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MINISTERIAL FOREWORD

Every suicide is a terrible tragedy. Each suicide leaves the question, why? It asks us all to address our conscience and ask could something different have been done to save that life.

We have collective responsibility to address the impact of a suicide in our communities. In addressing the problem of suicide, in facing up to its implications and causes within our society and culture we will have the chance to try and turn the tide. We have an urgent need to turn the tide because we recognise that suicide, especially among young men, is a growing problem in Northern Ireland.

The Taskforce was set up to try and further our understanding within Northern Ireland of the problem and to set out possible strategies to try and prevent suicide, notably in young people. The work of this report is vital and important to me, we will look back on its work and I hope to be able to say this is where we began to turn the tide.

There are no simple or quick fixed solutions, other countries facing similar challenges told us that at the outset. Even where resources have been increased, the results have been a mixed picture at best. But that doesn't let any of us off the hook. If we are to try and turn the tide, we must ensure we put resources where they can be effectively used and take nothing for granted.

The Taskforce's report begins to set out how we might better use existing resources, make use of further funding and pose questions around how we can better join up our existing services, giving them greater focus with strategic imperatives.

I ask everyone reading this to take part in the consultation which now follows. Government can play a part in reducing the number of suicides in Northern Ireland, but it is a part not the whole. It is our response, a collective response, of professional and volunteer, of state and individual, of community and family, of everyone, which if we want to turn the tide on this heartbreak, will achieve that end.

A handwritten signature in black ink that reads "Shaun Woodward". The signature is written in a cursive style with a large initial 'S' and 'W'.

Shaun Woodward MP

Minister for Health, Social Services, and Public Safety

KEY TERMS

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

Parasuicide – 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.

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

Suicidal Behaviour – a range of activities including suicidal thinking, self-harming behaviours not aimed at causing deaths and suicide attempts.

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 Preventing Factor – something that, for a particular person, reduces the risk of suicidal acts, e.g. personal support during a difficult period.

Suicide Rate – the number of suicides per 100,000 persons per annum, the figure is used to eliminate that impact of changes in population size or composition, and allows comparisons to be made between different populations or demographic groups.

Suicide Risk – the risk of suicide in the near future, sometimes the term 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 the rates of suicide among young people have been reported across most regions of the world, and in particular in Canada, New Zealand, the United States, Ireland, France, Belgium, Norway, the Netherlands, Spain, Italy, Colombia 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 (Gunnell and Frankel 1994¹).
- 1.2 Figure 1 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 Northern Ireland has more suicides per 100,000 persons than England and Wales, but less than our other close neighbours Scotland and the Republic of Ireland.

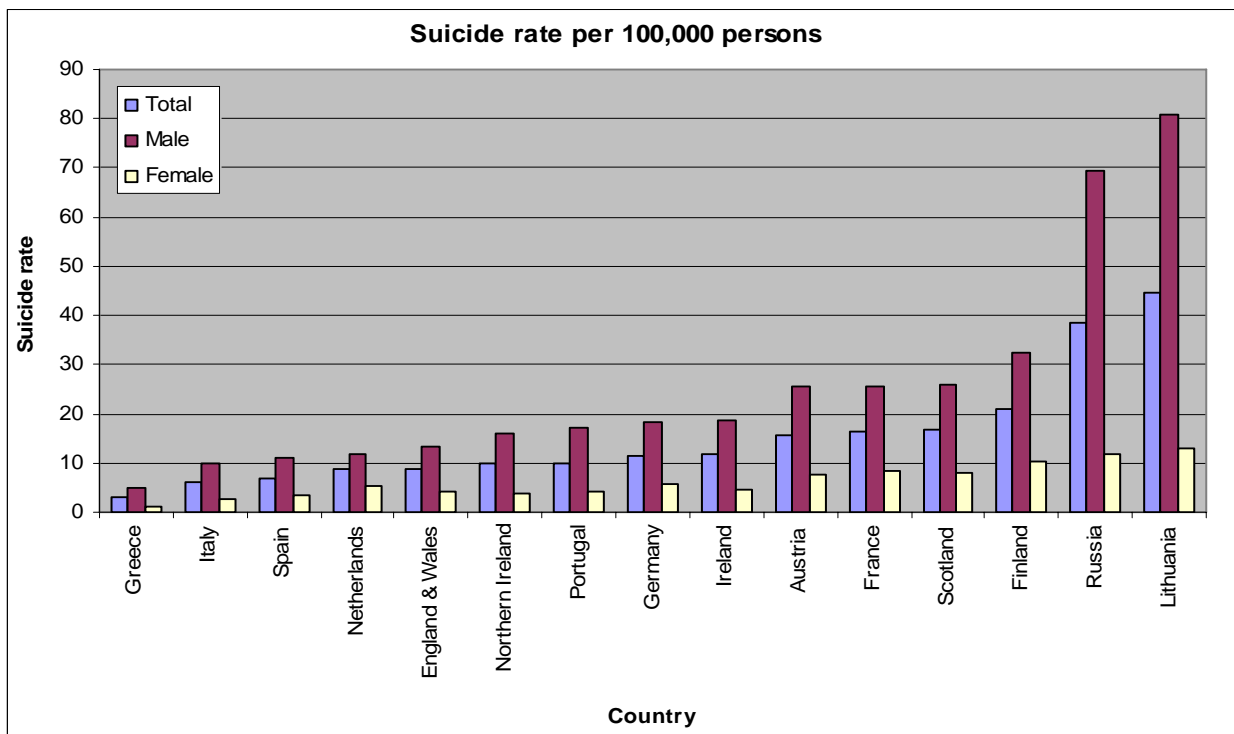


Figure 1: Suicide rate per 100,000 persons Age standardised to the European Standard Population (WHO 1999-2003)

- 1.3 In recent times there have been approximately 150 suicides each year in Northern Ireland, 41% of which are single males and some 22% of suicides are by males aged between 25 and 34.
- 1.4 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 (see **Annex 5**). While no specific intervention has been found to be universally effective it is important that these risk factors are addressed as part of a broader approach to promoting mental health and wellbeing.
- 1.5 The term self-harm covers a wide range of behaviours including parasuicide, habitual self-cutting, and poisoning. Northern Ireland has witnessed a substantial increase in self-harm related admissions to hospital in recent years, as outlined at paragraph 2.14. 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. There are many reasons why a person self-harms including: a release of tension, a perceived punishment for being “bad”, a desire to see blood as a means of cleansing.
- 1.6 There are many myths surrounding self-harm, one being that all of those who self-harm are seeking attention, but 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, and 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 by suicide.

DEVELOPMENT OF THE NORTHERN IRELAND SUICIDE PREVENTION

STRATEGY

- 1.7 The Promoting Mental Health Strategy and Action Plan², 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 wellbeing. Ten of these actions focus specifically on suicide prevention, including the promotion of coping skills, the development of suicide awareness programmes, and the need for enhanced outreach work with young people in areas of need. These actions are set out at **Annex 1**.
- 1.8 As a result of concern about an increase in the number of suicides, particularly among young people, the Minister for Health, Social Services and Public Safety, Shaun Woodward MP, established a Taskforce in July 2005 to develop a separate Suicide Prevention Strategy for Northern Ireland. The Terms of Reference and membership of the Taskforce are set out at **Annex 2**.
- 1.9 At the outset the Taskforce agreed the importance of taking views from interested parties and affording them the opportunity to influence the content of the new strategy. This engagement process 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.

1.10 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 implementation of the ten suicide prevention action points in the Promoting Mental Health Strategy and Action Plan²; and
- a review of the evidence base and identification of best practice in Northern Ireland and elsewhere.

1.11 This Strategy and Action Plan, was presented to the Minister by the Taskforce in early 2006.

IMPACT ASSESSMENT

1.12 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 conclusions from this screening exercise are set out in **Annex 3**.

CHAPTER 2 – SUICIDE AND SELF-HARM IN NORTHERN IRELAND

ANALYSIS OF SUICIDE IN NORTHERN IRELAND

- 2.2 To set the local suicide data in context, the Department undertook an analysis of suicides and self-harm in Northern Ireland for the last five years for which data is available. Some of the key findings of this analysis are outlined in the following paragraphs.
- 2.3 When a death is suspected to be a suicide, it 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 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 a 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 the inquest, can result in a considerable time delay between the actual death occurring and the date the death is registered. **The Taskforce therefore recommends that work needs to be undertaken in conjunction with the Coroners office in order to minimise future reporting delays, and to ensure increased sensitivity to the needs of bereaved families.**
- 2.4 The Coroner's Office has also indicated that the number of suicides recorded is likely to be inaccurate as in some cases coroners are unwilling to register "death by suicide", primarily due to respect for the wishes of relatives. **The Taskforce therefore notes that improvements in recording arrangements and greater acceptance by families to classify deaths as**

suicide, could in fact result in an increase in recording and therefore a perceived increase in the suicide rate.

2.5 During the period 1987 to 2003 there were 2,586 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.

2.6 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 males 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 15.9 per 100,000 persons for the period in question. During the same period the female suicide rate has remained fairly constant at 4.0 suicides per 100,000 persons. The overall suicide rates per 100,000 since 1991 are illustrated at Figure 2 below.

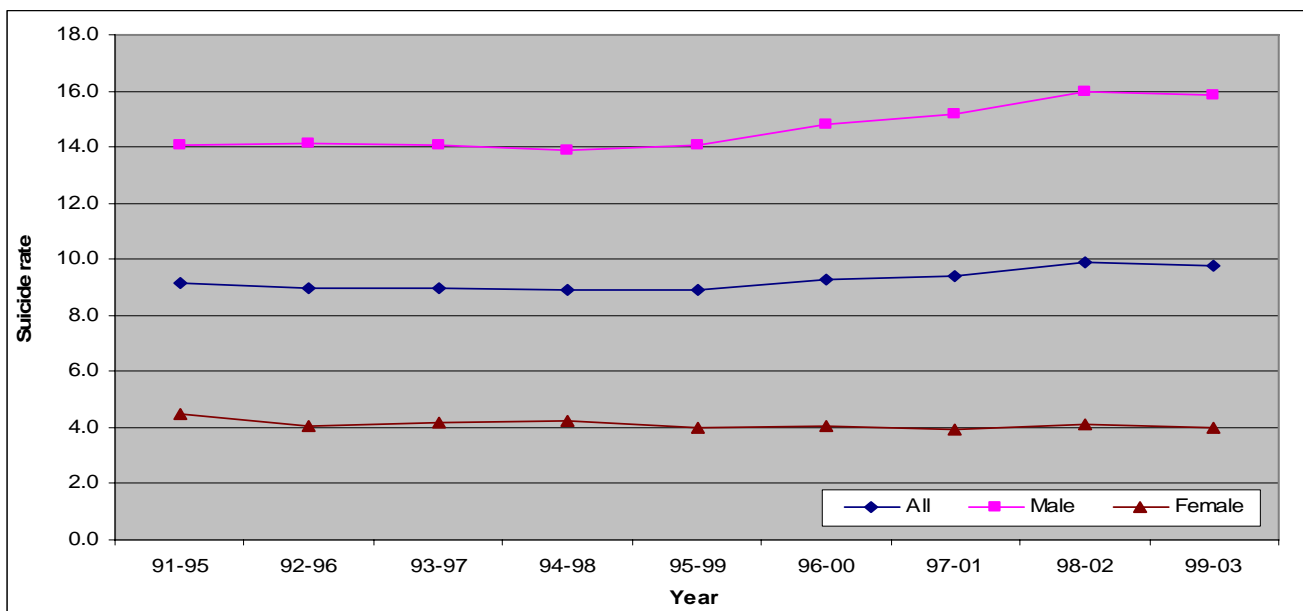


Figure 2: Age standardised suicide rate per 100,000 persons – five year moving average (1991-2003)

2.7 The figures presented in Table 1 indicate that suicide is the largest killer of males (1.84% of all male deaths) from external causes, more so than

transport accidents (1.5% of all male deaths) and considerably more than either accidental falls or poisoning (0.9% of all male deaths). Among females, suicide is less common (0.44% of all female deaths) than deaths from other external causes and accidental falls (0.9% and 0.6% of all female deaths respectively) but is slightly more frequent than deaths from transport accidents (0.4% of all female deaths).

	All		Male		Female	
	Count	Percent	Count	Percent	Count	Percent
Transport accidents	698	0.94%	535	1.51%	163	0.42%
Accidental falls	448	0.60%	235	0.66%	213	0.55%
Accidental poisoning	136	0.18%	94	0.27%	42	0.11%
Assault	157	0.21%	108	0.30%	49	0.13%
Suicide	824	1.11%	653	1.84%	171	0.44%
Other external causes	685	0.92%	355	1.00%	330	0.85%
All external causes	2,948	3.98%	1,980	5.58%	968	2.50%
Total deaths	74,127		35,467		38,660	

Table 1: Deaths from external causes (1999-2003)

2.8 Figure 3 shows a breakdown of the number of suicides between 1999 and 2003 by both age and sex and is presented as a percentage of all suicides occurring in Northern Ireland. Incidents of suicide were most common in the 25 to 34 age group, with 27.3% of all cases being recorded in that age band and a further 16.6% of suicides being carried out by males aged between 35 and 44. In meetings with Taskforce members young people emphasised that being able to trust those they engage with was crucial to encouraging help seeking behaviour (see paragraph 3.11).

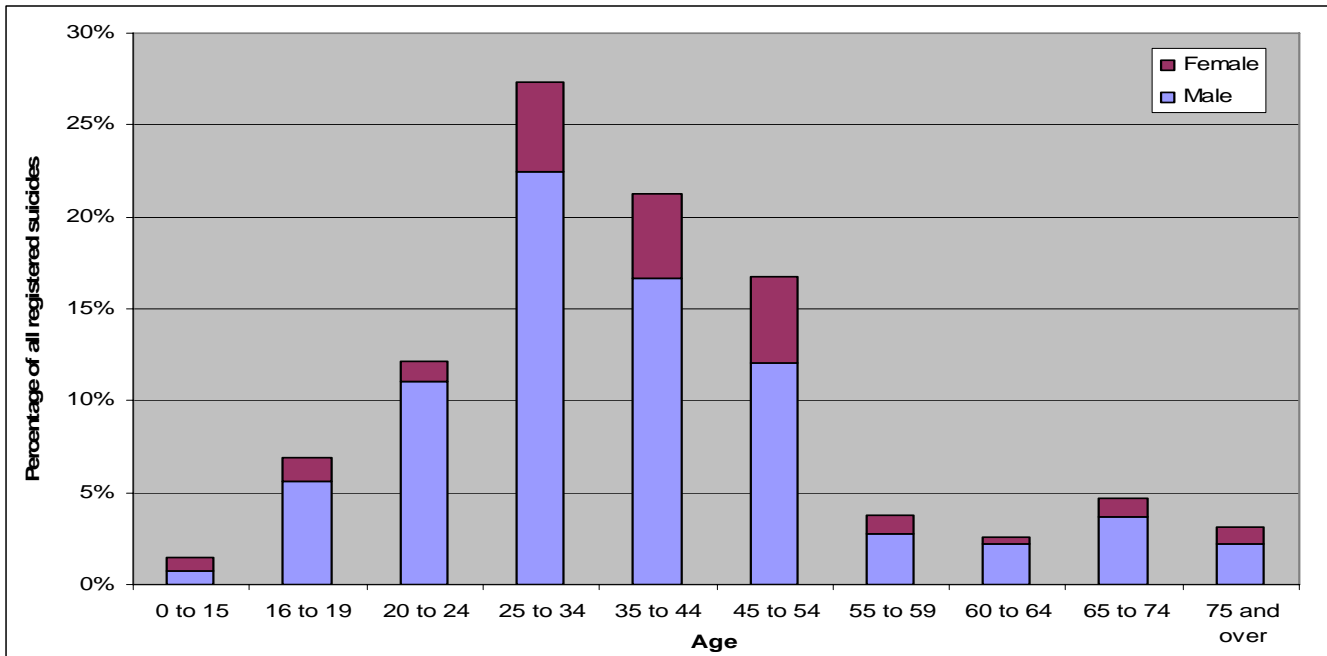


Figure 3: Percentage distribution of all registered suicides by age and sex (1999-2003)

2.9 The identification of 20% of the 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 14.9 per 100,000 persons compared to a rate of 8.5 per 100,000 persons in non-deprived areas (Figure 4). When focusing solely on economic deprivation comparisons the suicide rate gap increased even further to 17.0 per 100,000 persons in economically deprived areas as opposed to a rate of 8.2 suicides per 100,000 persons in non-economically deprived areas (Figure 4). While the Taskforce recognises the need to address this issue, and as such has included specific actions in the **Marginalised and Disadvantaged Groups** action area in **Chapter 5**, it also recognises that economic deprivation is a wider societal issue which needs to be addressed as part of the Government's Anti-Poverty Strategy.

2.10 Figure 4 also highlights that suicide rates in urban areas tended to be higher than those in rural areas, between 1999 and 2003 there were 10.5 suicides

per 100,000 persons in urban areas in Northern Ireland compared to 8.3 suicides per 100,000 persons in rural areas.

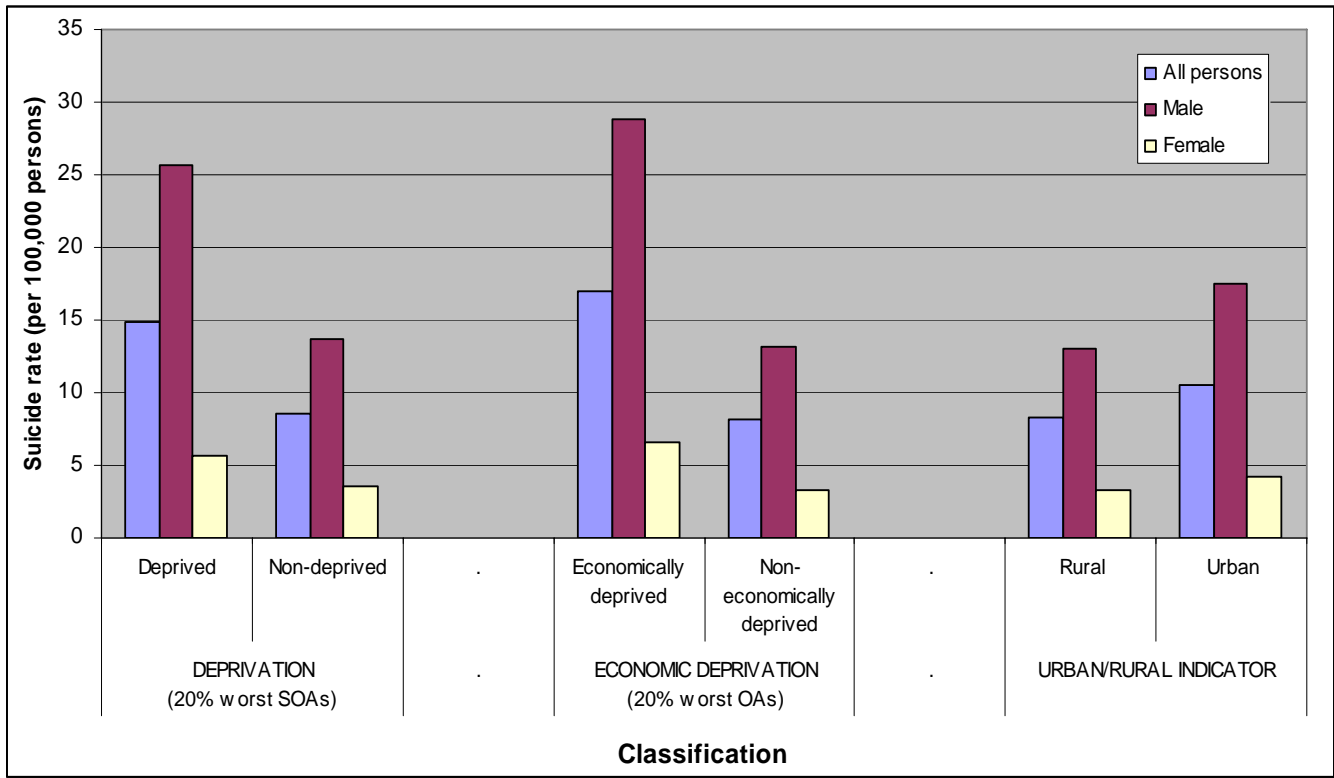


Figure 4: Age standardised suicide rate per 100,000 persons by indicators of deprivation and rurality (1999-2003)

2.11 The overall suicide rate in Northern Ireland is 9.8 per 100,000 persons, however there are sizeable variations across some local Parliamentary Constituencies (Table 2); in particular North and West Belfast have the extremely high rates of 17.9 and 18.1 suicides per 100,000 persons respectively. The Constituencies in question 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 acknowledges the need for further research into this matter as highlighted at paragraph 6.7.**

Parliamentary Constituency			
NI	9.8		
Belfast West	18.1	North Antrim	9.3
Belfast North	17.9	Lagan Valley	8.9
Upper Bann	11.3	Foyle	8.8
West Tyrone	10.9	Strangford	8.8
South Down	10.4	East Londonderry	7.9
South Antrim	9.9	Fermanagh and South Tyrone	7.9
Newry and Armagh	9.7	Belfast East	7.1
North Down	9.4	East Antrim	6.3
Belfast South	9.3	Mid Ulster	5.5

Table 2: Age standardised suicide rate per 100,000 persons by Parliamentary Constituency (1999-2003)

2.12 When analysing suicide rates by Local Government District Council area (Table 3) Banbridge came out highest with the rate of 14.1 per 100,000 persons compared to 12.9 per 100,000 persons in Belfast. **This further highlights the fact that suicide is not simply an urban issue but that it can and does affect people everywhere in Northern Ireland.**

Local Government District			
NI	9.8		
Banbridge	14.1	Down	9.2
Belfast	12.9	Antrim	9.1
Newry and Mourne	11.3	Derry	8.8
Omagh	11.2	Moyle	8.8
Strabane	10.5	Limavady	7.9
Lisburn	10.4	Coleraine	7.9
Craigavon	10.0	Armagh	7.8
Fermanagh	10.0	Castlereagh	7.6
Newtownabbey	9.9	Ballymoney	7.2
Ballymena	9.9	Cookstown	7.0
Ards	9.6	Magherafelt	6.4
Larne	9.4	Carrickfergus	6.3
North Down	9.2	Dungannon	3.3

Table 3: Age standardised suicide rate per 100,000 persons by Local Government District (1999-2003)

2.13 Hanging, strangulation and suffocation have been shown to be the most common methods of completing suicide in Northern Ireland (52.1%) as shown in Figure 5. The second most common method used is that of self-poisoning (26.8%), which includes all forms of poisoning and drug overdose.

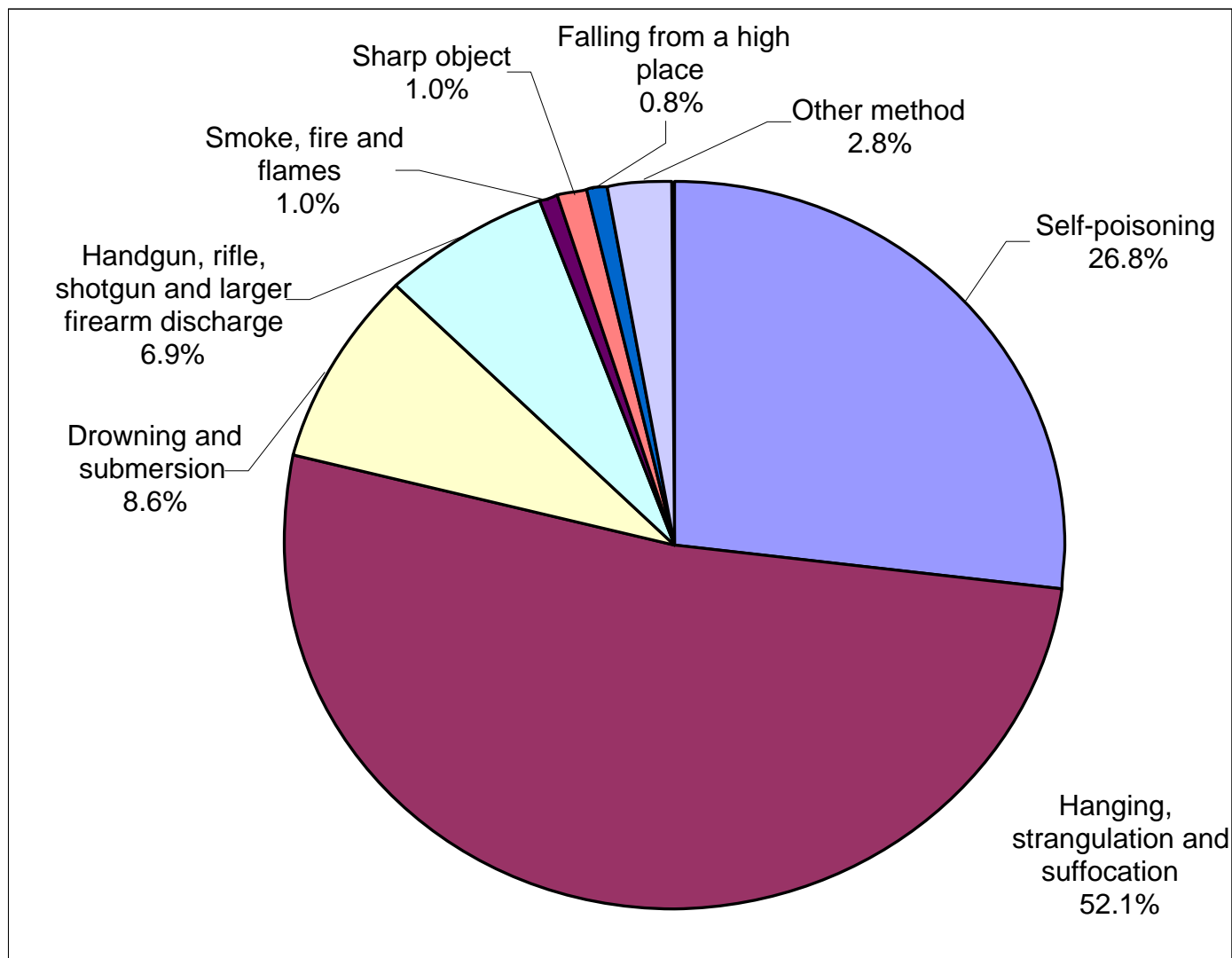


Figure 5: Percentage distribution of all registered suicides by method (1999-2003)

ANALYSIS SELF-HARM IN NORTHERN IRELAND

2.14 Over the five year period, 2000/01 to 2004/05, the number of admissions to hospital as a result of self-harm has increased by 2.7% from 4,583 to 4,705 (Figure 6), although there has 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 underestimate the scale of the problem since many people who self-harm do not seek help, and only a proportion of those who attend Accident and Emergency (A&E) following self-harm are admitted to hospital. Available information indicates that rates of self-harm are significantly higher in Northern Ireland than in the Republic of Ireland. **The Taskforce therefore recommends that it would be appropriate to develop a mechanism for monitoring self-harm attendances at A&E in Northern Ireland, similar to the Parasuicide Registry in the Republic of Ireland, in order to improve understanding of the issue locally and to further inform service developments. The Mater Hospital in Belfast is currently running a pilot scheme looking at ways of reducing the high levels of self-harm in Northern Ireland and its findings will need to be considered in more detail once the scheme has been fully evaluated.**

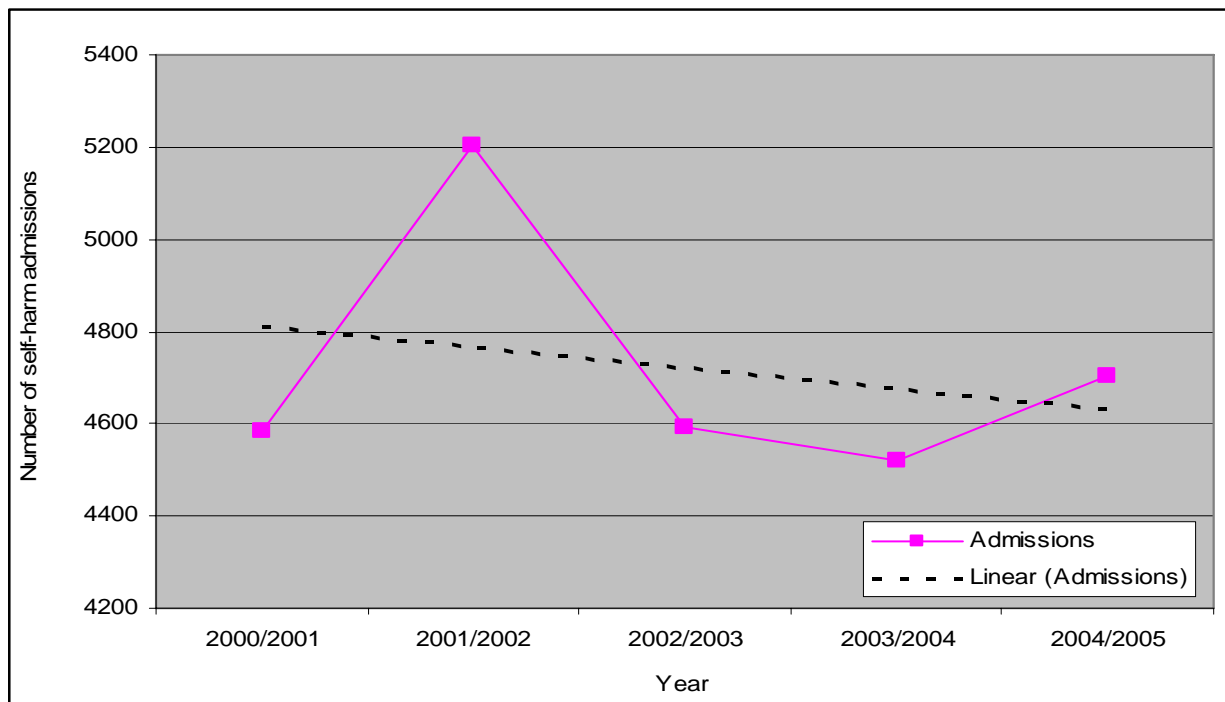


Figure 6: Number of hospital admissions as a result of self-harm (2000/01-2004/05)

2.15 During the five year period under review there were a total of 23,602 admissions to hospital due to self-harm (Table 4), and this figure accounts for around 1.0% of all admissions to hospital.

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%

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

2.16 Incidents of self-harm were more frequent in the middle age groups with 27.4% (Figure 7) of all cases being in the 35 to 44 year old age band, with females and males in this age group representing 15.0% and 12.4% of all self-harm incidents respectively. However, admissions to hospital due to self-harm were rare in the 75 and over age bracket.

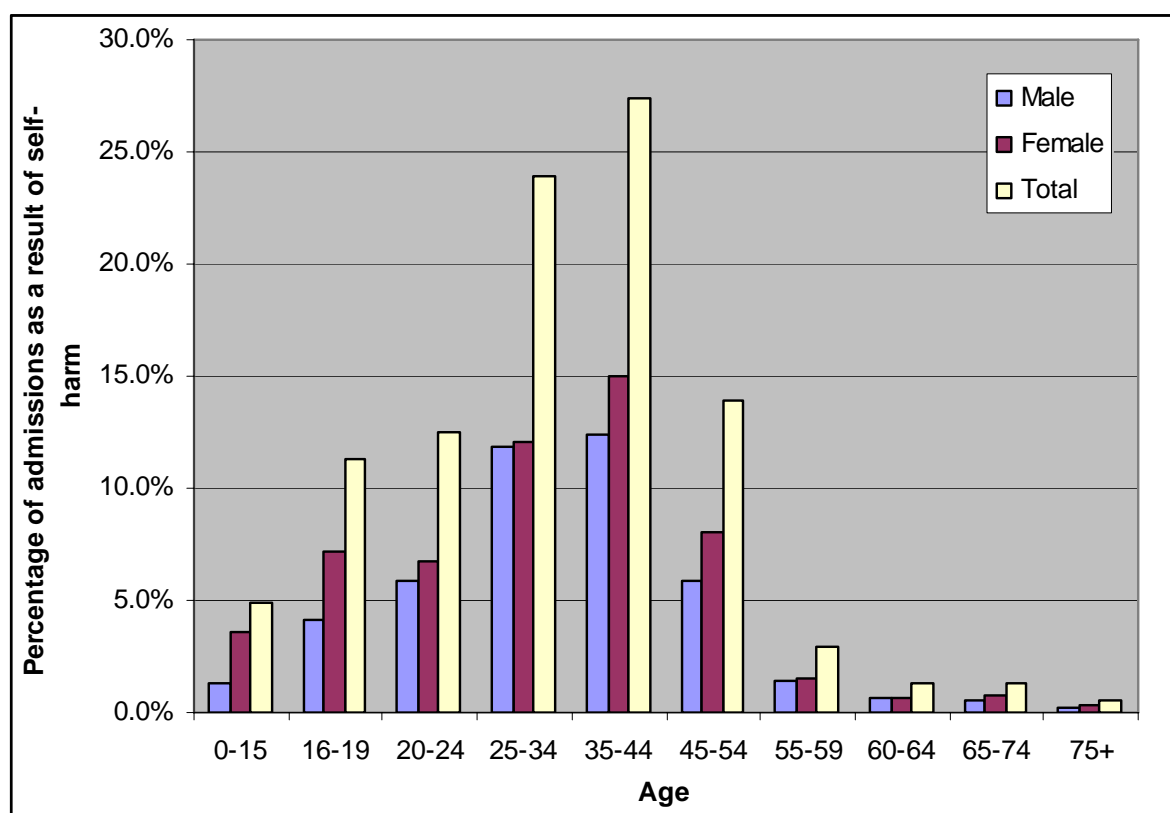


Figure 7: Percentage distribution of hospital admissions as a result of self-harm by age and sex (2000/01-2004/05)

2.17 A study of the Northern Ireland self-harm data by local government district (Figure 8) for the period in question also provides for some interesting analysis. For example, while there was a clear disparity in the suicide rates

between parts of Belfast and the Foyle area, no such distinction exists in relation to the number of hospitals admissions as a result of self-harm per 100,000 persons. The figures show both regions recording similar numbers of hospital admissions, which further illustrates the wide spread nature of self-harm in Northern Ireland. **The Taskforce therefore recommends that further in-depth research needs to be carried out in relation to self-harm in Northern Ireland.**

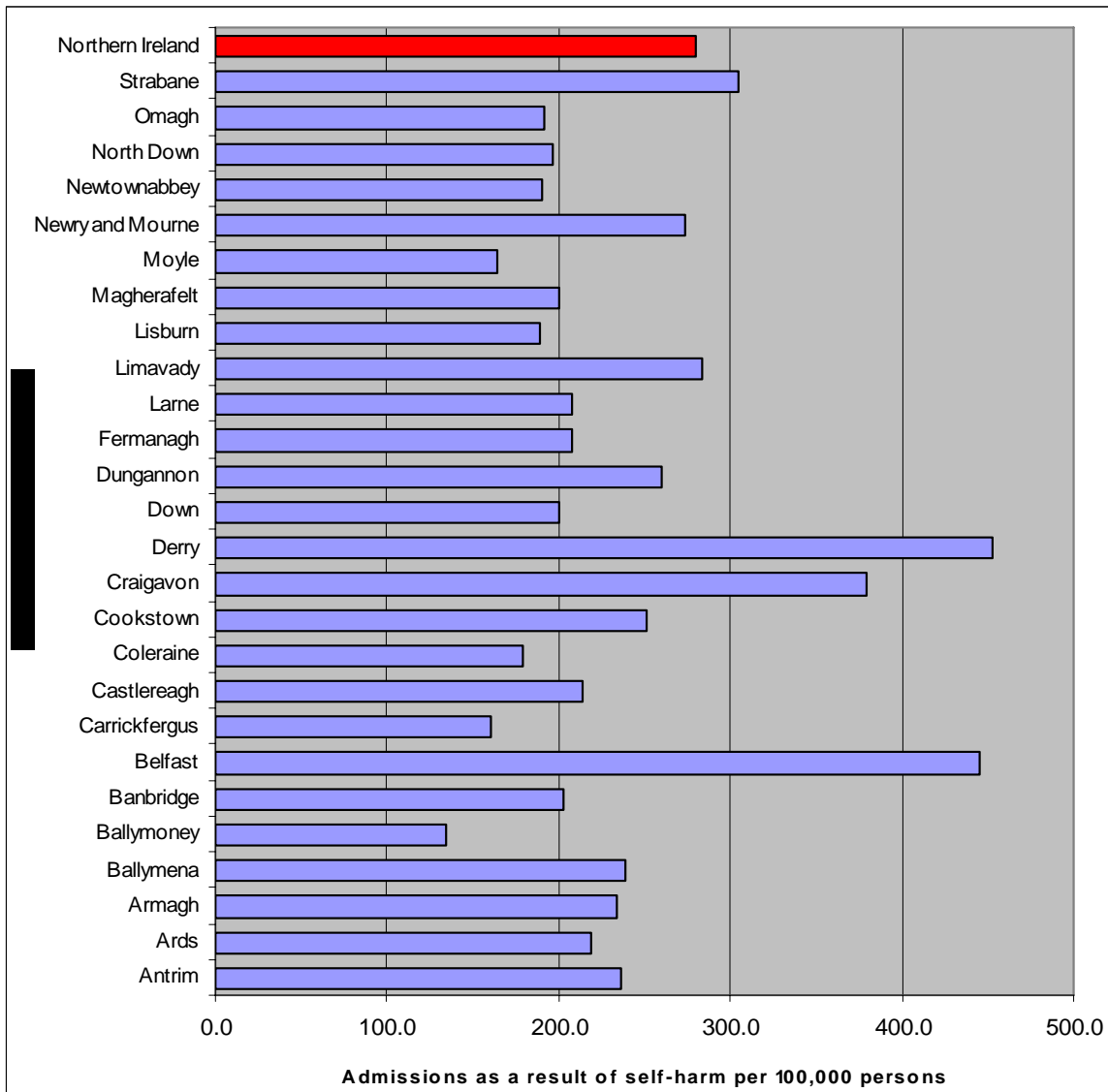


Figure 8: Number of hospital admissions as a result of self-harm per 100,000 persons by Local Government District (2000/01-2004/05)

ECONOMIC COST OF SUICIDE AND SELF-HARM IN NORTHERN IRELAND

- 2.18 Suicide and self-harm has a substantial impact on Northern Ireland in terms of both 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.
- 2.19 In order to establish the economic cost of suicide and self-harm to Northern Ireland the Taskforce asked the Department to estimate the economic loss using the latest available data.
- 2.20 During 2004 there were some 146 recorded suicides in Northern Ireland, equating to 4,350 potential years of life lost (PYLL) for that year. Associated with each suicide are the direct costs such as the post mortem, and funeral costs; the indirect costs which are 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 (voluntary work and 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.
- 2.21 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 are estimated to have cost the Northern Ireland economy £6.6 million in hospital costs, lost earnings and other lost output.
- 2.22 The enormity of the economic cost of suicide and self-harm in Northern Ireland, some £209 million in 2004/05 alone, clearly illustrates the economic benefits of the suicide prevention strategy outlined in this document.

2.23 The economic costs outlined above further reinforces the Taskforces view that, while recognising the importance of the need for additional investment in the provision of mental health services, this strategy should be primarily aimed at addressing the issue of suicide prevention (see paragraph 4.11)

CHAPTER 3 – FINDINGS AND FEEDBACK

REVIEW OF SUICIDE PREVENTION ACTIONS

3.1 As part of the review of the ten suicide prevention action points in the Promoting Mental Health Strategy and Action Plan 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. These provided the Taskforce with a very clear picture of progress, and the outcomes of each action point are set out at **Annex 1**. In summary the main findings 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 actioned;
- 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 sometime; 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.

The action areas set out at **Chapter 5** of this Strategy have incorporated the objectives contained in the ten suicide action points in the Promoting Mental Health Strategy and Action Plan². Particular attention has been given to addressing the main barriers to progress as well as those targets that have to date remained unachieved.

REVIEW OF EVIDENCE BASE

3.2 In order to inform the development of the Suicide Prevention Strategy the Taskforce also commissioned a review of the evidence base relating to self-

harm and suicide. A brief review of the literature was carried out to provide a pragmatic evidence base on which to develop the Strategy, rather than a rigorous academic review of the literature. A brief summary is outlined below. The full report is available at:

www.investingforhealthni.gov.uk/documents/reviewofbase.pdf

- 3.3 There are many factors which place an individual at higher risk of suicide or self-harm. A number of protective factors have also been identified, although the research is less strong in this area. Risk factors and protective factors are detailed in Annex 4.
- 3.4 There is limited evidence available in relation to interventions that are effective in reducing the risk of self-harm and suicide. In many instances studies show conflicting results and in general more evidence is required before strong recommendations can be made.
- 3.5 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 (Mann et al 2005⁴⁰):
- 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.
- 3.6 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.

3.7 Outcomes from this review have been incorporated throughout the Strategy, and particular attention has been paid to the findings in relation to the key elements that should be contained in a suicide strategy (see **Annex 5**). Some key facts arising from this review include:

- 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 years old and 74% under the age of 30 are likely to have had a psychiatric illness;
- 27% 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.

ENGAGEMENT

3.8 As outlined in **Chapter 1**, the Taskforce engaged with a wide range of individuals and organisations, and the following paragraphs highlight the main issues raised during this process. While the views expressed often rely on peoples' own perceptions, the Taskforce felt it was important that they were reflected in order to present a more comprehensive picture of the key issues. The issues raised have been categorised under 5 main headings as set out in paragraphs 3.9 to 3.14.

IMPROVED JOINED UP WORKING

3.9 While there was recognition of the good work already being carried out in many areas, the lack of proper co-ordination and joined up working within and between sectors was highlighted on a regular basis. Some of the key issues raised were:

- new strategy should contain strong linkages to both the Promoting Mental Health Strategy² and the new Drugs and Alcohol Strategy⁴;

- inter-Departmental commitment is required, as the new strategy will cut across several Government Departments;
- better co-ordination between different public sector organisations, particularly health and education;
- 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

3.10 The need for additional training and development was a common theme identified by a wide range of individuals and organisations, and in particular:

- 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;
- further development of parenting skills programmes in local communities;
- introduction of social/coping skills for young people still in school; and
- the need to provide suicide awareness training to staff in the coroners service, funeral directors and social security offices.

KEY SERVICE ISSUES

3.11 Local communities expressed a sense of isolation and hopelessness when attempting to access services in a time of crisis or when looking for help following the death of a friend or relative through suicide. Professional staff working in mental health services highlighted some of the excellent services already in place but expressed frustration at the general lack of

resources and options available to them, and the need for a holistic approach to be taken to the provision of mental health services. Some specific examples include:

- need to develop more accessible services outside normal working hours (9am – 5pm) and potential alternatives to hospital admission/attendance, particularly in response to crisis in the community e.g. 24/7 community based crisis response service;
- need to provide enhanced Child and Adolescent Mental Health Services (CAMHS), as highlighted in Professor Bamford's Review of Mental Health and Learning Disability (NI) (the Bamford Review);
- lack of follow up for vulnerable groups, particularly those who self-harm;
- need to provide appropriate training and support services for carers;
- 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;
- need to ensure that counselling services are properly regulated and resourced;
- need to provide additional support for those people with a history of mental illness;
- need to provide support to staff delivering 'front line' services such as A&E possibly through closer supervisory links with existing psychiatric services; and
- need to monitor and regulate the prescribing of anti-depressants to the under 18 age group.

PROMOTING GOOD MENTAL HEALTH

3.12 It was generally recognised that promoting good mental health was an essential element of any suicide strategy. Particular issues raised included:

- 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 focus health promotion messages on high risk areas including farmers, police officers and armed services, members of lesbian, gay, bi-sexual and transgender communities, victims of abuse, and families bereaved by suicide;
- 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.

GENERAL ISSUES

3.13 Other issues raised include:

- the strategy should be a “living document” that will be reviewed regularly, effectively implemented, and properly resourced;
- need to reduce the waiting period and enhance the sensitivity of the coroner’s office systems;
- need to encourage new and innovative approaches;
- need to initiate further study into what impact “the troubles” has potentially had on the suicide rate in Northern Ireland;
- support for Professor Bamford’s recommendation that the implementation of the local suicide strategy should be separately resourced from, but run in parallel to, the Promoting Mental health Strategy and Action Plan²;
- need to ensure that strategy implementation funding is ring fenced, and made recurrent; and

- acknowledgement of the need for churches to engage further with local communities in relation to how best to tackle the suicide problem.

3.14 One of the clearest messages coming from the consultation process was the need for action and not merely words in relation to the implementation of this Strategy. In this regard, the implementation and review process is outlined at **Chapter 5**.

POTENTIAL FOR NORTH/SOUTH CO-OPERATION

3.15 During the development of the Northern Ireland Suicide Strategy the Taskforce has been in the fortunate position of being able to draw on the experiences and support of counterparts in both the Republic of Ireland and Scotland, who are at differing stages of implementing their suicide strategies.

3.16 The Scottish suicide strategy is already well embedded in the statutory and community sectors and it will therefore remain an invaluable sounding board against which to gauge the potential pitfalls and benefits of proposed local actions.

3.17 However, given that the implementation of the regional strategy in the Republic of Ireland will be running almost parallel to that of this strategy, there are real and cost effective benefits to be gained from joint working in relevant areas. Further research into training and development options is one such example, but of even greater benefit would be the opportunity to instigate a major review into the recording methods used for suicide and self-harm on both parts of the Island. The potential to harmonise these approaches arising from this proposed review would allow for greater clarity in the recording of suicides. It would also allow for meaningful comparisons to be made regarding future trends, and highlight areas for further action.

3.18 The Taskforce therefore recommends that the Strategy Implementation Group explores the potential for enhanced North/South working where mutually beneficial.

CHAPTER 4 – STRATEGIC AIM AND OBJECTIVES OF THE STRATEGY

STRATEGIC AIM

4.1 The strategic aim of this Strategy is:

“To reduce the Northern Ireland suicide rate, particularly among young people and those most at risk.”

OVERALL TARGETS

- 4.2 The Taskforce has adopted the existing Priorities for Action target, which envisages a 10% reduction in the overall suicide rate by 2008.
- 4.3 The Taskforce believes that there is a need to set a further strategic target for the reduction of the overall suicide rate by the end of the Strategy’s five year action plan in 2011. However, given the uncertainty regarding the possible under reporting of suicides as highlighted at paragraph 2.4, the Taskforce believes that setting a further 5 % reduction target (i.e. 15% in total by 2011) is realistic in the present circumstances. **The Taskforce therefore recommends that this target should be kept under review pending the outcome of further work on suicide recording arrangements.**
- 4.4 Achieving the Strategy’s objective of reducing the Northern Ireland suicide rate will present a difficult and ongoing challenge, and one which will require regular review and updating. While the **Five Year Action Plan** outlined in **Chapter 5** will play a central role in the delivery of the Strategy’s key aims, it is recognised that the objectives cannot be met by health and social services alone. The onus is therefore on all of us, communities, voluntary organisations, the media, the statutory sector including not only those within Health/Social Services but the wider range of relevant sectors, including Education, Employment, and society as a whole, to work together to achieve a reduction in the Northern Ireland suicide rate.

GUIDING PRINCIPLES

4.5 The Taskforce has established a number of guiding principles which are reflected throughout the action plan, and which should also guide the Strategy's implementation. The full list of guiding principles are set out below:

- **Links to Other Strategies** - strong links to other relevant strategies including Investing for Health³, Promoting Mental Health Strategy and Action Plan², the Drugs and Alcohol Strategy⁴, Neighbourhood Renewal⁵, the forthcoming Childrens Strategy and the Bamford Review of Mental Health and Learning Disability (NI).
- **Joined Up Working** - the need for joined up working at Governmental 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 and Great Britain where appropriate.

KEY OBJECTIVES OF THE STRATEGY

4.6 Having analysed the feedback from the various stakeholder engagement exercises and the evidence based research the Taskforce has identified the following key objectives:

- to raise awareness of mental health and wellbeing issues;
- to ensure early recognition of mental illness, and to provide appropriate follow up action by support services;
- to enhance the support role currently carried out by the Voluntary/Community sectors, bereaved families and individuals who have made previous suicide attempts;
- 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 support the media in the development of 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.

PRIORITY TARGET AREAS

4.7 The Taskforce has also identified a number of key priority areas for targeting, and these are reflected in the specific actions in **Chapter 5**. They include:

- males aged between 18 - 34;
- bereaved families, individuals who have made previous suicide attempts, and carers;
- high risk occupations and groups including health care staff, farmers, Police Officers, armed forces, and survivors of abuse;
- people who misuse alcohol and drugs;
- marginalised and disadvantaged groups, including lesbian, gay, bi-sexual and transgender people;
- people who self-harm, and those who have previously had contact with mental health services; and
- people living in socially and economically disadvantaged areas.

APPROACH

4.8 To meet the challenging targets set within this Strategy, and those within the Promoting Mental Health Strategy and Action Plan², it is important to set the approach within the wider context of the Investing for Health performance measurement framework. The achievement of the Strategy's strategic aim will also play its part in helping to meet the existing Investing for Health⁴ targets, which include improving life expectancy, reducing health inequalities and improving the mental health of the people of Northern Ireland

4.9 While Investing for Health⁴ is primarily aimed at the population as a whole, **Chapter 2** of this Strategy clearly highlights that there is a direct association between suicide rates and gender, age groups, and socio-economic status. The Taskforce therefore agreed that to reduce the suicide rate in Northern Ireland a dual population and targeted approach should be adopted when implementing this Strategy.

- 4.10 The population approach seeks to tackle the issue of suicide in a wider generic 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 who are known to be at an increased risk must be complimentary. **Section A of Chapter 5 deals with the Population Approach and Section B of Chapter 5 deals with the Targeted Approach.**
- 4.11 While the focus of this Strategy is prevention, the Taskforce recognises the positive impact that properly resourced mental health services can have on reducing the rate of suicide. Professor Bamford in the review of Mental Health and Learning Disability (NI) identified significant gaps in resources for mental health services. **The Taskforce believes that these gaps need to be resourced and recommend that Government develop a co-ordinated plan to resource and implement the Bamford recommendations, and that the implementation of this Strategy should be taken forward in parallel.**

CHAPTER 5 – ACTION PLAN

5.1 This chapter sets out the action areas agreed by the Taskforce within the **Population** and **Targeted** approach.

MEASURING PROGRESS

5.2 It is vital to be able to measure the extent to which the strategic aim of Strategy has been met. To this end specific performance measurement targets have been suggested for the action areas. Overarching objectives have also been developed for both the **Population** and **Targeted** sections of this Action Plan. The achievement of these targets/objectives will play a central role in the annual review of the progress being made towards implementing this Strategy.

TIMESCALES

5.3 All performance measurement targets contained within this chapter have been assigned a specific timescale in which action 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).

5.4 While it is envisaged that the targets should be met within the allocated 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 Strategy Implementation Group and the Department to agree any revised targets.

SECTION A – POPULATION APPROACH

5.5 Having chosen to adopt a dual population and targeted approach for implementing the Strategy, the Taskforce set overarching objectives against each approach and identified key action areas. These will be measured by the success achieved in meeting the individual performance targets in each area. It is envisaged that the Strategy's Implementation Group will be responsible for monitoring achievement of the agreed targets, and for ensuring that plans are developed to take forward the relevant actions within each grouping.

5.6 The overarching objective for the population approach is:

Strengthening the protective factors against the risk of suicide afforded to the general population.

FAMILY	
Objective Enhance the emotional health and wellbeing support provided to families and individuals.	
Targets (s) & Timescales	1. By 2009 to provide families with the opportunity to avail of practical intervention skills to help improve parenting skills, emotional health, and interaction between children and parents.
	2. By 2009 to ensure that families have access to a local emotional health and wellbeing support network (including community/voluntary sector provision) within their local Health and Social Services Trust area.
Action (s) to take & Timescales	a. To identify and map current emotional health and wellbeing services available to families, and in particular highlight existing entry points or barriers into the services. Short Term
	b. Ensure that the models of emotional health and wellbeing support provision, including local support networks, are joined up and welcoming. Short/Medium Term
	c. To ensure that local support services are properly regulated. Short Term
	d. Encourage and support the development and provision of emotional learning initiatives, including Parenting Skills initiatives, life skills, etc. Medium Term

COMMUNITIES	
Objective	
Raise awareness of mental health and suicide related issues in the wider community.	
Targets (s) & Timescales	1. By 2007 to initiate a major information campaign that aims to de-stigmatise mental health and promote awareness and understanding of suicide and approaches to suicide prevention.
	2. By 2008 to ensure that all communities have access to community based suicide prevention support mechanisms within their local Health & Social Services Trust Area.
Action (s) to take & Timescales	a. To develop and implement a suicide awareness information campaign, which helps to de-stigmatise mental health and encourage help seeking behaviour. Short/Medium Term
	b. To monitor and evaluate the effectiveness of the information campaign and make necessary enhancements as required. Medium Term
	c. To ensure that agreed community support groups are appropriately resourced, and that monitoring mechanisms are put in place. Short/Medium Term
	d. To ensure that Health Impact Assessments are carried out on all Departmental and Public Body policies to ensure that potential adverse impacts, in terms of the mental health and wellbeing of local communities, are identified and mitigated as far as possible (e.g. Planning, Housing developments, etc.). Ongoing

	<p>e. To restrict access to means and methods of suicide in our communities. This includes the identification of suicide hotspots, and the promotion of safer prescribing of anti-depressants and, a reduction in the easy accessibility of certain over the counter drugs.</p> <p style="text-align: right;">Ongoing</p>
	<p>f. To develop a mechanism to allow timely access to statistics and geographical/demographic information at local level so that potential clusters of suicides can be identified early and appropriate preventative action taken.</p> <p style="text-align: right;">Short/Medium Term</p>

CHILDREN AND YOUNG PEOPLE

Objective

Promote the development of policies which enhance the positive mental health and wellbeing of children and young people, and which also protects them from bullying.

Targets (s) & Timescales

1. By 2008 to ensure that support services which promote positive mental health and protect children from bullying are available and accessible in all schools and youth settings.
2. By 2008 to ensure that buddying/mentoring type schemes are available via local community support networks in all Health and Social Services Trust areas for all young people in need.
3. By 2007 to improve the protocols for sharing information between relevant agencies with regards the health, safety and wellbeing of children and young people.

Action (s) to take & Timescales

- a. Explore with young people the support mechanisms needed to better develop coping skills, and protect them from bullying.
Short Term
- b. To develop and implement the identified support mechanisms.
Short/Medium Term
- c. To develop and implement programmes and protocols which discourage bullying.
Short/Medium Term
- d. To promote the inclusion of coping/life skills in the school curriculum.
Medium Term
- e. To identify and encourage the further development of integrated mechanisms to support young people, particularly in schools, youth settings, and the local community support networks.
Short/Medium Term

	<p>f. To make suicide awareness and positive mental health and wellbeing training a priority for all teachers and youth workers.</p> <p style="text-align: right;">Medium Term</p>
	<p>g. To develop and implement practices, protocols and referral pathways to smooth the transition from Youth to Adult health Services, and support the implementation of relevant recommendations in the Bamford review, in particular the report which considers the mental health of children and young people.</p> <p style="text-align: right;">Short/Medium Term</p>

HEALTH AND SOCIAL SERVICES

Objective

Make suicide prevention and reducing levels of self-harm priority issues for all Health and Social Services bodies and ensure greater co-ordination and co-operation between the different parts of the health and social services.

Targets (s) & Timescales

1. By 2008 to ensure that the proper linkages have been made between all mental health services including local community/voluntary support networks.

2. By 2007 to ensure that all priorities identified within the suicide strategy are also recognised as priorities in all relevant Departmental Public Service Agreements (PSA) and reflected in individual departmental annual priorities.

3. By 2011 to have implemented, in co-operation with other stakeholders, all the findings and actions in the suicide strategy.

Action (s) to take & Timescales

a. To review current linkages between all areas of health and social services which engage with people who have a mental illness and/or who are most at risk of suicide, and then implement necessary changes.

Short/Medium Term

b. To develop enhanced linkages between the statutory health and social services and the community/voluntary counselling and support networks, particularly in relation to transition services and where there are gaps in treatment.

Short/Medium Term

c. To make appropriate suicide awareness/prevention training a priority for all front line health service staff, in particular primary care staff.

Short/Medium Term

d. To develop clinical guidelines for all health service staff to use when dealing with people who have a mental illness.

Short/Medium Term

	<p>e. To assess existing crisis response models with a view to implementing the best practice model, which needs to be accessible by both the community and Health Service staff.</p> <p style="text-align: right;">Short/Medium Term</p>
	<p>f. To ensure cross Departmental buy-in into the local suicide strategy, and empower the Implementation Group to drive the strategy's implementation forward.</p> <p style="text-align: right;">Short Term</p>
	<p>g. To review all Public Service Agreements to ensure that they have addressed all possible suicide prevention related issues.</p> <p style="text-align: right;">Short Term</p>

WORKPLACES

Objective

Enhance the mental health and wellbeing of the workforce and strengthen employer's duty of care, particularly in relation to the prevention of suicide.

Targets (s) & Timescales

1. By 2008 to implement a targeted information campaign aimed at enhancing the mental health and wellbeing of all members of the workforce.
2. By 2009 to ensure that positive mental health training is available to all members of the workforce, including small/medium enterprises employers.

Action (s) to take & Timescales

- a. Work with employers, their representative bodies, and trade unions on how best to take target 2 forward.

Ongoing

- b. To develop and implement a targeted information campaign aimed at enhancing the mental health and wellbeing of the workforce.

Short/Medium Term

- c. Review all current workplace mental health related training strategies, and consult with employers, their representatives, and relevant statutory bodies, about how best to implement suitable training initiatives which promote mental health and prevent suicidal behaviour developing.

Short/Medium Term

- d. Work with relevant statutory bodies to make the promotion of mental health and wellbeing awareness training an integral part of all future training and award type schemes, and service level agreements.

Medium Term

POLICE AND EMERGENCY SERVICES

Objective

Provide the Police and the Emergency Services with the necessary skills and training in order to identify and assist those people they come into contact with who maybe at risk of suicide and self-harm.

Targets (s) & Timescales

1. By 2007 to ensure that suicide prevention is included as a priority in all the emergency services Public Service Agreements and reflected in individual services annual priorities.

2. By 2009 to make suicide awareness/intervention training mandatory for all frontline emergency services staff.

Action (s) to take & Timescales

a. To assess existing suicide related training available to the emergency services, identify any gaps/barriers, and implement any necessary enhancements.

Short/Medium Term

b. To incorporate relevant suicide training, including bereavement support, into existing regime, and/or initiate new training procedures.

Medium Term

c. To regularly refresh suicide awareness/intervention training for staff.

Ongoing

d. To further develop links between the emergency services, other relevant statutory services and the local community support networks.

Medium/Long Term

CHURCHES AND RELIGIOUS BODIES

Objective

Support the role played by churches/religious bodies in promoting positive mental health in the local community.

Targets (s) & Timescales

1. By 2007 to ensure that churches/religious bodies are aware of, and have access to, the local community support networks in their area.
2. By 2008 to ensure that all church/religious leaders have been offered the opportunity to avail of suicide awareness training.

Action (s) to take & Timescales

- a. To liaise with religious bodies and local support networks to increase mutual awareness and understanding of their potential support roles during crisis periods.
Short Term
- b. To encourage the development of enhanced links between churches/religious bodies and the local community support networks.
Short/Medium Term
- c. To make appropriate suicide awareness/mental health and wellbeing training available for all church/religious leaders.
Short/Medium Term
- d. To acknowledge and enhance the significant role that churches and religious bodies play in dealing with those in crisis and those bereaved by suicide.
Short/Medium Term

MEDIA	
Objective	
Promote positive mental health and wellbeing, and encourage sensitive and responsible portrayal of suicide and self-harm issues in the media.	
Targets (s) & Timescales	1. By 2007 agree reporting guidelines with the National Union of Journalism in relation to the portrayal of all suicide related matters.
	2. By 2007 to develop and implement positive media messages and accompanying public relations strategy.
Action (s) to take & Timescales	a. To work with the National Union of Journalism in relation to the development of the required guidelines. Short Term
	b. Agree appropriate media messages with all interested parties, including bereaved families, support groups and the media itself. Short Term
	c. To develop and implement appropriate media monitoring mechanisms. Short/Medium Term
	d. Explore the use of other media options, including the internet and text messaging, and how these may best be utilised. Short Term
	c. Liaise with survivors and bereaved families about what communication role (if any) they would feel comfortable with, and then provide them with the necessary support and training. Short Term

SECTION B – TARGETED APPROACH

5.7 The targeted approach addresses suicide prevention by reducing the risk factors for those within society who are identified as being most at risk. The overarching objective for the targeted approach is as follows:

Reducing the risk factors for those in society who are most at risk of suicide.

SELF-HARM	
Objective	
Provide a responsive care and buddying support service for those people who self-harm.	
Targets (s) & Timescales	1. By 2008 to ensure that responsive support services, which bridge the gap between treatment and community provision, are available in all local Health and Social Services Trust areas for people who self-harm.
	2. By 2008 to implement programmes in all local Health and Social Services Trust areas which enhance coping skills of those with a history of self-harm.
Action (s) to take & Timescales	a. To identify and assess gaps/linkages within existing support services, both statutory and community/voluntary, for those people who self-harm. Short Term
	b. To develop and implement mechanisms for bridging any identified gaps, and in particular in relation to the provision of buddying support type schemes. Short/Medium Term
	c. To support the strengthening of links between community/voluntary groups that work with those who self-harm and the statutory sector, and in particular in relation to the provision of appropriate aftercare follow up. Short/Medium Term
	d. To ensure that those who self-harm are appropriately cared for by statutory services, in particular within A&E and Mental Health Services. Initial care, treatment and subsequent follow up should be in accordance with NICE guidelines. Ongoing
	e. To develop and implement programmes which enhance coping skills of those with a history of self-harm. Short/Medium Term

MENTAL ILLNESS

Objective

Reduce the risk of suicide and self-harm among people with a mental illness.

Targets (s) & Timescales

1. By 2007 to ensure that those in contact with Mental Health Services receive regular follow up, which includes assessment of suicide and self-harm risk, on an ongoing basis.
2. By 2008 to ensure that all Health and Social Services Trust areas have proactive suicide awareness/intervention programmes in place for staff who work with people who have a mental illness.

Action (s) to take & Timescales

- a. To assess both the linkages and the accessibility of the existing mental health services.
Short Term
- b. To support the Bamford recommendations in relation to the enhancement of Mental Health Services in Northern Ireland.
Ongoing
- c. To establish protocols which ensure that all people with a history of previous mental health illness receive appropriate follow up support.
Short/Medium Term
- d. To enhance the role of the community/voluntary sector with regards to provision of follow up support services for those people who suffer from mental illness.
Short/Medium Term
- e. To provide appropriate support and information in order to promote awareness of potential suicide risk among carers of those with a mental health illness.
Ongoing

DRUG AND ALCOHOL MISUSE

Objective

Reduce the risk of suicide and self-harm among people who misuse alcohol and/or drugs.

Targets (s) & Timescales

1. By 2008 to ensure that appropriate suicide awareness/intervention training is available for all frontline health services staff, police officers, and other relevant professions.
2. By 2008 to enhance the health service's ability to carry out risk assessments, including mental health, on people who are under the influence of drugs and/or alcohol.

Action (s) to take & Timescales

- a. To identify and implement suitable training arrangements for the agreed occupations.

Short/Medium Term

- b. To develop agreed protocols with health service professionals with regards to the assessment and management of patients at risk while under the influence of drugs and/or alcohol.

Short/Medium

- c. To liaise with DAST, and relevant treatment service providers, to maximise the protection and minimise the risk of suicide for those people who misuse drugs/alcohol.

Ongoing

YOUNG MALES	
Objective Enhance the coping skills of young males and encourage them to seek help as an alternative to taking their own lives.	
Targets (s) & Timescales	1. By 2008 to ensure that targeted outreach programmes for young males who may be at risk of suicide and self-harm are available in all Health and Social Services Trust areas.
	2. By 2007 implement a targeted information and awareness campaign for young males, aimed at breaking down the current male culture of not discussing their problems openly.
Action (s) to take & Timescales	a. To work in appropriate fora with young males regarding how best to reach out to them, and to identify those initiatives that may be of help at times of crisis. Short Term
	b. To develop and implement appropriate personal development programmes for young males. Short/Medium Term
	c. To enhance the role of the community/voluntary sector with regards to the provision of buddying/mentoring support for young males at risk of suicide and self-harm. Short/Medium Term
	d. To design and resource an information and awareness raising campaign for young males. Short/Medium Term

BEREAVED BY SUICIDE

Objective

Ensure that effective, sensitive, and timely information and support is available across a range of settings, including the Police, coroner's office, community, churches, and health service, to those bereaved by suicide.

Targets (s) & Timescales	1. By 2008 to ensure that accessible information and timely support, both at community/voluntary and statutory level, is available in all Health and Social Services Trust areas.
	2. To consult on an annual basis with those bereaved by suicide, survivors and local communities throughout Northern Ireland when carrying out the yearly progress review of the implementation of Suicide Prevention Strategy.
Action (s) to take & Timescales	a. To assess existing support available to those bereaved by suicide, and in particular highlighting any gaps. Short Term
	b. To implement enhancements to make better support available to those bereaved by suicide, and to encourage the development of support networks/groups. Short/Medium Term
	c. To ensure that those bereaved by suicide are suitably represented on the Strategy Implementation Group. Short Term
	d. To work with the coroner's office to facilitate the provision of sensitive and timely information to those bereaved by suicide. Short/Medium Term
	e. To agree future review/consultation arrangements with those bereaved by suicide throughout Northern Ireland. Short Term

	<p>f. To raise awareness among local health service providers especially within Primary Care, regarding the increased risk of self-harm and suicide among those bereaved or affected by suicide.</p>
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Ongoing

VICTIMS OF ABUSE	
Objective Build awareness of the increased risk of suicidal behaviour among victims of abuse.	
Targets (s) & Timescales	1. By 2008 to provide an accessible support network in each local Health and Social Services Trust area for victims of abuse.
	2. By 2007 to initiate an information campaign which seeks to sensitively raise awareness of the increased risk of suicide and self-harm among victims of abuse.
Action (s) to take & Timescales	a. To consult with victims of abuse in order to establish what information and support services are required. Short Term
	b. To assess existing support services, in both the statutory and community/voluntary sectors, and highlight the investment required to bridge any identified gaps. Short Term
	c. To provide training to support workers for victims of abuse. Ongoing
	d. Collate and disseminate information regarding the risk of suicidal behaviour among victims of abuse to the relevant bodies/support networks. Short/Medium Term
	e. To develop a targeted and sensitive information campaign which raises awareness and encourages victims of abuse to seek help at time of crisis. Short/Medium Term

MARGINALISED AND DISADVANTAGED GROUPS

Objective

Identify the relevant support and intervention services that are available and accessible to marginalised and disadvantaged groups, and recommend improvements where appropriate.

Targets (s) & Timescales	<p>1. By 2008 to ensure support services which are in place reach out to all marginalised and disadvantaged groups, and in particular lesbian, gay, bi-sexual and transgender groups, the rural community, and people living in economically deprived areas.</p>
	<p>2. By 2007 to initiate a targeted information campaign which seeks to raise awareness of the increased risk of suicide and self harm amongst those groups that have been identified as being marginalised or disadvantaged.</p>
Action (s) to take & Timescales	<p>a. To further identify and prioritise the main marginalised and disadvantaged groups who are particularly at risk of suicide and self harm, and assess the existing services available to those groups, highlighting any service gaps that exist.</p> <p style="text-align: right;">Short Term</p>
	<p>b. To consult with the identified target groups and the local community network regarding how best to meet their needs.</p> <p style="text-align: right;">Short Term</p>
	<p>c. To implement agreed support services enhancements, and to support the call for intervention service improvements as required.</p> <p style="text-align: right;">Medium Term</p>
	<p>d. To develop a targeted and sensitive information campaign which raises awareness and encourages marginalised and disadvantaged groups to seek help at times of crisis.</p> <p style="text-align: right;">Medium Term</p>

HIGH RISK OCCUPATIONS

Objective

Provide targeted support for people in occupational groupings which have a high risk of suicide and self-harm.

Targets (s) & Timescales

1. By 2008 to develop an accessible support network for people in occupations which have a high risk of suicide and self-harm.
2. By 2007 to develop a crisis plan for targeting people in high risk occupations as and when emergency situations arise.

Action (s) to take & Timescales

- a. To identify and prioritise high risk occupations, and how best to raise awareness within these groups.
Short Term
- b. To liaise with members of the identified occupations in order to establish the most appropriate and effective forms of support.
Short Term
- c. To develop and agree a crisis action plan.
Medium Term
- d. To implement and resource any agreed support initiatives.
Short term

PRISONERS	
Objective To reduce the risk of suicide and self-harm to those people in custody.	
Targets (s) & Timescales	1. By 2009 to make appropriate suicide awareness, prevention and intervention training mandatory for all frontline prison and police custody staff, and where possible identified “listener” inmates.
	2. By 2008 to ensure that the environment for those held in custody, both in prison and at police stations, have been suitably adapted to reduce the possibility of suicide, including restricting the access to means of suicide.
Action (s) to take	a. To assess existing suicide awareness/intervention training options, and then agree a phased implementation of the most effective option. Short/Medium Term
	b. To regularly refresh suicide awareness, prevention and intervention training for staff. Ongoing
	c. To regularly audit the custody environment for potential risks in relation to attempted suicide. Ongoing
	d. Police, Prison and Health Services to review current handling of patients/inmates with mental health difficulties and in particular the initial 24hr support services available to them, and then implement any necessary changes. Short/Medium Term
	e. To work with the prison service to provide access to appropriate services to those in prison with a recognised mental health illness, including the development of appropriate “listener” groups for those in custody. Ongoing

	<p>f. To ensure that all remand and sentenced prisoners continue to receive initial and ongoing monitoring of their mental health and assessment of the risk of suicide.</p> <p style="text-align: right;">Ongoing</p>
	<p>g. To liaise with the probation service about the provision of follow-up support for those who have recently been released from custody.</p> <p style="text-align: right;">Short Term</p>
	<p>h. To provide appropriate support in relation to the removal of stigma from those people who have been released from custody without charge.</p> <p style="text-align: right;">Short Term</p>
	<p>i. To support implementation of the recommendations in the McClelland report “A Review of Non-natural deaths in Northern Ireland Prison Service establishments (June 2002 – March 2004).</p> <p style="text-align: right;">Ongoing</p>

CHAPTER 6 – IMPLEMENTATION, RESEARCH AND REVIEW

IMPLEMENTATION

6.1 Feedback from the Strategy's wide ranging engagement process has consistently highlighted that a greatly enhanced level of co-ordination, across government departments, different sectors, and at community level is crucial if a reduction in suicide rates is to be achieved. This view is supported by Professor Bamford in his review of Mental Health and Learning Disability Services in Northern Ireland and also by the United Nations/World Health Organisation, whose guidelines for the development of a National Suicide Prevention Strategy stress the need to establish central co-ordination for this purpose. Both Scotland and the Republic of Ireland have adopted this approach in relation to the delivery of their local suicide strategies. Scotland in particular was greatly influenced by the implementation model adopted by Finland, which is widely recognised as the forerunner in the preparation of national programmes for suicide prevention.

CO-ORDINATION

6.2 Greatly enhanced co-ordination and the establishment of a robust performance management mechanism are critical to the successful implementation of the Strategy. It is vital that progress is closely monitored and measured and that individuals and organisations are held to account.

Governmental Level

6.3 At Governmental level the Taskforce believes that suicide needs to be highlighted as a priority in the relevant Department's Public Service Agreements and that individual actions are reflected in annual Department Priorities within their sector. The Taskforce considers that this approach could be co-ordinated by the Ministerial Group on Public Health (MGPH).

Delivery Level

- 6.4 At planning and delivery level the Taskforce recommends the establishment of a Strategy Implementation Group that would oversee the implementation of the Bamford Review of Mental Health as well as the Promoting Mental Health² and Suicide Prevention Strategies. The group should be inter-agency and include the Chief Executives of public sector organisations with responsibility for commissioning and delivering services in this area, as well as those who use the services, in particular young people and those bereaved by suicide.
- 6.5 Also critical to the success of the strategy will be the establishment of specific resources at local level, which will need to work closely with those at regional level to ensure the Strategy is implemented in a consistent and focused manner. **The Taskforce recommends that the existing Investing for Health partnerships could be tasked with developing a local action plan, in partnership with all relevant stakeholders, for taking forward the implementation of the Strategy locally.**

REVIEW

- 6.6 It is proposed that this Strategy should be reviewed annually, and that the agreed objectives and performance measurement targets should provide a framework for a wide ranging review. Responsibility for initiating the review will lie with the Implementation Group, however the Taskforce intends to clear in advance with the Department the draft Terms of Reference for future reviews. Final ratification of any proposed changes to the strategy will remain the responsibility of the Department.

RESEARCH

- 6.7 As reported earlier in the Strategy, it is widely recognised that there is currently little evidence as to why people take their own lives. Research will therefore play a central role in the implementation process by both filling

existing gaps in our information and understanding, and also by allowing people in Northern Ireland to benefit from best practice worldwide.

6.8 While some of the research will be of a localised nature, specific to particular problems, much will be of a standard format which will allow for shared working with counterparts in the Republic of Ireland and Scotland. Recommended topics for initial research include:

- the effects of the “Troubles” on the mental health and emotional wellbeing of the people in Northern Ireland;
- a psychological profiling of deaths by suicide;
- a review of the current suicide reporting/recording arrangements (see paragraph 2.3);
- a review of telephone helpline options; and
- an extensive survey into the causation of self-harm in Northern Ireland.

NEXT STEPS

6.9 Prior to implementation the Strategy will be subject to a 12 week formal consultation exercise, and it is anticipated that this will be proactively managed. It will also provide all interested parties with a further opportunity to feed into the final suicide strategy document.

PREVENTING SUICIDE ACTIONS IN THE PROMOTING MENTAL HEALTH

STRATEGY AND ACTION PLAN

Action 21: DE and DEL in partnership with Education and Library Boards, Schools, Youth Council for NI, HPA and HSS Boards will implement programmes on awareness of suicide for teachers and youth leaders.

Target Date: April 2004.

Objective: Achieved.

Action 22: DE in partnership with the Youth Services, Youth Council for NI and voluntary and community sectors will continue to develop outreach work with young people in areas of need and especially young males.

Target Date: Ongoing.

Objective: Partially Achieved.

Action 23: HSS Boards will develop a suicide awareness programme in each board area.

Target Date: April 2004.

Objective: Partially Achieved.

Action 24 HSS Boards in partnership with HSS Trusts and the voluntary and community sectors will develop a support service and provide an information booklet for those bereaved by suicide.

Target Date: April 2004.

Objective: Partially Achieved.

Action 25: HSS Boards and HSS Trusts in partnership with Primary Care, and voluntary and community sectors will ensure that a suicide risk assessment training programme is initiated for health and social services personnel and staff in the voluntary and community sectors working with vulnerable people.

Target Date: April 2004.

Objective: Partially Achieved.

Action 26: HSS Boards and HSS Trusts in co-operation with Primary Care will develop and deliver a Depression Awareness training programme for GPs.

Target Date: September 2004.

Objective: Not Achieved.

Action 27: HSS Boards and HSS Trusts in partnership with the voluntary and community sectors will as part of policy development, consider how best to provide appropriate information on services available to people contemplating suicide.

Target Date: December 2003.

Objective: Partially Achieved.

Action 28: The Prison Service will ensure that all remand and sentenced prisoners continue to receive initial and ongoing monitoring of their mental health and assessment of the risk of suicide.

Target Date: Ongoing.

Objective: Achieved.

Action 29 The Prison Service and the Police Service will continue to address whatever steps are necessary to avert any opportunity for suicide to take place among those at risk.

Target Date: Ongoing.

Objective: Achieved.

Action 30: The Prison Service and the Police Service will ensure that suicide awareness is part of the in-service training for police and prison officers.

Target Date: Ongoing.

Objective: Partially Achieved.

SUICIDE TASKFORCE TERMS OF REFERENCE

- 1 Develop a regional strategy for Northern Ireland for prevention of suicides, with particular reference to prevention of young male suicide.
- 2 To produce an analysis of suicides and severe self harming in Northern Ireland in the last 5 years.
- 3 Review the current provision in health, education and the voluntary sectors in prevention of suicide strategies including a review of the 10 action points in the Promoting Mental Health Strategy and Action Plan².
- 4 Review factors and relevant research on suicide and self harm in Northern Ireland; elsewhere in the United Kingdom and the Republic of Ireland; and evaluation of best practice in Northern Ireland and elsewhere.
- 5 Consider and evaluate options and make recommendations for preventing suicide and self harm.
- 6 Examine provision and scope for a dedicated helpline for Northern Ireland and examination of existing telephone counselling service provision within statutory and voluntary agencies.
- 7 Examine option of developing greater links with existing voluntary agencies which provide counselling services in this sector.
- 8 Design and implement a survey for Northern Ireland of families of suicide victims, those who have self harmed and those experiencing counselling and working professionally with potential suicide victims and individuals who severely self harm.
- 9 Organise a conference in Belfast on Thursday 25 August 2005 to encourage debate and share best practice in Northern Ireland, elsewhere in the United Kingdom and the Republic of Ireland in prevention of suicide strategies.
- 10 Provide an interim report by 31 October 2005.
- 11 Provide final report by the end of the year, with a costed regional action plan.

MEMBERSHIP OF THE SUICIDE TASKFORCE

Chair Mr. Colm Donaghy, Chief Executive, Southern Health and Social Services Board

Dr. Brian Gaffney, Chief Executive, The Health Promotion Agency for Northern Ireland

Mr. John McGeown, North and West Belfast Trust

Mrs. Jo Murphy, North Belfast Partnership

Mrs. Patricia McQuillan, Lenadoon Counselling Project

Mr. Malcolm Emery, Rural Support

Mr. Shay McGovern, Department of Health & Children

Dr Stephen Bergin, Southern Health and Social Services Board

Ms. Madeline Heaney, Northern Health and Social Services Board

Mr. Barry McGale, Westcare Business Services

Mrs. Maureen Ferris, Eastern Health and Social Services Board

Mr. Pat McGreevy, Down Lisburn Trust

Dr. Philip McGarry, The Royal College of Psychiatrists

Dr. Ian Wales, Royal College of General Practitioners

Mr. Joe Ferns, Samaritans

Mr. Hugh McCann, Principal of St Colman's High School

Ms. Irene Ooi, Juvenile Justice Centre for NI

Ms. Helen McNamee, The Rainbow Project,

Ms. Sally Newton, N Ireland Prison Service

Ms. Dorothy Angus, Department of Education

Mr. Mark O'Donnell, Department of Social Development

Mr. Anthony Langan, Samaritans

Mr. John McCavana, Department of Education

Dr. Denise O'Hagan, Southern Health and Social Services Board

Dr. Glenda Mock, Department of Health Social Services and Public Safety

Mr. Charlie Bamford, Department of Health Social Services and Public Safety

Mrs. Pat Osborne, Department of Health Social Services and Public Safety

Mr. Aidan McCann, Department of Health Social Services and Public Safety

Mr. John Breen, Department of Health Social Services and Public Safety

Mr. Martin Bell, Department of Health Social Services and Public Safety

Dr. Tracy Power, Department of Health Social Services and Public Safety

INTEGRATED IMPACT ASSESSMENT SCREENING**1. What is an Impact Assessment?**

- 1.1 A fundamental requirement of good policy development by government is to ensure that emerging policy proposals comply with its basic policy objectives, wider initiatives, and with statutory obligations as set out elsewhere in legislation. It is important, when bringing forward policy proposals on specific issues, that the opportunity is also taken to ensure that these proposals do not have any unexpected or unacceptable impacts, or which conflict with other aspects of government policy.
- 1.2 To assist in this process, studies, generally referred to as impact assessments, are performed on policy proposals as they are developed. These help policy makers identify the expected impacts of emerging policy options on specific, defined groups or individuals. For example, people of differing community background, those living in rural areas, or businesses and voluntary organisations.
- 1.3 These various assessments are made by drawing upon available quantitative evidence. This may include relevant research either already performed, or specifically commissioned. Qualitative evidence can also provide valuable insights or help to address the limitations of more quantitative research. Consultation with the general public and specific stakeholder groups is an important aspect of the impact assessment process.
- 1.4 Where a policy is found to have a substantial adverse impact on any group or individual, consideration must be given to the scope for the policy to be adjusted to mitigate or lessen the impact before it is implemented. It is

therefore important that such impact assessments are performed early during the period of policy development so as to influence and shape the final outcomes.

- 1.5 The first stage in the Integrated Impact Assessment (IIA) process is the screening of policies to decide which, if any, aspects of the policy under consideration should be subjected to further impact assessment. To assist Northern Ireland Departments the Office of the First Minister and Deputy First Minister has developed an IIA Screening Tool which contains a number of standard preliminary questions for each of the impact assessments. This process provides a way of identifying which policy proposals are likely to have greatest impact, and which should be subject to further, more detailed consideration.

Suicide Prevention Strategy and Action Plan

- 1.6 As part of the development of this Strategy and Action Plan the Department undertook an Integrated Impact Assessment Screening Assessment (the completed screening tool and additional considerations can be found at <http://www.investingforhealthni.gov.uk/documents/Suicide-Self-Harm-Assess.pdf>). The conclusions the Department have drawn from this screening are that:
 - i. the Strategy will have a positive impact on the emotional health and wellbeing of the general population;
 - ii. the policy has been assessed as not having any significant impact on social, environmental, human rights, rural, victims and community safety, and full impact assessments in these areas are not required; and
 - iii. additional consideration needed to be given to the equality impacts and this work is set out below.

2. EQUALITY CONSIDERATIONS

Northern Ireland Act 1998

2.1 Section 75 (S75) of the Northern Ireland Act 1998 places the following statutory requirements on each public authority:

- “(1) A public authority shall in carrying out its function relating to Northern Ireland have due regard to the need to promote equality of opportunity–*
- (a) between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;*
 - (b) between men and women generally;*
 - (c) between persons with a disability and persons without; and*
 - (d) between persons with dependants and persons without.*
- (2) Without prejudice to its obligations under subsection (1), a public authority shall in carrying out its functions relating to Northern Ireland have regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group”*

Policy Aim and Groups Affected

2.2 The strategic aim of the draft suicide prevention strategy is to reduce the Northern Ireland suicide rate, particularly among young people and those most at risk. Suicide has a devastating affect for families and all those involved. It has a major impact on society. The policy will therefore affect the whole population and will impact on all of the S 75 groups.

Promoting Mental Health Strategy and Action Plan

2.3 The Promoting Mental Health Strategy and Action Plan, published by the Department of Health, Social Services and Public Safety in January 2003, 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. It contains ten specific actions which aim to reduce suicide in NI.

2.4 During the development of the Promoting Mental Health Strategy and Action Plan consideration was given to the equality implications of the policy. The responses to the consultation on “Minding our Health” identified certain groups at risk – post natal women, young men and women, ethnic minorities, Travellers, people with learning disability and deaf children. Consideration of available data and research also indicated that women, divorced people and Catholics were more likely to have poor mental health, boys were more likely than girls to be bullied and men were more likely to take their own life than women. Discussions with voluntary organisations had also indicated issues around sexual orientation and deafness.

Suicide Prevention Strategy and Action Plan

2.5 In order to meet the challenging targets set within the suicide prevention strategy it is essential that it is implemented in parallel to the Promoting Mental Health Strategy and Action Plan.

Consideration of Available Data

2.6 When considering the equality implications of the Promoting Mental Health Strategy and Action Plan the Department considered data from the Health and Social Wellbeing Survey 2001, the Health Behaviour of School Children 1997/98, and Safety First: National Confidential Enquiry into Suicide and Homicide in People with Mental Illness. The Department has revisited the available information, and in particular specific information from the General Registers Office (GRO) relating to suicide. Data on all nine equality groups outlined in the Northern Ireland Act (1998) is not recorded. 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. The Department also considered information from Carolan, F. & Redmond, S (2003) *Shout: The Needs of Young People in Northern Ireland who identify as lesbian, gay, bisexual and or transgender*. YouthNet: Belfast

and McNamee, H (2006) *Out on Your Own: An Examination of the Mental Health of Young Gay and Bisexual Men* The Rainbow Project: Belfast.

Assessment

2.7 Both suicide and self-harm have a substantial impact on Northern Ireland in terms of both lives lost and the resulting trauma for bereaved families and the local community. The Policy aims to reduce the rate of suicide in Northern Ireland and ameliorate the effects of such events.

2.8 Presented below are the key findings from the Department's consideration of the available information, the full report can be found at <http://www.investingforhealthni.gov.uk/documents/Suicide-Self-Harm-Assess.pdf>

Assess.pdf

- Males accounted for almost four-fifths of the 824 suicides (79.2%) that occurred in Northern Ireland between 1999 and 2003.
- 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.
- 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)*.
- The suicide level amongst the single marital status group (2.8%) was considerably higher than in the other groups.
- Suicide is more prevalent in economically deprived areas than in non-deprived areas.
- The "Shout" research highlights that 29% of those surveyed had attempted suicide, 26% had self harmed, and 44% had been bullied at school because of their sexuality.

- The “*Out on Your Own*” research highlights that 27.1% of those survived had attempted suicide, 71.3% had thought about taking their own life, 30.7% have self-harmed, and 20.6% self-harmed more than once.

2.9 This suggests that the policy is most likely to have an impact on gender, age, religion, marital status and sexual orientation. It will also impact on those from lower socio-economic groups. 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 disability, black and ethnic minority and those with/without dependants.

Overall Conclusion

2.10 Having considered all the relevant data the Taskforce agreed that to successfully reduce the suicide rate in Northern Ireland it is best to adopt a dual population and targeted approach when implementing this Strategy. The population approach seeks to tackle the issue of suicide in a wider generic context, with actions aimed at protecting the general population of Northern Ireland. The targeted approach seeks to tackle the issue by targeting actions at those within society who are most at risk of suicide, for example, young men and marginalised and disadvantaged groups. It is, however, important to stress that the general population approach to suicide prevention and targeting those who are known to be at an increased risk of suicide must be complimentary approaches.

2.11 The Department therefore 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 S 75 groups and therefore a full Equality Impact Assessment is not required.

ANNEX 4

REVIEW OF EVIDENCE-BASE AND BEST PRACTICE – RISK AND PROTECTIVE FACTORS

Many of the risk factors for suicide and self harm are similar. Since undertaking self harm places an individual at increased risk of suicide in the future, the risk factors for both suicide and self harm are considered together below. This information has been used to identify issues and groups of people in the population that should be targeted in terms of preventative action.

Social Factors

Increasing suicide rates have been linked to a wide range of factors and influences such as economic decline (Stack 2000a⁶ , 2000b⁷) unemployment (Platt and Hawton 2000⁸) low Income (Goldney 2004⁹), higher female participation in the workforce, decreased church attendance (Maskhill 2004¹⁰) and disrupted social ties (Ferguson and Lynskey 1995a¹¹).

Alcohol consumption is another key factor. Population studies show a correlation between the per capita alcohol consumption and the suicide rate with the relationship being particularly strong for suicide rates in young people. (Ramstedt¹²).

Psychiatric disorder /illness

Research has shown that a psychiatric disorder is present in a high proportion of those who present to A&E following self harm. Around two thirds have depression and around half may have a personality disorder. (NICE guideline¹³).

Likewise research has shown that a psychiatric disorder is present in around 90% of suicide victims (Cavanagh et al 2003¹⁴). In addition there is evidence to suggest that nearly all suicide victims have a psychiatric disorder which may have been unknown to their family, friends or healthcare professionals at the time of their death (Ernst 2004¹⁵). Note that the term psychiatric disorder as used above refers

to accepted disease classification systems and also encompasses alcohol and substance abuse disorders.

Research from NI relating to suicide deaths in the early 1990s revealed that among suicide victims 44% suffered from a personality disorder, 32% suffered from depression, 10% from anxiety disorders, 10%, 6% from schizophrenia and over half (55%) had more than one psychiatric disorder (Foster 1997¹⁶).

Although many people with mental health difficulties often do not seek help research indicates that there is significant contact with health services prior to suicide and self harm. Almost 80% of suicide victims in NI had seen their GP in the 12 months prior to their death (not necessarily with mental health problem). Over a third (36%) had seen their GP in the month prior to death. (Foster 97¹⁶/ 99¹⁷). This must be interpreted in the context of the very large number of patients who visit the GP every day and the relatively rare event of suicide. Over a quarter (28%) of people who die by suicide in NI have been under the care of mental health services in the year before death. (National Inquiry¹⁸).and a higher proportion (58%) had been in contact with mental health services at some stage in the past. (Foster 99¹⁷). This highlighted the importance of follow-up by either specialist services or primary care for patients with a serious mental illness.

One in five suicides occurring among people recently discharged from psychiatric hospitals are thought to be preventable. (Appleby and Shaw 1999¹⁹). In NI recent statistics reveal that over a quarter (7%) of suicide victims had been discharged from a psychiatric hospital in the three months before their death. (National Enquiry¹⁸)

Likewise there is significant contact with services prior to episodes of self harm. Around half of those attending A&E following self-harm are reported to have attended their GP in the month prior to the event however the contact may not

have been specifically about a mental health problem: (NHS Centre for Reviews and Dissemination²⁰).

This clearly indicates that there are potential opportunities for detection of mental illness and appropriate intervention.

Alcohol Misuse

People who abuse alcohol have a six times higher risk of suicide than the general population. (Harris and Barraclough 1997²¹). Research from NI in the early 1990s revealed that over one third (37%) of suicide victims had a history of alcohol addiction and the majority of these also suffered from a co-existing psychiatric illness. A smaller proportion of suicide victims misused alcohol but did not suffer from an alcohol addiction. (Foster 1997¹⁶).

About one quarter of cases of self-harm that attend A&E have an alcohol problem (Merrill et al 1992²², Horrocks et al 2003²³).

History of previous self harming behaviour

Research from NI in the early 1990s revealed that over half (51%) of suicide victims had a known history of self-harm. (Foster 1997¹⁶).

Other research elsewhere shows that:

- one in four who die by suicide have attended hospital with an episode of self-harm in the previous year (Owens and House 1994²⁴);
- one in six people who attend A&E with self-harm repeat the act, one in 100 die by suicide during the following year (Owens et al 2002²⁵);
- the rate of suicide in self-harm survivors is 50-100 times higher than in the general population during the year after the event (Hawton 2003²⁶, Owens 2002²⁵).

Age and gender

Females are more likely to self-harm than males, but males are more likely to engage in more serious self harm and thus die by suicide. (Hawton et al 2002 a²⁷) This may be explained by the method used. Males use more lethal methods than females. Self harm is most common among adolescents and young adults (Meltzer et al 2002²⁸).

Marital status

Suicide in males is more common among those who are divorced, widowed or never married.

Media reporting of suicide

There is evidence that inappropriate media reports of suicide can lead to copycat suicides (Hawton 2002 a²⁷).

Sexuality issues- there is some evidence of increased rates of self-harm among the gay and lesbian community and those experiencing uncertainty about their sexuality. (King and McKeown 2003²⁸)

People within the criminal justice system - rates of self-harm are much higher among prisoners and those on remand than among the general population. Around 1 in 10 prisoners self-harm during their prison term. Rates are highest among female prisoners. (Meltzer et al 1999²⁹)

Other factors known to increase the risk of suicidal behaviour include:

- family history of self harm or suicide (Beautrais 2003 c³⁰);
- impulsive aggressive and neurotic personality traits and poor coping skills -. (Hider P 1998³¹);
- adverse childhood experiences (Beautrais 2003a³²);
- psychological stress (Gould et al 1996³³);
- low educational attainment (Beautrais 2001b³⁴);

- certain high risk occupations (Boxer 1995³⁵);
- rural living (Levin 2005³⁶); and
- certain chronic physical illnesses (Quan et al 2002³⁷)

Protective Factors

It has been noted that many individuals with exposure to the risk factors detailed above do not take part in suicidal behaviour. This has led to an interest in protective factors that promote resilience. There is less research evidence in this area although the following have been identified as likely to be protective against suicide. It is not clear if the same protective factors apply to the prevention of self harm (Beatrais 2005³⁸).

- Effective clinical care for mental, physical and substance use disorders
- Easy access to a variety of clinical interventions and support for
- Support for help seeking (Knox 2003³⁹)
- Restricted access to highly lethal means of suicide
- Strong connections to family and community support
- Support through ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self preservation

**REVIEW OF EVIDENCE-BASE AND BEST PRACTICE - AREAS FOR INCUSION IN
A SUICIDE PREVENTION STRATEGY**

- a. A national multi-sector/multi -agency focus on suicide prevention.
- b. Policies restricting access to means of suicide.
- c. Raised awareness and de-stigmatisation of mental health issues:
 - promotion of positive mental health, resilience and coping skills to the entire community; and
 - targeted intervention with high risk groups.
- d. Early recognition of mental health problems and warning signs of suicide;
 - by the community; and
 - by Primary Care professionals.
- e. Provision of, and access to, various levels of support and intervention services including:
 - voluntary services; and
 - mental health services and alcohol and substance abuse services.
- f. Appropriate response to and follow-up for episodes of self-harm occurring in both adults and children.
- g. Appropriate response to a completed suicide by provision of information and support for families and communities.
- h. Appropriate provision of information to the media and careful reporting of suicide.
- i. Collection of surveillance data on self-harm and suicide.
- j. Improved understanding of factors that lead to suicide and self harm and what works to prevent suicide and self harm.

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TARGETS BY TIMESCALE

By 2007

AREA	ACTION
Communities	By 2007 to initiate a major information campaign that aims to de-stigmatise mental health and promote awareness and understanding of suicide and approaches to suicide prevention.
Children and Young People	By 2007 to improve the protocols for sharing information between relevant agencies with regards the health, safety and wellbeing of children and young people.
Health and Social Services	By 2007 to ensure that all priorities identified within the suicide strategy are also recognised as priorities in all relevant Departmental Public Service Agreements (PSA) and reflected in individual departmental annual priorities.
Police and Emergency Services	By 2007 to ensure that suicide prevention is included as a priority in all the emergency services Public Service Agreements and reflected in individual services annual priorities.
Churches and Religious Bodies	By 2007 to ensure that churches/religious bodies are aware of, and have access to, the local community support networks in their area.
Media	By 2007 agree reporting guidelines with the National Union of Journalism in relation to the portrayal of all suicide related matters.
	By 2007 to develop and implement positive media messages and accompanying public relations strategy.

Mental Illness	By 2007 to ensure that those in contact with Mental Health Services receive regular follow up, which includes assessment of suicide and self-harm risk, on an ongoing basis.
Young Males	By 2007 implement a targeted information and awareness campaign for young males, aimed at breaking down the current male culture of not discussing their problems openly.
Victims of Abuse	By 2007 to initiate an information campaign which seeks to sensitively raise awareness of the increased risk of suicide and self-harm among victims of abuse.
Marginalised and Disadvantaged Groups	By 2007 to initiate a targeted information campaign which seeks to raise awareness of the increased risk of suicide and self harm amongst those groups that have been identified as being marginalised or disadvantaged.
High Risk Occupations	By 2007 to develop a crisis plan for targeting people in high risk occupations as and when emergency situations arise.

By 2008

AREA	ACTION
Communities	By 2008 to ensure that all communities have access to community based suicide prevention support mechanisms within their local health & Social Services Trust area.
Children and Young People	By 2008 to ensure that support services which promote positive mental health and protect children from bullying are available and accessible in all schools and youth settings.
	By 2008 to ensure that buddying/mentoring type schemes are available via local community support networks in all Health and Social Services Trust areas for all young people in need.
Health and Social Services	By 2008 to ensure that the proper linkages have been made between all mental health services including local community/voluntary support networks.
Workplaces	By 2008 to implement a targeted information campaign aimed at enhancing the mental health and wellbeing of all members of the workforce.
Churches and Religious Bodies	By 2008 to ensure that all church/religious leaders have been offered the opportunity to avail of suicide awareness training.
Self-harm	By 2008 to ensure that responsive support services, which bridge the gap between treatment and community provision, are available in all local Health and Social Services Trust areas for people who self-harm.
	By 2008 to implement programmes in all local Health and Social Services Trust areas which enhance coping skills of those with a history of self-harm.
Mental Illness	By 2008 to ensure that all Health and Social Services Trust areas have proactive suicide awareness/intervention programmes in place for staff who work with people who have a mental illness.

Drug and Alcohol Misuse	By 2008 to ensure that appropriate suicide awareness/intervention training is available for all frontline health services staff, police officers, and other relevant professions.
	By 2008 to enhance the health service's ability to carry out risk assessments, including mental health, on people who are under the influence of drugs and/or alcohol.
Young Males	By 2008 to ensure that targeted outreach programmes for young males who may be at risk of suicide and self-harm are available in all Health and Social Services Trust areas.
Bereaved By Suicide	By 2008 to ensure that accessible information and timely support, both at community/voluntary and statutory level, is available in all Health and Social Services Trust areas.
Victims of Abuse	By 2008 to provide an accessible support network in each local Health and Social Services area for victims of abuse.
Marginalised and Disadvantaged Groups	By 2008 to ensure support services which are in place reach out to all marginalised and disadvantaged groups, and in particular lesbian, gay, bi-sexual and transgender groups, the rural community, and people living in economically deprived areas.
High Risk Occupations	By 2008 to develop an accessible support network for people in occupations which have a high risk of suicide and self-harm.
Prisoners	By 2008 to ensure that the environment for those held in custody, both in prison and at police stations, have been suitably adapted to reduce the possibility of suicide, including restricting the access to means of suicide.

By 2009

AREA	ACTION
Family	By 2009 to provide families with the opportunity to avail of practical intervention skills to help improve parenting skills, health behaviour, and interaction between children and parents.
	By 2009 to ensure that families have access to a local emotional health and wellbeing support network (including community/voluntary sector provision) within their local health and Social Services Trust area.
Workplaces	By 2009 to ensure that positive mental health training is available to all members of the workforce, including small/medium enterprises employers.
Police and Emergency Services	By 2009 to make suicide awareness/intervention training mandatory for all frontline emergency services staff.
Prisoners	By 2009 to make appropriate suicide awareness, prevention and intervention training mandatory for all frontline prison and police custody staff, and where possible identified "listener" inmates.

By 2011

AREA	ACTION
Health and Social Services	By 2011 to have implemented, in co-operation with other stakeholders, all the findings and actions in the suicide strategy.

ACTIONS BY TIMESCALE

SHORT TERM ACTIONS

AREA	ACTION
Family	To identify and map current emotional health and wellbeing services available to families, and in particular highlight existing entry points or barriers into the services.
	To ensure that local support services are properly regulated.
Children and Young People	Explore with young people the support mechanisms needed to better develop coping skills, and protect them from bullying.
Health and Social Services	To ensure cross Departmental buy-in to the local suicide strategy, and empower the Implementation Group to drive the strategy's implementation forward.
	To review all Public Service Agreements to ensure that they have addressed all possible suicide prevention related issues.
Churches and Religious Bodies	To liaise with religious bodies and local support networks to increase mutual awareness and understanding of their potential support roles during crisis periods.
Media	To work with the National Union of Journalism in relation to the development of the required guidelines.
	Agree appropriate media messages with all interested parties, including bereaved families, support groups and the media itself.
	Explore the use of other media options, including the internet and text messaging, and how these may best be utilised.
	Liaise with survivors and bereaved families about what communication role (if any) they would feel comfortable with, and then provide them with the necessary support and training.

Self-Harm	To identify and assess gaps/linkages within existing support services, both statutory and community/voluntary, for those people who self-harm.
Mental Illness	To assess both the linkages and the accessibility of the existing mental health services.
Young Males	To work in appropriate fora with young males regarding how best to reach out to them, and to identify those initiatives that may be of help at times of crisis.
Bereaved by Suicide	To assess existing support available to those bereaved by suicide, and in particular highlighting any gaps.
	To ensure that those bereaved by suicide are suitably represented on the Strategy Implementation Group.
	To agree future review/consultation arrangements with those bereaved by suicide throughout Northern Ireland.
Victims of Abuse	To consult with victims of abuse in order to establish what information and support services are required.
	To assess existing support services, in both the statutory and community/voluntary sectors, and highlight the investment required to bridge any identified gaps.
Marginalised and Disadvantaged Groups	To further identify and prioritise the main marginalised and disadvantaged groups who are particularly at risk of suicide and self harm, and assess the existing services available to those groups, highlighting any service gaps that exist.
	To consult with the identified target groups and the local community network regarding how best to meet their needs.
High Risk Occupations	To identify and prioritise high risk occupations, and how best to raise awareness within these groups.
	To liaise with members of the identified occupations in order to establish the most appropriate and effective forms of support.
	To develop and agree a crisis action plan.

Prisoners	To liaise with the probation service about the provision of follow-up support for those who have recently been released from custody.
	To provide appropriate support in relation to the removal of stigma from those people who have been released from custody without charge.

SHORT/MEDIUM TERM ACTIONS

AREA	ACTION
Family	Ensure that the models of emotional health and wellbeing support provision, including local support networks, are joined up and welcoming.
Communities Health and Social Services	To develop and implement a suicide awareness information campaign, which helps to de-stigmatise mental health and encourage help seeking behaviour.
	To ensure that agreed community support groups are appropriately resourced, and that monitoring mechanisms are put in place.
	To develop a mechanism to allow timely access to statistics and geographical/demographic information at local level so that potential cluster of suicides can be identified early and appropriate preventative action taken.
Children and Young People	To develop and implement the identified support mechanisms.
	To develop and implement programmes and protocols which discourage bullying.
	To identify and encourage the further development of integrated mechanisms to support young people, particularly in schools, youth settings, and the local community support networks.
	To develop and implement practices, protocols and referral pathways to smooth the transition from Youth to Adult health Services, and support the implementation of relevant recommendations in the Bamford review, in particular the report which considers the mental health of children and young people.
Health and Social Services	To review current linkages between all areas of health and social services which engage with people who have a mental illness and/or who are most at risk of suicide, and then implement necessary changes.
	To develop clinical guidelines for all health service staff to use when dealing with people who have a mental illness.

	To make appropriate suicide awareness/prevention training a priority for all front line health service staff, in particular primary care staff.
	To develop enhanced linkages between the statutory health and social services and the community/voluntary counselling and support networks, particularly in relation to transition services and where there are gaps in treatment.
	To assess existing crisis response models with a view to implementing the best practice model, which needs to be accessible by both the community and Health Service staff.
Workplaces	To develop and implement a targeted information campaign aimed at enhancing the mental health and wellbeing of the workforce.
	Review all current workplace mental health related training strategies, and consult with employers, their representatives, and relevant statutory bodies, about how best to implement suitable training initiatives which promote mental health and prevent suicidal behaviour developing.
Police and Emergency Services	To assess existing suicide related training available to the emergency services, identify any gaps/barriers, and implement any necessary enhancements.
	To incorporate relevant suicide training, including bereavement support, into existing regime, and/or initiate new training procedures.
Churches and Religious Bodies	To encourage the development of enhanced links between churches/religious bodies and the local community support networks.
	To make appropriate suicide awareness/mental health and wellbeing training available for all church/religious leaders.
	To acknowledge and enhance the significant role that churches and religious bodies play in dealing with those in crisis and those bereaved by suicide.
Media	To develop and implement appropriate media monitoring mechanisms.
Self-Harm	To develop and implement programmes which enhance coping skills of those with a history of self-harm.

	To support the strengthening of links between community/ voluntary groups that work with those who people self-harm and the statutory sector, and in particular in relation to the provision of appropriate aftercare follow up.
	To develop and implement programmes which enhance coping skills of those with a history of self-harm.
Mental Illness	To establish protocols which ensure that all people with a history of previous mental health illness receive appropriate follow up support.
	To enhance the role of the community/voluntary sector with regards to provision of follow up support services for those people who suffer from mental illness.
Drug and Alcohol Misuse	To identify and implement suitable training arrangements for the agreed occupations.
	To develop agreed protocols with health service professionals with regards to the assessment and management of patients at risk while under the influence of drugs and/or alcohol.
Young Males	To develop and implement appropriate personal development programmes for young males.
	To enhance the role of the community/voluntary sector with regards the provision of buddying/mentoring support for young males at risk of suicide and self-harm.
	To design and resource an information and awareness raising campaign for young males.
Bereaved by Suicide	To implement enhancements to make better support available to those bereaved by suicide, and to encourage the development of support networks/groups.
	To work with the coroner's office to facilitate the provision of sensitive and timely information to those bereaved by suicide.
Victims of Abuse	Collate and disseminate information regarding the risk of suicidal behaviour among victims of abuse to the relevant bodies/support networks.

	To develop a targeted and sensitive information campaign which raises awareness and encourages victims of abuse to seek help at time of crisis.
Prisoners	To assess existing suicide awareness/intervention training options, and then agree a phased implementation of the most effective option.
	Police, Prison and Health Services to review current handling of patients/inmates with mental health difficulties and in particular the initial 24hr support services available to them, and then implement any necessary changes.

MEDIUM TERM ACTIONS

AREA	ACTION
Family	Encourage and support the development and provision of emotional learning initiatives, including Parenting Skills initiatives, life skills, etc.
Communities	To monitor and evaluate the effectiveness of the information campaign and make necessary enhancements as required.
Children and Young People	To promote the inclusion of coping/life skills in the school curriculum.
	To make suicide awareness and positive mental health and wellbeing training a priority for all teachers and youth workers.
	To develop and implement practices, protocols and referral pathways to smooth the transition from Youth to Adult Health Services, and support the implementation of relevant recommendations in the Bamford review, in particular the report which considers the mental health of children and young people.
Workplaces	Work with relevant statutory bodies to make the promotion of mental health and wellbeing awareness training an integral part of all future training and award type schemes, and service level agreements.
Police and Emergency Services	To incorporate relevant suicide training, including bereavement support, into existing regime, and/or initiate new training procedures.
Marginalised and Disadvantaged Groups	To implement agreed support services enhancements, and to support the call for intervention service improvements as required.
	To develop a targeted and sensitive information campaign which raises awareness and encourages marginalised and disadvantaged groups to seek help at times of crisis.
High Risk Occupations	To implement and resource any agreed support initiatives.

MEDIUM/LONG TERM ACTIONS

AREA	ACTION
Police and Emergency Services	To further develop links between the emergency services, other relevant statutory services and the local community support networks.

ONGOING ACTIONS

AREA	ACTION
Communities	To ensure that Health Impact Assessments are carried out on all Departmental and Public Body policies to ensure that potential adverse impacts, in terms of the mental health and wellbeing of local communities, are identified and mitigated as far as possible (e.g. Planning, Housing developments, etc.).
	To restrict access to means and methods of suicide in our communities. This includes the identification of suicide hotspots, and the promotion of safer prescribing of anti-depressants and, a reduction in the easy accessibility of certain over the counter drugs.
Workplaces	Work with employers, their representative bodies, and trade unions on how best to take target 2 forward.
Police and Emergency Services	To regularly refresh suicide awareness/intervention training for staff.
Self-Harm	To ensure that those who self-harm are appropriately cared for by statutory services, in particular within A&E and Mental Health Services. Initial care, treatment and subsequent follow up should be in accordance with NICE guidelines.
Mental Illness	To support the Bamford recommendations in relation to the enhancement of Mental Health Services in Northern Ireland.
	To provide appropriate support and information in order to promote awareness of potential suicide risk, among carers of those with a mental health illness.
Drug and Alcohol Misuse	To liaise with DAST, and relevant treatment service providers, to maximise the protection and minimise the risk of suicide for those people who misuse drugs/alcohol.
Bereaved by Suicide	To raise awareness among local health service providers, especially within Primary Care, regarding the increased risk of self-harm and suicide among those bereaved or affected by suicide.

Victims of Abuse	To provide training to support workers for victims of abuse.
Prisoners	To regularly refresh suicide awareness, prevention and intervention training for staff.
	To regularly audit the custody environment for potential risks in relation to attempted suicide.
	To work with the prison service to provide access to appropriate services to those in prison with a recognised mental health illness, including the development of appropriate “listener” groups for those in custody.
	To ensure that all remand and sentenced prisoners continue to receive initial and ongoing monitoring of their mental health and assessment of the risk of suicide.
	To support implementation of the recommendations in the McClelland report “A Review of Non-natural deaths in Northern Ireland Prison Service establishments (June 2002 – March 2004).