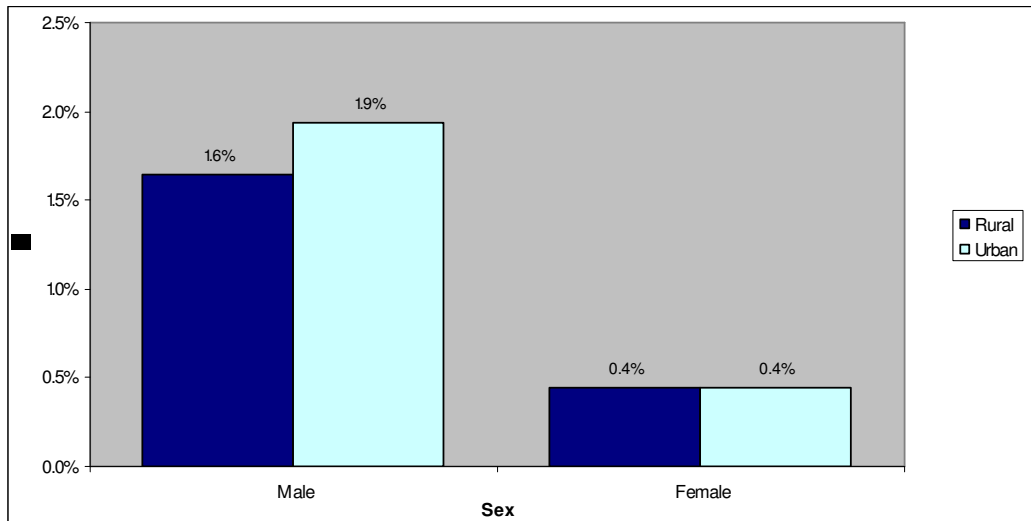
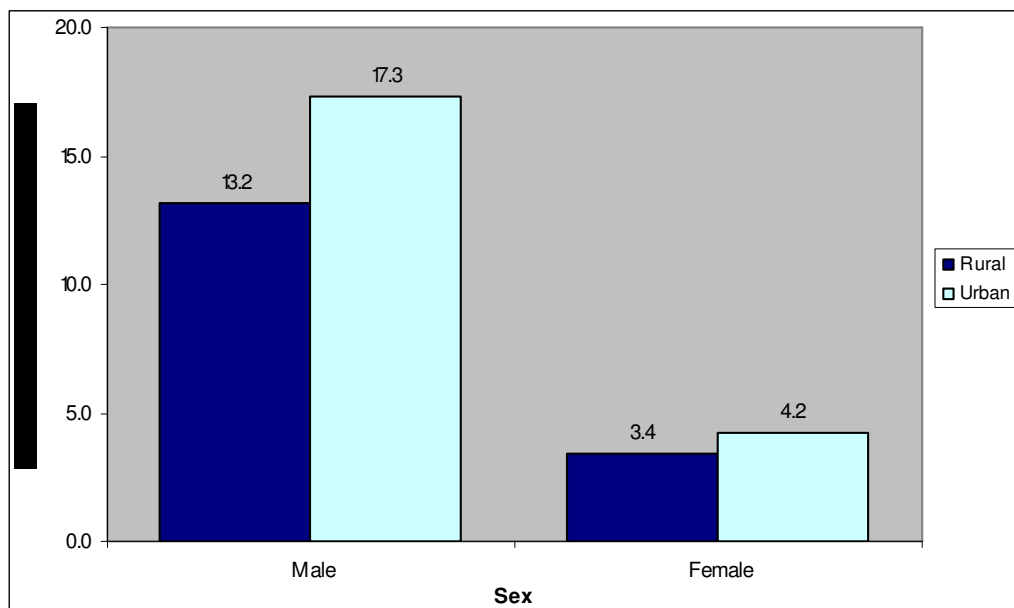


Figure 19: Average suicide rate per 100,000 persons by rurality and sex



The male suicide level was slightly higher in urban areas (1.9%) than in rural areas (1.6%), whereas the proportion for females was identical (fig 18). The average suicide rate per 100,000 persons was higher in urban areas for both males and females.

Rurality by age band

Fig 20: Proportion of all deaths due to suicide by rurality and age band

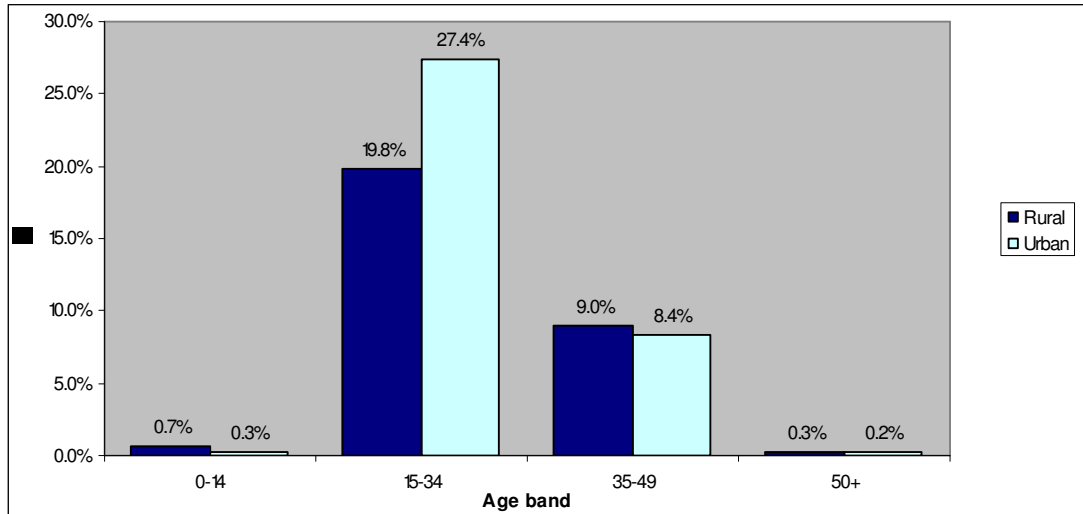
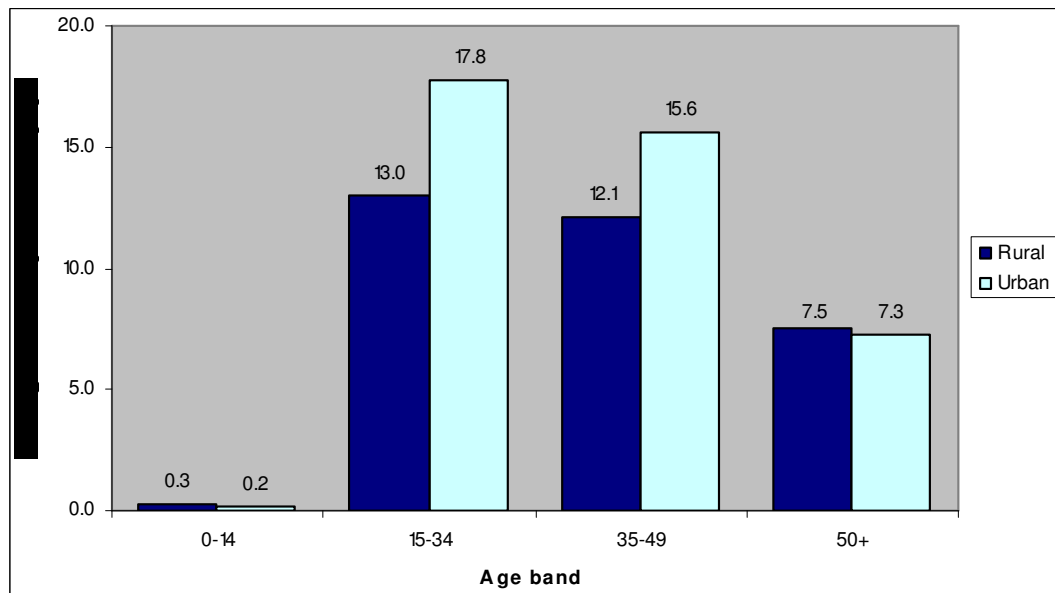


Figure 21: Average suicide rate per 100,000 persons by rurality and age band



Apart from the 15-34 age group, the proportions of all deaths due to suicide were broadly similar across age bands in urban and rural areas. Within the 15-34 age group, the proportion of suicides for urban areas (27.4%) was almost one and a half times the proportion in rural areas (19.8%). The average suicide rate per 100,000 persons for both the 15-34 and 35-49 age bands was considerably higher in urban areas (see figure 21).

Conclusion - Rurality

From this analysis, it would seem even when controlling for age and gender that suicide is more prevalent in urban areas. This is confirmed by comparing the proportion of deaths due to suicide of males in the 15-34 age group. The proportion of all deaths that were due

to suicide in urban areas (31.5%) was considerably higher than in rural areas (23.0%) (the average suicide rate per 100,000 persons was also higher in urban areas).

Economic Deprivation

Economic Deprivation is based on the Northern Ireland Multiple Deprivation Measure (2005), looking specifically at the Income, Employment and Proximity to Services Deprivation domains. The measure is calculated at Census Output Area (of which there are 5,022 in Northern Ireland). “Economically deprived” areas for the purpose of this analysis are defined as the top 20% most deprived Census Output Areas (1,004). Overall 19.1% of the population live in “economically deprived” areas. Broadly similar proportions of males live in deprived (47.7%) and non-deprived areas (48.9%). However the population living in economically deprived areas tended to be younger with 54.1% of the population aged 34 or younger compared with 49.7% in non-deprived areas.

Fig 22: Proportion of all deaths due to suicide by economic deprivation

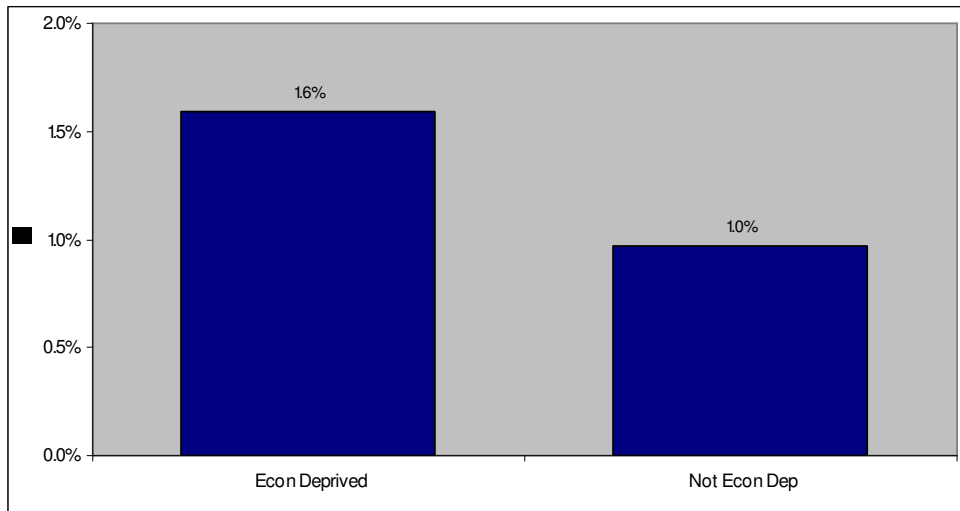
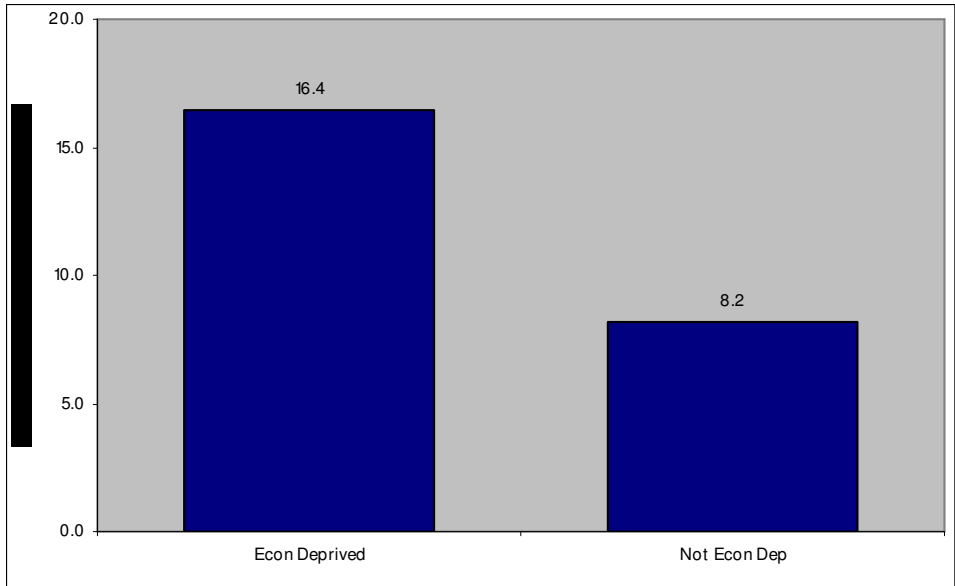


Figure 23: Average suicide rate per 100,000 persons by economic deprivation



A higher proportion of all deaths was due to suicide in economically deprived areas (1.6%) than in non-deprived areas (1.0%). The average suicide rate per 100,000 persons in economically deprived areas (16.4) was twice that in non-deprived areas (8.2).

Economic Deprivation by sex

Fig 24: Proportion of all deaths due to suicide by economic deprivation and sex

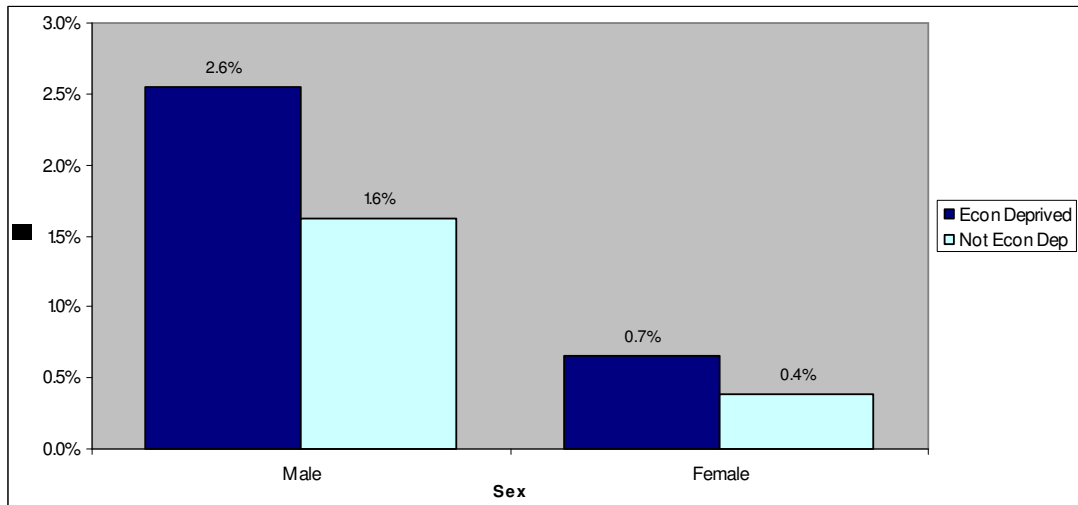
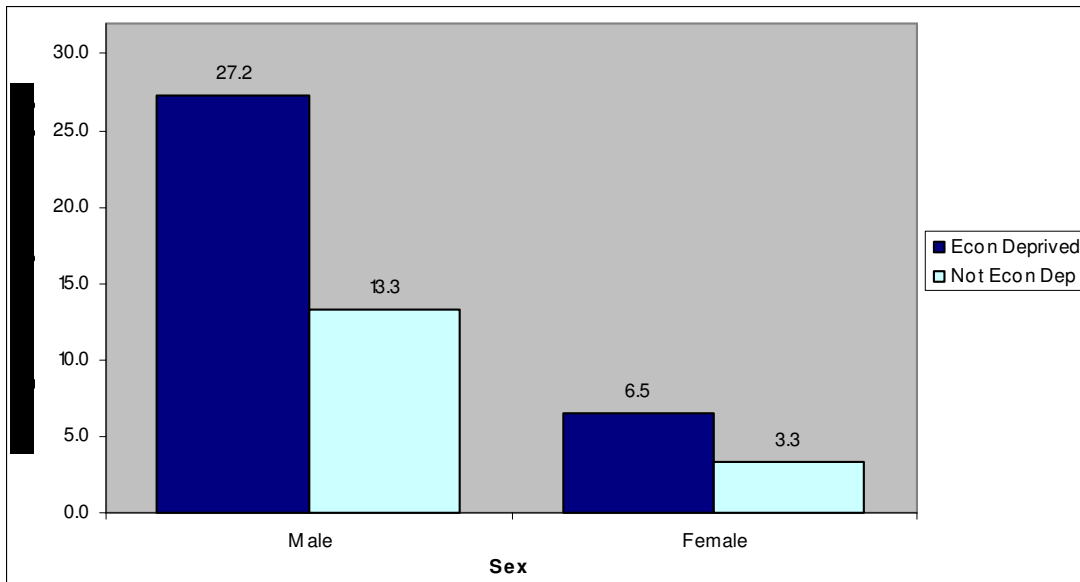


Figure 25: Average suicide rate per 100,000 persons by economic deprivation and sex



Both the suicide level and the average suicide rate per 100,000 persons were higher in economically deprived areas for males and females. The patterns by sex are similar to the overall economic deprivation patterns (see figures 22 and 23).

Economic deprivation by age band

Fig 26: Proportion of all deaths due to suicide by economic deprivation and sex

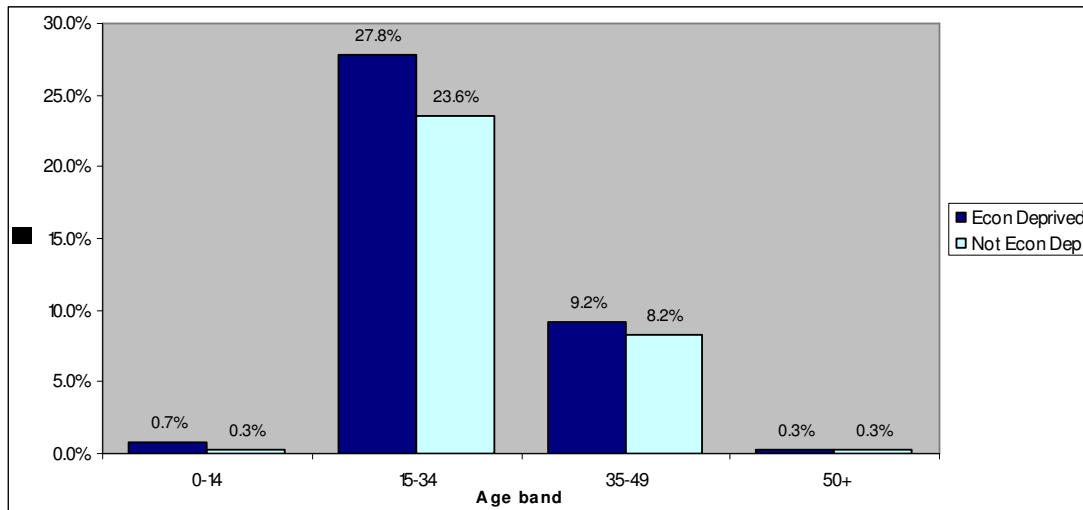
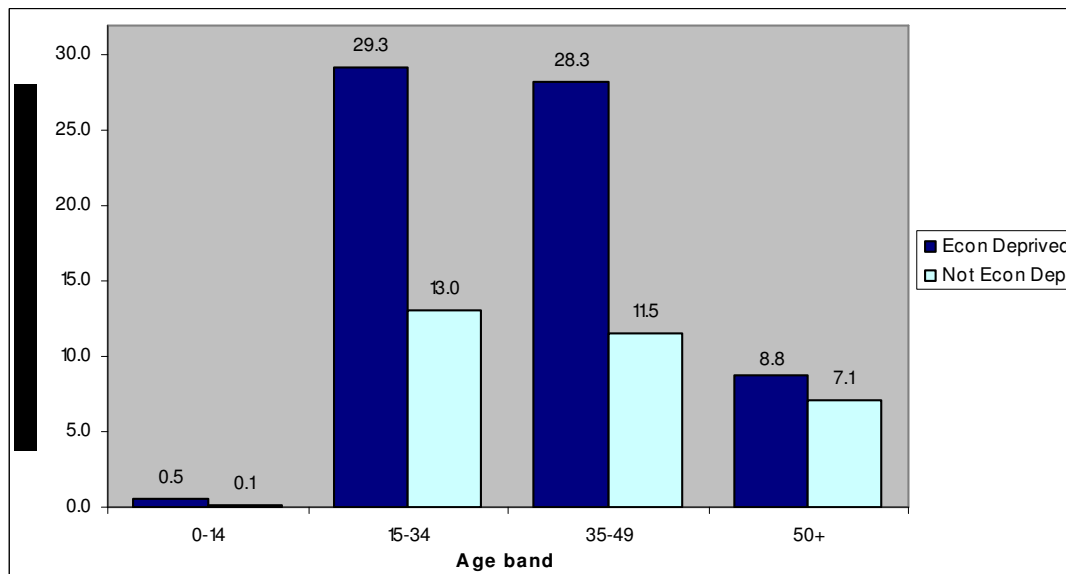


Figure 27: Average suicide rate per 100,000 persons by economic deprivation and sex



The proportion of deaths due to suicide was slightly higher in economically deprived areas across all age bands. The average suicide rate per 100,000 persons was also higher in each age category in economically deprived areas, with the largest disparity occurring in the 15-34 and 35-49 age bands.

Conclusion- Economic Deprivation

Suicide is more prevalent in economically deprived areas than in non-deprived areas. The difference between deprived and non-deprived areas is more evident when looking at the

suicide rate within the population than as a proportion of deaths. For male 15-34 year olds, the average number of suicides per 100,000 persons was 50.1 in economically deprived areas compared with 21.6 in non-deprived areas. Economic deprivation offers one possible explanation of the higher prevalence of suicide in predominantly Catholic areas as 45.7% of these were economically deprived. This compares with 13.4% of predominantly Protestant areas and 10.6% of mixed areas.

Socio-economic Group

This analysis is based on the National Statistics Socio-economic Classification (NS-SeC) which has been used by GRO to classify deaths occurring since 2002. Therefore this analysis is restricted to suicides that occurred in 2002 and 2003.

Fig 28: Proportion of all deaths due to suicide by socio-economic group (2002/03)

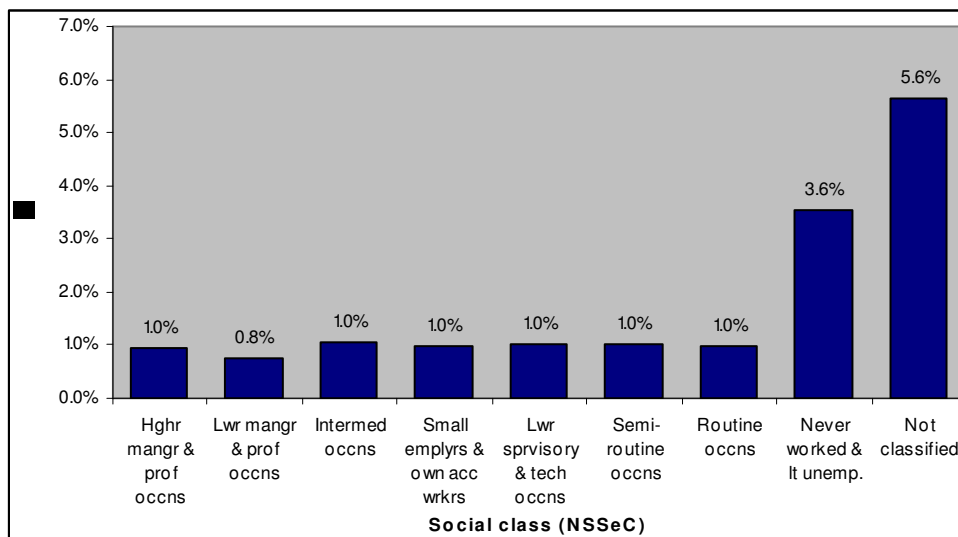
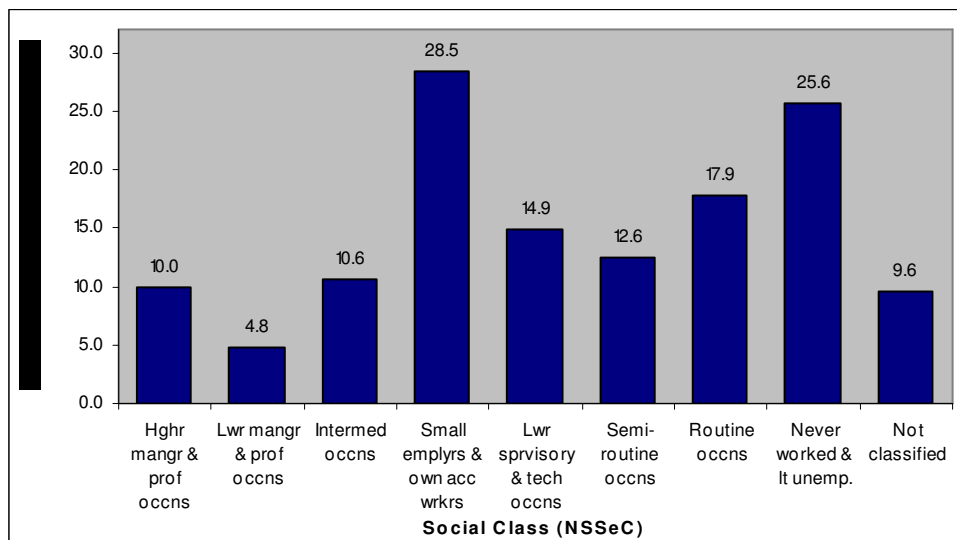


Figure 29: Average suicide rate per 100,000 persons by socio-economic group (2002/03)



With the exception of the never worked or long-term unemployed (3.6%) and the not classified group (5.6%), the suicide level was 1.0% or less for all socio-economic groups. The highest average suicide rate per 100,000 persons occurred in the small employers and own account workers group (28.5) and the never worked or long-term unemployed group (25.6). The lowest average suicide rate was in the lower manager and professional occupations group (4.8).

Geographical area

Local Government District (LGD)

Fig 30: Proportion of all deaths due to suicide by LGD

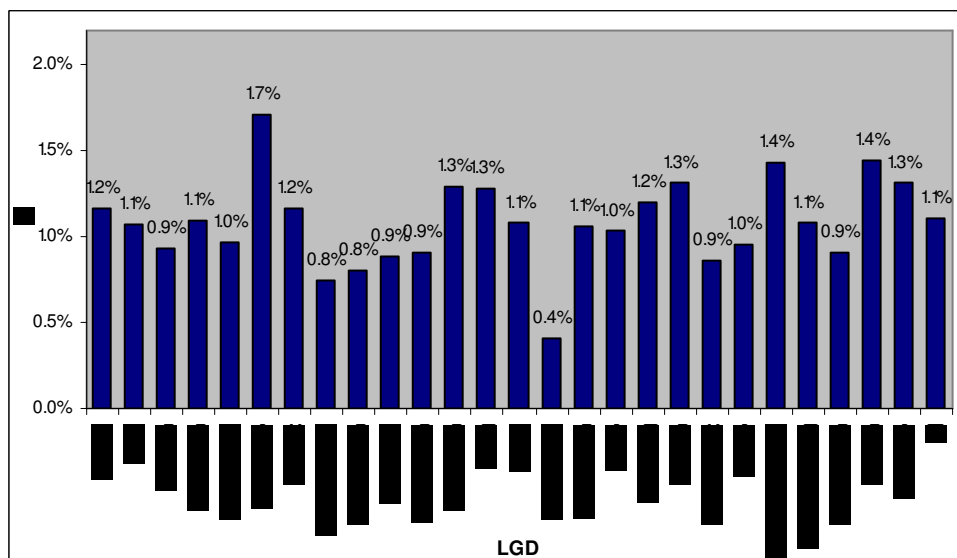
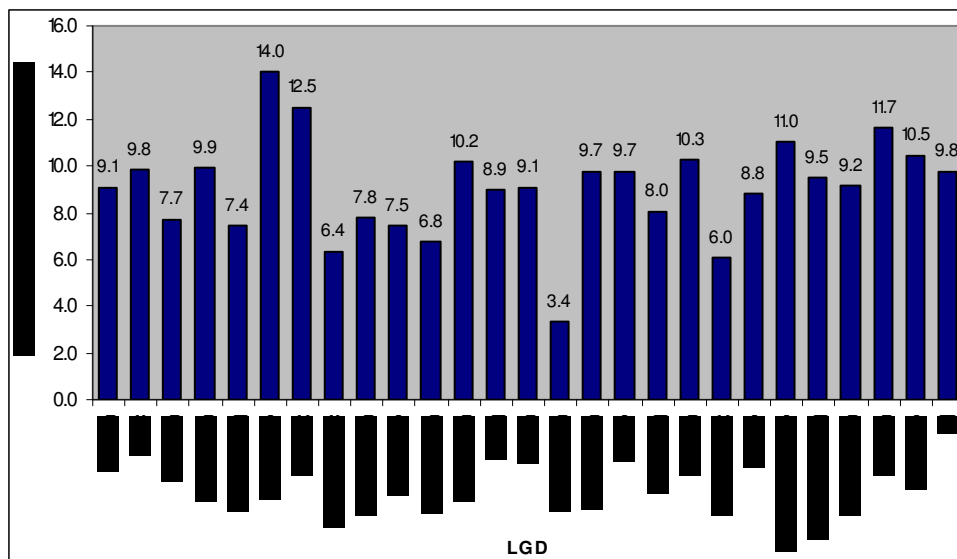


Figure 31: Average suicide rate per 100,000 persons by LGD



The highest suicide level occurred in Banbridge LGD (14.0) whilst the lowest proportion was in Dungannon LGD (3.4). Banbridge LGD (14.0) also had the highest and Dungannon LGD (3.4), the lowest average suicide rate per 100,000 persons. There were also relatively high average suicide rates in Belfast LGD (12.5) and Omagh LGD (11.7).

Parliamentary Constituency Area (PCA)

Fig 32: Proportion of all deaths due to suicide by PCA

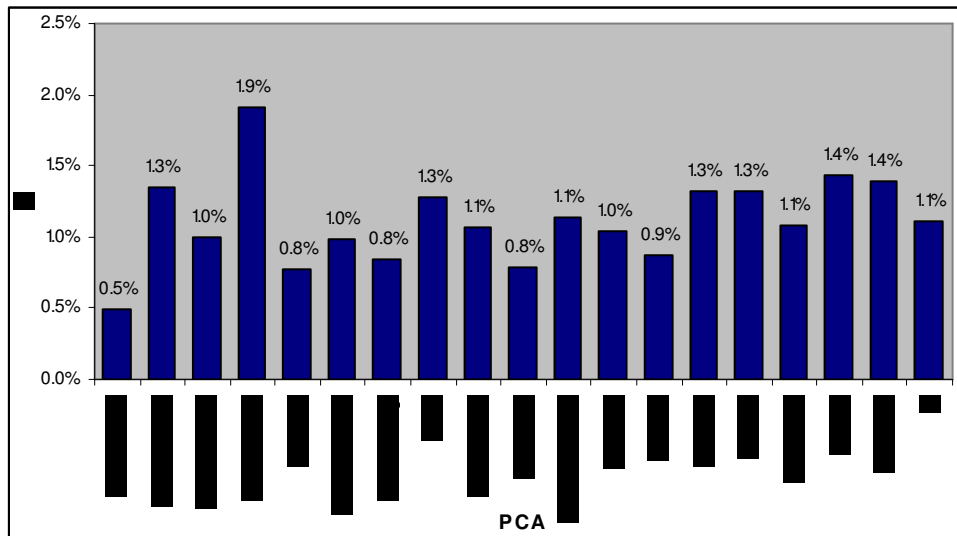
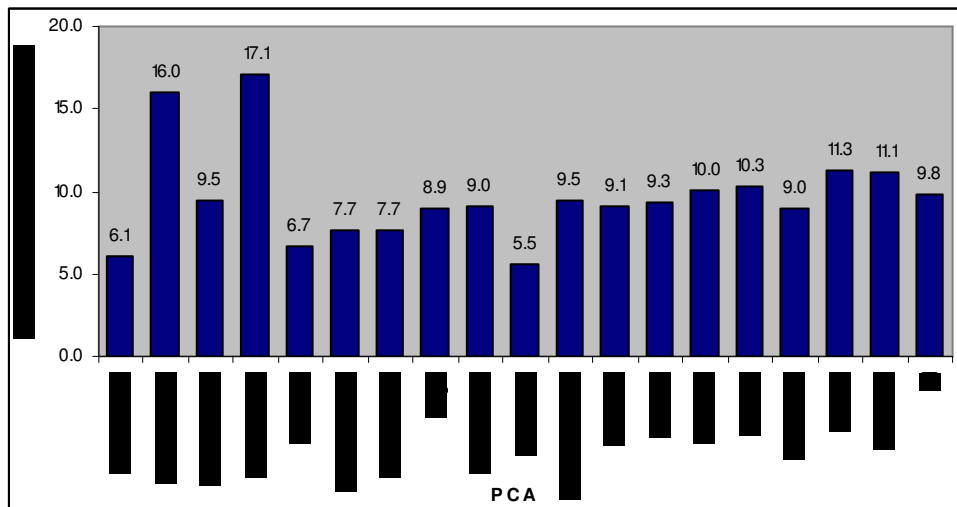


Figure 33: Average suicide rate per 100,000 persons by PCA



The highest proportion of all deaths due to suicide was in Belfast West (1.9%) whilst the lowest was in Belfast East (0.5%). Belfast West and Belfast North had the highest average suicide rate per 100,000 persons (17.1 and 16.0 respectively). The lowest suicide rates were in Mid-Ulster (5.5), Belfast East (6.1) and East Antrim (6.7).

Overall Conclusion - Suicide

Suicide is clearly most prevalent in males and young adults. However there is also evidence to suggest that it is more prevalent in urban and economically deprived areas. Banbridge LGD and Belfast West Parliamentary Constituency Area are relatively badly affected by suicide whereas Dungannon LGD and Belfast East PCA are least affected by the problem. Seemingly differential impact on the single marital status group can be explained by differences in the sex and age composition of each group whereas any impact on Roman Catholics may be explained by economic deprivation. Due to the limited equality data for deaths recorded by GRO, it is quite possible that there may be differential impact on other equality groups that have not been analysed such as sexual orientation, disability status, ethnicity and those with/without dependants.

Summary table

	Differential impact (Y/N)	Against	Possible causal factors
Sex	Y	Males	
Age	Y	15-34 and to a lesser extent the 35-49 age groups	
Religion	Y	Catholics	Economic Deprivation
Marital status	Y	Single group, also potentially against widowed/divorced group (but could not confirm due to the relatively small numbers in the group)	Sex and age
Rurality	Y	Urban areas	
Economic Deprivation	Y	Economically Deprived areas	

In analysing this data, use of a multivariate statistical tool was considered, however the effects could be reasonably isolated using simple crosstabulations.

SELF HARM IN NORTHERN IRELAND

The term self-harm covers a wide range of behaviours including parasuicide⁸ and habitual self-cutting and poisoning which involves differing degrees of risk to life and differing degrees of suicidal intent. Incidents of self-harm which result in admissions to hospital are recorded in the DHSSPS Hospital Inpatients System (HIS) which uses the same International Statistical Classification of Diseases and Related Health Problems (ICD) used in the classification of deaths⁹.

Over the five year period, 2000/01 to 2004/05, the number of admissions to hospital¹⁰ as a result of self-harm increased by 2.7% from 4,583 to 4,705 (Table 4)¹¹. Considerable variation in the number of admissions exists during these years with a peak of 5,204 admissions occurring in 2001/02. During the full five year period there were a total of 23,602 admissions to hospital due to self-harm. This represents 1.0% of all hospital admissions during this period.

Table 4: Number of hospital admissions as a result of self-harm (2000/01-2004/05)

Year	2000/01	2001/02	2002/03	2003/04	2004/05	Total
Admissions as a result of self-harm	4,583	5,204	4,591	4,519	4,705	23,602
All admissions	466,700	476,255	487,519	508,826	521,127	2,460,427
% of all admissions	0.98%	1.09%	0.94%	0.89%	0.90%	0.96%

While the numbers of admissions to hospital as a result of self-harm are high, the percentage of persons who die as a result of their injuries while in hospital is small. Such patients are likely to be registered as a death by suicide or event of undetermined intent by the General Register Office once any inquest is completed. However, such deaths

⁸ Parasuicide according to the World Health Organisation (WHO) is defined as 'an act with non-fatal outcome, in which an individual deliberately initiates a non-habitual behaviour that, without intervention from others, will cause self-harm and which is aimed at realising changes which the subject desired via the actual or expected physical consequences'.

⁹ ICD codes used in classifying self-harm using ICD10 are X60 to X84 and Y87.0. A full description of these codes is given in Annex B.

¹⁰ Deaths & Discharges are used as an approximation for admissions.

¹¹ These figures represent instances of self-harm, they do not represent individuals as a person may have more than one instance of self-harm.

make up only a small fraction (8.1%¹²) of the total number of deaths by suicide and self-inflicted injury¹³.

¹² The figure of 8.1% comes from the General Register Office for the period 1999-2003.

¹³ It is not currently possible to link self-harm with eventual suicide through administrative systems.

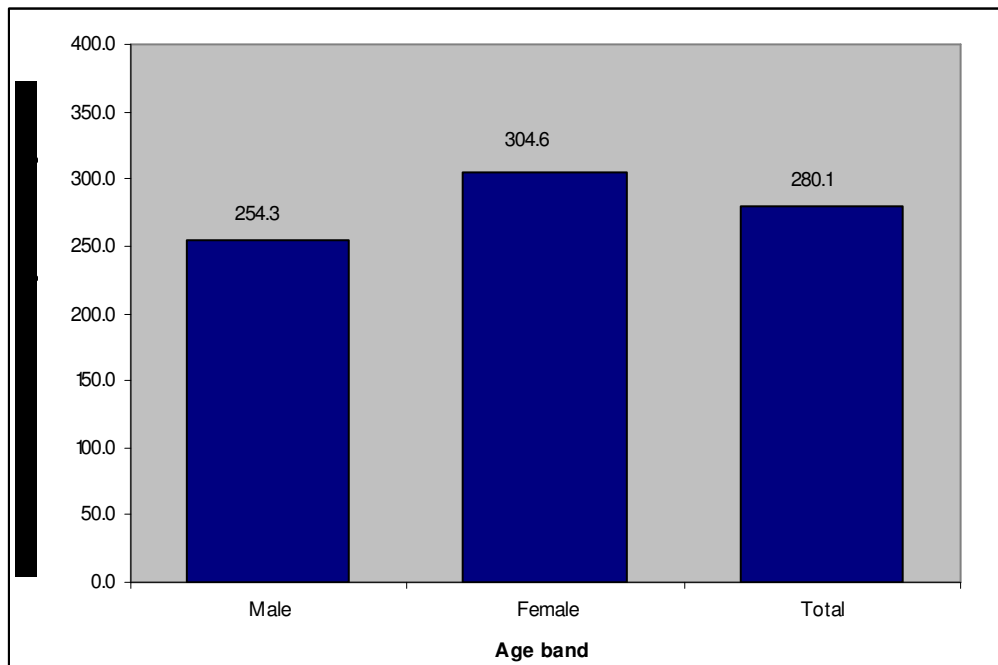
Equality groups

Currently the DHSSPS HIS only contains information on the sex and age equality groups. In order to compare the level of self-harm that is prevalent within each equality group, the average number of admissions each year between 2000/01 and 2004/05 is expressed as a ratio to each 100,000 persons within the total population (2001 Census of Population).

Sex

Females accounted for 13,156 of the total admissions to hospital (55.7%) for self-harm between 2000/01 and 2004/05.

Figure 34: Average admissions as a result of self-harm per 100,000 persons by sex

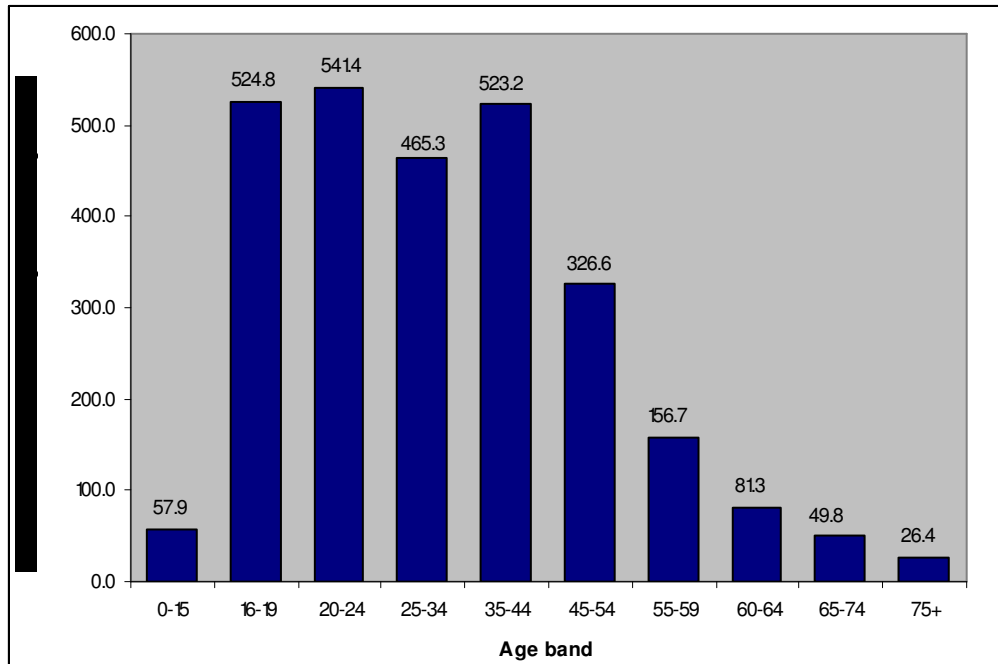


Overall, an average of 280.1 admissions per 100,000 persons were made as a result of self-harm in each year. Self-harm is more prevalent for females (with an average of 304.6 admissions per 100,000 persons) than males (254.3 admissions).

Age

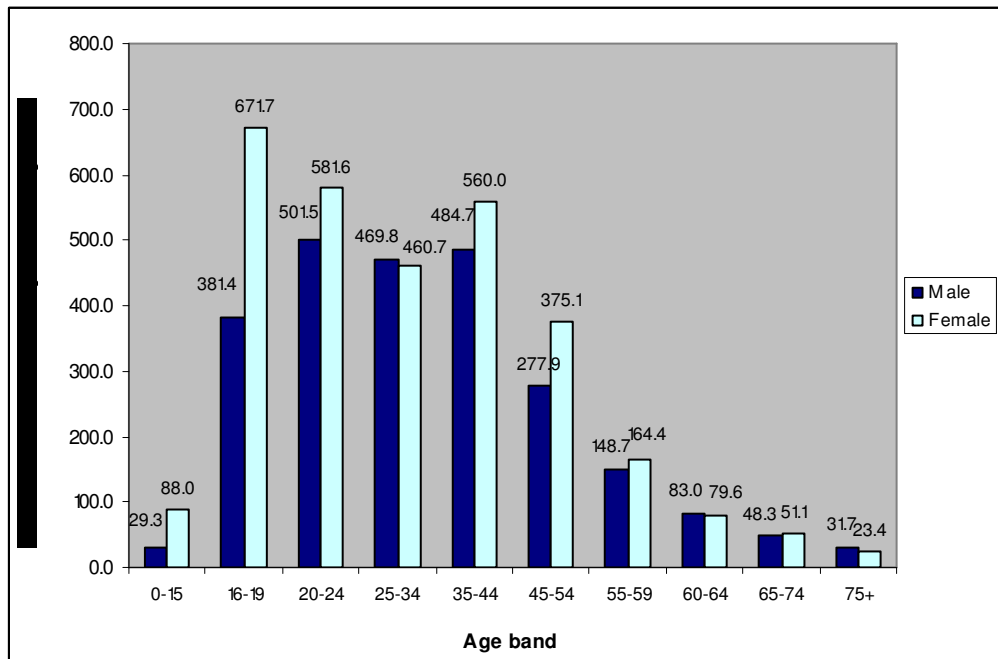
Four-fifths of all self-harm admissions (80.0%) between 2000/01 and 2004/05 were for persons aged 44 or younger.

Figure 35: Average admissions as a result of self-harm per 100,000 persons by age



Noticeably, the highest average admission rates for self-harm were for persons aged between 16 and 44 years old. The admission rate was lowest for the very young (0-15 age group) and the very old (65-74 and 75+ age groups).

Figure 36: Average admissions as a result of self-harm per 100,000 persons by sex and age



Females had a higher average admission rate than males for self-harm at every age band except 25-34, 60-64 and 75 & over. The highest average admission rate was for female

16-19 age group (671.7 admissions per 100,000 persons). This compares with 381.4 admissions for the male 16-19 age group.

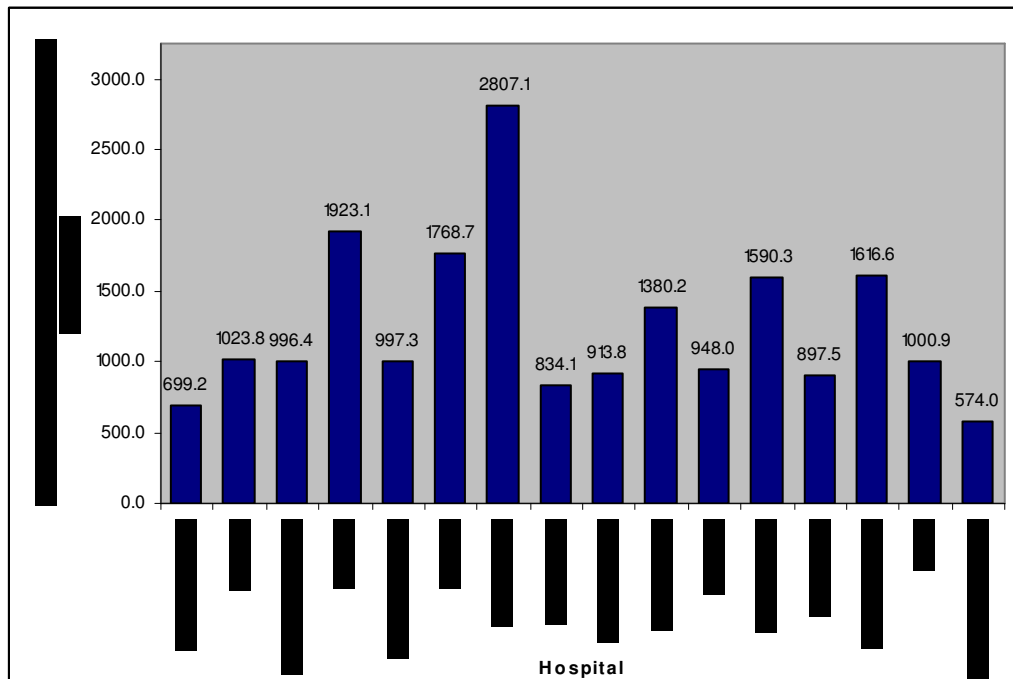
Conclusion – Equality groups

Due to a lack of equality information currently available, any equality impact assessment of self-harm will be extremely limited. It is clear that admissions for self-harm are more prevalent for females and also the population aged between 16 and 44 years old. Whilst it is unlikely that the apparent differential impact on females and certain age groups would totally disappear, some of the differences may be explained by other equality information, e.g. religion, marital status, sexual orientation etc.

Geographical area

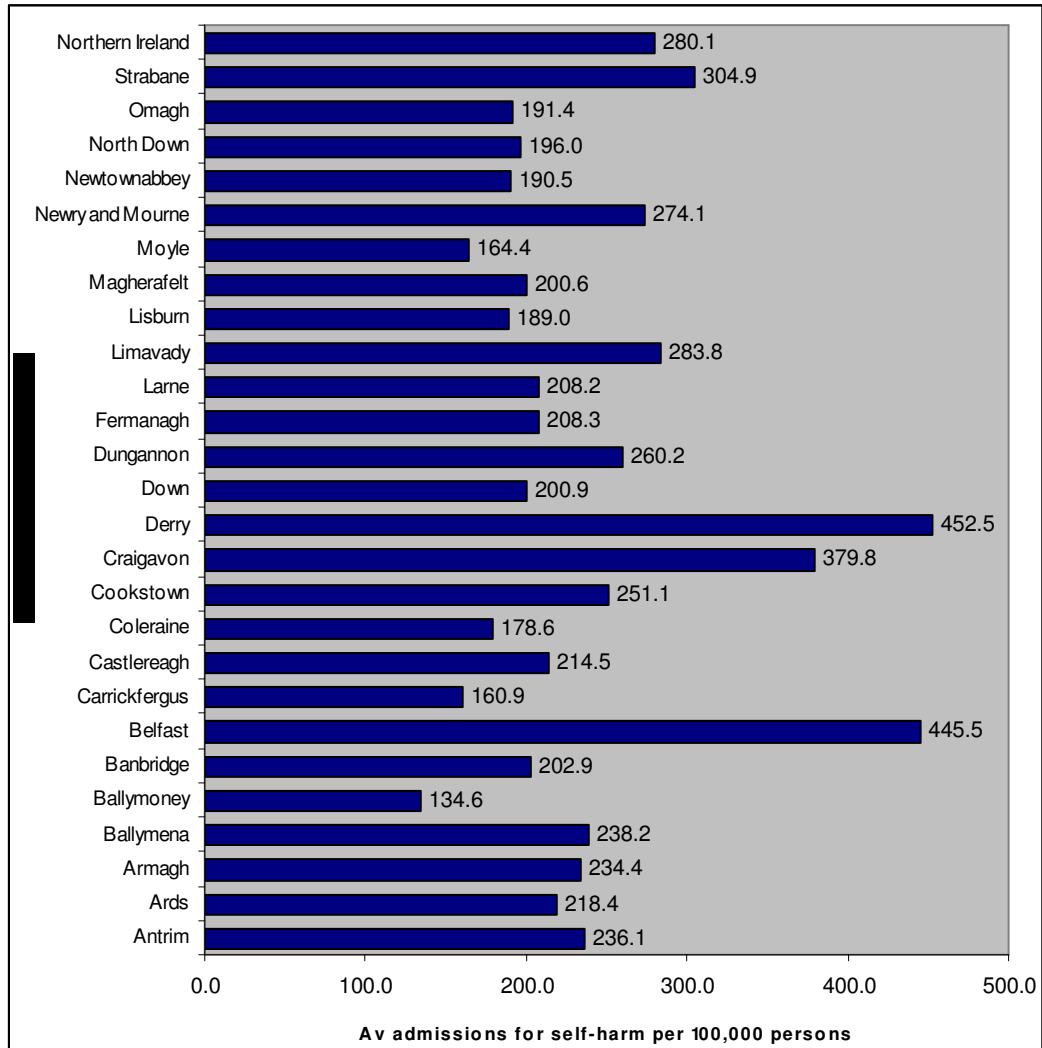
Hospital

Fig 37: Average admissions for self-harm per 100,000 hospital admissions



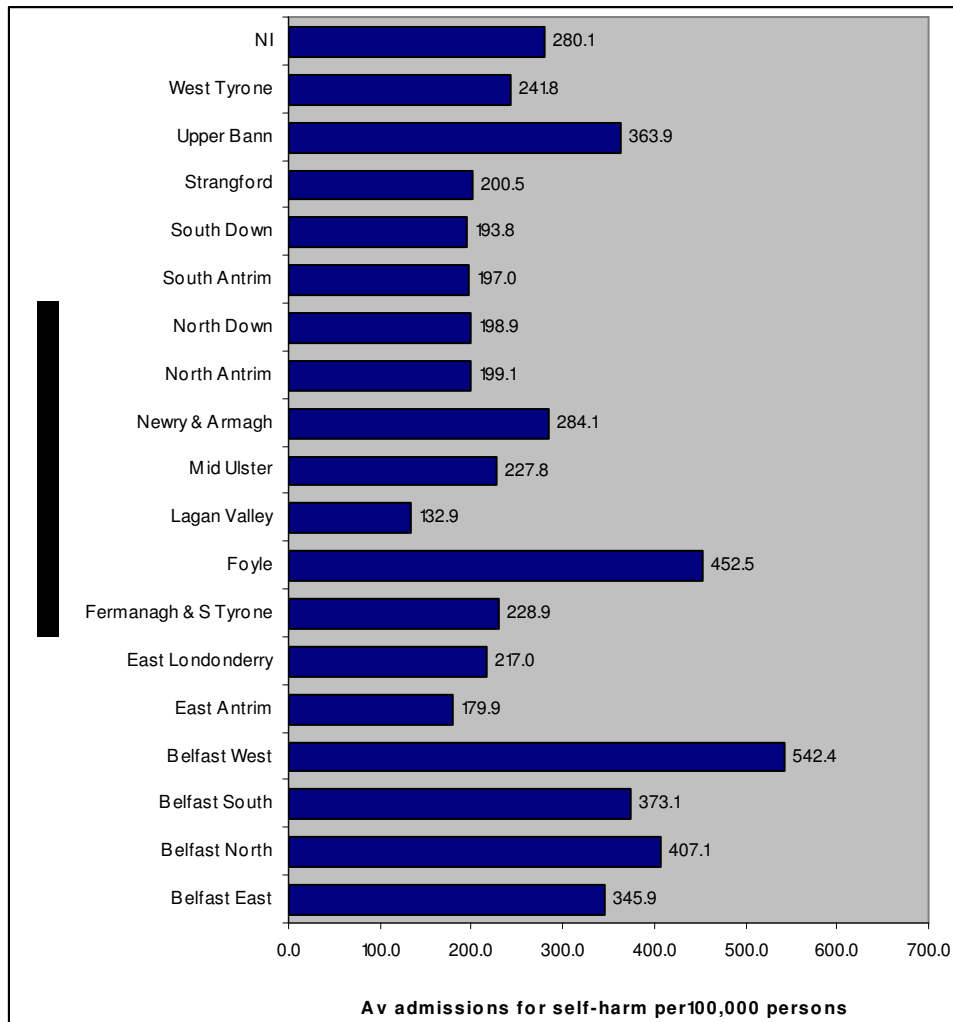
It should be noted that figure 37 does not include hospitals where no or only a very small number of admissions were made for self-harm. By far the highest average admission rate for self-harm was at Coleraine Hospital, however there were no admissions for self-harm and relatively few admissions after 2001/2. There were also relatively high admission rates at the Mater and Downe Hospitals.

Figure 38: Average admissions for self-harm per 100,000 persons by Local Government District (LGD)



The highest average number of admissions for self-harm per 100,000 persons were in Derry (452.5), Belfast (445.5) and Craigavon (379.8) Local Government Districts. In contrast, Ballymoney LGD had the lowest admission rate for self-harm with an average of 134.6 admissions per 100,000 persons.

Figure 39: Average admissions for self-harm per 100,000 persons by Parliamentary Constituency Area (PCA)



Belfast West PCA had the highest average number of admissions for self-harm per 100,000 persons (542.4). There were also relatively high average admission rates in Foyle (452.5) and Belfast North (407.1) PCAs. Lagan Valley PCA had the lowest admission rate for self-harm with an average of 132.9 admissions per 100,000 persons.

Annex A: ICD codes for intentional self-harm and event of undetermined intent

X60-X84 Intentional self-harm	
X60	Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics
X61	Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs nec
X62	Intentional self-poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified
X63	Intentional self-poisoning by and exposure to other drugs acting on the autonomic nervous system
X64	Intentional self-poisoning by and exposure to other and unspecified drugs, medicaments and biological substances
X65	Intentional self-poisoning by and exposure to alcohol
X66	Intentional self-poisoning by and exposure to organic solvents and halogenated hydrocarbons and their vapours
X67	Intentional self-poisoning by and exposure to other gases and vapours
X68	Intentional self-poisoning by and exposure to pesticides
X69	Intentional self-poisoning by and exposure to other and unspecified chemicals and noxious substances
X70	Intentional self-harm by hanging, strangulation and suffocation
X71	Intentional self-harm by drowning and submersion
X72	Intentional self-harm by handgun discharge
X73	Intentional self-harm by rifle, shotgun and larger firearm discharge
X74	Intentional self-harm by other and unspecified firearm discharge
X75	Intentional self-harm by explosive material
X76	Intentional self-harm by smoke, fire and flames
X77	Intentional self-harm by steam, hot vapours and hot objects
X78	Intentional self-harm by sharp object
X79	Intentional self-harm by blunt object
X80	Intentional self-harm by jumping from a high place
X81	Intentional self-harm by jumping or lying before moving object
X82	Intentional self-harm by crashing of motor vehicle
X83	Intentional self-harm by other specified means
X84	Intentional self-harm by unspecified means
Y10-Y34 Event of undetermined intent	
Y10	Poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics, undetermined intent
Y11	Poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified, undetermined intent
Y12	Poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified, undetermined intent
Y13	Poisoning by and exposure to other drugs acting on the autonomic nervous system, undetermined intent
Y14	Poisoning by and exposure to other and unspecified drugs, medicaments and biological substances, undetermined intent
Y15	Poisoning by and exposure to alcohol, undetermined intent
Y16	Poisoning by and exposure to organic solvents and halogenated hydrocarbons and their vapours, undetermined intent
Y17	Poisoning by and exposure to other gases and vapours, undetermined intent
Y18	Poisoning by and exposure to pesticides, undetermined intent
Y19	Poisoning by and exposure to other and unspecified chemicals and noxious substances, undetermined intent
Y20	Hanging, strangulation and suffocation, undetermined intent
Y21	Drowning and submersion, undetermined intent
Y22	Handgun discharge, undetermined intent
Y23	Rifle, shotgun and larger firearm discharge, undetermined intent
Y24	Other and unspecified firearm discharge, undetermined intent
Y25	Contact with explosive material, undetermined intent
Y26	Exposure to smoke, fire and flames, undetermined intent
Y27	Contact with steam, hot vapours and hot objects, undetermined intent
Y28	Contact with sharp object, undetermined intent
Y29	Contact with blunt object, undetermined intent
Y30	Falling, jumping or pushed from a high place, undetermined intent
Y31	Falling, lying or running before or into moving object, undetermined intent

Y32	Crashing of motor vehicle, undetermined intent
Y33	Other specified means, undetermined intent
Y34	Unspecified means, undetermined intent
Y87.0, Y87.2 Sequelae	
Y87.0	Sequelae ¹⁴ of intentional self-harm
Y87.2	Sequelae of events of undetermined intent

¹⁴ Late effects

Integrated Impact Assessment - Overview

Policy/project title:	Northern Ireland Suicide Prevention Strategy and Action Plan.
Brief description of policy/project	To develop a Suicide Prevention Strategy for Northern Ireland.
Policy Aim:	To reduce the Northern Ireland suicide rate, particularly among young people and those most at risk.
Relevant PfG sub-priorities and PSA/SDA Targets	<p>By 2012 increase the life expectancy at birth in NI by 3 years for men and 2 years for women.</p> <p>By 2012 halve the gap in life expectancy between those living in the fifth most deprived electoral wards and the NI average for men and women.</p> <p>By 2008 reduce the standardised suicide rate by 10%.</p>

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EQUALITY SCREENING

(This must be completed in line with the Equality Commission's [Guide to the Statutory Duties](#))

Policy Aim: To reduce the Northern Ireland suicide rate, particularly among young people and those most at risk

Screening Procedure

Proposed policies must be subject to screening and those identified as having significant implications for equality of opportunity following such a review must be subject to full impact assessment. For each policy, the criteria set out in the table below must be considered in relation to the nine equality categories. These are

- | | |
|---------------------------|--------------------|
| Age | Political opinion |
| Marital status | Racial Group |
| Men and Women generally | Religious Belief |
| Persons with a disability | Sexual Orientation |
| Persons with dependants | |

Screening Questions	Yes/No
<ul style="list-style-type: none"> • is there any evidence of higher or lower participation or uptake by different groups? 	Yes
<ul style="list-style-type: none"> • is there any evidence that different groups have different needs, experiences, issues and priorities in relation to the particular policy? 	Yes
<ul style="list-style-type: none"> • is there an opportunity to better promote equality of opportunity or better community relations by altering the policy or working with others in government or in the larger community? 	No
<ul style="list-style-type: none"> • have consultations with relevant groups, organisations or individuals indicated that particular policies create problems which are specific to them? 	No

In light of answers to the four questions above is a full equality impact assessment necessary?

Yes	No
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Please justify your decision:

The policy aims to promote the mental health and wellbeing of the whole population.

The policy will introduce measures to strengthen the protective factors against the risk of suicide afforded to the general population and to reduce the risk factors for those in society who are most at risk of suicide.

The equality implications were considered in the development of the Promoting Mental Health Strategy and Action Plan, which aims to improve people's mental and emotional wellbeing, and prevent or reduce the incidence of mental and emotional distress, anxiety, mental illness and **suicide**. The Promoting Mental Health Strategy and Action Plan contains ten specific actions which aim to reduce suicide in NI.

Given the growing concern regarding an increase in the number of suicides the Department has given further consideration to the equality implications and the conclusions are set out in Annex 3 of the Strategy.

The Equality Impact Assessment procedure is described more fully in Annex 1 of the Equality Commission's [Guide to the Statutory Duties](#) and their [Practical Guidance on Equality Impact Assessment](#). Your Equality Scheme includes a commitment to conducting equality impact assessments in accordance with this procedure.

It is the responsibility of the Gender Equality Unit to develop and implement a Gender Equality Strategy to tackle inequalities between men and women, and boys and girls where that inequality relates to their gender, marital or relationship status, whether or not they have dependants or caring responsibilities or are transgendered. As part of this strategy, guidance on gender equality impact assessment has been developed. This guidance is available at: <http://www.genderequalityni.gov.uk/impactguide.htm>

ASSESSMENT OF IMPACTS OTHER THAN EQUALITY IMPACT

Policy Aim: To reduce the Northern Ireland suicide rate, particularly among young people and those most at risk

Note: The IIA as a whole includes the essential components of a sustainability assessment. Further guidance on sustainable development can be accessed using this link. [Sustainability Assessment Guidance] [\[http://www.ofmdfmi.gov.uk/ia/pdfs/sustainability.pdf\]](http://www.ofmdfmi.gov.uk/ia/pdfs/sustainability.pdf)

Illustrative questions for consideration	Screening		Detailed Impact Assessment (if screening answer is yes) Brief Justification (if screening answer is no)		Scope for Mitigation/ Alternatives
	Answer Yes/No	Full Impact Assessment Necessary? Yes/No	Qualitative	Quantitative	
<i>ECONOMIC IMPACT ASSESSMENT: CONSUMERS (Questions 1-5) GUIDANCE</i> [http://www.ofmdfmi.gov.uk/ia/pdfs/consumer.pdf]					
1. Will the policy affect the cost, quality or availability of commercially available or publicly provided goods or services.	No	No			
2. Will it result in a change in the choice available to consumers, or the availability of information to enable them to exercise choice?	No	No			
3. Does the policy enhance the region's infrastructure, including maximising transport choice and exploiting opportunities offered by information technology?	No	No			
4. Will it introduce a new technology or process that will make existing goods redundant over time?	No	No			
5. Does the policy take sufficient account of unique regional characteristics, other policies within the region, and policies in the ROI and other parts of the UK?	No	No			
<i>ECONOMIC IMPACT ASSESSMENT: BUSINESS/CHARITIES/VOLUNTARY SECTOR (Questions 6-10) GUIDANCE</i> [http://www.ofmdfmi.gov.uk/ia/docs/businessguide.doc]					

Illustrative questions for consideration	Screening		Detailed Impact Assessment (if screening answer is yes) Brief Justification (if screening answer is no)		Scope for Mitigation/ Alternatives
	Answer Yes/No	Full Impact Assessment Necessary? Yes/No	Qualitative	Quantitative	
6. Will the policy impose or relieve a cost or burden on business, charities or the voluntary sector?	No	No			
7. Will it result in a change in the investment in people, equipment, infrastructure, or other asset?	No	No			
8. Will the policy develop a strong culture of enterprise and innovation?	No	No			
9. Will the policy promote indigenous growth and the development of the social economy?	No	No			
10. Will the policy benefit or impact adversely on tourism?	No	No			
ECONOMIC IMPACT ASSESSMENT: STATE AID (Questions 11-15) GUIDANCE [http://www.ofmdfmni.gov.uk/ia/pdfs/state_aid.pdf]					
11. Does the policy involve a measure granted by the State or through State resources such as a subsidy or tax/charge exemption?	No	Note: Only if you answer yes to all 5 questions is State Aid involved.			
12. Does it confer an advantage?	No	No			
13. Is it selective, favouring certain undertakings?	No	No			
14. Is the activity tradeable between EU Member States?	No	No			
15. Does the measure distort or have the potential to distort competition?	No	No			

Illustrative questions for consideration	Screening		Detailed Impact Assessment (if screening answer is yes) Brief Justification (if screening answer is no)		Scope for Mitigation/ Alternatives
	Answer Yes/No	Full Impact Assessment Necessary? Yes/No	Qualitative	Quantitative	
<i>ECONOMIC IMPACT ASSESSMENT: PUBLIC EXPENDITURE AND PUBLIC SERVICE (Questions 16-18)</i>					
<i>GUIDANCE: GREEN BOOK</i> [http://www.hm-treasury.gov.uk/economic_data_and_tools/greenbook/data_greenbook_index.cfm]					
<i>& NORTHERN IRELAND PRACTICAL GUIDE TO THE GREEN BOOK</i> [http://www2.dfpni.gov.uk/economic_appraisal_guidance/index.htm]					
16. Does the policy incur public expenditure implications?	Yes	No	Will result in additional services and information campaigns. See costed action plans		
17. Will it result in receipts or savings in public expenditure?	No	No			
18. Will it impose administrative or other burdens on public service providers, eg frontline staff in health, education, local government or criminal justice?	Yes	No	Will result in additional services and information campaigns. See costed action plans		
<i>SOCIAL IMPACT ASSESSMENT: NEW TARGETING SOCIAL NEED, SOCIAL CAPITAL, COMMUNITY AND EDUCATION (Questions 19-24)</i>					
<i>GUIDANCE</i> [http://www.ofmdfmi.gov.uk/ia/pdfs/tsn.pdf]					
19. Will poverty and social exclusion be addressed positively in this policy?	Yes	No	The action plan contains specific measures aimed at tackling the issue within marginalised and disadvantaged groups		
20. Will the policy impact differentially on people with different economic circumstances?	No	No			
21. Will it affect the capacity for parents/guardians to provide a stable environment for their children?	Yes	No	This policy contains measures to improve the mental and emotional wellbeing, and coping skills, of the general population		
22. Will it enhance the level of skills and education, in the workforce, among children, or otherwise?	Yes	No	This policy contains measures to improve the mental and emotional wellbeing, and coping skills, of the general population		
23. Will it affect access to, and the range of, facilities for the arts, culture, sports and leisure pursuits?	No	No			
24. Will the policy affect the number of people involved in voluntary and community activities?	No	No			

Illustrative questions for consideration	Screening		Detailed Impact Assessment (if screening answer is yes) Brief Justification (if screening answer is no)		Scope for Mitigation/ Alternatives
	Answer Yes/No	Full Impact Assessment Necessary? Yes/No	Qualitative	Quantitative	
SOCIAL IMPACT ASSESSMENT: HOMELESSNESS (Questions 25-29) GUIDANCE [http://www.ofmdfmini.gov.uk/ia/docs/homelessness.doc]					
25. Will it affect people's access to information or social network?	Yes	No	This policy contains measures to improve the information and support offered to the population within their local community		
26. Will the policy ensure that the housing stock meets the housing needs of all parts of the community?	No	No			
27. Will the policy impact differentially on people who are of no fixed address, homeless or residing in temporary accommodation?	No	No			
28. Will the policy promote user and community involvement in policy development and service delivery?	Yes	No	This policy contains measures to improve the information and support offered to the population within their local community		
29. Will the policy maintain or increase the choices available to future generations to meet their needs?	No	No			
HEALTH IMPACT ASSESSMENT (Questions 30-34) GUIDANCE [http://www.ofmdfmini.gov.uk/ia/pdfs/hia-guidance.pdf]					
30. Will the policy have an impact on: diet; physical activity; safe sex; substance use (alcohol, tobacco, illegal drugs)?	Yes	No	This policy is designed to improve public health and wellbeing and make a positive contribution to the attainment of wider health objectives. It is not envisaged that there will be any negative health impacts and a full HIA is not required		

Illustrative questions for consideration	Screening		Detailed Impact Assessment (if screening answer is yes) Brief Justification (if screening answer is no)		Scope for Mitigation/ Alternatives
	Answer Yes/No	Full Impact Assessment Necessary? Yes/No	Qualitative	Quantitative	
31. Will the policy have an impact on health in terms of: air quality; built environment and land use; noise; water supply and quality?	No	No			
32. Will the policy affect the wider determinants of health such as crime; education; employment, including workplace; family cohesion; housing; income; recreation; social cohesion; transport?	Yes	No	As 30		
33. Will the policy have an impact on access to health services?	Yes	No	As 30		
34. Will the policy enhance or harm public safety, or health and safety at work?	No	No			
RURAL IMPACT ASSESSMENT (Questions 35-36) GUIDANCE [http://www.ofmdfmi.gov.uk/ia/pdfs/rural.pdf]					
35. Will the policy apply in rural areas and communities?	Yes	No	The policy will effect the whole population. There are no adverse impacts on the rural population		
36. Is the policy consistent with ensuring that, as far as possible, public services are accessible on a fair basis to the rural community?	Yes	No	As 35		
ENVIRONMENTAL IMPACT ASSESSMENT: CLIMATE CHANGE (Questions 37-38) GUIDANCE [http://www.ofmdfmi.gov.uk/ia/pdfs/climatechange.pdf]					
37. Will the policy lead to a change in the emissions or any of the six greenhouse gases, for instance by consumption of fossil fuel?	No	No			

Illustrative questions for consideration	Screening		Detailed Impact Assessment (if screening answer is yes) Brief Justification (if screening answer is no)		Scope for Mitigation/ Alternatives
	Answer Yes/No	Full Impact Assessment Necessary? Yes/No	Qualitative	Quantitative	
38. Will it affect, or be affected by, vulnerability to the predicted effects of climate change eg flooding?	No	No			
ENVIRONMENTAL IMPACT ASSESSMENT: AIR QUALITY (Questions 39-41) GUIDANCE [fhttp://www.ofmdfmi.gov.uk/iia/pdfs/airquality.pdf]					
39. Will the policy lead to a change in the emissions of air pollutants?	No	No			
40. Will it result in greater or fewer numbers of people being affected by existing levels of air pollution?	No	No			
41. Will it have a bearing on areas of existing poor air quality?	No	No			
ENVIRONMENTAL IMPACT ASSESSMENT: LANDSCAPE AND LAND USE (Questions 42-48) Regional Development Strategy [http://www.drdni.gov.uk/shapingourfuture/regional_dev/foreword/foreword.htm]					
42. Does the policy conform or have regard to the Regional Development Strategy?	No	No			
43. Will the policy involve visually intrusive construction works?	No	No			
44. Does the policy contribute to the protection/conservation and management of the natural and built environmental assets of the region?	No	No			
45. Does the policy enhance and improve the environmental quality of the region including high standards of design?	No	No			
46. Will it impact on a location in such a way as to change its sense of place, community or identity in any other way?	No	No			

Illustrative questions for consideration	Screening		Detailed Impact Assessment (if screening answer is yes) Brief Justification (if screening answer is no)		Scope for Mitigation/ Alternatives
	Answer Yes/No	Full Impact Assessment Necessary? Yes/No	Qualitative	Quantitative	
47. Does the policy maximise the re-use of previously used land?	No	No			
48. Does the policy ensure that decisions about the distribution and location of activity are consistent with sustainable development principles, for example, in terms of the impact on travel?	No	No			
ENVIRONMENTAL IMPACT ASSESSMENT: USE OF NATURAL RESOURCES (Questions 49-53) [DN: guidance to be provided]					
49. Will the policy safeguard natural non-renewable sources?	No	No			
50. Will it affect the efficient use of energy or water?	No	No			
51. Will the policy seek to minimise waste and encourage re-use and recycling of waste material?	No	No			
52. Will it lead to an increase or decrease in water pollution?	No	No			
53. Will it increase or decrease water abstraction or otherwise affect the flow, run-off or recharge of water?	No	No			

Illustrative questions for consideration	Screening		Detailed Impact Assessment (if screening answer is yes) Brief Justification (if screening answer is no)		Scope for Mitigation/ Alternatives
	Answer Yes/No	Full Impact Assessment Necessary? Yes/No	Qualitative	Quantitative	
ENVIRONMENTAL IMPACT ASSESSMENT: BIODIVERSITY (Questions 54-55) [DN: guidance to be provided]					
54. Will the policy involve disturbance or relief of disturbance to habitats or species by change of land use, light or noise?	No	No			
55. Will it lead to severance, fragmentation, isolation or change in size of habitats?	No	No			
ENVIRONMENTAL IMPACT ASSESSMENT: NOISE (Questions 56-58) GUIDANCE[http://www.ofmdfmni.gov.uk/ia/pdfs/noise.pdf]					
56. Will the policy lead to an increase or decrease in exposure to noise of sensitive buildings such as schools and hospitals?	No	No			
57. Will it lead to an increase or decrease in the number of people affected by existing noise?	No	No			
58. Will it lead to a change in standards or use that would increase or decrease the noise generated by products?	No	No			

Illustrative questions for consideration	Screening		Detailed Impact Assessment (if screening answer is yes) Brief Justification (if screening answer is no)		Scope for Mitigation/ Alternatives
	Answer Yes/No	Full Impact Assessment Necessary? Yes/No	Qualitative	Quantitative	
HUMAN RIGHTS IMPACT ASSESSMENT (Questions 59-69) GUIDANCE – OFMDFM HUMAN RIGHTS WEBSITE[http://www.humanrightsni.gov.uk/]					
59. Does the policy include provisions creating, or governing the imposition of, criminal penalties or penalties of an administrative nature?	No	No			
60. Does the policy provide enforcement powers including in particular powers of entry and inspection and powers to require the production of or to seize documentary and other records?	No	No			
61. Does the policy provide powers of compulsory purchase, destruction or disposal?	No	No			
62. Does the policy contain provisions prohibiting or restricting the movement, use or other forms of the peaceful enjoyment of private property?	No	No			
63. Does the policy apply restrictions by way of licensing or registration requirements before certain forms of economic or social activity can be undertaken?	No	No			
64. Does the policy contain provisions relating to the withdrawal or suspension of such licensing or registration or the imposition of conditions in connection therewith?	No	No			

Illustrative questions for consideration	Screening		Detailed Impact Assessment (if screening answer is yes) Brief Justification (if screening answer is no)		Scope for Mitigation/ Alternatives
	Answer Yes/No	Full Impact Assessment Necessary? Yes/No	Qualitative	Quantitative	
65. Does the policy contain provisions setting standards for the construction and/or maintenance of real or personal property or the use which may be made thereof, including for example, building control, health and safety at work provisions, etc?	No	No			
66. Does the policy set up schemes for giving grant-aid loans and provisions for the withdrawal or recovery of such grant or loans?	No	No			
67. Does the policy impact on the giving of various types of social benefit, including, for example, housing benefit, and provision for the withdrawal or recovery of such benefit?	No	No			
68. Does the policy contain provisions relating to private or family life including, in particular, provisions conditioning the circumstances in which a person may be married or divorced or may have rights or obligations granted to or imposed on them in relation to children?	No	No			
69. Does the policy contain any provisions which might have a retrospective effect?	No	No			
VICTIMS IMPACT ASSESSMENT (Question 70) GUIDANCE [http://www.victimsni.gov.uk/pdf/victimsbrochure.pdf]					
70. Is there any evidence to suggest that the policy would have a particular impact on victims of conflict?	No	No			

Illustrative questions for consideration	Screening		Detailed Impact Assessment (if screening answer is yes) Brief Justification (if screening answer is no)		Scope for Mitigation/ Alternatives
	Answer Yes/No	Full Impact Assessment Necessary? Yes/No	Qualitative	Quantitative	
COMMUNITY SAFETY IMPACT ASSESSMENT (Questions 71-73) GUIDANCE [http://www.ofmdfmni.gov.uk/iia/pdfs/community_safety.pdf]					
71. Will the policy contribute to community safety?	No	No			
72. Is it likely to have an impact on any specific type of crime, especially vehicle crime or domestic burglary?	No	No			
73. Will it help victims of crime or reduce public fear about being a victim of crime?	No	No			
<i>OTHER IMPACT ASSESSMENT (Question 74)</i>					
74. Will the policy have a significant impact that does not appear to be reflected in any of the categories above?	No	No			

Illustrative questions for consideration	Screening		Detailed Impact Assessment (if screening answer is yes) Brief Justification (if screening answer is no)		Scope for Mitigation/ Alternatives
	Answer Yes/No	Full Impact Assessment Necessary? Yes/No	Qualitative	Quantitative	
<p>RISK</p> <p>For full guidance see “The NI Practical Guide to the Green Book”[http://www2.dfpni.gov.uk/economic_appraisal_guidance/index.htm]</p> <p>Abbreviated Guidance[http://www.ofmdfmi.gov.uk/jia/docs/riskguidance.doc]</p> <p>Summary of main risks identified, and of any special assumptions made.</p>					

NEXT STEPS

Comment on the extent to which it is necessary to adjust your proposed policy in light of the findings documented above.

What further steps/discussions are needed within your Department, with other Departments and with other stakeholders in developing the way forward?

Discussions held with relevant Departments. Views on specific issues will be taken during consultation.

CONSULTATION

The details of consultation should be set out if it differs from the consultation undertaken on the Equality Impact Assessment.

During strategy development a wide ranging and inclusive engagement process was undertaken

The Suicide Strategy and Action plan will be subject to a three month public consultation exercise.