Department of
Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Equality Screening, Disability Duties and Human Rights Assessment Template

Part 1 – Policy scoping

Part 2 – Screening questions

Part 3 – Screening decision

Part 4 – Monitoring

Part 5 – Disability Duties

Part 6 – Human Rights

Part 7 – Approval and Authorisation

Part 1. Policy scoping

1.1 Information about the policy / decision

1.1.1 What is the name of the policy / decision?

Protect Life 2 - A Strategy for Preventing Suicide and Self Harm in Northern Ireland 2019-2024

1.1.2 Is this an existing, revised or a new policy / decision?

Revised

1.1.3 What is it trying to achieve? (intended aims/outcomes)

Purpose
The purpose of this strategy is to set the priorities and define the key actions for reducing the prevalence of suicide and self-harm over the period 2019 – 2024.

AIMS

- Reduce the suicide rate in Northern Ireland by 10% by 2024.
- Ensure suicide prevention services and support are delivered appropriately in deprived areas where suicide and self-harm rates are highest.

OBJECTIVES

- Ensure a collaborative, co-ordinated cross departmental approach to suicide prevention.
- Improve awareness of suicide prevention and associated services.
- Enhance responsible media reporting on suicide.
- Enhance community capacity to prevent and respond to suicidal behaviour within local communities.
- Reduce incidence of suicide amongst people under the care of mental health services.
- Restrict access to the means of suicide.
- Enhance the initial response to, and care and recovery of, people who are suicidal.
- Enhance services for people who self-harm, particularly for those who do so repeatedly.
- Ensure the provision of effective support for those who are exposed to

suicide or suicidal behaviour.

- Strengthen the local evidence on suicide patterns, trends and risk, and on effective interventions to prevent suicide and self-harm

1.1.4 If there are any Section 75 categories which might be expected to benefit from the intended policy, please explain how.

Following consultation, the Strategy has moved away from priority groups to highlight that everyone can be at risk of suicide. The whole population of Northern Ireland, including people in the Section 75 categories, might be expected to benefit from the Strategy due to the significant improvement in outcomes envisaged for those with suicidal ideation, those who self-harm, bereaved families, professionals caring for others, and those with poor mental health.

1.1.5 Who initiated or wrote the policy?

Department of Health

1.1.6 Who owns and who implements the policy?

Department of Health owns the Protect Life 2 Strategy. The PHA leads on implementation.

1.2 Implementation factors

Are there any factors which could contribute to/detract from the intended aim/outcome of the policy/decision? If yes, are they

Financial	✓	Please explain: A costed implementation plan has been developed to support the Strategy. The existing £8.7m budget is retained for the implementation of the health actions. An additional £1.35m has been provided in 19/20 through the transformation programme. Further funding is provided by other Departments for their actions. However, there are a number of actions in the Strategy which are dependent upon additional funding being allocated.
Legislative		
Other		

1.3 Main stakeholders affected

Who are the internal and external stakeholders (actual or potential) that the policy will impact upon?

Staff	✓
Service users	✓
Other public sector organisations	✓
Voluntary/community/trade unions	✓
Other, please specify	Carers, family members, social acquaintances, schools, and workplaces.

1.4 Other policies with a bearing on this policy / decision. If any:

Policy	Owner(s) of the policy
Preventing Suicide: a global imperative	WHO
Budget Allocations	DoF
HSC Transformation agenda	DoH
Draft Mental Health Services 5 year plan	DoH
Improving Health within Criminal Justice Strategy	DoH and DoJ
Improving Children's Life Chances: the Child Poverty Strategy	TEO
The New Strategic Direction for Alcohol and Drugs Phase 2	DoH
Making Life Better – Strategic framework for Public Health	DoH
Infant Mental Health Framework for Northern Ireland	PHA
Stopping Domestic and Sexual Violence and Abuse Strategy in Northern Ireland	DoH
Service Framework for mental Health and Wellbeing	DoH

1.5 Available evidence

What evidence/information (both qualitative and quantitative*) have you gathered to inform this policy? Specify details for each of the Section 75 categories.

<table>
<tr><th>Section 75 category</th><th>Details of evidence/information</th></tr>
<tr><td>Religious belief</td><td>

There is a health inequality aspect to the burden of suicide with the suicide rate in the 20% most deprived areas almost twice the average in Northern Ireland and three times the rate experienced in the 20% least deprived areas. Research by The Detail[i] has shown that 80% of the most deprived wards in Northern Ireland are predominantly Catholic.

Population Data

On Census Day 2011, the population of Northern Ireland was 1,810,863. The table below shows the change in the religious make-up of Northern Ireland between the 2001 and the 2011 Census.

Changes in religious make up of Northern Ireland between 2001 and 2011 censuses.

(Source: NISRA, Table KS07b (2003); KS212 (2012))

<table>
<tr><th></th><th colspan="2">Census 2001</th><th colspan="2">Census 2011</th><th></th></tr>
<tr><th>Religion/ religion brought up in</th><th>Count</th><th>Percentage (%)</th><th>Count</th><th>Percentage (%)</th><th>Percentage change (%)</th></tr>
<tr><td>Protestant/other Christian</td><td>895,377</td><td>53.1</td><td>875,717</td><td>48.4</td><td>-2.2</td></tr>
<tr><td>Roman Catholic</td><td>737,412</td><td>43.8</td><td>817,385</td><td>45.1</td><td>10.8</td></tr>
<tr><td>Other religions</td><td>6,569</td><td>0.4</td><td>16,592</td><td>0.9</td><td>152.6</td></tr>
<tr><td>None</td><td>45,909</td><td>2.7</td><td>101,169</td><td>5.6</td><td>120.4</td></tr>
</table>

Other

A personal belief system allied with strong personal relationships and positive coping strategies have been identified by the World

</td></tr>
</table>

	Health Organisation[ii] as protective factors against suicide. The World Health Organisation also recognises that there can be a risk factor in “Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma)”.[iii] Protect Life 2 will apply equally to all irrespective of religious belief.
Political opinion	Suicide and self-harm rates in Northern Ireland by political opinion are not collected. Evidence indicates that Northern Ireland has high levels of, often untreated, post traumatic stress disorder (PTSD) and other mental health disorders as a result of almost 40 years of conflict.[iv] Research[v] [vi] into the effects of decades of violence has indicated strong evidence that experience of the conflict is associated with poorer mental health, particularly depression and alcohol misuse. Some researchers have suggested a possible link between the conflict in Northern Ireland and the relatively high suicide rates experienced here. The contention is that the increased rates of suicide since the peace agreements in 1998 are the result of a decline in social cohesion and social connectedness (which was characteristic of the conflict period), coupled with high levels of mental disorders (which are partly the result of previous exposure to violence). Further local research[vii] found that children who grew up in the worst years of the violence in the 1970s are experiencing the highest suicide rates, indicating that they remain at risk as they grow older. Protect Life 2 will apply equally to all irrespective of political opinion.
Racial group	Since the 2001 Census, there has been a marked change in Northern Ireland’s ethnic diversity. On Census Day 2011, 1.8% (32,400) of the resident population belonged to minority ethnic groups, more than double the proportion in 2001 (0.8%). The main minority ethnic groups were Chinese (6,300 people), Indian (6,200), Mixed (6,000) and Other Asian (5,000), each accounting

	for around 0.3% of the population. It is acknowledged that these figures are likely to have increased since 2011. It is recognised that some Black and Minority Ethnic persons can face barriers e.g. language in relation to accessing services and that at times additional support is needed. The number of requests received by the NI HSC Interpreting Service increases annually and has risen from 10,257 in 2005/6 to 130,025 in 2018/19. The most recent top twelve language requests were for: Polish, Arabic, Lithuanian, Romanian, Portuguese, Bulgarian, Tetum, Slovak, Chinese (mandarin), Chinese (Cantonese), Hungarian and Russian. *Source: NIHSCIS* The All Ireland Traveller Survey 2010[viii] estimates there were 3905 Irish Travellers in Northern Ireland. The main areas of traveller population are Belfast, Newry and Armagh, Foyle, Mid Ulster and West Tyrone. The All Ireland Traveller survey highlights external causes of deaths being particularly prevalent among men which includes alcohol and drug overdose and suicide. The survey stated that male travellers have a suicide rate which is 6.6 times that of men in the general population, however it should be noted that this is a small sample size. Barriers to Accessing Mental Health Services – Views of Black and Minority Ethnic People in Ballymena 2013 highlighted that 53% of respondents believed there is a lot of stigma towards mental health issues within their community; and that 34% agreed that if they had a mental health problem, language difficulties would prevent them from obtaining help. The National Confidential Inquiry into Suicide and Homicide by people with mental illness has highlighted that ethnic minority people with mental illness have particular needs which need to be addressed for them to access services. The Inquiry's 2018 report[ix] notes that 1% of patients who died by suicide between 2006 and 2016 were from a Black and Ethnic Minority Group. The DH assessment of impacts on equalities for the "Preventing suicide in England"[x] observed:

	"*The evidence on the incidence of mental health problems in Black, Asian and ethnic minority groups is complex. This covers many different groups with very different cultural backgrounds, socioeconomic status and experiences in wider society.* *Research shows that some Black and minority ethnic groups have high rates of severe mental illness, which may put them at high risk of suicide. The rates of mental health problems in particular migrant groups, and subsequent generations, are also sometimes higher. More recent arrivals, such as some asylum seekers and refugees, may also require mental health support following their experiences in their home countries*."
Age	**Population** The latest NISRA mid-year population estimates[xi] reported:- • The population continues to age with the number of those aged 65 and over increasing by 1.8% in the year ending mid-2017 to reach 303,000 people (16.2% of the population). Within this group, the population aged 85 and over increased by 1.9% to reach 37,200 people (1.9% of the population). • In the year ending mid-2017 the working age population (people aged 16 to 64 years) increased by 0.1% (from 1,174,600 to 1,177,200). The main reason for this growth is more people 'ageing into' this age group (24,200) than those 'ageing out' (18,200). • The older working age population (people aged 40 to 64 years) also grew in the year ending mid-2017 to 597,400 people (a 0.5% increase). For the past five consecutive years, the older working age population has been larger than the younger working age population. • In the year mid-2016 to mid-2017, the older population (people aged 65 and over) increased by 1.8%% to 303,000.At these ages, there is minimal migration; the increase is the result of more people 'ageing into' this population than those 'leaving' through mortality. The population aged 85 and over increased by 1.9% to 37,200 between mid-2016 and mid-2017.

- Number of children aged under 16 was 390,700
- Number of people aged 16 and over was 1,480,200

Suicide

In the period from 2004 to 2017, suicide accounted for 1.8% of all deaths in Northern Ireland. Men in their late teens to mid-50s have the highest rates of suicide.

The rate of suicides in those aged under 18 is low compared to other age groups and suicide remains rare amongst the under 15s. However, suicide is one of the main causes of mortality in young people. Local surveys indicate that a quarter of 16 year olds have experienced serious personal, emotional, behavioural or mental health problems.

Increasing numbers of children and young people who contact ChildLine and growing numbers of younger children are feeling suicidal. In 2018/18 Childline delivered 461 counselling sessions to children from Northern Ireland who had suicidal thoughts or feelings. This represents 1 in 10 of all contacts to Childline from Northern Ireland.

Consultation response from NICCY indicated that amongst youth referrals to Cruse NI, suicide accounts for 17% of bereavements (compared to 7.5% in UK).

Self-harm

The Northern Ireland Registry for Self-Harm shows that self-harm rates are highest among young people in the 15-24 age range. 70% of under 18 year olds presenting to Emergency Departments are female.

The highest rates for females are in those aged 15-19 at 1184 per 100,000 people. In males the highest rates are in those aged 20-24 at 909 per 100,000 people. Self-harm presentations by those under 18 years of age accounted for 12% of all self-harm presentations during 2017/18.

The Lifestyle and Coping Survey has shown that 10% of 15/16

year olds in Northern Ireland self-harm.

Lifeline

The age distribution of Lifeline callers shows the highest numbers of callers are for those aged between 20-34. 0.6% of calls were made by those under 14 and 6.6% of calls were made by those aged 15-19. The greatest numbers of those attending follow-up support sessions with Lifeline are in the 15-29 age range.

The National Investigation into Suicide in Children and Young People[xii] identified Ten common themes in suicide by children and young people:

- family factors such as mental illness;
- abuse and neglect;
- bereavement and experience of suicide;
- bullying;
- suicide-related internet use;
- academic pressures, especially related to exams;
- social isolation or withdrawal;
- physical health conditions that may have social impact;
- alcohol and illicit drugs; and
- mental ill health, self-harm and suicidal ideas.

People over 65 are more likely to have physical health conditions that can lead to social isolation and depression. Research by the Institute of Public Health in Ireland[xiii] found that loneliness can have a significant impact on the physical and mental health of older people and is of increasing concern for public health. The research suggests that approximately 10% of older people are affected by chronic or persistent loneliness.

	A more detailed breakdown of suicide in Northern Ireland by age and gender is available[xiv]. Towards a Better Future[xv] report highlights that traumatic experiences and exposure to violence can lead to adverse mental health and other consequences not only for the person themselves, but also for their children and potentially, their grandchildren, resulting in a trans-generational cycle which impacts upon the well-being of subsequent generations.
Marital status	The 2011 Census shows that almost half (48%) of people aged 16 years and over on Census Day were married, and over a third (36%) were single. Just over 1,200 people (0.1%) were in registered same-sex civil partnerships. A further 9.4% of residents were separated, divorced or formerly in a same-sex civil partnership, while the remaining 6.8% were either widowed or a surviving partner (Source: NISRA (2012) Table KS103). There is no self-harm or Lifeline data available in relation to marital status. The University of Ulster Research *Death by Suicide: A Report based on the Northern Ireland Coroner's Suicide Database* shows that between 2005-2011 47% of those who died by suicide were single at the time of death and 22.9% were married.17.5% had experienced a marriage breakdown. Research indicates that people who are married have a lower risk of suicide.[xvi] A Danish study[xvii] found the suicide rate among gay men in civil partnerships is eight times higher than in heterosexual couples and twice as high as the rate in men who have never married. However, the same study showed no statistically significant increase in suicide rate among women in civil partnerships.
Sexual orientation	**Population** Accurate figures are not available on the sexual orientation of the general population, and estimates vary considerably. The Northern Ireland Statistics and Research Agency (NISRA), along

with other UK census offices, concluded that the census was not suitable for obtaining such information, however, there are proposals to address this in the 2021 census in NI. It is estimated that between 5% and 10% of the population would identify as lesbian, gay or bisexual.

Research by HM Treasury shows that between 5%–7% of the UK population say they are gay, lesbian, bisexual or ´trans´ (transsexual, transgendered and transvestites).

Current Lifeline statistics show that 4.8% of callers to the service identify as lesbian, gay or bisexual. 4% of those attending follow-on Lifeline support sessions identify as lesbian, gay or bisexual.

The 2010 Northern Ireland Life and Times survey (1,205 adults) reported the figure as 1%. The Office for National Statistics 2010 report (450,000 respondents) found that in Northern Ireland 92.5% said they were heterosexual and 0.9% of respondents said they were LGB, although 0.4% reported as ‘other’ and 6.2% said they didn’t know or refused to respond.

The Rainbow Project’s Through Our Minds Report[xviii] highlighted that 35.3% of respondents in the north of Ireland had experienced self-harm; 25.7% had experienced a suicide attempt; 46.9% had experienced suicidal ideation and 70.9% had experienced depression.

The Lifestyle and Coping Survey[xix] highlighted that 10% of 15/16 year olds self-harm and that sexual orientation was a significant risk factor.

Research by NICCY quotes previous research: “McNamee’s (2006) research into the mental health needs of young same-sex attracted men in NI highlights the extent and severity of mental ill health amongst this group. Her 2006 study with 190 same-sex attracted young men revealed that:

- 32.4% of respondents had a potential psychiatric

disorder;

- 34.4% had been diagnosed with a mental illness at some time

	of their lives; • 37.9% had received professional help – this was in relation to their same-sex attraction in almost two thirds of cases; • 27.1% had attempted suicide; • 71.3% had thought about taking their own life – four fifths attributed this to their same-sex attraction; • 30.7% had self-harmed – two thirds attributed this to their same-sex attraction.” Source: NICCY's Children's Rights Review.[xx] Stonewall’s Gay and Bisexual Men’s Health Survey 2013[xxi] (with 6861 respondents across Britain) reported that, in regard to suicide: “This increases to five per cent for bisexual men and to five per cent for black and minority ethnic gay and bisexual men. In the same period, 0.4 per cent of all men attempted to take their own life. One in ten (ten per cent) gay and bisexual men aged 16 to 19 have attempted to take their own life in the last year. One in sixteen (six per cent) gay and bisexual men aged 16 to 24 have attempted to take their own life in the last year. In the same period, 0.7 per cent of all men aged 16 to 24 have attempted to take their own life. In the last year, 27 per cent of gay men thought about taking their own life even if they would not do it. This increases to 38 per cent for bisexual men and 35 per cent for black and minority ethnic gay and bisexual men. Just four per cent of men in general thought about taking their own life in the last year. Half (50 per cent) of gay and bisexual men said they have felt life was not worth living compared to 17 per cent of men in general. Almost half (46 per cent) of gay and bisexual men who have felt this way did so in the last year.”
Gender (Men and women	In the Northern Ireland population 49% are male and 51% are

generally)	female. Men are three times more likely to die by suicide than women. This is partly the result of differences in the lethality of methods used. There is also evidence that cultural perceptions of masculinity impact negatively upon men's help-seeking behaviour. Males can be reluctant to disclose mental health concerns to their GP and often present with physical symptoms even when there are underlying mental health issues. Some men turn to problematic "coping strategies" such as alcohol use, repression of feelings, and social withdrawal as a means of responding to psychological distress. The 2012-15 Self Harm Registry 3 year report showed an even balance of men and women reporting self-harm at Emergency Departments. The highest rate of male self-harm is in 20-24 year olds. The highest female rate is in 15-19 year olds. The 3 year Self Harm Registry Report shows that the female rate of self-harm among 10-19 year-olds was 75% higher than the male rate. The female rate was also higher among 45-49 year-olds (+28%). However the male rate of self-harm was 39% higher across 20-39 year-olds (603 vs. 434 per 100,000). Between 2012 and 2018, 77% of self-harm presentations in under 18s were female. Current Lifeline data on gender shows that females made 53% of helpline interactive calls; males made 46%; transgender people made 0.2%; Lifeline data on clients who received follow-on Lifeline counselling show that 57% were female; and that 38% were male; 0.1% were transgender and 4.6% classified as other. A detailed breakdown of suicide in Northern Ireland by age and gender is available[xxii]. Transgender research[xxiii] funded by the Scottish Government via the Scottish Transgender Alliance in 2012 suggested that, from a dataset of 889 people, 53% of transgender people had self-harmed at some point; 84% had thought about ending their lives; 35% had attempted to take their lives at least once; and 25% had attempted to do so on more than one occasion. Transgender people who are rejected by their families or lack social support are much more likely to both consider suicide, and

to attempt it. Conversely, those with strong support were 82% less likely to attempt suicide than those without support, according to one recent study. Another study[xxiv] showed that transgender youth whose parents reject their gender identity are 13 times more likely to attempt suicide than transgender youth who are supported by their parents.

Other factors included: discrimination, physical abuse, and, being seen as transgender or gender non-conforming.

Research from The Royal College of Midwives and Netmums has shown that women who experience depression during pregnancy could be at increased risk of suicide in later life. The research found that around one third of females who suffer from depression when with-child subsequently have thoughts about taking their own life.

2017 research by the Royal College of General Practitioners[xxv] highlights that perinatal psychiatric disorder has been a leading cause of maternal mortality for the last two decades contributing to 15% of all maternal deaths in pregnancy and the first six months postpartum. Over half of women who tragically die during this time have a history of severe mental illness and over half of the deaths are caused by suicide.

ChildLine also reports that, like adult counterparts, boys are less likely than girls to seek help if they are feeling suicidal. Childline advise suicide is the 3rd most common reason for girls to contact the organisation and 5th most common for boys. Girls are five times more likely than boys to contact Childline about suicide in Northern Ireland.

Disability (with or without)	

Northern Ireland

In November 2018, the number of people in Northern Ireland in receipt of Disability Living Allowance was 114,300.[1] A further 99,710 Personal Independence Payments were made during the same month.[2] The number of people with a limiting long standing illness or disability in 2017 is noted below for all of Northern Ireland and by Health and Social Care Trust (HSCT):

	2017
	Limiting longstanding illness (%)
Location	All
Northern Ireland	31.9
Belfast HSCT	35.7
Northern HSCT	30.3
South Eastern HSCT	35
Southern HSCT	26.6
Western HSCT	33.4

Census figures show that in 2011 just over one in five of the resident population (21%) had a long-term health problem or disability that limited their day-to-day activities. Strabane and Belfast (both 24%) had the highest proportions of residents with a long-term health problem or disability.

Disability	Count	Percent %
Long-term health problem or disability: day-to-day activities limited a lot	215,232	11.9
Long-term health problem or disability: day-to-day activities limited a little	159,414	8.8
Long-term health problem or disability: day-to-day activities not limited	1,436,217	79.3

Source: NISRA (2012) Table KS301 – Health and unpaid care

[1] https://www.communities-ni.gov.uk/publications/benefits-statistics-summary-publication-national-statistics-november-2018
[2] https://www.communities-ni.gov.uk/system/files/publications/communities/personal-independence-payment-statistical-bulletin-nov-2018.pdf

According to a NISRA survey carried out in 2006; some 37% of households include at least one person with a disability and 20% of these include more than one disabled person.

For both men and women, the rate of disability increases with age. Women on average live longer than men therefore disability tends to be more common among women. The rate is particularly high for women aged 75 and above (at 62%). It is only among the youngest adults aged 16 to 25 that the rate for men (at 6%) is higher than for women (4%) (Northern Ireland Survey of Activity Limitation and Disability (2006/07).

Some 25% of the 3,780 adults receiving direct payments from their local Health and Social Care Trust have a physical or sensory disability (October – December 2018)[3].

In Northern Ireland there are about 16,500 people with a learning disability; this is predicted to increase by 20.5% by 2021[4].

Type of long – term condition	**Percentage of population with condition %**
Deafness or partial hearing loss	5.14
Blindness or partial sight loss	1.7
Communication Difficulty	1.65
Mobility of Dexterity Difficulty	11.44
Learning, intellectual, social or behavioural difficulty.	2.22
Emotional, psychological or mental health condition	5.83
Long – term pain or discomfort	10.10
Shortness of breath or difficulty breathing	8.72
Frequent confusion or memory loss	1.97
A chronic illness (such as cancer, HIV, diabetes, heart disease or epilepsy.	6.55
Other condition	5.22
No Condition	68.57

Source: Census 2011

The National Confidential Inquiry[xxvi] reported in 2015 that physical illness is known to be a risk factor for suicide. The report found that around a quarter of patients who die by suicide have a major

[3] https://www.health-ni.gov.uk/publications/quarterly-direct-payments-statistics-december-2018
[4] McConkey et al, (2006) Accessibility of healthcare information for people with a learning disability. A Review and Discussion Paper

	physical illness and the figure rises to 44% in patients aged 65 and over. The Assessment of Impacts on Equalities in England[xxvii] made the following observations: People in the care of mental health services, including inpatients are a group at high risk of suicide, and account for around one quarter of deaths by suicide each year. They were included as a high risk group in the previous suicide prevention strategy published in 2002, and despite some reductions in suicide rates, they remain a group at high risk in the new suicide prevention strategy. Physical illness is associated with an increased suicide risk. Epilepsy, in particular, is associated with an increased suicide risk. There is also evidence that receiving a diagnosis of cancer, coronary heart disease and airways diseases is associated with a jump in suicide risk. For cancer, the risk of suicide increases by more than ten times in the week after diagnosis. Many people who live with long-term conditions – including physical illness, disability and chronic pain – will, at some time, experience periods of depression that may be undiagnosed and untreated. Depression is a risk factor for suicide. While depression explains some of the increased suicide risk in people with physical health conditions, it does not explain all of the increase. Evidence suggests that rates of suicide and attempted suicide among people with severe learning disabilities are lower than in the general population. There is evidence to suggest that suicide risk factors and rates are higher in people with limited intellectual functioning (including mild or borderline learning disabilities).
Dependants (with or without)	Data on the caring responsibilities of those affected by suicide and self-harm is not routinely collected. We are not aware of evidence of higher rates of suicide or attempted suicide among carers. However, it is recognised that support is required for families and carers caring for suicidal individuals and helping them manage suicidal behaviours and emotional distress. Census data is available in respect of caring responsibilities of

the NI population. In the 2011 Census respondents were asked whether they provided any unpaid help or support to family members, friends, neighbours or others because of long-term physical or mental ill-health/disabilities, or problems related to old age. Twelve per cent of the population (213,980) provided such unpaid care, around a quarter (26%) of whom did so for 50 or more hours a week, a total of 56,000 people. The table below shows the provision of unpaid care in Northern Ireland.

	2011 Census	
Care provided	**Count**	**Percentage %**
Provides no unpaid care	1,596,883	88.2
Provides 1-19 hours unpaid care per week	122,301	6.8
Provides 20-49 hours unpaid care per week	35,369	2.0
Provides 50+ hours unpaid care per week	56,310	3.1
Total	1,810,863	100

Sources: NISRA (2012) Table KS301 – Health and unpaid care (2011 numbers)

Based on information from Carers Northern Ireland (June 2011), the following facts relate to carers:

- 1 in every 8 adults is a carer;
- There are about 207,000 carers in Northern Ireland;
- One quarter of all carers provide over 50 hours of care per week;
- People providing high levels of care are twice as likely to be permanently sick or disabled as the average person;
- About 30,000 of people in Northern Ireland care for more than one person; and
- 64% of carers are women; 36% are men.

In 2012, the Carers Trust estimated that around 49,000 carers in

	Northern Ireland were over the age of 60. Between the 2001 and the 2011 Censuses there was an increase in the number of people providing unpaid care. In 2011, Carers NI estimated that by 2037 the number of carers could increase to 400,000. In November 2018, the Department published results from the Health Survey Northern Ireland First Results 2017/18 which revealed that of the 3,355 interviews undertaken, 13% of respondents across all age groups (16+) indicated that they had caring responsibilities.[xxviii] Around three-fifths of carers stated their own health had been affected by their caring role, with feelings of tiredness, stress and disturbed sleep the most commonly reported symptoms. Over half of the carers (55%) received help from family members, while almost a third (32%) stated that they didn't receive help from anyone else. Almost three-quarters of carers (73%) received no money for their help.

* Qualitative data – refers to the experiences of individuals related in their own terms, and based on their own experiences and attitudes. Qualitative data is often used to complement quantitative data to determine why policies are successful or unsuccessful and the reasons for this.

Quantitative data - refers to numbers (that is, quantities), typically derived from either a population in general or samples of that population. This information is often analysed either using descriptive statistics (which summarise patterns), or inferential statistics (which are used to infer from a sample about the wider population).

1.6 Needs, experiences and priorities

Taking into account the information recorded in 1.1 to 1.5, what are the different needs, experiences and priorities of each of the following categories, in relation to the particular policy/decision? Specify details for each of the Section 75 categories

Section 75 category	Details of needs/experiences/priorities
Religious belief	A personal belief system allied with strong personal relationships and positive coping strategies have been identified by the World Health Organisation as protective factors against suicide. It is also likely that church and faith leaders may be among the first to be told or recognise the symptoms of poor mental health. Training and promotion of suicide prevention initiatives in the faith setting will be promoted in Protect Life 2.
Political opinion	As researchers have suggested a possible link between the conflict in Northern Ireland and the relatively high suicide rates experienced here, there is a particular need to retain a focus on those affected by the conflict and on PTSD. Protect Life 2 includes measures to address this and will apply equally to all irrespective of political opinion.
Racial group	The National Confidential Inquiry into Suicide and Homicide by people with mental illness has highlighted that ethnic minority people with mental illness have particular needs which need to be addressed for them to access services. Research has indicated that Travellers experience poorer mental health and a higher rate of suicide than the settled community. Poor mental health can also be interrelated with substance misuse and other factors including domestic violence and social support. Low rates of help seeking and negative perceptions of mental

	health services are also noted for this group. Targeted emotional health and wellbeing programmes will continue to be a priority for travellers. Language issues can create considerable barriers for black and minority ethnic people accessing suicide prevention services. There may also be particular requirements for services offered by voluntary, community and statutory organisations that are appropriate to meet cultural needs. Black and minority ethnic people may respond less to mainstream communication methods and therefore have a requirement for targeted communication. Continued programmes targeted at outreach to black and minority ethnic groups will continue to be a priority. Asylum seekers who have experienced considerable trauma may also have particular needs.
Age	Suicide Research and statistical evidence have demonstrated that the highest suicide rates are in young and middle aged men. This is partly the result of differences in the methods used in terms of lethality. Cultural perceptions of masculinity also impact negatively upon men’s help seeking behaviour. The Engaging Young Men[xxix] project also found that young men’s inability to seek help for emotional and mental health problems is influenced by low educational attainment, low socio-economic background and by adopting the traditional masculine ideal. It also found that young males are more likely to turn to alcohol and drugs as coping strategies and less likely to report personal susceptibility to depression. This indicated a need for interventions that focus on the different means of suicide; recognising that young men use the internet and technology as a way to seek help for mental health issues; and that young men are known to benefit from broader measures to prevent suicide such as action on alcohol and drugs; economic inactivity and treatment of

	depression in primary care. It is important to retain a focus on children and young people in order to prevent future suicidality. The rate of suicides in those aged under 18 is low compared to other age groups and suicide remains rare amongst the under 15s. However, suicide is one of the main causes of mortality in young people. Local surveys indicate that a quarter of 16 year olds have experienced serious personal, emotional, behavioural or mental health problems, with this figure increasing to over 40% for those from a disadvantaged background. Self-harm Northern Ireland Registry of Self-Harm figures show the highest rates of self-harm in females are in those aged 15-19 years of age at 1184 per 100,000 people. For males the highest rates are in those aged 20-24 at 909 per 100,000 people. Self-harm Registry figures only cover those who present at Emergency Departments and do not cover GP presentations, C&V presentations or those who do not seek help. The true figure is therefore likely to be higher. It is recognised that the response to children who self-harm, who are in emotional crisis and at risk of suicide, or who have been bereaved by suicide, has to be tailored to their particular circumstances and may not be the same as the response for adults. Research has shown that around 10% of those aged 15/16 have self-harmed.
Marital status	Living alone and social isolation have been identified as a risk factor for adult men. It is reasonable to assume that individuals who are living alone and not living with their families are at a higher risk of suicide and self-harm. The recording of adverse events is a key factor in the

	decision for someone to take their own life. In a third of those who have died by suicide relationship breakdown has been noted. Supporting people with relationship difficulties and helping people manage conflict in relationships is important to prevent suicide.
Sexual orientation	Research has shown that Lesbian, Gay and Bisexual people are at significantly higher risk of mental disorder, suicidal ideation, substance misuse, and deliberate self-harm than heterosexual people. This population group has particular requirements regarding the services offered by voluntary, community and statutory organisations that are sensitive to their needs. Reasons behind increased risk of suicide and self-harm for this population group may include victimisation, bullying, isolation, trauma, exposure to violence, and hopelessness.
Gender (Men and women generally)	Higher male suicide rates are partly the result of differences in the methods used in terms of lethality. There is also evidence that long accepted cultural perceptions of masculinity – characterised by competitiveness, risk-taking and enduring hardship without displaying feelings – impact negatively upon men's help seeking behaviour. Males can be reluctant to disclose mental health concerns to their GP and often present with physical symptoms rather than mental health issues. Evidence has shown that young men use the internet and technology as a way to seek help for mental health issues in preference to more conventional health services. The Protect Life 2 Strategy will continue as a priority to recognise the need to engage men in light of disproportionate suicide rate. The perceived barrier for men in accessing health services will require careful communication and ongoing monitoring. 63% of presentations to Emergency Departments with suicidal ideation are male; 37% of suicidal ideation

	presentations are female. Presentations to Emergency Departments for self-harm are equally split between male and female.
Disability (with or without)	There is an increased risk of mental ill health for individuals with a physical disability and an association between unemployment, poverty and social exclusion. People with sensory impairment have particular needs in accessing a telephone based service such as Lifeline. Transport and access to buildings can pose key barriers for people with a physical, sensory or learning disability in accessing suicide prevention services. People with sensory and learning disabilities have a need for written information in accessible formats and appropriate communication methods and support.
Dependants (with or without)	Those with dependents can have particular needs with regard to accessing services and cost. Collaborative working between service providers, service users and carers may be required. It is recognised that caring for dependants with self-harm, or suicidal ideation can be demanding and there is a need for greater support for carers.

Part 2. Screening questions

2.1 What is the likely impact on equality of opportunity for those affected by this policy, for each of the Section 75 equality categories? (minor/major/none)			**Level of Impact**
Section 75 category	Positive/ Negative	Details of policy impact	minor/major/ none
Religious belief	Positive	Suicide prevention services will be provided which are based in localities to ensure fair distribution of finite resources across different communities. Flourish churches suicide prevention initiative aims to support churches to develop a focused and shared approach to addressing the needs of vulnerable people and people affected by suicide, Flourish also develops and provides appropriate training and good practice guidelines for clergy, church leaders and pastoral teams.	Minor
Political opinion	Positive	A range of suicide prevention services are provided for people affected by the legacy of the conflict. The development of the new Mental Trauma Network will support the recovery of those who are experiencing significant mental health issues as a result of trauma, including issues arising from the conflict in Northern Ireland such as untreated Post Traumatic Stress Disorder. Suicide prevention services are provided in neutral or a mix of venues to ensure accessibility for all.	Minor

Racial group	Positive	Communications strategies will be accessible and culturally sensitive to black and ethnic minority people. Specific programmes for black and ethnic minority people who require support to engage with suicide prevention services will be provided. Lifeline and the Self Harm Improvement Programme is free at point of delivery for everyone.	Minor
Age	Positive	A wide range of suicide prevention and emotional health and wellbeing programmes are targeted at particular ages, including children and young people, to promote equality of opportunity and where there is a particular issue to be addressed. Lifeline is available to all ages. The Self Harm Improvement Programme is available to everyone from the age of 11.	Minor
Marital status	Positive	Suicide prevention programmes are available to everyone irrespective of marital status. Programmes targeted at men have an opportunity to address increased risk in single or separated men. 24/7 access to Lifeline helpline reduces the barrier to engagement when in crisis. Recent research has highlighted a potential risk for people experiencing a relationship breakdown and this may offer an opportunity for early intervention.	Minor
Sexual orientation	Positive	A wide range of suicide prevention and emotional health and wellbeing programmes are targeted at lesbian, gay and bisexual people given the higher risk of mental disorder, suicidal ideation, substance misuse and self-harm in this population group.	Minor

Gender (Men and women generally)	Positive	The wide-ranging Protect Life communications strategy and awareness raising programmes have a particular focus on males given the increased risk previously outlined. A wide range of suicide prevention and emotional health and wellbeing programmes are also targeted specifically at males, often employing innovative methods to reach this population group. Regional services such as Lifeline, Self Harm Improvement Programme and counselling support are available to everyone.	Minor
Disability (with or without)	Positive	Protect Life 2 will ensure promotional materials are sensitive in particular to the needs of people who are sensory impaired or who have a disability. All suicide prevention services are freely available to those with or without a disability.	Minor
Dependants (with or without)	Positive	Protect Life 2 has a specific action to seek patient / client permission to engage trusted family or friends in safety planning for that person. There is also an objective with associated actions within the Strategy to ensure effective support for those who are exposed to suicide or suicidal behaviour. Suicide prevention services are freely available for everyone irrespective of having dependants. The continued focus on ensuring locality based suicide prevention services ensures accessibility for those with dependants.	Minor

2.2 Are there opportunities to better promote equality of opportunity for people within the Section 75 equalities categories?		
Section 75 category	If **Yes**, provide details	If **No**, provide reasons
Religious belief	The further development and implementation of the Flourish churches suicide prevention initiative through Protect Life 2. This will involve the promotion of Flourish to clergy so they are aware of how to access resources to help in the event of suicide and work directly with bereaved families. The promotion of self-care is also planned for clergy as they are often first responders and a point of contact for those in emotional distress.	
Political opinion	The development and implementation of the Mental Trauma Network provides an opportunity to support the recovery of those who are experiencing significant mental health issues as a result of trauma, including issues arising from the conflict in Northern Ireland such as untreated Post Traumatic Stress Disorder. The continued provision of suicide prevention and emotional health and wellbeing services for those who have been affected by the conflict.	
Racial group	The continued provision of specific programmes targeted at black and ethnic minorities in conjunction with targeted suicide prevention communications to engage these groups.	

Age	Through Protect Life 2 a wide range of suicide prevention and emotional health and wellbeing programmes will continue to be targeted at specific age groups. The Self-Harm Intervention programme has been extended to 11-18 year olds. Protect Life 2 has a specific action to develop a joined up framework across government to support the wellbeing of children and young people in educational settings and beyond. This will include the development and implementation of policies and guidance which promote emotional resilience in educational settings. Subject to available funding there is potential to pilot programmes in schools and universities to enhance resilience and emotional health and wellbeing.	
Marital status	Suicide prevention programmes targeted at men have an opportunity to address the increased risk in single or separated men. Programmes may also benefit from awareness raising around the increased risk to men who have recently experienced a relationship breakdown.	
Sexual orientation	The provision of specific programmes targeted at the lesbian, gay and bisexual community. Enhanced signposting and culturally competent services to promote service engagement. There may also be potential to consider improved data collection for this population grouping in Protect Life 2 service provision. This will inform the evidence base for future service delivery and decision making.	
Gender (Men and women	Higher suicide rates in men necessitate targeted awareness raising and services for	

generally)	this group. This will be delivered through population level mental health and wellbeing campaigns, anti-stigma campaigns, targeted awareness raising, service provision and through the promotion of the Lifeline and Self Harm Improvement Programme (SHIP). Further work is required under Protect Life 2 to address very high rates of self-harm in young females through support in the educational setting and through SHIP.	
Disability (with or without)	Suicide prevention services will continue to be provided to all irrespective of disability. There is potential to increase equality of opportunity through the availability of promotional materials which are sensitive to the needs of people who are sensory impaired or who have a disability. The Lifeline model encourages positive attitudes towards disabled people and challenges negative stereotypes through the use of inclusive language in Lifeline promotional communication.	
Dependants (with or without)	The continued provision of suicide prevention, self-harm and emotional health and wellbeing services at a local level will ensure accessibility for those with or without dependants. The implementation of new actions to support those caring for an individual who may be suicidal will also provide greater equality of opportunity going forward. The same will apply in the action relating to involvement of trusted family/friends in safety planning for individuals who are at risk.	

2.3 To what extent is the policy likely to impact on good relations between people of different religious belief, political opinion or racial group? (minor/major/none)		
Good relations category	Details of policy impact	Level of impact minor/major/none
Religious belief	The Flourish suicide prevention initiative for churches is being implemented among the four main Christian churches in Northern Ireland. A series of workshops, training and events are planned which involve the bringing together of groups with different religious beliefs with the consistent aim of reducing suicide, and enhancing training and disseminating good practice guidelines for clergy, church leaders, pastoral care teams.	Minor (positive)
Political opinion	There is agreement amongst all political parties in Northern Ireland that tackling suicide and self-harm is a priority. The Protect Life 2 Strategy will be led at Ministerial level through the Ministerial Group on Suicide Prevention. Protect Life 2 contains an action to work with the All Party Group on Suicide Prevention to build further societal commitment to reduce suicide and self-harm.	Minor (positive)
Racial group	Funding is currently provided to the South Tyrone Empowerment Programme to encourage Black and Ethnic Minority communities to engage	Minor (positive)

	with suicide prevention and mental and emotional wellbeing programmes. Funding is also provided to promote emotional health and wellbeing for those in the traveller community.	

2.4 Are there opportunities to better promote good relations between people of different religious belief, political opinion or racial group?		
Good relations category	If **Yes**, provide details	If **No**, provide reasons
Religious belief	The further development and implementation of the Flourish![xxx] churches suicide prevention programme will provide opportunities for enhanced working across those with different religious beliefs. If funding permits there may also be an opportunity for expansion to other faith groups. A conference is planned in October 2019 across denominations titled “Pastoring the Pastor”. This will acknowledge the role of clergy in looking after those with mental health issues or who are bereaved by suicide and provide opportunities to gain awareness in self-care.	
Political opinion	All Departments have endorsed and agreed the actions within protect Life 2. There are a number of events including World Suicide Prevention Day, World Self-harm Awareness Day, suicide prevention initiatives, support groups, workshops and conferences which create an opportunity to promote good relations between those of differing political opinion with the combined	

	aim of reducing suicide. The All Party Group on Suicide Prevention brings together elected representatives with differing political opinions in a common aim of reducing suicide.	
Racial group	The continued promotion and funding of suicide prevention and emotional wellbeing programmes specifically targeted at those in the travellers community and those from a Black and Minority Ethnic background.	

2.5 Additional considerations

Multiple identity

Provide details of data on the impact of the policy on people with multiple identities (e.g. minority ethnic people with a disability, women with a disability, young protestant men, young lesbian, gay or bisexual persons). Specify relevant Section 75 categories concerned.

Research has shown that various population groups can experience increased risk of suicide. Similarly adverse experiences have been shown to increase the risk of suicide or self-harm. In a situation where an individual has experienced negative stereotypes or oppression as a result of a combination of sexual orientation; political opinion; religious belief; racial group; age; marital status; gender; disability or dependants it is reasonable to assume that particular individual may be at increased risk of suicide or self-harm. Suicide prevention services are available to everyone and the Lifeline crisis response service is available at any time to any person who is in distress or despair.

Within the context of the whole population there are a range of potential people with multiple identities. The whole population might be expected to benefit from delivery of Protect Life 2 services.

2.6 Was the original policy / decision changed in any way to address any adverse impacts identified either through the screening process or from consultation feedback. If so please provide details.

Following consultation the original Strategy has been altered to reflect that the whole population can be at risk of suicide and self-harm. The Strategy no longer specifies specific population groups following concern that this could disadvantage groups which were not identified. The Strategy has also been amended to more fully cover the needs of children and young people in relation to emotional health and wellbeing, self-harm and suicide prevention. The Self Harm Intervention Programme has already been extended to cover the 11-18 age group since the consultation period. A range of actions have been included more specifically targeted at younger people. There were views supporting a Towards Zero Suicide approach during the consultation. These have been taken on board and is supported through Protect Life 2 and a regional Towards Zero Suicide initiative has commenced across all HSC Trusts. Some respondents wished to see a target set for reducing suicide. A 10% reduction target has been set in Protect Life 2 which is in line with the towards Zero Suicide approach being adopted.

Part 3. Screening decision

3.1 How would you summarise the impact of the policy / decision?

No impact		
Minor impact	X	Consider mitigation (3.4 – 3.5)
Major impact		

3.2 Do you consider that this policy / decision needs to be subjected to a full Equality Impact Assessment (EQIA)?

Yes - screened in	
No - screened out	X

3.3 Please explain your reason for making your decision at 3.2.

Equality impacts related to Protect Life 2 are intentional and specifically designed to promote equality of opportunity for particular groups of disadvantaged people. The Protect Life 2 Strategy has identified a number of **positive** impacts to promote equality of opportunity across the range of Section 75 groups. It is clear that the Strategy will impact positively on the health and emotional wellbeing of the population as a whole. The Strategy and proposed action plan does not impact adversely on any of the Section 75 groups and therefore a full equality impact assessment is not required.

Mitigation

If you have concluded at 3.1 and 3.2 that the likely impact is '**minor**' and an equality impact assessment is not to be conducted, you must consider mitigation (or scope for further mitigation if some is already included as per 2.6) to lessen the severity of any equality impact, or the introduction of an alternative policy to better promote equality of opportunity or good relations.

3.4 Can the policy/decision be amended or changed or an alternative policy introduced to better promote equality of opportunity and/or good relations?

Yes	
No	X

3.5 If you responded "**Yes**", please give the **reasons** to support your decision, together with the proposed changes/amendments or alternative policy.

Equality impacts are positive, intentional and designed to promote equality of opportunity for particular groups of disadvantaged people. The Strategy and proposed action plan does not impact adversely on any of the Section 75 groups. Amendments have already been made to the Strategy as specified at section 2.6.

Part 4. Monitoring

Monitoring is an important part of policy development and implementation. Through monitoring it is possible to assess the impacts of the policy / decision both beneficial and adverse.

4.1 Please detail how you will monitor the effect of the policy / decision?

An evaluation framework will be developed under the Strategy Steering Group to critically examine the outcome and impact of interventions and programmes against the strategy objectives.

Qualitative data will include feedback from the new Protect Life 2 Steering Group against each of the actions within the Strategy, Protect Life Implementation Groups and other working groups.

4.2 What data will you collect in the future in order to monitor the effect of the policy / decision?

Through the evaluation framework measureable “outcome indicators and process indicators” will be linked to each objective to help assess progress towards that objective. Further work will be taken forward by the Strategy Steering Group to develop appropriate performance indicators and to identify or establish the necessary data sources to monitor their progress over time. Potential examples of these indicators have been set out in Appendix 2 of the Strategy.

The Department of Health and Public Health Agency will also monitor official suicide statistics, Lifeline key performance indicators, Self-Harm Registry data, suicide inequalities data, and local and international research.

Part 5. Disability Duties

5.1 Does the policy/decision in any way promote positive attitudes towards disabled people and/or encourage their participation in public life?

Suicide prevention services are available to all including Lifeline on a 24/7 basis. The Lifeline model encourages positive attitudes towards disabled people and challenges negative stereotypes through the use of inclusive language in Lifeline promotional communication. Suicide prevention promotional materials will be made available which are sensitive to the needs of people who are sensory impaired or who have a disability.

5.2 Is there an opportunity to better promote positive attitudes towards disabled people or encourage their participation in public life by making changes to the policy/decision or introducing additional measures?

Consideration will be given to any opportunities to promote positive attitudes towards disabled people within public awareness campaigns.

Part 6. Human Rights

6.1 Please complete the table below to indicate whether the policy / decision affects anyone's Human Rights?

ARTICLE	POSITIVE IMPACT	NEGATIVE IMPACT = human right interfered with or restricted	NEUTRAL IMPACT
Article 2 – Right to life	✓		
Article 3 – Right to freedom from torture, inhuman or degrading treatment or punishment			✓
Article 4 – Right to freedom from slavery, servitude & forced or compulsory labour			✓
Article 5 – Right to liberty & security of person		✓	
Article 6 – Right to a fair & public trial within a reasonable time			✓
Article 7 – Right to freedom from retrospective criminal law & no punishment without law.			✓
Article 8 – Right to respect for private & family life, home and correspondence.	✓		
Article 9 – Right to freedom of thought, conscience & religion	✓		
Article 10 – Right to freedom of expression	✓		
Article 11 – Right to freedom of assembly & association	✓		
Article 12 – Right to marry & found a family			✓
Article 14 – Prohibition of discrimination in the enjoyment of the convention rights	✓		
1st protocol Article 1 – Right to a peaceful enjoyment of possessions & protection of property			✓
1st protocol Article 2 – Right of access to education			✓

6.2 If you have identified a likely negative impact who is affected and how?

In relation to the human rights to liberty and security of a person it is recognised that in protecting the life of individuals identified as being at risk of suicide there may be legitimate restriction of their right to liberty. This would include instances in which individuals may be detained under the terms of mental health legislation in order to protect the individual's own right to life due to their state of mental well-being.

6.3 Outline any actions which could be taken to promote or raise awareness of human rights or to ensure compliance with the legislation in relation to the policy/decision.

The Lifeline service, Self-Harm Intervention Programme and Change Your Mind anti-stigma campaign all promote and actively encourage the freedom of expression by encouraging people to talk about their mental health. Change Your Mind also tackles the issues of discrimination by addressing the taboo that still exists around discussion and disclosure of mental health issues. All the actions within the protect Life Strategy are aimed at preventing suicide and protecting the right to life. The monitoring arrangements of the Strategy will ensure compliance with Human Rights legislation.

	Name	**Grade**	**Date**
Screening completed by	Sholto Carnew	DP	24/6/19
Approved by[1]	Bryan Dooley	G7	1/7/19
Forwarded to E&HR Unit[2]	Judith Tener	DP	1/7/19

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[xxviii] Health Survey https://www.health-ni.gov.uk/sites/default/files/publications/health/hsni-first-results-17-18.pdf
[xxix] A Report on the all-Ireland Young Men and Suicide Project http://www.mhfi.org/ymspfullreport.pdf

[xxx] Flourish! website http://www.wewillflourish.com/