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# Response by the NSPCC to the draft Protect Life 2: A Strategy for Suicide Prevention in the North of Ireland

## November 2016

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**National Society for the Prevention of Cruelty to Children (NSPCC).** Royal Patron: Her Majesty The Queen. President: HRH The Countess of Wessex.
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## Introduction

The NSPCC is the leading child protection non-governmental organisation, providing a range of local evidence-based therapeutic, protection and support services to children and young people and their families across Northern Ireland (NI). We work together with partners in criminal justice, education and the sport sector to promote safeguarding and positive mental health and wellbeing. NSPCC NI has statutory child protection powers under the Children (NI) Order 1995, and we are statutory members of both the Safeguarding Board for NI and Public Protection Arrangements NI.

The NSPCC warmly welcomes the much anticipated draft Protect Life 2 strategy and we commend the Department for its ongoing commitment to this very complex issue. Protect Life 2 rightly places an onus on statutory, voluntary and community sectors to work in co-operation, collaboration and co-production of services to meet the needs of children and young people and their families. We acknowledge that the NSPCC's Childline service is recognised as a key frontline intervention service. We would therefore encourage the Department to contact us at any stage where it is felt that we may be of assistance in the future development of Protect Life 2 and the currently under-developed action plan.

## Childline

Through Childline, the NSPCC support thousands of children and young people suffering with issues of suicide and self-harm. Childline is unique in the reach it has with young people as it is available 24 hours a day, 365 days a year, on the phone and online via email or 1 to 1 chat on the website childline.org.uk which also offers advice and support and a space for peer support in respect of self-harm and suicidal feelings. Over the past year Childline responded to almost 19,000 contacts from young people across the UK who had intentionally self-harmed, and almost 20,000 under 18's who contacted Childline were plagued with thoughts of ending their own lives – more than double the number five years ago.

Childline counsellors often hear from young people who are desperate and are reaching out for support and help because, to them, suicide seems to be the only option left. In 14 per cent of counselling sessions recorded about suicide during 2015/16, young people told counsellors that they were actively suicidal and had established a plan, timescales and means to end their own life. Young people are encouraged to devise coping strategies and if they are thought to be in immediate danger, or when they ask to be referred, we make a referral to an external agency. Our experienced supervisors and trained counsellors therefore play a key role in



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preventing and de-escalating crisis situations for those young people at risk of suicide and self-harm. The *On the edge* spotlight report on suicide provides details on children and young people contacting Childline for support with suicide and self-harm.[1] We would strongly urge that the findings from this report be used to help inform the Department's understanding of the challenges faced by children and young people in the further development of Protect Life 2.

## General comments

**Invisibility of children and young people**

The NSPCC are extremely concerned that children and young people are largely invisible throughout the draft version of Protect Life 2. We accept that the rate of suicides in under 18's is lower than other age groups. However, as the strategy rightly recognises "suicide is one of the main causes of mortality in young people" and "self-harming, which is strongly associated with future suicide, is relatively common among adolescents and teenagers, especially females." (pp. 34). Notwithstanding, currently only 5 per cent of the total 65 strategic actions refer to under 18's.

Statistics show that Northern Ireland has the highest suicide rate across the UK for 10 to 14 year olds and as rightly noted there has been a threefold increase amongst under 15's over the past two decades. (pp. 34). In addition, since 1984, the five-year average suicide rate among 15 to 19 year olds has increased by some 257 per cent in Northern Ireland. By way of comparison, in England the same rate has decreased by 24 per cent since 1985.[2] We recognise that an inconsistency in coronial reporting impacts on neighbouring jurisdictional comparisons – but nevertheless, the disparity is alarming and reduction of this rate must be a central tenet of Protect Life 2. **The NSPCC ask the Department to revise the strategy to ensure a much greater focus on children and young people. In light of the trends identified we would also encourage the development of a young person's version of the strategy.**

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[1] NSPCC (2014) On The Edge - Childline Spotlight: Suicide. London: NSPCC. Available at https://www.nspcc.org.uk/globalassets/documents/research-reports/on-the-edge-childline-suicide-report.

[2] Bentley, H., O'Hagan, O, Raff, A. and Bhatti, I. (2016) How safe are our children? The most comprehensive overview of child protection in the UK 2016. London: NSPCC. (pp.22).



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**Crisis prevention and early intervention**
Throughout the development of Protect Life 2 it was recognised that the strategy would encompass (i) crisis intervention/postvention; and (ii) early intervention. Indeed, in the pre-consultation draft strategy it was noted that "*there is general consensus that action to address suicide and self-harm, in addition to identifying and supporting those who are suicidal, must be wide ranging and address the social determinants that adversely affect our mental health and wellbeing. In light of this, the overall strategy is in two parts.*" The NSPCC are therefore deeply disappointed that the scope of the strategy has now been revised because we believe that upstream preventative measures and early intervention should be linked under a single strategy, albeit it with separate work streams.

It is noted within the consultation document that the Department "intends to develop a specific action plan for the promotion of positive mental health under the Public Health Strategic Framework Making Life Better….complementary to the Protect Life 2 Action Plan and to the Service Framework for Mental Health" (pp. 13-14). Through our membership of the Public Health Agency Infant Mental Health Reference Group, the NSPCC contributed some time ago to comments to the Department, on a draft section of a then anticipated mental health action plan. It is essential that the existing work is taken forward, and that actions are particularly prioritised to promote the importance of infant mental health within this agenda**.**

**It is critical that all of these disaggregated action plans under separate strategies are taken forward in a cohesive and effective way to avoid duplication**.

**Increased and ring-fenced investment**
Protect Life 2 recognises the clear link between deprivation and suicides with suicide rates in the most deprived communities being three times more prevalent than the least deprived communities. Our concern is that the draft document fails to identify how, in the midst of stringent financial constraints, the strategic actions can be realised. More so, despite the fact that mental health accounts for approximately 25 per cent of all health cases, we understand that it only receives 8.5 per cent of the overall health budget in Northern Ireland. **Moving forward we strongly believe that increased and ring-fenced investment is required to address the lack of services and support for children and young people with mental ill health, to stem the increase of suicides and self-harm.**



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## Specific comments

**Core Principles**

We welcome the core principle at pp. 14. which notes that the strategy should 'be *coordinated across government. Improve cross-sectoral, cross-departmental and cross-jurisdictional collaboration in the development and delivery of policy and services which contribute to suicide prevention.'* Key to the strategy's success will be its ability to align with other departmental priorities across government, however we note that there is no clear direction on how this integration will be achieved.

**Objectives**

While we agree with the 10 strategic objectives, they are too general and lack sufficient detail. We would ask that the strategy be more specific on how achievements of the strategic objectives are to be measured, taking into consideration the specific needs for children and young people with regards to self-harm and suicide prevention. **It is our view that the objectives would benefit from redrafting to articulate the ambitions of the strategy and should be revised into smart and comprehensive objectives with dedicated timescales and achievable priority outcomes.**

Specific comments to a number of the objectives are included below.

- **Objective 2:** The draft strategy's commitment to reducing the incidence of repeat self-harm presentation to hospital emergency departments is an important objective. However it limits the potential for roll out to primary care and voluntary and community groups. We therefore suggest that objective 3 is redrafted to include **"Reduce the incidence of repeat self-harm presentation to hospital emergency departments, primary care and voluntary and community groups."**
- **Objective 3:** We broadly agree with the actions within objective 3 that relate to children and young people. In particular, the stated actions for the Department of Economy; and the Department of Education's to "Develop and implement policies, guidance and resources for schools to include positive mental health; protecting life and the management of critical incidents." (pp.71). The NSPCC understands that the Protect Life document for schools that has recently been published under the "iMatter" programme. It is also important to widen the pool of training/awareness-raising to include sports club personnel and local community groups. There is a clear need for targeted staff training in respect of self-harm and suicide prevention to support staff in their role to equip young people with effective problem-solving skills.



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- **Objective 4:** Crucial to the effectiveness of this objective is the training of frontline staff to deal with children and young people presenting in a crisis. We support the objective action to "Develop, deliver & evaluate training in suicide awareness and suicide prevention targeted at "first responders" and community "gatekeepers". (pp. 70). In particular, our staff group suggest that the Applied Suicide Intervention Skills Training (ASIST) and SafeTALK programmes are a necessity for personnel to ensure that skills and confidence to provide mental health first aid for a person with suicidal thoughts or behaviours. The challenge is ensuring that training is undertaken. There needs to be a clear line of accountability, and fundamentally this training needs to be embedded in training programmes for all staff across all sectors i.e. community and voluntary as well as statutory (including health, justice, education etc.).

  It is important to note that through Childline our counsellors encourage young people to get support earlier, we work to break the silence and stigma that surrounds self-harm and suicide. We ask that Childline's role is strengthened within the priority actions and we would encourage other agencies to signpost children and young people to Childline and to our website childline.org.uk which provides advice and support and a space for peer support in respect of self-harm and suicidal thoughts.

- **Objective 6:** The provision of effective and timely information and support for individuals and families bereaved by suicide is critical. We are therefore concerned that this priority fails to reflect the needs of children and young people bereaved by suicide. The actions within this objective must include suicide bereavement counselling for school personnel, to ensure that emotional support tailored to the age and needs of children and young people impacted by suicide, is available to build resilience and to help support a healthy grieving process.

- **Objective 8 and 9:** The inclusion of objectives that relate to the increased risk of 'copycat' suicides, particularly among young people is welcomed. It is vital that effective measures to reduce the incidences of 'copycat' or 'social contagion' behaviour be implemented. We ask that Childline's postvention service for young people is referenced in the developing strategy. Childline provides round the clock emotional support for those who are experiencing suicidal thoughts, but also for young people who are affected by the loss through suicide.



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**Policy Context – the Internet**

We agree that "the *Internet* can be a powerful tool for suicide prevention, for example, in promoting awareness-raising and sign posting to sources of help." (pp.24). In particular, we have found that the online element of the Childline service offers a safe, trusted and anonymous space for young people to explore their feelings. During the period of 2015/16, 71 per cent of all counselling sessions took place online. More so, four out of five mental health and wellbeing counselling sessions, including those about self-harm and suicide took place online. With increased access to computers, tablets and mobile phones, Childline have seen an increase in counselling sessions late at night with more than a quarter of self-harm and suicidal counselling sessions taking place between 9pm and midnight. Young people tell Childline that they find it easier to talk to someone about these issues in the online environment rather than talking about them over the phone.[3]

In response to the increasing demand online Childline has recruited and trained more volunteers to respond exclusively to online contacts to ensure that every young person's support needs are met. **We feel strongly that greater recognition for service provision via online and digital mediums should feature in the Protect Life 2 strategic action plan.**

While acknowledging the positive role that the internet and social media has in respect of suicide prevention and self-harm, Childline also offers a unique insight into the downside of the online world and the harmful role that social media can have on self-harm and suicide. (pp.36). Young people have told our counsellors that they use the internet to research painless ways to end their life and that some websites provide instruction on where to buy products to overdose / self-poison. Other young people told Childline that their suicidal feelings had been triggered by harmful content they had seen on websites, including blogs and videos relating to suicide and self-harm which normalise suicidal behaviour, making young people believe it was a viable way out of their desperate situation. **Going forward greater regulation of social media and suicide / self-harm promoting sites is needed to negate harm online. It is paramount that the actions relating to the internet dovetail with measures contained in the anticipated SBNI E-Safety.**

[3] NSPCC (2016) Childline annual review 2015/16: It turned out someone did care. London: NSPCC. Available at https://www.nspcc.org.uk/globalassets/documents/annual-reports/childline-annual-review-2015-16.pdf



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**Action plan**

In its current format the action plan is less than satisfactory and focuses more on operational detail rather than overarching strategic planning. The actions presented are too vague and lack sufficient detail on how they will be implemented; the resources required; and potential timeframes. It focuses primarily on service delivery by Health and Social Care and overlooks the key role of third sector organisations including Childline, whose role and accountability are not evident in the document. This is a grave oversight that should be revised to enable integrated service delivery.

We acknowledge that a more detailed implementation plan will be developed by the Public Health Agency post the consultation period. We suggest that the plan considers the development and inclusion of specific performance measurement indicators that could monitor the progress of actions in delivering on quantifiable targets. More so and as previously noted, there are limited actions that refer to children and young people. **We would ask that a dedicated action plan for under 18's is developed, or at the very revised actions should be subdivided into specific performance measured indicators directed specifically to support, wellbeing and protection to ensure the provision of high quality suicide and self-harm prevention services are made available.**

**Priority population groups**

The NSPCC generally agree with the groups that have been identified in the Strategy as high risk, however, we would like to highlight two additional high risk groups.

- We agree that young people who self-harm or who are at risk of suicide require *"different needs in terms of support and care"* (pp.13). In light of this agreed approach and due to the upward trajectory of suicides of under 18's, we strongly believe that children and young people feature as a high risk group in Protect Life 2.
- Secondly, those who self-harm, particularly those presenting to A&E should be considered as a priority group because as noted *"The risk of suicide in the first year after self-harm is between 60 to 100 times the risk of suicide in the general population*" (pp. 15).

It is unclear whether young people under 18 are included in some of the high risk groups. It is important to specify whether groups such as LGBT people; those in contact with the justice system; people with mental illness; and those who have experienced abuse/conflict, include young people. This is because there is a very



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real risk of under 18's being overlooked and local areas just focusing on adults. We also believe that the population approach should be across the lifespan and targeted and also be responsive to new at risk groups as they emerge.

We particularly welcome the focus on looked after children and care experienced children and ask that measures relating to this group be strengthened in the developing action plan.

It is positive that featured within the high risk group are "Those who have experienced abuse/conflict, including sexual abuse and domestic violence." (pp.33). Presumably this is inclusive of children and young people? Accordingly, it is well documented that childhood abuse is a major indicator for mental ill health.[4] Childline data from 2015/16 indicated that in one third of counselling sessions about abuse and neglect, the child also talked about issues with their mental health, including self-harm and suicidal feelings. Notwithstanding, there is no automatic entitlement to an assessment or ongoing support for survivors of abuse to help prevent psychological distress from escalating into severe mental health issues. The NSPCC is particularly concerned about both the impact of abuse on mental health of children in respect of self-harm and suicidal ideology and conversely the fragmented approach to therapeutic interventions. While we understand that these issues largely fall outside of this Strategy's scope, we ask that these issues are prioritised within the developing mental health promotion action plan.

NSPCC also agrees that the LGBT+ population group is disproportionately affected by suicide, self-harm and poorer mental health. Childline data from 2015/16 indicates that in nearly a quarter (24 per cent) of counselling sessions about sexuality or gender identity, young people mentioned that they suffered from a mental health issue, including depression, low self-esteem, self-harm, suicidal thoughts or an eating disorder. Many young people told us about previous self-harm or suicide attempts as a way of coping with their identity issues. Furthermore, the RaRE research report (2015) suggests that 48 per cent of transgender young people had made at least one suicide attempt in their lives. One of the large contributing factors to low self-esteem and mental health disorders seems to be society's negative perceptions of being LGBT. **Going forward we would ask that LGBT population groups are prioritised within the mental health promotion action plan including actions to address individual and institutional prejudice.**

[4] NSPCC (2016) It's time: campaign report. London: NSPCC.





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**Suicide Prevention Services**
The NSPCC warmly welcome the inclusion of Childline as a suicide prevention service, (pp.42) and kindly ask that the suggested text included below is used in the developed Strategy.

*"Childline provides support to thousands of children and young people under 18 across the UK who are at points of crises in their lives. Supervisors and trained counsellors are available around the clock, 365 days a year, on the phone and online via email and instant messaging, who are experienced in engaging with suicidal young people and in reducing and managing the risk of self-harm. Advice and peer support in respect of self-harm and suicidal feelings is also available on the Childline website. Through Childline we work to focus on supporting the young person to take action, to devise coping strategies through suicide and self-harm thoughts and feelings and to provide help for young people who have planned or attempted suicide.* If young people are thought to be in immediate danger, or when they ask to be referred, we make a referral to an external agency."

**Data Collection**
The accuracy of suicide reporting is an ongoing concern for the NSPCC and we feel there is a need for more comprehensive data on those who die by suicide. We are aware that Public Health Agency funded research based on the Northern Ireland Coroner's database made a number of recommendations in relation to suicide data. In particular it was noted that there is a need *"for revised data collection procedures to ensure that the circumstances surrounding each death are recorded appropriately……that existing data, such as that contained within health and social care databases and the self-harm registry, is linked with the data on deaths by suicide."*[5] We would encourage the Department to action these recommendations. Further exploration of advanced reporting in other countries should also be undertaken and lessons learnt. More so, we would encourage that recording takes into account the feelings of families of the bereaved to ensure a more accurate reporting.

**We trust you will find our comments helpful. If there is any further way in which we could contribute to this process we would welcome the opportunity to do so.**

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[5] Bunting, B. et al. (2014) *Death by Suicide: A Report Based on the Northern Ireland Coroner's Database.* University of Ulster. (pp.17).



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