



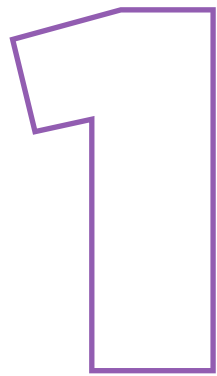
REVIEW OF PROTECT LIFE 2

Action Plan: Report
and Recommendations

September 2024

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**BACKGROUND AND
CONTEXT FOR
THIS REVIEW**

Background and Context for this Review

Protect Life 2¹, launched in 2019, is Northern Ireland's strategy for the prevention of suicide and self-harm. The 5-year Strategy (2019-2024) is based on feedback and learning from a 2016 consultation report. It is clear in its ambition that suicide prevention is a collective responsibility and achieving that is the primary purpose of the strategy. It recognises that the ambitions set out in the strategy can only be achieved by working together across all government departments and with stakeholders from all sectors of society.

Governance arrangements for the implementation of the strategy, as set out in 2019, are as follows:

- ▶ **Department of Health:** provides strategic oversight and support by setting suicide prevention priorities and outcomes in relevant commissioning plans for the Health & Social Care system which are updated annually and in Programme for Government Delivery Plans.
- ▶ **Public Health Agency:** Lead organisation with responsibility for co-ordinating implementation of the Strategy.
- ▶ **Protect Life 2 Steering Group:** Implementation of the Strategy is via this forum. The Steering Group's role is to drive delivery via a more detailed implementation plan. This is achieved through monitoring delivery, agreeing annual action plans and milestones, and identifying factors that are hindering progress.
- ▶ **Local Protect Life Implementation Group:** These local groups support the Protect Life 2 Steering Group by ensuring effective implementation of the strategy in a way that takes account of local needs and local assets. They develop local action plans based on the Protect Life 2 action plan and oversee the delivery of these. Networking and information sharing is an important role for the Local Protect Life Implementation Group.

1 [Protect Life 2 - Suicide Prevention Strategy | Department of Health \(health-ni.gov.uk\)](#)

In September 2023, the Department of Health Permanent Secretary, Peter May, announced the extension of the Protect Life 2 Strategy (2019) for a further three years to the end of 2027, with the potential for an additional extension to 2029.

It was recognised that whilst solid progress has been made in delivering on the strategy's objectives since it was published in September 2019, challenges in relation to the budget and the impact of the COVID-19 pandemic have prevented full delivery. The three-year extension is to allow more time for fuller implementation and for the existing actions to be delivered.

As part of the Strategy extension, the Department agreed to undertake a **Review of the Protect Life 2 Action Plan**. This Review is to inform the future Action Plan and its implementation. The aims and objectives of the Protect Life 2 Strategy are not being reviewed and will not change at this point.

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**TERMS OF REFERENCE
FOR THE REVIEW**

Terms of Reference for the Review²

(excerpt from agreed Terms of Reference December 2023)

Scope of the Review

The Permanent Secretary has advised this should be a proportionate Review with a focus on the Action Plan. The aims and objectives of the Strategy are not within the scope of this Review. However, the Review of the Action Plan may elicit feedback relevant to the Objectives of the Protect Life 2 Strategy and this will be included in the Review Report for information only at this stage.

The relevant literature and evidence underpinning the Strategy will also be reviewed and updated if necessary to ensure it reflects latest data.

Stakeholder engagement is imperative to inform the Review and development of a succinct final Report providing a clear overview of the outputs contained within this Terms of Reference.

Consultants

To ensure independence in the Review and separation from the oversight role of the Department, the Review will be led by two consultants appointed through the HSC Leadership Centre who have relevant experience of suicide prevention, emotional health and wellbeing, mental health and of working with the community and voluntary sector.

The final review Report will include discussion and recommendations answering the key questions:



Do the current actions support the progress of the objectives of the Strategy?



Do the current actions fulfil the principles contained within the Strategy?

² [doh-pl2-tor.PDF \(health-ni.gov.uk\)](#)

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**REVIEW
METHODOLOGY**

Review Methodology

Independent Consultants were commissioned in November 2023 to undertake the independent review of the Protect Life 2 Action Plan as per the Terms of Reference.

In parallel the Department undertook a literature review comparing differences between the Protect Life 2 Action Plan and action plans contained within suicide prevention strategies in other parts of the UK and Ireland. This is contained in Annex 1 of the Report.

An academic review of evidence of suicide prevention and best practice led by the Mental Health Champion, who chairs the Research and Evidence sub-group of the Protect Life 2 Strategy, was also undertaken. This is contained in Annex 2 of the Report.

In progressing this independent Review, the Consultants conducted an online survey and led extensive stakeholder engagement with relevant groups, organisations and individuals who contribute to and have an interest in shaping suicide and self-harm prevention in Northern Ireland.

The Public Health Agency assisted with co-ordination, venues and invitations using local Protect Life networks.

The Action Plan for the Protect Life 2 Strategy contains 10 Objectives and a total of 44 Actions to progress these Objectives. The Action Plan was developed to align with 10 key principles as set out in Chapter 2 of the Strategy.

The key aspects of the Review were therefore in response to the following two questions:



Do the current actions support the progress of the objectives of the strategy?



Do the current actions fulfil the principles contained within the strategy?

Further Detail of Engagement Methodology

Enabling significant and meaningful stakeholder engagement was undertaken in two forms:

1. **An initial online survey:** The survey was open and available 3rd January 2024 to 26th January 2024. It was extensive and quite lengthy by necessity, covering all elements of the Action Plan that was under-review.

It offered individuals and organisations the space to, in turn, consider the actions related to each of the 10 objectives as well as how they align with the strategy's underpinning principles.

2. **A series of 8 face-to-face regional workshops:** These were held in various locations across Northern Ireland, ensuring maximum accessibility for any individual, group or organisation that wished to contribute to shaping suicide and self-harm prevention in Northern Ireland.

The 8 workshops were held through January, February and March 2024. The format of each workshop was highly participative and utilised principles of co-production to engage participants in review of the Action Plan. For the majority of stakeholders these were the main fora where feedback and information were collated.

Participants at all the workshops were provided opportunity to consider analysis of the online survey and given space for deeper discussion and exploration. This included review of sets of overarching themes that emerged from the survey and subsequent engagement as well as consideration of principles and time for focus on every individual action within all objectives.

3. It is important to note that participants in the survey and in the workshops came with a variety of experiences. A total of 239 people registered for all the workshops. Participants included those from cross-departmental statutory organisations; representatives from the voluntary and community sector; and vitally, those with lived experience as it relates to Protect Life 2.

4. The Consultants used an iterative approach to the process i.e., workshop participants utilised and interacted with the information gathered from the survey and previous workshops, allowing participants to connect to the thinking of others. Participants were given time and space to challenge previous feedback, to build upon it and suggest solutions and improvements. This creates the greatest level of ownership and consensus building into any future actions.
5. In the 6th and 7th regional workshops, based on all the feedback and suggestions from previous workshops, participants were asked to focus specifically on a small number of Actions and to suggest the following:
 - a. Does this action need removed?
or
 - b. Does this action need amended to make it SMART/SMARTer?
 - c. Who should be responsible for implementation of this action?
 - d. Do any new Actions need added?
6. Based on all of the information and feedback collated from the survey and the 8 regional workshops, the Consultants recommended that a further and final facilitated workshop (Workshop 9) with the Department of Health Suicide Prevention Policy Lead and Health Intelligence and Health Improvement staff from the Public Health Agency should take place. The purpose of this workshop was to test and implement as early as possible a key recommendation that emerged from the stakeholder engagement as follows:
 - ▶ Objectives to be grouped together into overarching Strategic Action Areas;
 - ▶ Actions to be reviewed to ensure they are aligned to the corresponding Action Area; and
 - ▶ Each Action should be analysed and amended to make sure it is SMART/SMARTer.

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**FINDINGS FROM
THE REVIEW**

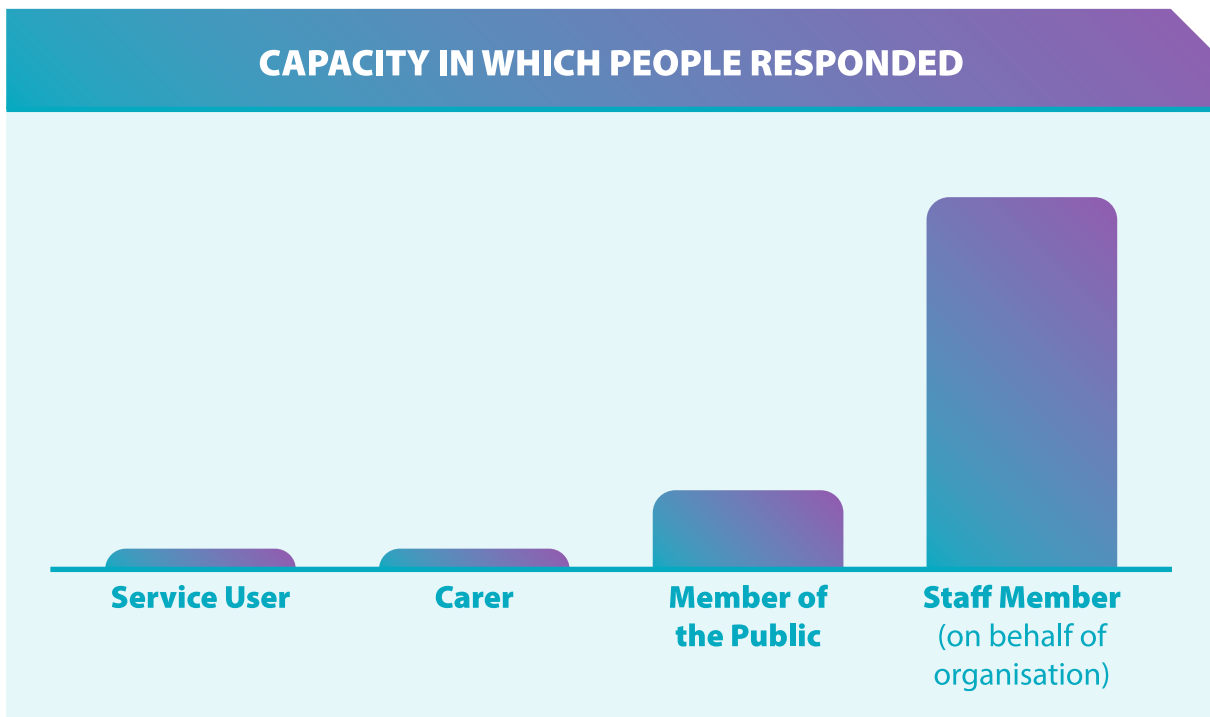
Findings from the Review

The Initial Survey - Response

As previously noted, an online survey was open and available for completion from 3rd January 2024 to 26th January 2024. There was a total of 22 complete responses. It is also to be noted that a number of these responses were collaborative responses, covering the views of multiple individuals or whole organisations.

The majority of responses to the survey were, as would be expected, from staff members on behalf of organisations who have an interest in making a contribution to shaping suicide and self-harm prevention in Northern Ireland.

Figure 1



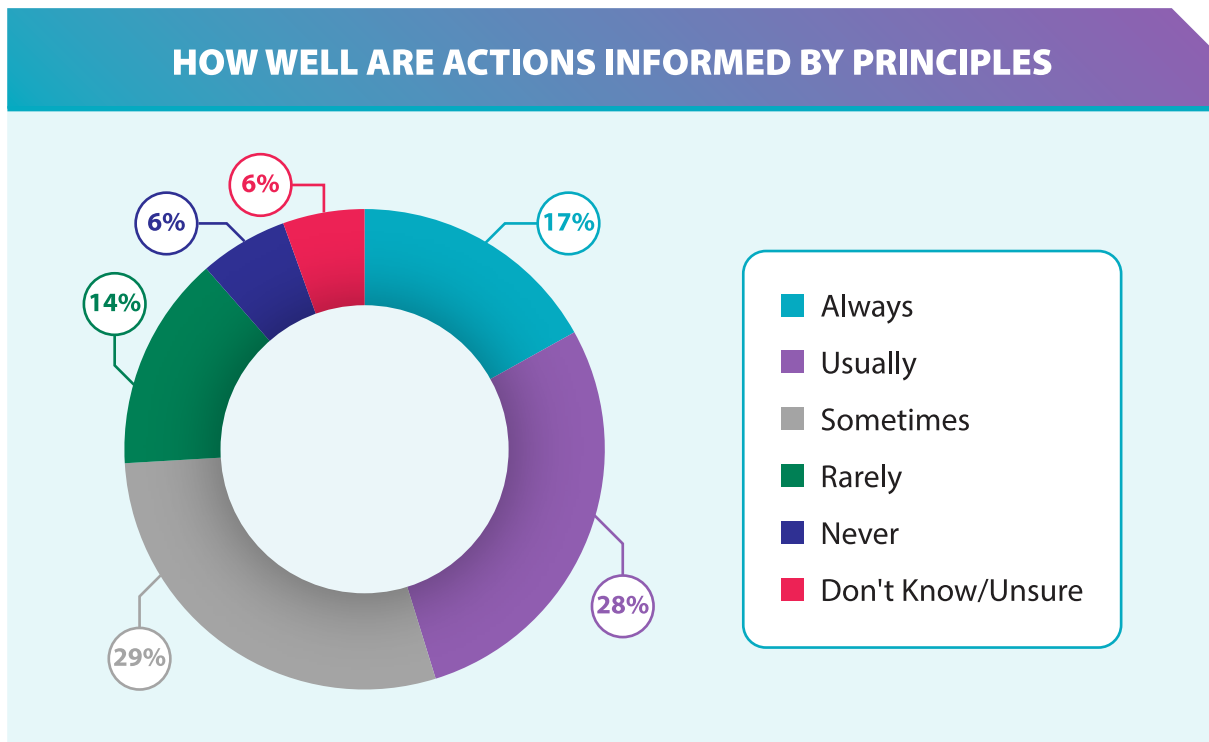
Principles

Chapter 2 of the Protect Life 2 Strategy sets out the Aims, Principles, Scope and Objectives of the Strategy. As set out in this Chapter (Page 12 of the Strategy), *“in striving to achieve the aims of the Strategy, all actions are informed by a set of agreed principles. These are set out below:*

- 1. Be evidence-based where possible, achieve measurable outcomes and be fully evaluated.**
- 2. Be collaborative with public/private sector organisations, academia, professional bodies, service users, carers, voluntary & community agencies, and groups representing bereaved families.**
- 3. Be co-ordinated across government.**
- 4. Be informed through engagement and learning from suicide prevention approaches in other jurisdictions, especially those that have achieved reduction in suicide rates.**
- 5. Contribute to reducing inequalities.**
- 6. Be person centred and informed by those with lived experience of suicide and self-harm.**
- 7. Where appropriate, action will be tailored to the diverse needs of different sub-populations at greater risk of suicide in terms of age, gender, ethnicity, social class, sexual orientation, location, physical and mental health, and occupation.**
- 8. Promote sustainable funding for suicide prevention.**
- 9. Be aware that measures to address the wider determinants of mental health and wellbeing also contribute to reducing suicide.**
- 10. Build on existing strengths such as strong community engagement.”**

Respondents to the survey were asked their views on how well the actions are informed by these principles, with the following being collated:

Figure 2



Observable in the data is that 45% of respondents were of the view that the principles are always or usually informing actions, with a further 29% stating the principles sometimes informed the actions.

Two principles were particular outliers in the positive response noted above. The two principles - Principle 3. *Be co-ordinated across government* and Principle 8. *Promote sustainable funding for suicide prevention*.

This survey was completed at a time when there was no functioning government in Stormont. It is therefore not unreasonable that 25% of respondents highlighted that Principle 3 was rarely informing the actions.

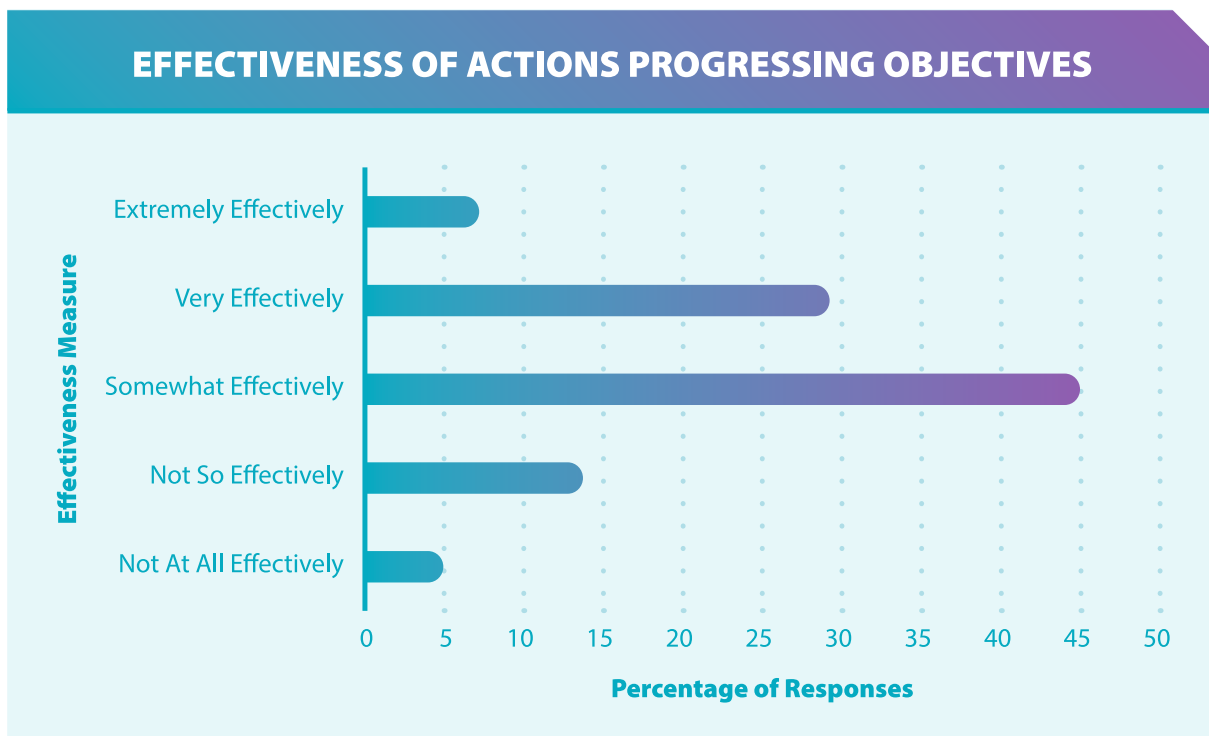
In relation to Principle 8, there are ongoing funding pressures right across health delivery and particularly so for many voluntary and community organisations. In this context, it is again unsurprising that 40% of respondents were of the view that Principle 8 rarely or never informs the action plan.

These two particular points were considered in the workshops, along with relevant qualitative information which is presented later in this Report.

Progress of the actions

Respondents were asked to consider the progress of the actions in various ways through the survey. In the first instance, data was gathered regarding the effectiveness of the actions to progress the ten objectives of the Strategy. Results are illustrated in Figure 3 below.

Figure 3

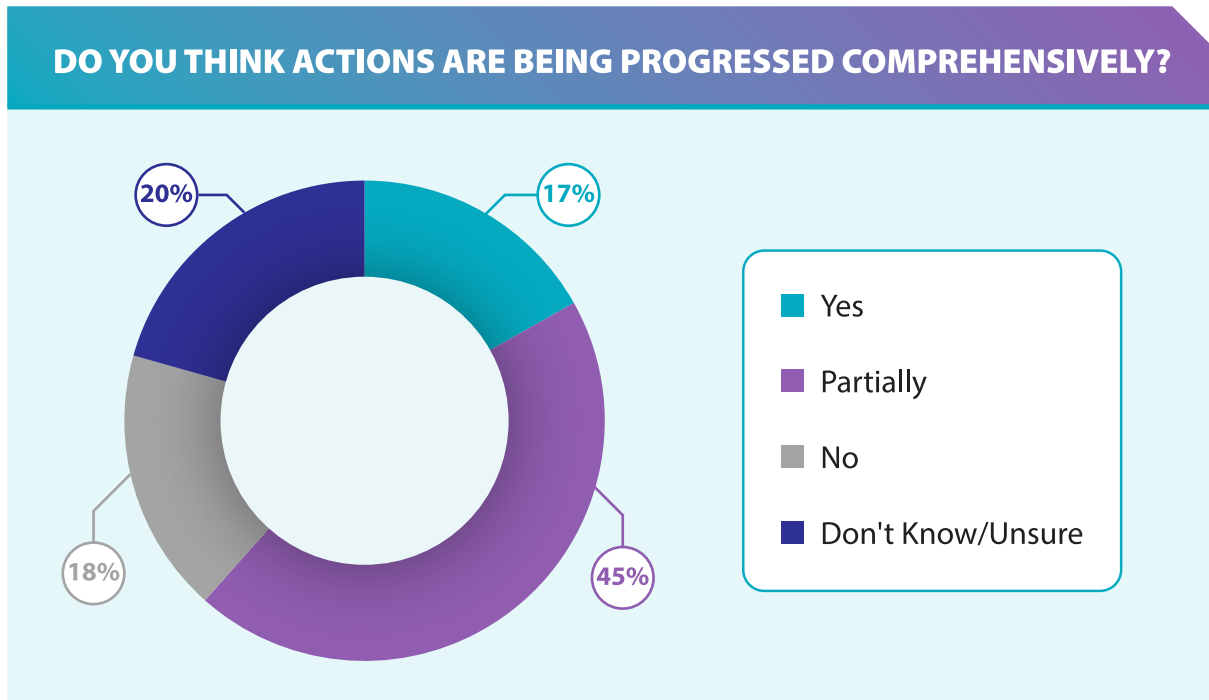


As can be seen clearly in Figure 3 above, less than 20% of respondents were of the view that the actions were not at all or not so effective at progressing the objectives. Whilst clearly there is still work to be done to improve this situation, it is encouraging that at the time of the Review over 80% of respondents were of the view that the effectiveness of progressing objectives were at least somewhat effective.

Respondents were also asked to consider the progress of the actions. This was asked in relation to each individual action, providing a clear picture of views on progress of the entire action plan.

The Figure 4 below provides a summary picture of views on progress.

Figure 4



The first point to note is that 20% of respondents selected 'Don't Know/Unsure'.

There were some notable areas where this 'Don't Know/Unsure' response was well above average. This includes actions relating to:

- ▶ Objective 3: **Enhance responsible media reporting on suicide.** Actions included best practice on memorials, public gatherings and social media postings; and ensuring Northern Ireland is part of UK wide arrangements.
- ▶ Action 4.2: Ensure effective co-ordination with Council community planning on suicide prevention by embedding suicide prevention in all District Council "Community Plans" (**new action**).
- ▶ Objective 6: **Restrict access to the means of suicide.** Actions included reduction of risk at high-risk locations; encouraging safer prescribing; and ensuring safe custody.
- ▶ Objective 7: **Enhance the initial response to, and care and recovery of people who are suicidal.** Specifically, Action 7.2 regarding training frameworks.

This 'Don't Know/Unsure' selection also speaks to further need for sharing of information regarding progress and activity. This point was expanded upon in qualitative elements of the survey and was explored further during workshops. This exploration is presented in more detail during the workshop section of this Report.

It is next important to note that over 60% of respondents were of the view that actions were at least partially being progressed. As with the effectiveness of progressing the objectives, this is positive and something to build upon going into the next strategic phase.

This process of questioning in the survey also allows for identification of particular actions that respondents thought were not being progressed effectively. It is of note that respondents especially considered actions relating to Objective 1: **Ensure a collaborative, co-ordinated cross-departmental approach to suicide prevention**, and Objective 4: **Enhance community capacity to prevent and respond to suicidal behaviour within local communities** as not being progressed comprehensively.

This was especially so for Action 1.1: **Support the Ministerial Co-ordination Group on Suicide Prevention to link suicide and self-harm risk prevention to strategic activity across Government**. This was explored further during the workshops. This exploration is presented in more detail during the workshop section of this Report.

Outcomes of the survey

This quantitative summary along with qualitative analysis of the initial survey responses highlighted general issues, constraints and suggestions to improve the Protect Life 2 Action Plan.

As part of the qualitative analysis, responses were grouped into a number of significant themes. These themes were explored in detail in the workshop process.

Information relating to each of these themes is detailed below as the perspectives developed through the workshop journey.

The Workshops - Process

Following quantitative and qualitative analysis of the initial survey, themes were collated, presented and further tested and explored through a series of 8 workshops. One workshop was held in each HSC Trust area comprising statutory organisations, voluntary and community organisations, people with lived experience and members of the public. Workshops were also held with the Protect Life 2 Steering Group, Statutory Sector and Families Voices Forum. Some workshops had up to 40 people attending.

An iterative process was initiated which enabled participants to provide deeper responses and suggestions for improvement in all subsequent face-to-face workshops. The theme in relation to communication was expanded following the third face-to-face workshop to include an exploration of the connection between the Protect Life 2 Action Plan and local service delivery when feedback related to that emerged at that point in the Review process.

Members of the Family Voices Forum attended and contributed to all workshops held across the region in January and February 2024. On 6th March 2024 a specific workshop was held with the Family Voices Forum where all of the feedback and themes from the survey and preceding 7 workshops were presented for further exploration and discussion. Outlined below is also a brief summary of the feedback from this workshop, which echoed feedback from all stakeholders during the workshops. The Reviewers felt it was important that this was specifically highlighted separately in this Report.

To help support the process to completion and continue with the principle of co-design, the Consultants recommended an additional workshop (Workshop 9). This took place in April 2024 with the Department of Health and the Public Health Agency to test and organise the feedback immediately and ensure the recommendations emerging from this Review are practical, achievable and feasible.

The specific purpose of Workshop 9 was to:

- ▶ Group Objectives into Action Areas;
- ▶ Re-align Actions to corresponding Action Area;
- ▶ Identify Actions for further discussion/exploration; and
- ▶ Commence process to analyse and amend each existing Action to make sure it is SMART/SMARTer.

Themes captured from Survey and 8 Workshops

A total of 7 clear themes emerged during the Review from both the Survey and the 8 Workshops. General and consistent feedback on all the Actions informed the themes below. These themes remained consistent throughout the engagement. They are:



Feedback in relation to each individual action in the Strategy was also captured from both the Survey and the Workshops. The feedback included very specific general suggestions to group some actions, to create sub-actions and to re-consider use of unmeasurable terms such as 'encourage' and 'promote'. There was also significant comment re: the need for clarity on who is the responsible lead for each Action. This feedback was the basis of Workshop 9. Initial output from Workshop 9 is included in this Review Report. This feedback is also the basis of the Recommendations in this Review Report.

Below is further detail on the themes, with a summary to reflect key points consistently raised. The order of presentation is arbitrary and is not a reflection of their importance. All themes are relevant. The themes are also intrinsically linked and co-dependent, however, based on the strength of the stakeholder feedback, each theme is individually presented in this Report.

1 Governance Structure

At the point of the survey being conducted and analysed (3rd January 2024 – 26th January 2024), the key feedback under this theme was in relation to the impact of the absence of Government (Northern Ireland Executive/Ministers).

On the day of the first face-to-face workshop on 30th January 2024 with the Regional Protect Life Steering Group, an announcement was made that the Assembly may be recalled. The Northern Ireland Assembly was successfully re-instated on 3rd February 2024 after a 24-month hiatus.

In spite of this positive development, the stakeholder feedback through the workshops was that the issues remained the same. Findings from this theme were therefore consistent throughout the stakeholder engagement period. Key issues raised were:

- ▶ The need for an overarching structure under Programme for Government
- ▶ A strong need to ensure Protect Life 2 Strategy has consistent ownership in all Government Departments
- ▶ A lack of co-ordination and collaboration between Departments and also groups/agencies who are working on the Action Plan
- ▶ A need for strong leadership at department levels so as joint working/co-ordination can happen at local levels
- ▶ Better joined up strategic planning and commissioning
- ▶ A full refresh and communication of the governance structure:
 - Ministerial level (PfG)
 - All Party Group
 - Regional Protect Life Steering Group
 - Local Protect Life Implementation Groups
 - Communities of Interest

2 Funding/Resources

Key issues raised throughout the Review from both the Survey and the Workshops are summarised below:

- ▶ The Action Plan needs to be properly costed and resourced with clarity on Actions that are specifically funded versus those which require co-ordination and collaboration
- ▶ Sustainable investment needed in Community and Voluntary services which understands and sustains what is already working well
- ▶ A need for clarity on funding streams from different strategies across Departments
- ▶ Lack of funding generally
- ▶ The impact of short-term funding
- ▶ The need for equity across the region
- ▶ The need for long-term workforce planning

3 Multiple Strategies

Key issues raised throughout the workshops in relation to the number of Strategies and areas of overlap are summarised below:

- ▶ A Need for an overarching framework that covers all multiple relevant strategies (a list of links to co-dependent Actions in other Strategies should be included in the refreshed PL2 Action Plan)
- ▶ A need for development of a mechanism for integration and connection between co-existing Strategies and consideration given to capacity issues and resources to do this
- ▶ The need for an accountable oversight body
- ▶ Suggestion of a Tracker system to help this

4 SMART/SMARTer³ Actions

This was a strong theme throughout, from the survey through all 8 workshops. It was also a focus in workshop 9. The general feedback under this theme is set out below and also referenced, where relevant, in other themes. It has informed the recommendations for refreshing the Action Plan for 2024 – 2027. Key points raised:

- ▶ Principles should be at forefront of the Action Plan
- ▶ Actions should be time bound
- ▶ Actions should be more explicit in terms of their links with other Strategies
- ▶ Action Plan should set out targets and deliverables for next 3 years
- ▶ There should be fewer Actions and these should be more focussed and prioritised for high-risk groups. Current scale and breadth of work in current Action Plan is very high
- ▶ Actions should be able to be monitored and evaluated
- ▶ Actions should be categorised and grouped – some are too similar
- ▶ Actions should all have a specified owner/responsible lead who has the authority to progress the Action but recognising interdependency and inter-connectedness and also include those who support and feed into this and how this is done
- ▶ Sub-actions should be developed that are SMART and contribute to progressing high level actions i.e., more targeted work by local PLIGs
- ▶ A red/amber/green status needed on the refreshed Action Plan with this information publicly available

This theme is closely related to the following data and outcomes theme.

3 Specific Measurable, Achievable, Realistic, Timebound

5 Data and Outcomes

This was a strong and consistent theme throughout, from the survey through all 9 workshops. It was also a focus in Workshop 9. The general feedback under this theme is set out below and also referenced, where relevant, in other themes. It has informed the recommendations for refreshing the Action Plan for 2024 – 2027. Key points raised:

- ▶ Use an Outcomes Based Accountability approach⁴ - How much did we do? How well did we do it? Is anyone better off? What is the baseline?
- ▶ Be clear about outputs versus outcomes
- ▶ Train and resource organisations to provide data and outcomes
- ▶ Set cross-departmental research priorities
- ▶ All organisations and services need to use a common, joined up method of data collection that is clear on what is being measured:
 - Quantitative – programme and process
 - Qualitative – stories/narrative – value of the difference made to individuals and families – service-user friendly
 - Thematic analysis – case studies
- ▶ Develop a dataset for everyone to use consistently to grow the evidence base and foster innovation and learning
- ▶ Cross departmental agreement needed for collecting data; community and voluntary organisations can have a number of commissioners to provide monitoring returns to and streamlining would support monitoring as well as delivery
- ▶ Surveillance data needed for higher risk groups
- ▶ Creation of a scorecard in relation to actions so that what is happening and working is accessible. This would be built on information from local PLIGs so full picture of impact is observable
- ▶ Better use of local intelligence is needed

4 [Outcomes Based Accountability and the Programme for Government \(niassembly.gov.uk\)](https://niassembly.gov.uk)

- ▶ Better use of health intelligence and data
- ▶ Centralised system needed for data collection
- ▶ Need service-user and carer involvement in developing data collection surveys
- ▶ Employ statisticians and analysts to do this
- ▶ Digital dashboard on DOH website would be helpful
- ▶ Prioritise an evidence-base to inform change that will lead to meaningful improvement to wellbeing and the public
- ▶ Fund pilots to test and build evidence

6 Inclusion and Health Inequalities

When all stakeholders were asked about the 10 principles that should inform all Actions, principles 5 and 7 were highlighted particularly during the qualitative feedback from the survey and throughout the workshops.

Principle 5: Contribute to reducing inequalities.

Principle 7: Where appropriate, action will be tailored to the diverse needs of different sub-populations at greater risk of suicide in terms of age, gender, ethnicity, social class, sexual orientation, location, physical and mental health, and occupation.

The feedback in relation to a cross-departmental governance structure and alignment with multiple strategies is relevant to this theme.

Summary of feedback in relation to these principles and how Actions should align with these is below:

- ▶ Put principles at the front of the Action Plan and ensure no-one is excluded
- ▶ Identify vulnerable groups/lead organisations/advocates who work with higher risk groups and ensure strong collaboration to understand needs and barriers to accessing services
- ▶ Ensure identified key groups are invited/involved with Protect Life 2 governance structures, conferences and workshops
- ▶ Focus on training
- ▶ Implementation needs to be consistent but take account of regional variations – PLIGS work well in this respect
- ▶ Use technology

- ▶ Particular populations referenced during engagement:
 - Neurodivergent population
 - Children and Young People (inc Looked After Children)
 - Care leavers
 - Irish Traveller Community
 - BAME communities
 - Those who have experienced domestic and sexual violence
 - Refugee/asylum seeking population
 - LGBTQ+ population
 - Older people
 - People with Disabilities
 - People in financial crisis

7

Communication and Connection Between Action Plan and Local Delivery

Communication in relation to highlighting and celebrating progress, highlighting learning, raising issues and keeping abreast of all developments across the region was raised consistently as something that could be improved. It also became apparent in the early workshops that stakeholders felt varying degrees of connection or disconnection with the Action Plan. This was explored further in all subsequent Workshops.

Summary of feedback in relation to this theme is below:

- ▶ PLIGs connect multiple organisations which is positive but it is timely to revitalise the role and function and membership to ensure representation, collaboration and ownership i.e., each member is responsible for communicating within their organisation
- ▶ Need for a consistent communication plan across PLIGS
- ▶ Review input of diverse populations
- ▶ Ensure Families Voices Forum are on every PLIG
- ▶ Minutes on DOH website
- ▶ Use technology
- ▶ Full action plan discussed at all PLIGs – not all relevant but important to know all
- ▶ Strategic vision needs communicated
- ▶ Quarterly reports – less narrative
- ▶ Involve Service-users in creation of the refreshed Action Plan

Families Voices Forum Meeting

This was the last workshop of the original 8 regional workshops planned for the Review. It offered those with lived experience the opportunity to engage with all information gathered, collated and analysed. The participatory process ensured full consideration of the various themes that had developed as well as some amendments to actions proposed by workshop participants that had grown from the survey and through the workshop journey.

Summary of key feedback is as follows:

- ▶ Communication needs improved
- ▶ Dashboard would be helpful
- ▶ Clear roles and responsibilities within departments is imperative
- ▶ Performance Monitoring Returns need regulated and streamlined – ensure data captured is relevant and contextual
- ▶ Regular networking event important and identification of who would lead and organise this
- ▶ Establish a knowledge sharing base
- ▶ Basic services should be standardised regionally
- ▶ Should be a standard baseline in each organisation
- ▶ Co-design is important
- ▶ Data along with a person-centred approach with established structure to provide updates, obtain input and provide feedback
- ▶ Regional Protect Life Steering Group minutes should cascade down to a local level
- ▶ Review membership of PLIGs and related meetings – feed information to a DOH co-ordinator to disseminate

- ▶ Maximise use of the FVF to improve influence of lived experience e.g.
 - Interact with smaller bereavement groups and individual forums (substantial piece of work)
 - Disseminate information
 - Part of core governance structure/embedded in core structure
 - Ensure information is relatable and accessible
 - Formalise groups – have a light agenda
 - Newsletter
 - Voice of families at meetings/events

Workshop 9 – Suicide Prevention Policy Lead, Department of Health and staff from Health Improvement and Health Intelligence, Public Health Agency

Following the Survey analysis and collation of feedback from the 8 workshops, the Consultants recommended an immediate review of key feedback in relation to the Action Plan. To do this effectively a 9th workshop was facilitated with Department of Health Suicide Prevention Policy Lead and Health Intelligence and Health Improvement staff from the Public Health Agency.

The objective of the workshop was to commence the process to:

- ▶ Group Objectives into Action Areas;
- ▶ Re-align Actions to corresponding Action Area
- ▶ Analyse and amend each current Action to make sure it is SMART/SMARTer

In preparation for this workshop, the facilitators presented the Department of Health and Public Health Agency staff with a comprehensive and detailed summary of all the feedback from the Survey and the 8 workshops. This included the 7 themes as summarised in this Report plus detailed feedback and suggestions in relation to each Action. They also received a first draft of this Report. This was key to guiding and informing the workshop.

The initial output from this workshop is below. It is the foundation level to commence the full co-design process of the refreshed Action Plan for 2024 – 2027.

Output from Workshop 9

Figure 5 shows the overarching Strategic Action Areas settled upon and the Objectives contained within these areas:

Figure 5

Strategic Action Area	Objectives within this Action Area
1. Whole of Government and Society Approach	Objective 1: Ensure a collaborative, co-ordinated cross-departmental approach to suicide prevention.
2. Awareness and Prevention	Objective 2: Improve awareness of suicide prevention and associated services.
	Objective 3: Enhance responsible media reporting on suicide.
	Objective 4: Enhance community capacity to prevent and respond to suicidal behaviour within local communities.
3. Supporting Compassionate Responses to Suicide	Objective 6: Restrict access to the means of suicide.
	Objective 5: Reduce the incidence of suicide amongst people under the care of mental health services.
	Objective 7: Enhance the initial response to, and care and recovery of people who are suicidal.
4. Supporting Compassionate Responses to Self-Harm	Objective 9: Ensure the provision of effective support for those who are exposed to suicide or suicidal behaviour.
	Objective 8: Enhance services for people who self-harm, particularly for those who do so repeatedly.
5. Research, Evidence and Planning	Objective 10: Strengthen the local evidence on suicide patterns, trends, and risk, and on effective interventions to prevent suicide and self-harm.

Actions previously agreed under the Protect Life 2 strategy were individually reviewed in the context of feedback from all stakeholders and, with the Strategic Action Areas agreed, were readily re-aligned.

The Strategic Action Areas agreed in Figure 5 will now form the basis from which to progress the Recommendations set out in the Review Report. An implementation update against the previous action plan is currently being developed and will shortly be published on the Departmental website.

5

DISCUSSION

Discussion

The response to and engagement with this Review was extensive. The Consultants noted throughout the process a consistent and impressive energy and passion for the successful implementation of the Strategy from all stakeholders; Statutory, Community, Voluntary, those with lived experience and members of the public.

The process also highlighted the breadth and progress of the very positive work going on and the strong relationships and partnership working and commitment from people involved.

A general sense, however, was that stakeholders had varying degrees of interaction with and connection to the Action Plan with a significant number of stakeholders reporting seeing it for the first time at the workshops. All found it to be lengthy and challenging to engage with in its current form.

Recommendations made in this Report are based on the analysis of suggestions made by stakeholders throughout the process. The feedback from this review along with the output of the 9th workshop now provides a good foundation from which to take forward a collaborative approach to implementing the Recommendations in this Review Report. The Review of Suicide Prevention Strategy Action Plans in other parts of the UK and Ireland (Annex A) and the Academic Review of Evidence (Annex B) provide relevant and useful reference material which will also inform the development of the revised action plan and ensure it reflects current evidence.

6

RECOMMENDATIONS

Recommendations

Based on all the feedback encapsulating issues, suggestions for improvement and recognised constraints, the following recommendations have been developed. The interconnectedness of the recommendations means that progress will need to be made in a coherent, planned and interconnected manner.

The defined Strategic Action Areas and initiation of the process to re-align and define high level Actions has now been initiated as set out in Figure 5. This work is now the foundation for the co-design of the Action Plan going forward. Defining the Strategic Action Areas assists greatly with the progress towards improved monitoring and evaluation.

Recommendation 1

Action Plan to be co-produced and launched as a 'stand-alone' document with a vision and the 10 core principles front and centre.

It should contain a smaller number of high-level Actions. This Action Plan should remain static for the duration of the Strategy.

The Regional Protect Life Steering Group should drive delivery via a more detailed implementation plan as per governance arrangements set out in the Strategy.

Local Protect Life Implementation Groups can then develop local action plans based on this that will be tailored to local needs and assets.

Recommendation 2

Each Objective in the Action Plan to contain a brief outline of its rationale and benefit.

Recommendation 3

All interlinked Strategies should be cross-referenced and consideration given to how this is explicit in the Action Plan.

There also needs to be clarity on the mechanism for monitoring and tracking co-dependent Actions.

Recommendation 4

Following from Recommendation 3, a clear 'owner' should be designated against each Action.

It should be clear following recommendations 2 and 3 who has the remit to deliver Actions. The 'owner' is not considered responsible for all delivery but it will be the responsibility of the 'owner' to ensure co-ordination of delivery and communication between partners in any delivery.

This will involve collation of monitoring data across partners, enabling achievement of measurement of progress. The 'owner' would be expected to support this process of monitoring.

Recommendation 5

The Action Plan needs to be fully costed. Costings should also take cognisance of and include the infrastructure needed to co-ordinate, plan, commission and monitor services within this Strategy.

Recommendation 6

When work is complete to make actions SMART/SMART(er), the specific outcomes and required data measurement should be made apparent.

This should involve streamlining of monitoring returns for delivery partners, especially those in the voluntary and community sector. As per Recommendation 5 above, cost relating to this data collection, monitoring and the related measurement should be taken account of and included.

This may require the addition of data support staff to ensure full and adequate completion.

Recommendation 7

With improvements in monitoring, it is recommended that progress reports are made publicly available. This would include creation of online dashboard where progress against measurables can be presented.

It is considered that this would involve a format of red/amber/green system to allow easy and clear understanding of effective progress of actions.

Recommendation 8

Full review and refresh of the governance structures set out in the 2019 Strategy should be undertaken.

This should include reviewing the scope, role and function of the Executive Working Group on Mental Wellbeing, Resilience and Suicide Prevention, the All-Party Group, the Regional Protect Life 2 Steering Group and the Local Protect Life Implementation Groups. This review will need to take into account progress of Recommendation 4, relating to co-ordination of delivery across a range of partners.

This review should take cognisance of, and a pragmatic approach to, ensuring membership is representative and that conflicts of interest are noted in relation to commissioner/provider relationships in such forums. Terms of Reference should be explicit in this regard.

The Consultants recommend that the positive elements of the local Protect Life Implementation Groups in terms of local expertise, connectedness, sharing of learning and information and mutual support is harnessed and there is no ambiguity of role or function.

Annex

1

REVIEW OF SUICIDE PREVENTION STRATEGY ACTION PLANS

Annex 1: Review of Suicide Prevention Strategy Action Plans

The Department undertook a review of UK and Ireland Suicide Prevention Strategy Action Plans to highlight any areas which warrant consideration for incorporation within Protect Life 2.

There is much that is common across the various Suicide Prevention Strategy Action Plans. Key themes which differ from the existing Protect Life 2 Strategy have been identified for further consideration.

England

The *Suicide Prevention Strategy for England 2023-2028 Action Plan*⁵ has a particular action to encourage employers, including in largely male industries to have adequate and appropriate support in place for employees – including, for example, people trained in mental health first aid, mental health support and suicide prevention awareness. This has been done to some extent in the past in Northern Ireland through Lifeline for example however consideration could be given to including this within training actions.

The English Strategy also has a specific focus on autistic people that is not currently in Protect Life 2. This includes future work with National Confidential Inquiry into Suicide and Homicide to develop a clearer national picture of suicides in autistic adults, children and young people. As Northern Ireland contributes to NCISH this can be delivered at no additional cost.

England also seeks to consider opportunities to provide support for autistic children within the education system and any tailored support that might be needed for different groups including autistic children.

A recent development which has taken prominence since Protect Life 2 was published is that of financial difficulty and economic adversity. As part of their Action Plan England will consider the links between suicide and debt and explore how support and training offered for suicide prevention can be strengthened in frontline services.

5 [Suicide prevention strategy: action plan - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/114142/suicide-prevention-strategy-action-plan-2023-2028.pdf)

Gambling is another issue which has had increased profile since Protect Life 2 was published. As part of their Action Plan England will seek to explore opportunities to improve current treatment provision for gambling-related harms, including gambling related suicidality. The Royal College of Psychiatrists will develop continuous professional development resources to improve professionals' understanding of harmful gambling. This will include suicide risk as a result of gambling. This will be of benefit to Northern Ireland.

England's Action Plan will also consider how to improve training for staff and better embed routine enquiry around domestic abuse, including links to suicide through the Domestic Abuse and Sexual Violence Programme.

England also has a focus on investment in crisis alternative support including crisis cafes, sanctuaries and safe havens.

Scotland

Scotland's *Suicide Prevention Action Plan Creating Hope Together 2022-2025*⁶ recognises the need for developing new approaches to prevent suicidal behaviours in older adults with a focus on delivering actions in key settings.

Scotland's Action Plan also recommends in settings and services where people are at higher risk of suicide, to ensure there is a suicide prevention action plan in place which takes account of risk and protective factors and connects to statutory partners and local suicide prevention plans.

Scotland also gives focus to hosting learning events to disseminate information and share learning and good practice between and across sectors on suicide prevention.

Wales

Wales is currently redrafting their suicide prevention Strategy and a revised action plan will be published in due course. The Welsh *Talk To Me 2*⁷ Strategy and Action Plan covers many of the same areas as Protect Life 2 and also recognizes the need for a specific suicide prevention and self harm website. Currently in Northern Ireland some information is held on DoH website and some on the Minding Your Head website.

⁶ [Creating Hope Together: suicide prevention action plan 2022 to 2025 - gov.scot \(www.gov.scot\)](https://www.gov.scot/resources/documents/2022/06/Creating_Hope_Together_suicide_prevention_action_plan_2022_to_2025.pdf)

⁷ [Suicide and self harm prevention strategy 2015 to 2022 | GOV.WALES](https://gov.wales/sites/default/files/2022-06/suicide_and_self_harm_prevention_strategy_2015_to_2022.pdf)

Ireland

Ireland's *Connecting for Life Suicide Prevention Strategy*⁸ Action Plan recognises the need to integrate suicide prevention into the development of relevant national policies, plans and programmes for people who are at increased risk of suicide or self-harm.

Ireland also seeks to strengthen the data systems to report and learn from investigations and reviews on child protection and deaths of children in care in order to review the profile of need and requisite service response to vulnerable young people.

⁸ [gov - Connecting for Life: Ireland's National Strategy to Reduce Suicide 2015 - 2024 \(www.gov.ie\)](http://www.gov.ie)

Annex

2

**ACADEMIC REVIEW
OF EVIDENCE**

Annex 2: Academic Review of Evidence

Updated Review of Literature on Suicide and Suicidal Behaviour in Northern Ireland



Prof Siobhan O'Neill,
Dr Nicole Bond

Introduction and context

Protect Life 2 is Northern Ireland's (NI's) Strategy for the prevention of suicide and self-harm. This Strategy will be extended to the end of 2027 with the Department of Health undertaking a Review of the Protect Life 2 Action Plan to inform the extension and future Action Plan and implementation. In 2020, Rory O'Connor and I published a [review](#) of the evidence regarding suicide prevention in NI with the goal of informing suicide prevention policies and practice in the region. This current Review serves as an update of that paper, summarising the evidence published on suicide in populations in NI, since that review was completed (March 2019- April 2024).

Suicide statistics

The 2020 review stated that NI had the highest rate of suicide in the UK and Ireland. However, the suicide statistics have since been revised following changes to the statistical collection and collation process, and a review of individual undetermined and drug related deaths from 2015 to 2018. The review resulted in the re-classification of a number of 'drug related' deaths from being undetermined (and within the suicide definition) to accidental (and outside of the suicide definition). This review led to a decrease in the numbers of deaths classified as suicide. This review was later extended to include 2020 data as well as some non-drug related cases from 2015-2019. The review process is described in detail in NISRA's [May 2022 review report](#). In addition, the criteria used to classify a death as a suicide for statistical purposes changed in 2015. NISRA state "Comparisons with earlier data prior to 2015 should be treated cautiously given the 2015-2021 review exercise".

Since the classification criteria change in 2015, the number suicide [deaths](#) registered in NI were; 195 in 2016, 199 in 2017, 236 in 2018, 205 in 2019, 219 in 2020 and 237 in 2021. The most recent figures for 2022 show that 203 suicide deaths were registered in NI. This represents a decrease of 34 (14.3 %) from the 237 suicide deaths registered in 2021, however it is important to consider the possible impact of procedural delays. Additionally, suicide rates fluctuate necessitating the review of longer-term trends. The three-year rolling average rate of suicide deaths has remained relatively stable since 2017. Since 2015 NI's rates have been [higher](#) than England and Wales and lower than Scotland, with the exception of 2021. The age-standardised suicide rate in NI reduced from 14.3 deaths per 100,000 in 2021 to 12.3 deaths per 100,000 in 2022. In 2022, 156 (76.8 %) of the 203 total suicide deaths were males and 47 (23.2 %) were females. The rate for males decreased from 21.6 per 100,000 males in 2021 to 19.2 in 2022, while for females, the equivalent rate decreased from 7.2 per 100,000 females in 2021 to 5.7 in 2022. The crude death rate per 100,000 population was higher for those suicide deaths in 2022 with a marital status of divorced (20.8) or single (17.7), compared to those recorded as widowed (11.4) or married (9.5). The percentage of suicides in 2022 from NI's most deprived areas (31.0 %) was over three times that of the least deprived areas (9.4 %).

Literature Review Search Method

Peer reviewed published studies were extracted from PsychInfo, Medline, and Embase electronic catalogues. The search was restricted to the April 1st, 2019, - 29th April 2024 time period using search terms "suicide", "suicidal ideation", "suicidality", "self-harm", "self-injury", and "NI". Publications were selected where studies reported on suicide or self-harm in a population which included the NI population. There were no language restrictions.

Hospital/ED Crisis Presentations

The self-harm registry in NI and the Republic of Ireland records presentations of self-harm and suicidal ideation. Since the original review several studies have been published examining hospital presentations. [Griffen](#) and colleagues (2019) examined risk of repetition in 62,213 presentations to hospitals in NI and found that the rate of self-harm was more than twice the rate of hospital-presenting ideation. Rates of ideation were higher among men, and both self-harm and ideation rates peaked for girls aged 15-19 and men aged 20-24 years. 12% of ideation presentations were followed by a subsequent self-harm presentation, whereas 4% of self-harm presentations were followed by ideation. The cumulative probability of repeat attendance to hospital was higher following ideation (52% after 12 months). The same team examined 14,695 presentations to hospital due to suicidal [ideation](#) in NI. The cumulative incidence of repeat presentation to hospital was 40.5% within five years, with an 18.3% risk of subsequent self-harm. Previous ideation had the strongest association with repeat presentation and higher numbers of presentations carried and increased risk. In contrast, risk of subsequent self-harm was highest after the first or second presentation. Males and those who had taken alcohol were more likely to return with further ideation, and females and young people were more likely to attend again with self-harm. These studies highlight that hospital presentation with suicidal ideation carries a high risk of future suicidal behaviour and those affected should receive evidence-based interventions.

Analyses of NI self-harm registry data also demonstrated [variation](#) across EDs in relation to the proportion of patients receiving mental health assessment and likelihood of admission to general and psychiatric wards. The study highlighted a significant variation in suicide risk depending upon which ED was attended, even after adjustment for patient characteristics, variation in types of self-harm, and care management at the ED. The researchers concluded that the “availability and access to, and level of engagement with, the subsequent management and care in the community rather than the immediate care at EDs that is most critical for patients presenting to ED with self-harm. However, the initial care in ED is an important gateway in initiating referrals to these services”. The study also reported a variation in self-harm method across hospitals with, one hospital recording a higher number of attempted drowning. Similar to [other studies](#), suicide risk was three-times higher for those presenting with drowning or hanging or mixed methods; it was twice as high for males compared with females, and risk also increased with age. The risk was lower (but not significantly so) in those who received a specialist mental health assessment in the ED, and significantly lower when a referral was made for later mental health assessment. The risk was higher in those admitted to a hospital ward compared to those who were discharged from the ED after treatment. The analyses revealed a difference between hospitals in relation to death by suicide, but not for other causes of death, and this difference was not accounted for by characteristics of the person, method of self-harm or care received. Differences across EDs were unaffected by excluding those who refused care or left without being seen.

A further analysis of the Registry data from 2012 to 2015 examined the factors associated with self-harm and [mortality](#) through linking primary care registrations and death records to 2018. Rates of self-harm were highest in females, those aged 20-24 years and those residing in the most deprived areas. There were 35 suicide deaths in the period, including five who had previously presented with self-harm died by suicide (23%). Suicide risk was increased 19-fold in those who presented with self-harm. Increased suicide risk was observed in males and those using more violent methods of self-injury.

Ross and colleagues (2023) also analysed data on 15,267 people who presented to the ED with ideation compared with the general population. Those who presented with suicidal ideation had a 10-fold increased risk of death from suicide and from all-external causes, and a threefold risk of death from all-causes. They also had an increased risk of accidental death drug-related and alcohol-related death. Males, those from deprived backgrounds, those from urban areas, and those who lived alone were more likely to present with suicidal ideation than the general population.

Together these studies illustrate how attendance at an ED is associated with a high risk of suicidal behaviour and death. The focus on self-harm as a predictor of death by suicide needs to continue, and those who have self-harmed need to be offered continuous effective suicide prevention interventions. There is now a strong body of evidence showing that compassionate safety planning interventions which focus on underlying thought patterns behaviours and problem-solving approaches are very effective in reducing suicidal behaviours. These need to be available as a matter of urgency. Less attention has been given to the risk associated with suicidal ideation, not least because this is a more common experience. However, these studies show that ED attendance with suicidal ideation is associated with a high rate of self-harm and suicide, and other preventable causes of death. Those who attend with suicidal ideation need to have access to effective crisis services to address underlying difficulties. [McDaid](#) and Parke's 2022 analysis of the cost effectiveness of mental health services also highlights crisis intervention services as cost effective in reducing the burden of suicide and self-harm. The need for attention to suicidal ideation in research, clinical care and policy more generally, is also highlighted in a recent review by [Jobes](#) and colleagues (2024). They identify the need for more research on the controllability of suicidal ideation and ways of detecting and measuring ideation and treatments to reduce the frequency, intensity, or duration of suicide ideation.

The variation on the levels of follow up care across NI's hospitals is also a cause of concern. All those attending in crisis need equal access to effective services. The disproportionate levels of suicide attempt by drowning in one area is indicative of contagion, and public health approaches to address this need to be progressed. The most cost-effective way of preventing suicide is the restriction of access to methods ([McDaid](#) and Parke, 2022), therefore priority must be given to reducing access to sites of drowning through the installation of safety barriers. The associations with alcohol and other substances also merit consideration through the progression of the actions in the Preventing Harm from [Substance](#) Use Strategy, and the Towards Zero suicide programme needs to be extended to include addiction services.

Many commentators have noted that the Emergency Department is not an appropriate location for the delivery of suicide prevention services for people who do not have a mental illness, and who do not require physical health services. A study of an alternative crisis service, the Community [Crisis](#) Intervention Service (CCIS) in Derry-Londonderry, used an anonymised database and interviews with five service users to assess the impact of the service. In the 11-month period from the opening of the service the CCIS had 187 service users. These were 98 males (52.4%), 88 females (47.1%) and one transgender person (0.5%). 102 came to the service themselves, via their family or a member of the community. A local rescue organisation brought 57 individuals (34 males and 23 females) to the service and the Police brought 18 individuals (15 males and three females). The referral rates from other voluntary and community groups were very low. The majority used no further services (at that time) ($n = 117$; 62 males and 54 females). A further 17 individuals (12 males and five females) only required signposting to other non-emergency services. Only 45 clients (18 males and 27 females) required liaison with other emergency services such as the ED, PSNI or FSR. The themes from the qualitative interviews were that the service provided a more appropriate setting for a crisis intervention than the ED. Their states of suicidal crisis; risk factors and fluctuations, and the service users' unmet needs. The non-clinical setting and the utility of the intervention in de-escalating states of crisis were valued.

Helplines also provide suicide prevention services to people in crisis and one study in the review period examined the most common reasons for contacting the [Lifeline](#) crisis helpline. The analysis found that calls where the caller cited reasons relating to suicide were the most common reasons for contacting Lifeline and were associated with higher risk ratings. Callers reporting suicidal intent or ideation, childhood abuse, transgender callers and callers who were classified as high risk to others had the highest risk ratings. These findings confirm that Lifeline responds to people who are suicidal and who are high risk, however the other groups who are high risk also merit attention in suicide prevention policy.

One study in the study period examined the impact of a patient suicide on [general practitioners](#) in NI. **Qualitative** interviews with 19 GPs found that GPs were impacted both personally and professionally by a patient's suicide and may not access formal help due to commonly held idealised beliefs "of a 'good' GP who is regarded as having solid imperturbability" and fear of professional repercussions. The authors highlighted the need for a culture shift in primary care to normalise helpseeking to prevent burnout and protect GPs' mental health.

Population wide studies

Researchers in NI's Administrative Data Research Centre (ADRCNI) published several studies in the review period with outcomes relevant to suicide. The 2011 NI census included single item questions on physical and mental health and this enabled an examination of the associations with dispensed prescription [medication](#) and death registrations to suicide to the end of 2015. The ADRCNI analysis showed that over half of those who died by suicide in the study period (n=429, 50.1%) had neither indicator of mental ill health. The rate of suicide was six times higher among those with both self-reported mental ill health (OR=6.13, 95%CI: 4.94–7.61) and those in receipt of psychotropic medication (OR=4.00, 95%CI: 3.28–4.88). People with dispensed psychotropic medication only, had four times the risk of suicide, and those with self-reported poor mental health only had almost three times the suicide risk. The study demonstrates the importance of targeting people with self-reported mental illness, as well as those in receipt of treatment. It also demonstrates that suicide may occur in the absence of mental illness, and among people who have mental ill health who have not disclosed this in the census, and/or received psychotropic medication as treatment for a mental illness.

The analysis of census data also revealed that around one in eight individuals had two or more [physical health](#) conditions, and a quarter had a limitation of daily activities. Both were associated with death by suicide, however the association with suicide risk by number of physical conditions disappeared following adjustment for activity limitation. Individuals with a lot of activity limitation were over three times more likely to die by suicide compared to those with no limitations, however this was reduced to 1.72 with adjustment for poor mental health. The relationship between activity limitation and suicide was most pronounced among those aged 18-34 years. In other words, suicide prevention interventions should be available for people who have a mental illness and those who do not, or who have undisclosed poor mental health. Together these studies illustrate the need for suicide prevention interventions to be available for people who have a mental illness and those who do not have a mental illness but who have physical limitations or undisclosed poor mental health. The association with physical limitations highlights the importance of supporting inclusion, equality, and suicide specific interventions for this group.

[Rosato](#) and colleagues examined the impacts of pro social behaviours (caregiving and volunteering) on mental health and suicide risk in the NI population using census data. The results showed that Intense caregiving was associated with worse mental health and volunteering with better mental health. For those engaged in both activities, likelihood of poor mental health was determined by caregiving level. People engaged in both caregiving and volunteering had the lowest risk of suicide. Engaging in either activity was associated with lower suicide risk for those with good mental health at baseline but not for those with baseline poor mental health. The results maybe interpreted as demonstrating the protective effect of purposeful activity, however they also highlight the need to support carers to reduce their risk of poor mental health.

Children and young people

There is a strong body of evidence demonstrating the importance of childhood factors and particularly childhood [adversities](#) on mental health and suicide risk across the lifespan. In a population-wide, longitudinal, record-linkage study of adults in NI (born between 1985 and 1997, n=437 008) the ADRCNI group found that the 11.7% of the cohort who had childhood [social care](#) contact (n=51 097) accounted for 39.7% of suicide deaths (& 35.3% of sudden deaths). Risk of suicide or sudden death increased stepwise with level of childhood contact and was highest in adults with a history of out-of-home care. Children in contact with the social care system who were assessed as not being in need, and those deemed a child in need had four times the risk of death by suicide in young adulthood compared with unexposed peers. This study demonstrates that childhood contact with social services is a risk marker for death by suicide and sudden death in young adulthood. This risk is not confined to adults with a history of out-of-home care but extended to the much larger population that had contact with social services but never entered care.

The same group also used linked data from the 2011 NI Census to death records (2011-2016) to assess the association between [parental](#) mental illness and suicide and mental health. Again, around one in 10 people (11.6%) lived with parents with poor MH, and they had almost three times the risk of having poor mental health (OR = 2.8). Even after adjusting for other risk factors, including current mental health, that group were 76% more likely to die by suicide compared to children of parents who did not report poor mental health. The effect size increased for children living with two parents with poor mental health and was higher in children aged under 24 years. Together these studies add weight to the argument for childhood intervention to reduce the risk of poor mental health and suicide.

The NI Youth Wellbeing Survey ([NIYWS](#)) prevalence study of children and young people in NI for the first time provided epidemiological data on young people aged 2-11 years in the year prior to the pandemic Jan 2019-March 2020. **This study** investigated associations between adverse and positive childhood experiences and risk of common mood and anxiety disorders, self-harm, and suicidal ideation in 1299 young people aged 11-19 years. Over one in 10, **12%, of the sample reported suicidal ideation and 10% self-harm. 16% had a common mood or anxiety disorders (16 %).** ACEs and [Protective Childhood Experience \(PCEs\)](#) both independently predicted common mood and anxiety disorders, self-harm and suicidal ideation. Every additional ACE increased the likelihood of a common mood and anxiety disorder (81 %), self-harm (88 %) and suicidal ideation (88 %). Every additional PCE reduced the risk of poor mental health outcomes; common mood and anxiety disorders (14 %), self-harm (13 %) and suicidal ideation (7 %). There was no moderating effect of PCEs on ACEs and mental health outcomes. The findings suggest that PCEs act largely independently of ACEs and that initiatives to increase PCEs can assist in the prevention of mental health problems.

The [NI schools](#) and wellbeing study of 1673 adolescent pupils conducted in 2014 found that in the previous twelve months, 354 pupils (21.2%) had thought seriously about harming themselves (females, 27.1%; males, 11.1%). Similar to the Youth Wellbeing Survey 10.2% had harmed themselves (females, 14.4%; males 4.7%). Risk of self-harm in the past twelve months was strongest among fifteen-year-olds, those from minority religions (who had 6.58 times the risk), those who were atheist or agnostic (OR=2.72) and those who had their own bedroom (OR=1.99). A higher risk of self-harm for both males and females was associated with lower scores on the Family Life and Home Life scales. Joint family activities were protective for females, less so for males. Poor school attendance increased risk of self-harm for males (OR=2.68), but not among females.

In this study 14.7% had seriously thought about taking their own lives. These were much more likely to be female (19.3%) than male (7.1%) and from a minority religion (OR=4.86) or atheist/agnostic beliefs (OR=2.56). Poor school attendance increased the risk of thinking about self-harm for both males and females. Lower scores on the Family Life, and Home Life scales increased the likelihood of self-harm thoughts, again more strongly among females. Protective factors included living in a larger town and higher levels of joint family activity. Those who had attempted suicide in the past 12 months were much more likely to be from either minority religious groups or those stating atheist/agnostic beliefs. While the complete sample had a mean help-seeking Trust in GP score of 4.20 (SD=1.2), indicating a relatively high overall trust, 36% of the scores were under 3.7, indicating low trust. Females were less likely than males to seek help (OR=0.77, 95% CI=0.67–0.75), controlling for other socio-demographic variables (age, free school meals, urban/rural residence, religion and own-bedroom). However, the effect of gender disappeared when the model was adjusted for mental health scores generally. Compared to males, females were more than twice as likely to have mental health problems and a four-fold increased risk of self-harming behaviour, with such risks more pronounced in 14–15-year-olds but lessening by age seventeen. Surprisingly, neighbourhood and family socioeconomic indicators (deprivation, family affluence, free school meals) appear to have had little influence on either mental health outcomes or trust in GPs. While overall trust in GPs was high, more than 36% of the sample reported low trust. GP Trust was associated with positive home life factors. The study showed that the young people who would have benefited most from suicide prevention and mental health interventions were least likely to trust their GP and ask for help, as such the study highlights the need for alternative ways of accessing suicide prevention and crisis services.

College Students

The original review of suicidal behaviour included several papers from The Ulster University Student Wellbeing Study, which was part of the World Mental Health International College Surveys initiative. [This study](#) was since expanded to include DNA and oral microbiome analyses, an online intervention study (the Student Psychological Intervention Trial (SPIT)) and incorporates a sample from the Republic of Ireland (RoI). The study found that rates of all suicidal thoughts and behaviours were higher in RoI, however the sample size in RoI was smaller (1439 vs 360). 28% of the sample had suicidal thoughts (26% in NI and 36.4% in RoI), 14.3% had a suicide plan (12.1% and 23.3%), 7.7% had attempted suicide (6.9% and 10.7%) and 13.4% engaged in self-harm (11.7% and 20.2%). Students were significantly more likely to experience mental health problems if they were female ($p < 0.001$), non-heterosexual ($p < 0.0001$), and over the age of 21 ($p < 0.0001$). These findings show that many students are starting university with high levels of psychopathology and suicidal behaviour, highlighting the importance of early intervention which may need to be tailored to different student populations.

[Data from this](#) study highlighted the variation in rates of mental health symptoms, including suicidality across different academic disciplines. Students from Life and Health Sciences reported the lowest rates of a range of psychological problems in the year prior to commencing college, while participants studying Arts and Humanities displayed the highest levels (e.g. depression 20.6%; social anxiety 38.8%). However, within faculty variations were found. For example, psychology students reported high rates, while nursing students reported low rates. Variations in help seeking behaviour were also revealed, with male students less likely to seek help. The same team found a higher prevalence of suicide behaviours and self-harm (Non-Suicidal Self Injury NSSI) among students with [ADHD](#) than those without. Rates of suicidal ideation were 44.8% for those with ADHD (compared with 21.7% in the non-ADHD group); 26.6% had a suicide plan (compared with 9.8%); 13.4% had attempted suicide (compared with 5.5%); and 23.4% had engaged in self-harm (compared with 9.6%). ADHD increased suicidal behaviours and NSSI through its impact on depression; depression, ADHD and the co-variables age and gender also had indirect effects on suicidal behaviours via substance use. Students with ADHD were more likely to develop problematic substance use, which in turn was associated with suicidal behaviours. These studies highlight the importance of providing tailored support and suicide prevention interventions, in the college setting, particularly for those engaged in self-harm and ideation.

They also identify students with ADHD as a high-risk group and demonstrate the need for support and services to identify students with ADHD and to provide appropriate treatments.

Early life experiences, such as childhood adversities or poor parenting practices, can impact on the ability to cope with stressors across the lifespan. Furthermore, poor coping skills can lead to the development of mental illnesses, self-harm, and suicidal behaviour. A further study of students using data from the Ulster University Student Wellbeing Study examined demographic differences in stress levels and to determine if those who had endured negative childhood experiences would be more likely to develop psychological problems and display suicidal behaviour when current stress levels were accounted for. The study also explored the link between coping and mental health problems and aimed to predict risk and protective factors related to good coping skills. Females, non-heterosexuals, and older students experienced more current stress. When current stress levels were high, childhood adversities and parental overcontrol and overindulgence were related to higher rates of mental health problems, self-harm, and suicidal behaviour. Poor coping skills were associated with negative mental health outcomes. Social support and good emotion-regulation strategies were related to effective coping, while parental overcontrol and overindulgence, female gender, and younger age were related to poorer coping. The study highlights the importance of developing good coping skills to deal with life stressors, thereby minimizing the risk of psychological problems and suicidal behaviour. The findings provide support for initiatives to help parents improve their parenting skills and other programs to help young people cope with stress, and to develop social networks and adaptive emotion-regulation strategies.

Veterans

The NI [Veterans](#) Health and Wellbeing Study examined suicidality in veterans in the context of trauma exposure and PTSD. Latent Class Analysis revealed three distinct classes within the sample: a low endorsement 'baseline' class (36%), a 'Moderate Symptomatic' class (27%), and a high endorsement 'Probable CPTSD' class (37%). Both the Moderate Symptomatic and CPTSD classes were predicted by cumulative trauma exposure. Depression was highly comorbid ($OR = 23.06$ in CPTSD), as was anxiety ($OR = 22.05$ in CPTSD) and suicidal ideation ($OR = 4.32$ in CPTSD), with suicidal attempt associated with the CPTSD class ($OR = 2.51$). The results highlight the need to provide trauma focused therapies and additional suicide prevention interventions targeting this group specifically.

The Covid 19 Pandemic

[Paterson et al. \(2023\)](#) used nine years of linked administrative data from the Self-Harm Registry and health records to examine changes in hospital-presenting self-harm and suicidal ideation before and during the pandemic. **There was a reduction in the** number of individuals presenting with self-harm or ideation at the beginning of the pandemic (March-May 2020), before returning mostly to expected trends from June 2020. There were similar presentation trends across most demographic subgroups except for those aged over 65 years, people living alone and those who lived in more affluent areas, where presentations remained unaffected. In under 16-year-olds the numbers presenting with self-harm or ideation increased above expected levels. This suggests that this cohort may have been more adversely impacted by the pandemic and may benefit from additional support.

Whilst not on the NI population specifically, a UK population wide cohort study using primary care electronic health records by Carr et al. (2021) is worthy of inclusion because of huge sample size and the representative sample from NI. The analysis of 14,210,507 patients from 1697 UK general practices found that the incidence of primary care-recorded depression had reduced by 43.0%, anxiety disorders by 47.8%, and first antidepressant prescribing by 36.4% in English general practices in April 2020. Reductions in first diagnoses of depression and anxiety disorders were largest for adults of working age (18-44 and 45-64 years) and for patients registered at practices in more deprived areas. The incidence of self-harm was 37.6% lower than expected in April 2020, and the reduction was greatest for women and individuals aged younger than 45 years. By September 2020, rates of depression, anxiety disorder, and self-harm were similar to expected levels. In NI, Scotland, and Wales, rates of depression and anxiety disorder remained around a third lower than expected to September 2020. In April 2020, the rate of referral to mental health services was less than a quarter of the expected rate for the time of year (75.3% reduction).

In a novel study Mallon et al (2019) analysed the coroner records relating to 63 individuals who had not attended health services in the 12 months before they died by suicide. The vast majority of individuals who did not seek help were males (n=60, 15% of all suicide deaths). Lack of consultation in the year before suicide was consistent with their behaviour over the lifespan; with over two-thirds having no previous consultations for mental health. In coronial records, suicides with no prior consultation were primarily linked to relationship breakdown and job loss. These findings highlight the impact of these life events and may indicate no mental illness, or untreated mental illness. There was a high rate of supported consultation among those who had previously sought help demonstrating the responsiveness of primary care when help was sought. The findings support the promotion of help seeking from primary care and other sources among vulnerable groups at times of crisis. The results also highlight the potential impact of economic issues related to the cost-of-living crisis and the need for suicide prevention interventions to target those with relationship crisis and those experiencing job loss specifically in novel arenas.



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Belfast
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Public Health Agency
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Belfast
BT2 8BS.