

From: Population Health Directorate



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Via email at:

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Dear Sara

FREEDOM OF INFORMATION ACT 2000

I am writing to confirm that the Department of Health has now completed its search for the information you requested on 7 November 2019.

For ease of reference I am copying your FOI request below with our response attached to each.

The Protect Life 2 Suicide Prevention Strategy 2019-2024 sets out the following aim 'to reduce the suicide rate in Northern Ireland by 10% by 2024'.

Please provide me with the following information:

1. The evidence base used to establish this target.

The 10% target is based on World Health Organisation (WHO) guidance as detailed in their 2014 report: *Preventing Suicide: A Global Imperative*.

The report is available at

https://apps.who.int/iris/bitstream/handle/10665/131056/9789241564779_eng.pdf;jsessionid=B07DFBD7A46257F1724BC8156E054ACE?sequence=1

Reference to the 10% target can be found at pages 2, 7, 9, 11, 23, and 71 of the report.

The WHO *Mental Health Action Plan 2013-2020* referred to in *Preventing Suicide: A Global Imperative* can be found at

https://apps.who.int/iris/bitstream/handle/10665/89966/9789241506021_eng.pdf;jsessionid=06A9C2D0E234E714981F88F99EF46E5B?sequence=1

2. All relevant documentation relating to the development of this target, including minutes of meetings, consultation documents and equality screening documents.

Redacted submissions to the former Minister and current Permanent Secretary which included reference to a 10% target have been attached as PDF documents in the covering email to this letter.

The post consultation document for Protect Life 2 is available at <https://www.health-ni.gov.uk/sites/default/files/publications/health/protect-life-2-consultation-analysis-report.pdf>

Reference to the 10% target can be found at pages 3, 4, 6, 10, 34, and 35 of this document.

For your convenience extracts from consultation responses that were received which contained requests for a 10% reduction in the suicide rate are attached separately **at Tab A and B.**

The Protect Life 2 Strategy document can be found at <https://www.health-ni.gov.uk/sites/default/files/publications/health/pl-strategy.PDF>

Reference to the 10% target can be found at pages 2, 11, and 16.

The Equality Screening document is found at <https://www.health-ni.gov.uk/sites/default/files/publications/health/pl-disability-duties.PDF>

Reference to the 10% target can be found at pages 2 and 36.

3. Clarification on what the 10% target means, including the projected number of lives to be saved over the 5 year lifetime of the strategy, year on year.

Detail on how the 10% reduction will be measured can be found at page 11 of the strategy document <https://www.health-ni.gov.uk/sites/default/files/publications/health/pl-strategy.PDF>

If you feel that the information we have provided does not fully meet your request please contact me at the above number in the first instance. You have the right to request that the Department formally review this decision within two calendar months of the date of this letter. If you wish to do so, please write to Mr Brendan O'Neill (foi@health-ni.gov.uk), Annexe 3, Castle Buildings, Stormont, Belfast BT4 3SQ.

If after such an internal review you are still unhappy with the response, you have the right to appeal to the Information Commissioner at Wycliffe House, Water Lane, Wilmslow, CHESHIRE SK9 5AF, who will undertake an independent review.

If you have any queries about this letter, please contact me. Please remember to quote the reference number above in any future communications.

Yours sincerely

Laura Roddy

Laura Roddy
Local Information Manager

Extract from Suicide Down to Zero Consultation Response

Protect Life 2 – a draft strategy for suicide prevention in the north of Ireland
Consultation Questionnaire

PURPOSE, AIMS AND SCOPE

Q1. Do you agree with the overall purpose of the Strategy. If not, what alternative do you suggest? (p 14)

Yes No

If No, please state why.

The purpose of the Strategy to reduce the suicide rate in Northern Ireland and reducing the differential in the suicide rate between the most deprived areas and least deprived areas are supported by Suicide Down to Zero (SDZ).

However, it is not clear how by 2021 the Strategy would be judged. The baseline for evaluating a reduction the suicide rate is not stated nor is it clear what reduction in suicide rates would be acceptable as no quantifiable target is included. It is puzzling that the Strategy seems to be at pains to explain why it's difficult to set a target for a reduction in deaths by suicide (pages 18-20). If it is accepted that deaths by suicide are preventable then there should be a target. The Scottish Government set itself a target of reducing deaths by 20% and achieved a reduction of 18%; the Irish Government in its 2015 Strategy Connecting for Life has included an outcomes focus that measurable improvements are made in relation to the incidence of suicide and self-harm and has included the WHO 2014 target of a 10% reduction by 2020, even though it acknowledges that setting a target is challenging.

Given the unacceptable numbers of deaths from suicide then the Strategy should include a target that all parts of government and partners work towards.

Q6. Do you agree with the stated objectives of the Strategy? If not, what alternatives do you suggest? (p 66-69)

Yes No

If Yes, please provide comments.

While most of the objectives are fine, there is no objective relating to an overall target for reducing the number of deaths from suicide. The Scottish Government's target is to reduce the suicide rate in Scotland by 20% by 2013. Since 2002 – when the target was originally set as part of the Choose Life strategy and action plan –there has been an 18% reduction in the suicide rate. In the years 2009 to 2012 Scotland has seen the lowest number of suicides since the early 1990s and a reduction in the number of suicides at a time when most other jurisdictions are seeing an increase.

Objective 3 is crucial. There is recognition of the need to tackle the stigma around suicide. However it is essential in a suicide prevention strategy that there should be greater emphasis on raising awareness of suicide not just mental health as this is not a mental health strategy. The second paragraph on page 66 under Objective 3 suggests that the awareness raising is around issues of mental health. SDZ would urge greater prominence to the issues of tackling stigma of suicide through public awareness campaigns. SDZ would commend the approach taken by the Scottish Government. In its National Programme's ongoing commitment to promote greater public awareness of suicide, it has developed and delivered two national campaigns in partnership with key stakeholders. The campaigns have targeted individuals at risk of suicide and those who are in contact with them or in a position to support them. The campaigns have used television and radio, print, out of home (buses, poster sites, washrooms and community venues), and digital marketing and social media. In the "Suicide Prevention in Scotland Market research" (May 2015) An evaluation of the campaigns showed there was an increase in people's understanding of suicide risk and an increase in likelihood of intervention. The research showed that a major strength of the campaigns was their longevity, as they have consistently reinforced key suicide prevention messages. Respondents who recalled any kind of messaging about suicide showed that posters gained high levels of recall, with 39% mentioning posters in a healthcare environment and 27% recalling posters in more general public places. Television was also a common source of messaging (mentioned by 38%) and radio adverts were mentioned (21%). Social media (12%) and other online sources (9%) were two kinds of digital media sources also mentioned

MEASUREMENT, REVIEW AND EVALUATION

Q8. Progress in delivering the Strategy will be monitored and its effectiveness will be reviewed periodically. We would welcome your views on how best to monitor and assess the impact of the Strategy over time. (p 78)

Comments:

We would ask that evaluation takes place at the macro level. The fundamental question that needs to be considered is 'Is the Strategy working'? If there is no distinct reduction in deaths – and there should be inclusion of a target such as the 10% (WHO target) or 20% (Scottish Government) - then we would conclude that the Strategy is failing to deliver the stated aim. It is crucial that the evaluation does not get bogged down on the micro-level activities, important as they are, and loses sight of the overall purpose of achieving fewer deaths from suicide.

Extract from Belfast Alliance for Suicide Prevention Consultation Response

Protect Life 2 – a draft strategy for suicide prevention in the north of Ireland
Consultation Questionnaire

Q2. Do you agree with the stated aims of the Strategy? If not, what alternative do you suggest? (p 14)

Yes

No

Currently the Aims of the Draft Strategy listed on page 5 are:

1. Gain a better understanding of suicide behaviour in the North of Ireland
2. Improve the identification of and response to suicidal behavior
3. Prevent suicide by people in crisis
4. Support recovery from suicide behavior and repeat self-harming
5. Support those bereaved by suicide

It should be said first of all that there is a distinct gap between the overall purpose of this draft Strategy and the above listed aims. They do not seem to correlate.

Aims are important vision steps that are taken that match up with the overall intention. In this Draft Strategy, the aims do not seem to work to support the overall purpose.

This list should therefore include an **Aim** that refers to the overall Purpose of this Draft Protect Life 2 Strategy which is to '**reduce the differential in the suicide rate between the most deprived areas and the last deprived area**'.

On reading the 10 Objectives (listed on pages 8-11 and pages 65-68) and the details of how each Objective is to be achieved (pages 69-73) – nowhere can the word 'deprived' be found.

The question then needs to be asked - how can the overall **purpose** of this Draft Strategy which is to 'reduce the differential between the most and least deprived areas' be achieved through the 10 Objectives when the word 'deprived' isn't there? In Objective 4 (page 71) it talks about providing services to 'people in crisis and at high risk' but it should clearly state for example that such services will be proportionately directed to areas where rates are highest i.e. deprived zones. Also it is worth noting in the priority groups listed on page 7, the word 'deprived' is used once in the reference to 'males aged 19-55 especially those who live in areas of deprivation' but what about women, children, teenagers and grandparents who also live in deprived areas? As indicated in Objective 4, page 71, the action is to: "deliver targeted suicide prevention services for people who are in the priority groups." We feel these priority groups should be reviewed and we supply more detail about this below.

The aims should be SMART. For example a measurable reduction should be built in. For example the goal of reducing suicide rates in deprived areas by 20% by 2021. This rate is higher than what the World Health Organisation (WHO) advocate in their Mental Health Action Plan for 2013-2020 which is 10%. However we feel it is achievable with the right approach, support pathways and systems in place.

The aims should reflect a deep, embedded approach towards suicide prevention that involves all 9 government departments: The Executive Office, Department of Agriculture, Environment & rural Affairs, Department for infrastructure, Department for the Economy, Department of Education, Department of Finance, Department of Health, Department of Justice and Department for Communities.

This is to reflect the inter-connectedness and complex nature of suicide in that it touches on most aspects of life and hence government workings. We feel this practice of cross sectoral and cross departmental working should be an explicit aim rather than a vague principle of working as stated on p14. To support this position we recommend the 2014 WHO report *Suicide Prevention - A Global Imperative* which states that: “*Suicides are preventable. For national responses to be effective, a comprehensive multi-sectoral suicide prevention strategy is needed.*”

WHO recommends countries involve a range of government departments in developing a comprehensive coordinated response. High-level commitment is needed not just within the health sector, but also within education, employment, social welfare and judicial departments. Suicide is multi-faceted and requires a multi-faceted approach to health and life issues.

This WHO Suicide Prevention Report also states that “Communities play a critical role in suicide prevention. They can provide social support to vulnerable individuals and engage in follow-up care, fight stigma and support those bereaved by suicide.”
http://www.who.int/mental_health/suicide-prevention/key_messages.pdf?ua=1

Therefore another **Aim** of this Draft Strategy should concern itself with the Strategy being driven not only by the Health Minister but a **functioning** cross departmental working process that is given the ability to perform well and will work hard to achieve positive outcomes.

Resilience is missing from these aims. They should refer to the importance of resilience as a key way of early prevention as listed in the Strategy’s ‘scope’ section (p13).

These aims do not take cognizance of the scale of time it takes to support an individual. Commissioned interventions need to have a flexibility built in to allow a holistic response to client need as opposed to 6-8 pre-set sessions.

These aims should reflect the Strategy’s position, and also the Health Minister’s position which is a ‘Person Centred Care’ (Health & Wellbeing 2026: Delivering Together p11)

<https://www.health-ni.gov.uk/sites/default/files/publications/health/health-and-wellbeing-2026-delivering-together.pdf>

It should also take into consideration the Minister’s visionary position via WHO as stated in this same document: “The World Health Organisation defines health as “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity”. That is the health outcome I want to deliver for all our people”.

Some of these aims are repetitive. For example 1, 2 & 3 are really about the same thing.

This is a suicide prevention strategy and prevention needs to be a key aim/commitment here. WHO report 2014 suicide prevention should be a core element of any strategy worldwide.

Young people perspective is missing.

Early intervention is critical.

The Cradle to the Grave approach is missing.

We note that there are 31 strategies referenced in Appendix 2 that Protect Life 2 should complement. Who will oversee this? We note the importance of the Children's Services Co-Operation Bill, legislation passed in December 2015 which places a legal duty on government agencies to co-operate when it comes to children's services and to consider physical and mental health implications. We note this Legislation is not listed in Appendix 2. This list also does not reference the new and proposed Programme for Government.

Another aspect of these aims to consider is PfG's OBA approach as detailed here: <https://www.northernireland.gov.uk/sites/default/files/publications/newnigov/pfg-outcomes-chart.pdf>

There are 14 broad outcomes in this second draft of the PfG. Several we feel are very applicable to suicide prevention.

Outcome 3: We have a more equal society

Outcome 4: We enjoy long healthy active lives

Outcome 8: We care for others and we help those in need

Outcome 14: We give our children and young people the best start in life.

Within Outcome 4 **We enjoy long healthy active lives** there is a section on preventable deaths which includes road traffic deaths, cancer deaths, drug deaths and suicide. If you click on the link below it takes you to a series of actions that will be overseen by Dr Anne Kilgallen Deputy Chief Medical Officer, Public Health, Department of Health.

<https://www.northernireland.gov.uk/sites/default/files/publications/newnigov/dp-preventable-mortality.PDF>

Comment: This group category of '**preventable deaths**' is very significant. It includes actions that relate to **suicide, road traffic deaths, heart disease, respiratory disease, throat cancer, lung cancer, breast cancer, colon cancer, alcohol related deaths, transport accidents, and accidental injury.**

Within this document it contains 1 '**commitment to act**' in relation to suicide prevention:

What? Protect Life 2 and Reduction in repeat self-harm

Who? DOH, PHA, HSCB

When? Protect Life 2 to be issued for consultation by November 2016.
Implementation and expansion of Self Harm Intervention Programme (SHIP) by June 2017.

Note: SHIP has not been assessed for effectiveness yet it has been listed for expansion in draft PfG out for consultation late October 2016. This is an example of yet another work-plan being rolled out and yet the deadline for responses to this Draft Strategy has not arrived November 4, 2016

The RQIA have reviewed perinatal mental health services. This Report is due out shortly. It would be useful to see RQIA's report in advance of this deadline for responses to this Protect Life 2 Draft Strategy but unfortunately we can't. In March 2016 the then Health Minister Simon Hamilton stated that the "recommendations of this RQIA review will inform future development of this service".