

**Edwin Poots: Launch of the “National Confidential Inquiry into Suicide and Homicide by People with Mental Illness”.**

**Mossley Mill, Newtownabbey – 29 June**

Good morning ladies and gentlemen. I am pleased that you could join me here this morning for the launch of this important report on suicide and homicide by people with mental illness in Northern Ireland.

I would like to take this opportunity to pay tribute to Professor Appleby and his Inquiry team for their diligent work on this study. The Inquiry has a vital role in gathering national data on suicide and homicide, together with associated clinical information on mental health service users. This information helps to improve mental health services and reduce the risk of suicide or homicide by people with mental illness.

Suicide presents a complex and deeply concerning challenge for all sectors of society in Northern Ireland. As the Inquiry indicates, the number and rate of suicide in the general population here increased from 1998 to 2008. That trend has continued. A total of 313 suicides were recorded in 2010 – the highest figure ever recorded here. This upward trend has occurred despite strenuous suicide prevention efforts across the statutory, community and voluntary sectors.

Clearly, suicide is an issue that is not going to go away.

The risk factors remain persistently stubborn.

Unemployment is rising, large sections of society have been economically inactive for a long time, personal debt is growing, and community fragmentation and violence are a common feature of life in some areas.

Children and adults are dealing with the impact of family breakdown, depression, social isolation, poor educational

attainment, poverty, addiction, abuse and bullying on a daily basis.

These experiences make people more susceptible to suicide. They are also more frequently experienced by people living in areas of social and economic disadvantage. This is reflected in the Northern suicide figures which show that suicide rates are twice as high in deprived areas, and the gap continues to widen.

Unfortunately, the current economic downturn is going to make a difficult challenge even more formidable. Studies indicate that unemployed people are at 2-3 times more risk of suicide and that every 1% increase in unemployment nationally is associated with a 0.8% increase in suicide. Employment and employability are clearly important areas for action.

Broader action across Government and all sectors of society is necessary to address the root causes of suicide. The Health Committee 2008 Report on its Inquiry into Suicide and Self Harm set out a number of recommendations for a range of Departments. Progress has been made on implementing these recommendations, but we need to ensure that this is sustained over the longer term.

Health cannot address suicide on its own. Suicide is a societal issue and we need to secure the commitment of all relevant Government Departments. The previous Executive agreed that all departments should play a proactive role in support of suicide prevention. I intend to keep this momentum going and to work collaboratively with Ministerial colleagues.

The focus will be on how we can work together more effectively on the underlying issues. From my initial

discussions, I sense a renewed willingness across Government to contribute to suicide prevention.

My Department is also leading the development of a new Mental Health and Wellbeing Promotion Strategy. The aim will be to promote positive mental health and address some of the more “upstream” factors that can lead to poor mental health. Success here will, over the longer term, help in reducing suicide levels. This new strategy will also draw out the cross-departmental and cross-sectoral nature of mental health promotion.

Action to address the root causes and risk factors for suicide will need to be long term. Early intervention for positive mental health and wider measures to improve the quality of life are undoubtedly the long-term answer. But frontline preventative services, that respond promptly and effectively when people are suicidal, continue to be essential.

I have given a commitment to protect suicide prevention funding. This will help ensure continuation of services and initiatives such as:

- Lifeline
- Community-led suicide prevention services;
- Suicide prevention posts in each Trust;
- The Deliberate Self-Harm Registry;
- Early identification and prompt response to suspected suicide clusters;
- Regional training on suicide awareness and prevention; and
- Media monitoring.

In addition, mental health services, primary care, and accident and emergency services all have key roles in suicide prevention. These are often the frontline services that someone who is suicidal or in distress will come to for help.

Mental health crisis intervention teams, and child and adolescent mental health services have been enhanced in recent years. Accident and emergency sites have introduced protocols for caring for people who have self harmed or present in emotional crisis. A large number of GPs have undertaken training in suicide and depression awareness.

However, we still hear of concerns from families about access to mental health support and treatment services. We need to ensure that these services are accessible and responsive to vulnerable people.

We also need to ensure that referral systems are working effectively and appropriately. In this regard, I will be very interested in the forthcoming evaluation of implementation of the “Card Before You Leave” scheme at accident and emergency departments.

The nature of recent media coverage also indicates that, in addition to ensuring that services are accessible, there may be a need to get the message across more effectively on how services operate and the legal parameters that apply.

GP training in relation to mental health and suicide awareness needs to be looked at again. GPs also need to be made more aware of the range of service options that are available. For example, referral to accident and emergency units might not be the best approach in some cases. Depending on the circumstances, services such as the Lifeline 24/7 crisis response may be a more viable alternative.

The “Protect Life” strategy is currently being updated to reflect the experience gained since 2006 and latest

international evidence on effective interventions. New priorities will include:

- further research into the root causes of suicide
- improved co-ordination in the delivery of the strategy
- enhanced cross-departmental working
- a focus on building emotional resilience and
- addressing the disproportionately higher rates of suicide in deprived areas.

Overall evaluation of the Strategy will also be taken forward during 2011. The evaluation findings which will help shape future suicide prevention policy in Northern Ireland.

Two of the findings in the Inquiry Report that drew my immediate attention are:

- that 29% of suicides involved people who had been in contact with mental health services; and
- the largest difference between suicide rates here and other UK countries was in young people and in their level of contact with mental health services.

Reflecting on these, it would appear that many people who are suicidal, and therefore likely to have mental health difficulties, are not accessing statutory mental health services. As a high proportion of suicides are by young and middle-aged men it could well be that this is a male issue.

We know that men can bottle up their feelings and tend to be reluctant to seek help. Services therefore need to be made accessible to men and delivered in ways that are relevant to them. This has been underscored in recent research published by the Public Health Agency. This

study “Learning from the experiences of suicidal men to inform Mental Health Care services” highlights the need for pro-active outreach approaches especially for young men experiencing emotional difficulty.

The need for more joined up services and improved patient follow-up with discharged patients are also key findings in the report. Despite the difficult economic circumstances that we find ourselves in, it should not be beyond our capability to ensure that we have follow-up contact with all patients within 7 days of their discharge.

Other findings from the report are consistent with issues that have been raised previously. For Example, the association between alcohol and suicide is well established. Heavy drinking patterns are linked to a higher incidence of suicide.

The “New Strategic Direction for Alcohol and Drugs” and the “Young People’s Drinking Action Plan” aim to reduce specific behavioural patterns of alcohol misuse, such as “binge drinking”. Further consideration also needs to be given to issues such as the advertising, marketing, labelling and pricing of alcohol.

The need to address the stigma associated with mental illness is also a common thread running through the Inquiry Report. Stigma discourages people from seeking help and excludes people from mainstream society. It can also make patients reluctant to engage with services after their discharge.

Action to address the stigma that, sadly, is still associated with mental illness has been taken forward under the Mental Health Promotion Strategy. Tackling this particular issue will be given renewed focus under the new Mental

## Health and Wellbeing Promotion Strategy.

The Inquiry Report presents detailed data that looks behind the headline statistics in relation to some of the 1,865 lives lost here in the period 2000-2008. By presenting a better understanding of these deaths, this piece of research will assist in fine tuning policy and practice for the care of people within mental health services. I believe that this will help to prevent further deaths.

I am very pleased that my Department continues to invest in research so that, through reports such as the one I am launching today, we have a greater understanding of suicide in today's Northern Ireland. We need to understand clearly who is most at risk; what are the reasons why people are choosing to end their lives in this way and what are the actions we need to take to prevent suicide.

The research that we support through our Health and Social Care Research and Development Fund is providing essential evidence that directly benefits our professional staff who must deliver cost-effective services and succeed in their goal of lowering the burden of suicide in our society.

The evidence and recommendations of the Inquiry Report need to be considered in detail. This is something that will be taken forward through the Bamford Action Plan Steering Group. Undoubtedly the recommendations present a test for mental health services. But it is a test that needs to be taken.

Thank you for attention and your warm welcome today.