

Report

North and West Belfast Health Action Zone
Task Group on the Prevention of Suicide and Self Harm

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GLOSSARY OF TERMS

A&E	Accident and Emergency Services
ASIST	Applied Suicide Intervention Skills Training
Autopsy	An examination of the body to determine the cause of death
Communities in Schools	A key HAZ programme which aims to use the school as a setting to improve education and health and wellbeing outcomes based on the participation of the community, parents and pupils, school authorities and support services provided to the school (similar to the notion of a 'fully serviced' or 'extended' school)
Coroner	The official responsible for the investigation of violent, sudden or suspicious deaths
Database	A central mechanism for the storage of information
DHSSPS	Department of Health, Social Services and Public Safety
GPs	General Practitioners (family doctors)
HAZ	Health Action Zone: name given to geographical areas which bring together all those who can contribute to improving the health of the local population, in this case in North and West Belfast
HAZ Council	The decision-making body of the Health Action Zone made up with senior officials from eighteen formal partners from the statutory, voluntary, community and private sectors working in North and West Belfast
Intersectoral	Work which involves more than one sector or agency
Meta Directory	Comprehensive directory of information
Multisectoral	Work which is based on a joint approach with several sectors, typically community, voluntary, statutory and private sectors
N&WBHSST	North and West Belfast Health and Social Services Trust, the agency responsible for providing community health and social care services and a number of specialist services in North and West Belfast
NICE	National Institute for Health and Clinical Excellence
PIPS	Public Initiative for the Prevention of Suicide and Self Harm, a community grown information and support service for those at risk of suicide and self harm and their families
Postvention	Refers to the period following a suicidal act and therefore relates to the support and services required by individuals who survive the act or the people who have been bereaved through suicide
Stigma	An unhelpful label or impression which can be thought of as shameful or negative in some way by society – in this case associated with suicide

FOREWORD

There are very few issues which have had such an impact on a local community as the loss of young people as a result of suicide over the recent past in North and West Belfast. Not just the loss of young people, but those of all ages. Each leaving those closest with a sense of loss, and hope that their loved one will be the last to take their own life.

Suicide is a complex issue. It requires a comprehensive approach. No one sector or group, specialism or profession can tackle this alone. This is why this Report of the North and West Belfast Health Action Zone Task Group on the Prevention of Suicide and Self-harm brings with it the hope of all involved that after some time, a strategic approach to this problem will now happen.

The process of developing this report has demonstrated how partnership working, through the Health Action Zone, between those involved in the community, voluntary, and statutory organisations can produce a response which addresses a comprehensive range of needs with imaginative solutions. All those who contributed to this process are to be commended for their determination and commitment. Recognition should also be given to those individuals from North and West Belfast who influenced the development of the forthcoming Regional Strategy from inception to implementation.

This report will form the basis of the North and West Belfast response to the current consultation on the Regional Draft Suicide Prevention Strategy – "Protect Life a Shared Vision". This strategic approach is welcomed and we look forward to the implementation of this strategy at a local and regional level.



Richard Black
Chairman
North and West Belfast Health Action Zone

EXECUTIVE SUMMARY

Report of the North and West Belfast HAZ Task Group on the Prevention of Suicide and Self Harm

North and West Belfast Health Action Zone (HAZ) is a partnership of statutory, community, voluntary and private sector organisations who have been working together to tackle inequalities in health and social exclusion since April 1999. The HAZ area has a population of almost 145,000, and includes some of the most socially and economically disadvantaged wards in Northern Ireland.

The HAZ Task group on the Prevention of Suicide and Self Harm

The establishment of the current Task Group grew out of increased community concerns at the rise in the number of suicides across the area and the decision by HAZ Council to address mental health and wellbeing in North and West Belfast as a priority. The work builds on an earlier multiagency initiative led by North and West Belfast Health and Social Services Trust together with the important work of community and voluntary organisations. The Task Group was chaired by Ms Bernie McNally, Director of Mental Health, Children and Social Work, North and West Belfast Health and Social Services Trust.

- **Suicide**

In Northern Ireland there are on average 150 deaths from suicide per year, the majority of whom are under 35 years of age representing 9.8 per 100,000 (average 1999-2003). However, within North and West Belfast the rate is much higher with an average approaching 18 per 100,000.

- **Self Harm**

Self-harm may be defined as an act of self-injury or poisoning regardless of the purpose of the act. Acts of self harm may be a coping mechanism and not linked to the intention of ending one's life. The National Institute for Clinical Excellence Guidance (NICE) guidelines report an attendance at hospital of 300 per 100,000 for the UK. In NI there are on average 7,200 admissions per year to hospital with self harm equivalent to a rate of 421 per 100,000 population.

- **Task Group Process**

It was widely agreed that the approach of the Task Group should be:-

based on the evidence of effective intervention;
 build on existing good practice in the field;
 inclusive;
 participative;
 integrated; and
 based on partnership between the various interest groups.

- **Terms of reference**

The Task Group and its five working groups had clear terms of reference. HAZ partners were asked to nominate individuals to the proposed Task Group and a first seminar was planned to launch the initiative on 12 April 2005.

Over 120 individuals attended the seminar and formed a broad Reference Group for the initiative. They gave overwhelming support for the process as outlined, and many opted to join one of the five working groups. These covered Vulnerable Young People; Schools; Self Harm; Family Support; and Communications and Media.

- **Research**

To inform the HAZ Task group on the needs of the families bereaved by suicide, a short term piece of research was carried out. This work documented the experiences, and identified the support needs, of families before, at the time of, and after bereavement.

- **Communication**

A key factor which helped support learning was a clear commitment from all partners to engage in the process and to communicate within and between working groups as well as with the Regional Group. Pro-active communications planning supported this process.

- **Regional links**

Representatives from the HAZ Task Group also joined the NI Regional Taskforce established by the then Minister for Health, Shaun Woodward MP. This promoted communication and congruence between both initiatives.

The work of the HAZ Task Group on the Prevention of Suicide and Self harm spanned the period from April 2005 to March 2006.

RECOMMENDATIONS

Strategic Development

1. The Regional Task Group should support the implementation of a Regional Strategy to prevent suicide and self harm through the allocation of dedicated resources, in particular to address gaps in current service provision. This strategy and its local implementation should be based on a long term approach.
Regional Implementation Group
2. A multi-sectoral Action Group should be established to plan, co-ordinate and drive the implementation of action plans which will:
 - build on existing partnership between statutory, community and voluntary organisations;
 - promote joint working and improved decision making, in particular about allocation of new and existing resources leading to a more co-ordinated and strategic approach;
 - monitor the implementation of a local Action Plan based on the deliberations of the HAZ Task Group within an agreed timeframe**Regional and Local Implementation Groups**
3. A mapping exercise of all available services from statutory, community, voluntary and private sectors should be undertaken to create a database of services available, access and referral mechanisms, quality control and standards, and evaluation in place. Such a mapping exercise will highlight opportunities for joint working and service improvement areas as well as identify gaps.
Local Implementation Group

Training and Education

4. A Training Plan should be developed in order to make training on suicide and self harm prevention available for a range of different practitioners and at varying degrees of depth. Primary groups to be trained include: teachers, youth workers, non teaching staff in schools, community workers, GPs, community and hospital nurses, ancillary and reception staff of various facilities, city council staff, emergency services, Youth Justice and probation staff, church leaders and staff, and specialist groups such as funeral undertakers. Such training should include addressing the special needs of families bereaved through suicide and for people at risk of suicide.
Local Implementation Group
5. Training materials should be collated and developed on all aspects of the prevention of suicide and self harm.
Local Implementation Group

6. Action should be taken to ensure that training is made a pre-requisite for key functions within a range of services. This should include appropriate resourcing, for example, to ensure teachers' attendance which will require substitute teachers cover.
Regional and Local Implementation Groups
7. Schools should be supported and encouraged to include positive mental health promotion and the promotion of child self esteem as part of the personal and social development of pupils, and ensure that appropriate links are made with other areas of the curriculum and the implementation of existing policies. In particular, a clear coordinated approach should be taken to the issue of bullying (both within, travel to and from school, after schools clubs and so forth).
Regional and Local Implementation Groups
8. An information flowchart should be developed for schools detailing the action steps which should be taken in an emergency situation. The existing DENI booklet 'Suicide; Managing the Issues in Schools' should be revisited.
Regional and Local Implementation Groups

Support Services

9. Access and availability of high quality counselling services for schools should be assessed setting out clear standards of practice and including the possibility of complementary therapies where the evidence of benefit is strong. Those providing services to schools should comply with procurement practice in order to assure quality standards.
Regional and Local Implementation Groups
10. Service pathways should be developed across community, voluntary and statutory services in order to improve signposting and access to various levels of service provision. Such pathways will help build a network of advice, support and care. The particular needs of vulnerable groups such as young people in care or those misusing alcohol and drugs should be considered.
Local Implementation Group
11. The lack of adequate child and adolescent mental health services needs urgent investment. The review of Mental Health and Learning Disability (Bamford Review) should be examined to inform service development needs locally and adequate investment secured for delivery of services.
Regional Implementation Group

RECOMMENDATIONS

12. A model of 24 hour crisis support and response should be piloted in North and West Belfast which can be directly accessed by individuals, families and service providers.
Regional and Local Implementation Group
13. A model of bringing together and concentrating expertise in the field of suicide and self harm prevention and support should be piloted in North and West Belfast. Such a 'centre' would offer the opportunity of ensuring that all efforts are co-ordinated and strengthened.
Regional and Local Implementation Groups
14. A clear plan of action should be prepared to address the specific needs of families supporting someone at risk of suicide. Such a plan is likely to include information, access to counselling, respite, and emergency provision in a crisis situation.
Local Implementation Group
15. The specific needs of families bereaved through suicide should be recognised (including bereaved children) and a package of information, support and care developed to address such need.

Regional and Local Implementation Groups

Information

16. Information should be made widely available on access to various advice and support services including welfare rights as part of creating an holistic approach to care.
Local Implementation Groups
17. Public awareness campaigns and materials should be supported and, in particular, should pay attention to the broader social context of mental health, health inequalities and the unfolding impact of the conflict. A clear communication plan should be implemented which seeks to engage stakeholders (including media) in a broader discourse on the issues surrounding suicide and self harm as well as challenging negative stereotyping and use of language.
Regional and Local Implementation Groups

Sharing Knowledge and Research

18. Consideration should be given to further areas of research including the tracking and long term support of those who have attempted suicide and self harm, experience of families most directly affected, and evaluation of service developments.
Regional Implementation Groups
19. Conferences and workshops should be held regularly as useful opportunities for sharing and developing knowledge and practice.
Regional and Local Implementation Groups

Funding

20. The particular funding situation of community and voluntary sector providers of services should be examined as part of developing a more co-ordinated and sustainable approach to tackling the issue of suicide prevention.
Regional and Local Implementation Groups
21. The pattern of need in North and West Belfast should be clearly articulated in different arenas (including the media) in order to increase understanding and advance arguments which will secure the best level of funding available to address such need, including the current basis of the capitation formula.
Regional and Local Implementation Groups

This Executive Summary is available on the HAZ website:
www.haz-nwbelfast.org.uk

1. INTRODUCTION

Suicide is a distressing and complex issue. For society it is a shared problem. Although its impact is felt most painfully and acutely by some, its effect stretches deep into the fabric of life in North and West Belfast, and elsewhere. It represents one symptom of disadvantage and inequality, a sense of unhappiness and lack of wellbeing as a community, that some choose to end their lives. It follows then that any proposal to address the problem will require a multi layered response. There is no simple or immediate solution. This report sets out to capture the nature of the problem, describe the process of working to develop an integrated approach, and makes a number of recommendations for action.

In developing this work the Health Action Zone (HAZ) Task Group has been mindful of the need to communicate and share information widely. Throughout the process it has been important to ensure close liaison with the regional sub-group established by the Department of Health, Social Services and Public Safety to specifically review progress on the ten recommendations of the Promoting Mental Health Strategy which dealt with suicide prevention. This group subsequently evolved into the Suicide Taskforce established by Minister Shaun Woodward. Local experience has been used to inform and influence the regional approach, the work of which is in turn reflected in this local initiative.

The broad thrust of the HAZ Task Group is based on prevention. However, it is also recognised that prevention, intervention and postvention are inextricably linked and is one of the reasons why the views of those most directly affected by the issue have been an integral part of this process. In the same way any proposed strategy will aim to promote the factors which support good mental health and wellbeing for the population as a whole, as well as reducing the risk for those who are at greater risk of suicide or self harm.

This work has formed part of the developing HAZ programme. North and West Belfast Health Action Zone is a partnership of statutory, community, voluntary and private sector organisations working together to tackle inequalities in health and social exclusion since April 1999. North and West Belfast experiences social and material deprivation on an unprecedented scale against almost every indice – poverty, unemployment, low wages, poor educational achievement, and this is in turn reflected in poor health status with health and social care indicators mirroring other patterns of disadvantage. The practice of partnership working has been developing over several years and offers an important asset in the development of integrated approaches to suicide prevention. A multisectoral focused approach is being used to good effect in other areas of work. The principles of such work – the co-ordination of partners' contributions alongside community participation remain critical factors in developing an integrated approach to suicide and self harm prevention. This commitment has driven the current initiative.

2. BACKGROUND

2.1 The Issue

Suicide

The World Health Organisation estimates that around one million people die from suicide each year – a global mortality rate of 16 per 100,000. In the last 45 years suicide rates have increased by 60% with young people being the group at highest risk in a third of all countries. Suicide has a major impact on society ranking third in term of life years lost after cardiovascular disease and cancer.

Suicide is a growing public health concern accounting for 1% of all deaths each year in Northern Ireland, (exceeding deaths on the road) and is responsible for a high proportion of deaths in young people (since there are fewer deaths from other causes in this age group) and has a high social class gradient, in common with other health concerns. Suicide accounts for almost one third of all deaths among males aged 25-34 years (Regional Taskforce 2006)¹. In Northern Ireland there are on average 150 deaths per year, the majority of whom are under 35 years of age representing 9.8 per 100,000 (average 1999-2003). However, within North and West Belfast the rate is much higher with an average approaching 18 per 100,000.

Suicide rates in males have increased since the mid 1990s from 14.1 to 15.9 per 100,000, while rates for females have remained stable (Regional Taskforce 2006). This rise also coincides with the ceasefires and the move toward an end of the conflict in Northern Ireland. In common with other areas a strong gender pattern is evident in deaths for North and West Belfast (See Appendix I) with almost four male suicides for every female suicide and there is an even distribution across the geography of North and West Belfast. Significantly, the overwhelming majority (86.5%) of people who died by suicide were not known to the Mental Health Services, compared to some 70% who died by suicide in Northern Ireland as a whole.

Causes of Suicide

There are many causes of suicide which are related to the individual, society and a wide range of other factors. Known risk factors for suicide include: mental illness, alcohol and other substance use disorders, hopelessness, impulsive and/or aggressive tendencies, history of trauma or abuse, some physical illnesses, previous attempts or family history of suicide, job or financial loss, access to lethal means, lack of social support and sense of isolation, homophobia, stigma associated with help-seeking behaviour, barriers to accessing health care especially mental health and substance abuse treatment, certain cultural and religious beliefs, exposure to, including through the media, and influence of others who have died by suicide, and local clusters of suicide which may have a contagious influence (from Regional Task Force 2005). One can postulate about why there is such a high level in North and West Belfast but it is likely to be (at least in part) a response to the circumstances and context outlined below, notably the impact of the conflict and its geographical concentration in North and West Belfast.

¹ Regional Task Force Protect Life – A Shared Vision DHSSPS 2006

Self Harm (from Regional Task Group report)

Self-harm may be defined as an act of self-injury or poisoning regardless of the purpose of the act. Acts of self harm may be a coping mechanism and not linked to the intention of ending one's life. Such acts may be an attempt to communicate with others, to influence or to secure help or care from others or a way of obtaining relief from a difficult and otherwise overwhelming situation or emotional state.

National surveys in Britain indicate that around 5-6% of people have self-harmed in the past. Results in the 15-16 year old age group indicate that around 13% have self-harmed in the past with 7% having done so in the previous year.

The National Institute for Clinical Excellence Guidance (NICE)². guidelines report an attendance at hospital of 300 per 100,000 for the UK based on data from the self-harm monitoring system in Oxford.

In NI there are on average 7,200 admissions per year to hospital with self harm equivalent to a rate of 421 per 100,000 population. The rate of admission for self harm among males in NI is 383 per 100,000 and for females 457 per 100,000 population. The number of attendances at Accident and Emergency Departments for self-harm is not reported to the Department of Health, Social Services and Public Safety. Some individual Trusts may collate this data.

2.2 Context

The Health Action Zone area has a population of almost 145,000, and includes some of the most socially and economically disadvantaged wards in Northern Ireland. Research conducted by the University of Ulster, A Primary Care Needs Assessment³., evidenced that there is a significantly higher incidence of mental illness in the Trust area. Some 29% of male respondents and 35% of female respondents were identified as suffering from borderline or severe psychotic disorder compared to 17% of men and 27% of women elsewhere in Northern Ireland.

The Institute of Conflict Research (2001)⁴. further highlighted the impact of the Troubles on the physical and mental health of the population in North and West Belfast. The research indicates that more residents in North and West Belfast classified their health as being poor (11.2% compared to 6.3% in the rest of Northern Ireland). Some 40% of people reported feelings of distress, emotional upset and helplessness and 60% acknowledged feelings of rage. The overall conclusion was that the effects of the Troubles on communities in North and West Belfast were pervasive and widespread. The Troubles coloured and complicated other social problems, and everyone in the community was affected to some extent.

2.3 Origins of the Current Approach

² Hawton, K., et al (2003 d) Deliberate Self harm in Oxford, 1999 - 2000: Psychological medicine, 33(6) 987-995.

³ Whittington, D., Thompson, K., A Primary Care Needs Assessment Carried out on behalf of North and West Belfast Total Purchasing Pilot practices. Primary Care Research Group, University of Ulster pp110, 2000.

⁴ Smyth, M., Morrissey, M., & Hamilton, J., Caring Through The Troubles, North and West Belfast Health and Social Services Trust, 2001.

In 1998 the North and West Belfast Health & Social Services Trust in partnership with the West Belfast Partnership Board established a multi-agency Task Group on suicide. One element of the group's strategy was the production of a manual 'Giving Hope in the Community' intended as a guide for those with face to face contact with young people in North and West Belfast. The recommendations of this earlier Task Group informed the work of North and West Belfast Health and Social Services Trust over the years and helped shape the development of the present initiative. The establishment of the current Task Group grew out of increased community concerns at the rise in the number of suicides across the area and the decision by HAZ Council to address mental health and wellbeing in North and West Belfast as a priority within the second phase Action Plan. Following debate during meetings of HAZ Council between September and December in 2004 which included discussion with local community organisations, it was agreed to establish a new multisectoral Task Group under the direction of Ms Bernie McNally, Director of Mental Health, Children and Social Work, North and West Belfast Health and Social Services Trust, to lead the development of an integrated approach to the prevention of suicide and self harm.

2.4 Existing Practice

A wide range of practice has been developing over the years in a number of areas to address the concern over suicide and self harm. This has included a general focus on factors known to be protective, health promotion programmes in schools such as Communities in Schools, a Service Improvement Project to tackle self harm (including major conferences in 2005 and 2006) and the development of more specific interventions in a range of settings aimed at suicide prevention. This work has been led variously by community, voluntary and statutory sector organisations as well as supporting partnership approaches between different interest groups. The current approach grew out of a need to bring greater co-ordination and focus to these efforts.

A number of initiatives are actively and urgently addressing the immediate needs in the field. Key interventions are included below:

2.4.1 Development of Support Infrastructure

North and West Belfast Health and Social Services Trust created a post in 1998 to co-ordinate and develop mental health promotion. This development by the North and West Belfast Health and Social Services Trust Mental Health Services was echoed by the commitment of other organisations to dedicate staff time and resources, as well as the voluntary contribution of many in the community over the years. The resulting infrastructure, whilst fragile due to the instability of funding arrangements, has been an important factor in building a collaborative approach.

2.4.2 ASIST (Applied Suicide Intervention Skills Training)

ASIST (Applied Suicide Intervention Skills Training) is an interactive 2 day training workshop. It is an evidence based programme developed by Living Works Education in Canada (www.livingworks.net).

North Belfast has completed a roll out programme, which included training seven individuals from the community as trainers of ASIST. Following this a series of workshops was delivered across a wide range of groups and areas, aimed at helping people in the community identify when someone is having thoughts of suicide and help the individuals access appropriate help. Over 250 people have now completed an ASIST workshop in North Belfast and there are plans to develop local Community Response Teams to provide support and signposting on a 24/7 basis, to those at risk or concerned about someone in relation to suicide.

ASIST workshops have also been delivered through local community groups in the West Belfast and Shankill areas. A proposal to increase the number of people trained as trainers of ASIST has been approved to enable both these areas to increase the number of local people completing an ASIST workshop as part of a capacity building strategy.

Emergency services are often first on the scene when a suicide has been attempted or completed, and a training programme has been developed in partnership with key agencies.

Teachers, clergy and A&E staff, have been included in all the workshops held to date. There has however been a difficulty for some teachers being released from their duties due to the cost of replacement staff for the two days.

2.4.3 Bereaved by Suicide Support Groups

The emergence of support groups has been of great strength to those who have been bereaved through suicide. Many of the members have shared phone numbers and ring each other between meetings. PIPS (Public Initiative for Prevention of Suicide and Self harm) recently opened a house in Duncairn Gardens (provided by the Housing Executive). This has provided a safe haven for those families and friends to meet up to share their experiences and to take part in a range of therapies e.g. art therapy as well as complementary therapies through supports such as the Ashton Centre. PIPS have recently appointed an administration worker to help with the development of supports and services.

2.4.4 "Reaching Out" booklet

The "Reaching Out" booklet was a community driven initiative. This booklet comprises stories from individuals and families who had been bereaved or affected by suicide with helpline numbers and website addresses. The booklet was distributed through community groups to all households in North & West Belfast.

2.4.5 Celebration of Life

Three musical events utilizing the theme of suicide prevention have been held, two as part of North Belfast Feile in 2003 and 2004, and latterly a third was held to mark World Suicide Prevention Day on 9 September 2005. The aim of this event was to provide an opportunity to celebrate the lives of those who lost their lives through suicide whilst offering support and comfort to those who had been bereaved. To acknowledge the pain many experience

at Christmas time, two Memory Trees of Lights were erected, one in North and the other in West Belfast. Mementoes of family members and friends who had lost their lives to suicide were placed on the trees.

2.4.6 Mental Health Promotion

- **Primary schools art competition**

A variety of initiatives have taken place with the aim of promoting good mental health. An art competition for primary schools was held in May 2005. The idea behind this was to encourage young people to think about the resources they can call on when they are feeling sad. Prize money was distributed to the three winning schools for use in purchasing equipment or activities of direct benefit to the children.

- **"Turn it Around" mental health resource pack**

A new resource for teachers in post primary schools has been developed and distributed to schools. The "Turn it Around" pack consists of a video/DVD and a workbook, which enables pupils to discuss a range of issues which may affect their mental health. An evaluation of this pack will take place in 2006.

- **"Heads Away Just Say" campaign**

The "Heads Away" campaign was designed with the help of young people. It consisted of an advertisement, website and supporting marketing material. Initially it was shown in the cinemas in North West Belfast. Subsequently the campaign was rolled out on TV and radio. The aim of the campaign was two-folded – to provide relevant information to young people and to encourage young people to seek help. A recent extension of the campaign has used mobile messaging.

- **West Belfast Young People's Health Conference**

A conference was held in West Belfast to elicit the views of young people about their emotional health and to provide them with information of relevant helping agencies/ services.

2.4.7 Service Developments

- **Community Responses**

A series of important community responses have grown in order to address need in North and West Belfast including PIPS (Public Initiative for the Prevention of Suicide and Self Harm), Bereaved Support Groups, community based counselling projects such as Lenadoon, New Life, Shankill Stress and Trauma, Corpus Christi, ICPD, and Contact Youth. A fuller list of support services is available on HAZ website www.haz-nwbelfast.org.uk

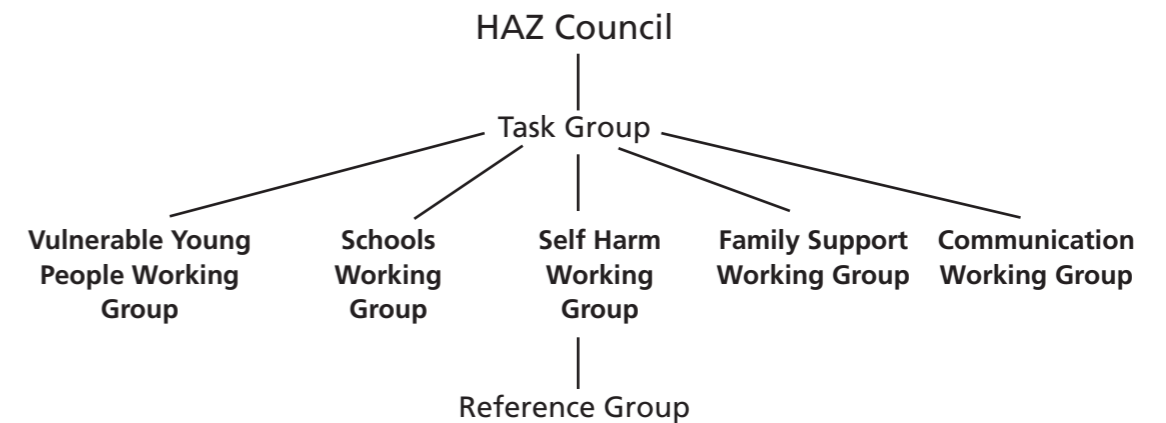
3. PROCESS OF DEVELOPING AN INTEGRATED APPROACH

- **Service Improvement Project**

The Service Improvement Project is jointly operated by the Mater Trust and North & West Belfast HSST. The project aims to improve the experience of those who attend A&E in the Mater following a self-harm incident and for 48 hours following discharge.

Excellent work continues through many local community/voluntary groups and statutory agencies.

Following the decision by the Health Action Zone Council in December 2004 to establish a Task Group, a Project Initiation Document (Project Management Plan) was prepared for discussion with key stakeholders setting out clearly the aim, objectives and methodology against a defined timeframe. A number of principles characterised the approach such that it should be: based on the evidence of effective intervention; building on existing good practice in the field; inclusive (of all views); participative (promote the active participation of all, including local community); integrated (multisectoral); and based on partnership between the various interests. The Task Group had a clear function and Terms of Reference (Appendix II) and aimed to develop a coordinated and integrated approach to the prevention of suicide and self harm in North and West Belfast. Five working groups were proposed also with clear Terms of Reference (Appendix III). The proposed structure can be seen on the diagram below.



Timeframe: April 05 – March 06

The first step in the process was to build on the existing consultation with key stakeholders, including the community. HAZ partners were asked to nominate individuals to the proposed Task Group and a first seminar was planned to launch the initiative on 12 April 2005 (Appendix IV). In February those with a wide range of interests were invited to this seminar including politicians, community, voluntary and statutory organisations and interested individuals. It was proposed to expand membership of the Task Group from workshop discussions on the day in order to ensure that the process encouraged participation and was representative of key interests. In preparation for the seminar a Policy Briefing was developed setting out the facts about suicide and self harm and a summary of the evidence of known effective interventions. A brief was also prepared to help guide the workshop discussions. Copies of existing leaflets and the 'Giving Hope' report were also made available for participants.

Over 120 individuals attended the seminar and formed a broad Reference Group for the initiative. They gave overwhelming support for the process as outlined, and many opted to join one of the five working groups being set up to explore specific elements of the approach, that is, Vulnerable Young People; Schools; Self Harm; Family Support; and Communications and Media. The Working Groups agreed to meet regularly within the

4. REPORTS FROM WORKING GROUPS

proposed reporting arrangements, nominated a chairperson, and made two nominations to the Task Group, one of which was the chairperson of the Working Group.

The Task Group held meetings in May, September, January, February, March and May 2006. The Working Groups met regularly from April to December 2005. The Reference Group had further seminars in December 2005 and March 2006 both with large attendance. This inclusive process has been important. It has facilitated as broad a level of participation as possible and fostered a partnership approach encouraging shared understanding toward a common goal. It is worth noting that there were strong feelings voiced at the outset of this process, indeed scepticism and anger were commonplace amongst a range of participants. It was essential that those concerns were taken seriously in developing the method of working.

A key factor which helped support learning was a clear commitment from all partners to engage in the process and to communicate within and between working groups as well as with the Regional group. A number of communication tools helped this process: the HAZ office established a database of interested partners and shared reports and information freely including the Child Safety Directory, Little Book of Stuff (a young people's directory), and The Republic of Ireland strategy 'Reach Out'; a round up of key developments, issues discussed and decisions made (based on the minutes of the Working Groups) was shared in a regular e-mail to all participants; frequent update letters were issued from the chairperson of the Task Group; and members were encouraged to participate in the work of the Regional Taskforce, particularly in the conference and consultation exercises.

The value of this communication approach was the feeling among participants that they could identify with the range of work in progress and contribute both inside and across sub-groups as appropriate. This helped build a sense of ownership of the overall process and outcomes.

A number of other actions took place during this time, notably the Celebration of Life event. This was the third of such events led by community organisations to celebrate the lives of those who lost their lives through suicide. On this occasion the evening was hosted by Frances Black, singer/songwriter, and was held to mark World Suicide Day on 9 September 2005. A second spiritual event took place on Sunday 30th April 2006 following an offer from Dean Houston McKelvey of St Anne's Cathedral. In addition, information about access to services existing throughout North and West Belfast was made widely available, as well as the publication of 'Reaching Out' by a local group (a support guide from the Suicide Awareness Support Group). Meetings were also held with politicians and interested individuals regarding the issue and method of working. A letter expressing concern about the impact of the funding cuts in education was also sent to the Minister Angela Smith MP highlighting the links between one area of government policy and suicide prevention. Groups were encouraged to contribute to the Review of Mental Health and Learning Disability (the Bamford Review) led by the Department of Health, Social Services and Public Safety. Further, representatives from the HAZ Task Group joined the Regional Taskforce established by Minister Shaun Woodward MP which promoted communication and congruence between both initiatives.

All of the Working Groups had membership drawn from community, voluntary and statutory sectors. The membership was large and often fluid with members able to attend all, or some, of the regular meetings. They operated within a common framework (Appendix III) and used their collective knowledge and experience to address the specific task, often addressing members' concerns, frustrations and strongly held convictions about the issue of suicide prevention. Working Groups provided specialist input to the Task Group with the Chairperson and one other nominee joining the Task Group. The full reports are posted on the HAZ website www.haz-nwbelfast.org.uk

4.1 Vulnerable Young People Working Group

The Group shared evidence of existing practice, effective interventions from elsewhere, and defined a number of gaps, in particular the need to hear directly from 'vulnerable' young people and their views about appropriate support. A pilot survey was undertaken of a small number of young people in one part of North and West Belfast (Upper Springfield) highlighting several key issues: the importance of peers/friends as sources of information and advice; low numbers of young people citing teachers, youth workers, GPs and helplines as appropriate sources of support; and low numbers of young people prepared to access support from mental health services with higher numbers prepared to seek out counselling support. Key barriers to accessing support services were a lack of contact telephone numbers, phone lines being busy and previous negative experience of seeking and receiving support; what assisted young people to seek out support was having had a previous positive experience; and that young people tended to turn to people with whom they had already an established relationship such as friends, family, youth worker, teacher and counsellor.

Recommendations (contained in Appendix V) highlighted the need for funding, in particular for community and voluntary organisations working with vulnerable young people. Specific recommendations identified the need for comprehensive information to be made available on existing services as well as the provision of new services such as a 24 hour response team. The group also emphasised the need to undertake a review of adolescent mental health services and address serious gaps in service provision.

4.2 Schools Working Group

The group discussed the range of relevant practice currently in place in schools locally and elsewhere. Following consideration of the gaps and in order to engage schools in the work of the Task Group, it was decided to conduct a survey of the existing practice and concerns of staff in primary and post primary schools in North and West Belfast. The findings of this survey led to a number of proposed areas of action.

Recommendations (contained in Appendix V) included the need to provide staff development and support. Staff training such as ASIST (Applied Suicide Intervention Skills Training) was also highlighted as being of particular relevance, as well as understanding procedures and postvention support. Whilst the overriding approach of work in schools was focused on promoting good mental health, the Group also recommended an extension of various supports to schools such as specialist counseling and therapy services.

5.0 RESEARCH ON THE NEEDS OF FAMILIES BEREAVED BY SUICIDE

4.3 Self Harm Working Group

The Group shared information on existing practice, literature reviews and evidence of effective interventions and research as well as linking closely with the work of the Service Improvement Project, which included the views of service users. The gap in knowledge and understanding about self harm/injury was a constant theme of the group's work.

Recommendations (contained in Appendix V) highlighted the need for a comprehensive 'mapping' of existing services and the need to understand better service pathways in order to ensure easier access to services. The Group also emphasised the need for high quality appropriate information, support and training in the field of self harm prevention.

4.4 Families Working Group

The group shared evidence and reviewed material from a wide range of sources and experience throughout the world. A mapping exercise of existing services and a flow chart to help detail the process of moving through the service 'system' was examined. Crucially the work was informed by families' own experience – both as direct contributions to the group and in shaping the qualitative research commissioned to help capture families' experience in order to better understand how services could be improved in the future. The centrality of postvention as part of a prevention strategy was highlighted by the group's work.

Recommendations (contained in Appendix V) highlighted the context for suicide prevention, the need for a comprehensive and integrated approach to prevention, intervention and postvention, and specifically the need for a 24/7 crisis response service. The coordination of existing services was also emphasised along with the need for long term tracking and support of those who have attempted suicide and self harm. Training for staff from a range of sectors also formed a key recommendation of the group.

4.5 Communications & Media Working Group

The Media and Communications Working Group considered the issue of communication in developing a co-ordinated approach to the prevention of suicide and self harm. Qualitative research was undertaken with young people 12 – 25 years in order to inform the communications plan. The working group produced a draft communication strategy which will run alongside the unfolding work of the Task Group. The strategy will naturally change to take account of the agreed work plan in due course.

Key recommendations (contained in Appendix V) included the need to provide easily accessible information on services and in particular to support public information programmes alongside resource material for staff. Guidelines for media reporting on suicide are also a priority.

As the work of the Prevention of Suicide and Self-harm Task Group progressed, the feeling grew across the sub-groups that there needed to be a more scientific recording of family experiences, and formalised identification of need. This research is an attempt to respond to this need and would not have been possible without the willing participation of relatives who had been bereaved by suicide across North and West Belfast. (Full report contained in Appendix VI)

Methodology

A semi-structured questionnaire was used with interviews lasting around one hour, with fifteen families taking part from across North and West Belfast. Consent forms were used and interviewees were assured of confidentiality and anonymity.

Personal histories

Those who had taken their lives had been through a range of life experiences. They ranged in age from 17 to over 40 with some showing signs of physical and/or mental illness before their death and others giving no indication of what was to come.

The 17-25 age group did show some common difficulties. Some had a history of self-harm, depression and stress. Problems engaging with school were usual, as were feelings of hopelessness about what the future held, and dissatisfaction with their surroundings. Substance misuse and alcohol were common coping mechanisms.

Access to services

For those families who had sought help, access to services was a major source of concern. Families were often left struggling with the role of round the clock caring with no respite, support or follow up.

• Primary care

General practitioners are acknowledged to be key in access to services. In all cases where GP's were involved, families felt that there had been little or no support offered. In cases where families were experiencing ongoing difficulty in coping, there was no evidence of support or follow up offered.

• Secondary care

For those who did access secondary care, in some cases in settings such as the Mater, the Royal, and Knockbracken the services were felt in many cases to be unsuitable and unresponsive. Often patients were sent home without a discharge plan.

• Adolescent services

Repeatedly families commented on both the lack of adolescent services and the vacuum in care caused by the transfer to adult services when a young person became 18.

• Counselling

Access to counselling was limited to those who had contact with community services. There was no evidence of counselling being offered at primary care by the GP.

Impact on family

There was strong evidence that the families involved were deeply affected by the experience before, during and after bereavement. Bereaved relatives talked about their families being “destroyed” by the experience.

• Stigma

Families mentioned stigma most often in the context of the time of bereavement. It was felt that there was a clear distinction between how people reacted to families at the time of “an ordinary death” and suicide. There was also some regret that families did not recognise what was mental illness and what was “just part of life”. People didn’t look for help because they didn’t know what was needed or where to go.

• Support at time of death

The shock of sudden bereavement is sometimes added to by the lack of knowledge of what to expect when the emergency services are involved. The formal requirements following a suicide also leave families at a loss. Steps such as getting a death certificate, the requirement for an autopsy, dealing with the Coroner’s office, and post mortem reports may be necessary but families are left without information or advice on what the next steps are likely to be. When families did get support following their bereavement it came from the few existing community services.

• Bereaved children

The involvement of children in such a distressing event as a suicide is a matter for special mention. In extreme cases, children as young as five - sons, daughters or siblings of the deceased, have been first on the scene after the suicide.

In all cases, help was eventually provided to children either through school or families looking for help. New Life Counselling has been a valuable support, although once again families have mentioned the need for more resources to avoid delay in getting support.

• The need for support and services

There was clear consensus that support and services were urgently needed to deal with the crisis facing the community. Families feel that there is “not enough being done” and that “something is needed in this area”. Services such as PIPS are held up as a lifeline, but not enough. Families feel that they need support 24 hours a day from an emergency response facility or service.

Conclusions

The North and West Belfast area has the second highest prevalence of suicide in Northern Ireland. From the interviews it is clear that the causes are complex, and that more needs to be done in prevention, intervention, and post bereavement support. It is the clear hope of those who took part in the research that these local needs will be recognised in the forthcoming regional strategy, and this research will inform any future developments.

Recommendations

Further consideration should be given to preventative work in the schools and community setting targeted at young people;

Awareness and education programmes for GP’s should be considered aimed at empowering GP’s to provide better support for people at risk of suicide;

Adolescent services should be established urgently to support young people at risk of suicide;

In-patient services should be more responsive to the needs of people in crisis. Training of A&E staff should be provided to deal with those threatening to take their lives;

Those admitted to secondary services should be provided with appropriate treatment and discharge plans which are shared with family carers where appropriate;

Families looking after those at risk of suicide should be recognised as carers and provided with appropriate support and respite to enable them to continue in their role;

Counselling services should be increased with special access to timely counselling when individuals are experiencing a crisis;

Family members bereaved through suicide should be recognised as being at risk themselves and follow up support should be offered following bereavement;

Consideration should be given to parenting support to enable individuals to cope with a young person at risk of suicide;

Awareness sessions for emergency services personnel on the special needs of families experiencing attempted or completed suicide should be provided. This could involve those who have been through the experience themselves;

Information sheets on procedures following suicide should be provided to relatives. This could cover, for example, matters such as return of possessions, the role of the Coroner’s office, and post mortems and autopsies.

Funding should be allocated to consolidate existing community services, develop counselling services and establish a 24 hour response service with a Telephone Helpline; the service should be community based with professional advisors;

Special attention should be given to the needs of bereaved children – for example through the provision of counselling and youth groups.

6.0 RECOMMENDATIONS OF THE HAZ TASK GROUP ON THE PREVENTION OF SUICIDE AND SELF HARM

The following recommendations flow from the work of the Task Group and its various sub groups and are presented as key recommendations from this process. Details on lead organisations and accountability arrangements will be informed by the consultation on the Regional Task Force report. Regional and local responsibilities are however detailed below:

Strategic Development

1. The Regional Task Group should support the implementation of a Regional Strategy to prevent suicide and self harm through the allocation of dedicated resources, in particular to address gaps in current service provision. This strategy and its local implementation should be based on a long term approach.
Regional Implementation Group
2. A multi-sectoral Action Group should be established to plan, co-ordinate and drive the implementation of action plans which will:
 - build on existing partnership between statutory, community and voluntary organisations;
 - promote joint working and improved decision making, in particular about allocation of new and existing resources leading to a more co-ordinated and strategic approach;
 - monitor the implementation of a local Action Plan based on the deliberations of the HAZ Task Group within an agreed timeframe.
Regional and Local Implementation Group
3. A mapping exercise of all available services from statutory, community, voluntary and private sectors should be undertaken to create a database of services available, access and referral mechanisms, quality control and standards, and evaluation in place. Such a mapping exercise will highlight opportunities for joint working and service improvement areas as well as identify gaps.
Local Implementation Group

Training and Education

4. A Training Plan should be developed in order to make training on suicide and self harm prevention available for a range of different practitioners and at varying degrees of depth. Primary groups to be trained include: teachers, youth workers, non teaching staff in schools, community workers, GPs, community and hospital nurses, ancillary and reception staff of various facilities, city council staff, emergency services, Youth Justice and probation staff, church leaders and staff, and specialist groups such as funeral undertakers. Such training should include addressing the special needs of families bereaved through suicide and for people at risk of suicide.
Local Implementation Group

5. Training materials should be collated and developed on all aspects of the prevention of suicide and self harm.
Local Implementation Group
6. Action should be taken to ensure that training is made a pre-requisite for key functions within a range of services. This should include appropriate resourcing, for example, to ensure teachers' attendance which will require substitute teachers cover.
Regional and Local Implementation Groups
7. Schools should be supported and encouraged to include positive mental health promotion and the promotion of child self esteem as part of the personal and social development of pupils, and ensure that appropriate links are made with other areas of the curriculum and the implementation of existing policies. In particular, a clear coordinated approach should be taken to the issue of bullying (both within, and travel to and from, school, after schools clubs and so forth).
Regional and Local Implementation Groups
8. An information flowchart should be developed for schools detailing the action steps which should be taken in an emergency situation. The existing DENI booklet 'Suicide; Managing the Issues in Schools' should be revisited.
Regional and Local Implementation Groups

Support Services

9. Access and availability of high quality counselling services for schools should be assessed setting out clear standards of practice and including the possibility of complementary therapies where the evidence of benefit is strong. Those providing services to schools should comply with procurement practice in order to assure quality standards.
Regional and Local Implementation Groups
10. Service pathways should be developed across community, voluntary and statutory services in order to improve signposting and access to various levels of service provision. Such pathways will help build a network of advice, support and care. The particular needs of vulnerable groups such as young people in care or those misusing alcohol and drugs should be considered.
Local Implementation Groups
11. The lack of adequate child and adolescent mental health services needs urgent investment. The Review of Mental Health and Learning Disability (Bamford Review) should be examined to inform service development needs locally and adequate investment secured for delivery of services.
Regional Implementation Group

12. A model of 24 hour crisis support and response should be piloted in North and West Belfast which can be directly accessed by individuals, families and service providers.
Regional and Local Implementation Group
Regional and Local Implementation Groups
13. A model of bringing together and concentrating expertise in the field of suicide and self harm prevention and support should be piloted in North and West Belfast. Such a 'centre' would offer the opportunity of ensuring that all efforts are co-ordinated and strengthened.
Regional and Local Implementation Groups
14. A clear plan of action should be prepared to address the specific needs of families supporting someone at risk of suicide. Such a plan is likely to include information, access to counselling, respite, and emergency provision in a crisis situation.
Local Implementation Group
15. The specific needs of families bereaved through suicide should be recognised (including bereaved children) and a package of information, support and care developed to address such need.
Regional and Local Implementation Groups

Information

16. Information should be made widely available on access to various advice and support services including welfare rights as part of creating an holistic approach to care.
Local Implementation Group
17. Public awareness campaigns and materials should be supported and in particular should pay attention to the broader social context of mental health, health inequalities and the unfolding impact of the conflict. A clear communication plan should be implemented which seeks to engage stakeholders, including media, in a broader discourse on the issues surrounding suicide and self harm as well as challenging negative stereotyping and use of language.
Regional and Local Implementation Groups

Sharing Knowledge and Research

18. Consideration should be given to further areas of research including the tracking and long term support of those who have attempted suicide and self harm, experience of families most directly affected, and evaluation of service developments.
Regional Implementation Group
19. Conferences and workshops should be held regularly as useful opportunities for sharing and developing knowledge and practice.
Regional and Local Implementation Groups

Funding

20. The particular funding situation of community and voluntary sector providers of services should be examined as part of developing a more co-ordinated and sustainable approach to tackling the issue of suicide prevention.
Regional and Local Implementation Groups
21. The pattern of need in North and West Belfast should be clearly articulated in different arenas (including the media) in order to increase understanding and advance arguments which will secure the best level of funding available to address such need, including the current basis of the capitation formula.
Regional and Local Implementation Groups

7. IMPLEMENTATION

It is clear from the preceding analysis that there is much to be done to develop a coherent and integrated approach to the prevention of suicide and self harm. It is now proposed to establish a multi sectoral Implementation Group which will oversee the development, co-ordination and implementation of detailed action plans based on this report, set within an agreed timeframe. Lead organisations will be identified against key areas of action and set out clear mechanisms for monitoring and evaluation. Whilst the detail of these arrangements awaits the outcome of the consultation on the report of the Regional Task Force and the establishment of the Regional Implementation Group, it is clear that a Local Implementation Group will be needed to drive forward the recommendations.

Clearly resources will be required to address the recommendations outlined by the Task Group. The HAZ aims to make best use of partners' collective resources by working together. Nevertheless, both the gaps in service provision, the uncertainty of funding in a number of sectors, most particularly community and voluntary organisations, and the retraction in some statutory organisations as a result of government spending plans, leads to an unstable environment in which to plan for service development. In particular youth services, both statutory and voluntary providers, are under increasing pressure, yet their role is arguably critical in the prevention of suicide and self harm. The ongoing legacy of the conflict means that the increased levels of need are likely to continue for many years to come.

It will be essential that local implementation arrangements take account of related work, such as the Neighbourhood Renewal Strategy, national and local strategies on alcohol and drugs, policy development in health and education, plans to integrate services for children and young people, and developments within the City Council. The Neighbourhood Renewal Strategy, for example, aims to combine the efforts of all relevant Departments and agencies to work in partnership with local communities to improve public services, promote sustainable economic activity and improve life chances for people living in the most deprived areas. In the locally developed action plan, communities can decide to prioritise actions to tackle important issues, including suicide and self harm. Thus, it will be essential that co-ordination of effort is given priority in local arrangements.

8. CONCLUSION

The North and West Belfast Health Action Zone has sought to develop an integrated and coordinated approach to the painful issue of suicide and self harm prevention. It is clear that there has been an overwhelming desire to improve the situation. Through this process of joint working much has been learned about the need to listen to the views of those most directly affected, about the value of crossing organisational boundaries, and of the anger and frustration generated by this issue in North and West Belfast. The Health Action Zone reaffirms the value of such a joint approach - one which respects the views of all participants and shares the hope that this work will go some way to reducing future need.

APPENDIX I

Profile of Suicides in North and West Belfast 1998 – 2004

Introduction

The following data is provided from returns supplied to the National Confidential Inquiry into Suicide and Homicide (the Inquiry) by people with mental illness and untoward incident records held by the Trust. Unfortunately, as with many other sources of data on suicide, this is almost certainly not a complete statement of the number of suicides which occurred during this period as there is often a time lag between the incident and its reporting. It also does not include undetermined deaths.

The total number of deaths by suicide reported to the Inquiry during this study period (1998 – 2004) was 126: 92 males and 34 females:

This Table represents those deaths by suicide reported to the National Confidential Inquiry and is not intended as a record of the number of actual deaths by suicide in any particular year. For example, six deaths by suicide were reported to the Inquiry in respect of 2001, an extremely small figure. Yet suicides in 2001 within North and West Belfast were on a par with other years.

Table 1. Number of suicides by gender

Year	Nos	Male	Female
1998	20	15	5
1999	26	20	6
2000	19	12	7
2001	6	6	0
2002	22	15	7
2003	19	12	7
2004	14	12	2
Totals	126	92	34

The age range is illustrated overleaf and shows that over 60% of those deaths recorded as suicide were of people 40 years and under:

Table 2. Number of suicides by age

AgeBands	Male	Female	Totals
<20years	7	6	13
21>30years	28	7	35
31>40years	23	5	28
41years>	34	16	50
Totals	92	34	126

There appears to be a fairly even distribution of deaths by suicide across the geography of North and West Belfast:

Table 3. Number of suicides by Postal codes

PostalCode	BT11	BT12	BT13	BT14	BT15
1998	6	6	3	5	0
1999	4	6	6	4	6
2000	3	2	6	5	3
2001	1	0	1	3	1
2002	3	4	5	4	6
2003	1	5	2	4	7
2004	2	2	3	5	2
Totals	20	25	26	30	25

The overwhelming majority of people who died by suicide during the period (86.5%) were not known to North and West Belfast Mental Health Services.

Table 4. Numbers known/unknown to Mental Health Services

Year	Known to Mental Health Services	Not known to Mental Health Services
1998	5	15
1999	5	21
2000	2	17
2001	1	5
2002	3	19
2003	1	18
2004	0	14
Totals	17	109

APPENDIX II

HAZ Task Group for the Prevention of Suicide and Self-harm

Terms of Reference

Primary aim of the Task Group is to develop a co-ordinated and integrated approach to the prevention of suicide and self-harm in North and West Belfast (against an agreed timeframe) through:

1. A Review of the evidence of effective intervention on an international, regional and local basis.
2. An analysis of information in order to assess levels of need in North and West Belfast.
3. Mapping existing practice and local initiatives currently underway/planned within North and West Belfast.
4. Providing an opportunity to share information across agencies and sectors, including the views of communities, families and young people in pursuit of a shared strategy and to drive forward change within those same sectors.
5. The Development of a local co-ordinated and integrated plan with reference to known effective interventions within an agreed timeframe to address key areas of need.
6. Informing and influencing the development of a regional strategy for suicide and self-harm prevention.
7. Ensure communication within the various strands of the strategy's development and ensure linkage with other relevant areas of development, including mental health service development, draft strategy for children and young people in Northern Ireland, Neighbourhood Renewal Strategy, victims and survivors of trauma and so on.
8. Contributing to the creation of a supportive climate for dealing with mental health needs and the issues of suicide prevention and self-harm.
9. Provide a report to HAZ Council and the wider community on agreed Action Plan.
10. Members of the Task Group will be committed to providing advice and support to staff working to co-ordinate an effective integrated response.

APPENDIX III

Working Groups for the Prevention of Suicide and Self-harm

Terms of Reference

The primary purpose of the working group is to focus on a specific area within the development of an overarching strategy to prevent suicide and self-harm through:

1. A Review of the evidence of effective practice on an international, regional and local basis with specific reference to the area of responsibility;
2. Map and examine existing practice currently underway which relates to the task of the working group;
3. Developing clear proposals for action with agreed pointers toward the short, medium and long term;
4. Ensure clear communication and linkage with other working groups and overall strategy development;
5. Promote the development of co-ordinated approaches with a range of sectors and including the views of communities, families, and young people as appropriate;
6. Identify potential resource implications of proposed areas of action;
7. Provide advice and support to the Task Group;
8. Provide regular reports to the Task group.

APPENDIX IV

Information Seminar on the establishment of the Task Group for the Prevention of Suicide and Self Harm

Programme

Aim: To provide information and consider an effective process for developing an integrated approach to the prevention of suicide and self-harm.

**12 April 2005
2.00 - 4.30 pm
Belfast Central Mission
The Grosvenor Hall**

- 2.00pm **Introduction and Welcome**
Mr Richard Black, Chairperson HAZ Council, Chief Executive N&WBHSST
- 2.05pm **Background to HAZ Task Group on Suicide and Self Harm**
Ms Bernie McNally, Director of Social Work, Children & Mental Health, N&WBHSST, Chairperson, Task Group for Prevention of Suicide and Self Harm
- 2.10pm **What do we already know - Overview of evidence of effective approaches to suicide and self-harm prevention.**
Ms Margaret Woods, Mental Health Promotion Manager
- 2.30pm **What is already happening - Examples of practice in:**
 - Education Ms Margaret Watson, Careers Education Advisor BELB
 - Community Ms Jo Murphy, Public Initiative for the Prevention of Suicide and Self Harm
 - Health & Social Services Dr Graeme McDonald, Consultant Psychiatrist Mater Hospital
- 3.00pm **Developing an Integrated Approach to Suicide and Self-Harm Prevention - An outline of proposed process**
Ms Mary Black, HAZ Leader
- 3.15pm **Tea/Coffee**

Working Groups to consider proposed process
- 4.00pm **Plenary Discussion**
- 4.30pm **Conclusions and way forward**

APPENDIX V

RECOMMENDATIONS FROM THE VULNERABLE YOUNG PEOPLE WORKING GROUP

1. **Recurrent funding is made available to a range of community organisations** working through different disciplines in order to ensure that the work they are currently undertaking with young people is sustained and that funding is available to enable them to offer these services to other young people. It is proposed that within this funding money is available to enable these organisations to externally evaluate the programmes and services they offer.
2. **A database that can be accessed via one telephone number (24 hour service) which houses a brief synopsis of the services offered by community and statutory organisations in N&W Belfast is set up and maintained.** The information to be stored within the database, are the types of services available, who the service is for, opening hours, contact details, and how to make a referral. Access to this service is open to both professionals and members of the public.
3. **A 24 hour response team** is set up to respond to the needs of vulnerable young people in the high risk areas of North & West Belfast.
4. **A review of the current provision of adolescent mental health services available to 16 – 18 years olds** to ensure that the **gaps in the service** for this age group are **highlighted and action is taken to address this.**
5. **Research is undertaken with those young people who have deliberately harmed themselves and who do not/have not accessed statutory services** i.e. not admitted to hospital or attended their GP.

RECOMMENDATIONS FROM THE SCHOOLS WORKING GROUP

1. **Staff Development and Support**
 - each school should be encouraged and supported to provide a developmental programme of positive mental health as a core part of its personal development curriculum. This will link to changes proposed as part of the revised curriculum.
 - all staff, teaching and non-teaching, should be provided with appropriate training around the issue of suicide intervention. It is envisaged that training along the lines of the existing ASIST training would be suitable. Resources to facilitate teachers' attendance needs to be addressed.
 - an information flowchart detailing precise and accurate steps to be taken in an emergency situation in schools should be compiled and made available as a matter of urgency. The existing DENI booklet 'Suicide; Managing the Issues in Schools' is helpful and should be revisited.

2. Services and Support for Pupils

- there is an urgent need to evaluate the extent and availability of existing external counselling services and for this information to be communicated to schools. Those providing services to schools should be asked to undergo existing rigorous procurement procedure in order to assure quality standards.
- there should be improved school-based access to external counselling services. In order to be assured of quality in such services BELB needs to develop a set of standards.
- with regard to the provision of counselling in schools, existing models should be appraised and good practice disseminated.
- consideration should be given to widening the availability of complementary therapy services as part of a school's positive mental health programme. Those providing services to schools should be asked to undergo rigorous procurement procedure in order to assure quality standards.

RECOMMENDATIONS FROM THE SELF HARM WORKING GROUP OF MENTAL HEALTH SERVICES RELATED TO SELF HARM

1. Undertake a Mapping Exercise of mental health services related to self harm:

- To be carried out by someone on a paid, full time basis.
- Time limited (Three/ Six months).
- Mapping the entire Statutory, Voluntary, Community and Private sectors.
- They should have knowledge and skills to interact competently and sensitively with each of the above sectors.
- What services are available?
- What type and level of service do they provide?
- How can they be contacted/accessed/referred?
- What is their capacity/waiting time?
- What experience and knowledge, specific to self harm/injury, does each service have?
- How is the service quality controlled? (qualifications and registration of workers, public liability insurance, supervision, complaints procedure, and funding timeline).
- An evaluation of spread, type of service to highlight gaps.

2. Establish pathways for those affected:

- Appropriately inter-connect services in the sectors.
- A flow-chart/description showing the inter-connections and how to access them.
- Establish user-friendly procedures to achieve above.
- A comprehensive guide to signpost to suitable support and services. Within this guide a full understanding of how each of these services operates.
- The above advertised in all suitable services.

3. Leaflet/Literature:

- User friendly leaflet/literature on self harm/injury, containing:
 - i. A description of what it is, and what it is not.
 - ii. What to do/ who to contact if you are injuring yourself.
 - iii. What to do/ who to contact if someone you know is injuring themselves.
 - iv. Phone numbers, addresses, etc.
 - v. The flow chart for accessing services.
- This leaflet/literature to be disseminated as widely as possible throughout all the sectors.

4. Training and training/information resources:

- Develop training and resources for services.
- Ensure the training is comprehensive and flexible so that it can be delivered in a variety of settings and at suitable level.
- Hold conference / workshop with established groups to design the above.
- Ensure that this conference is fully accessible to all sectors.
- Ensure that all sectors have the opportunity to feed into the design of the training and the resources.
- Once developed that resources and structures are in place for the delivery of the training and wide distribution of packs.

RECOMMENDATIONS FROM THE FAMILIES WORKING GROUP

1. That the Task Group should support the introduction of a regional strategy. Intersectoral implementation groups should be set up at regional and local levels to monitor the effectiveness of the strategic plan and make further recommendations for change during the life of the strategy.
2. That the Strategy for Suicide Prevention in North and West Belfast should be monitored to ensure effective implementation of the strategy through continued scrutiny by thematic groups based on the present process.
3. There should be a conceptual framework created that places suicide prevention in a wider social context than mental health. It should aim to change attitudes, language, educate and raise awareness.
4. Suicide Prevention needs to be properly resourced at many levels and the following actions are required:
 - There needs to be dedicated and realistic funding for a regional suicide prevention strategy.
 - Gaps in the delivery of mental health need to be reviewed and resourced, particularly those pertaining to child and adolescent services.

APPENDIX VI

- Additional monies are required and allocation of these additional funds should be skewed towards the community/voluntary sector.
 - The impact of the troubles and inequalities of health needs to be considered in the capitation formula for allocation of funding.
 - Local “health alliances” should be formed to co-ordinate delivery of services and allocation of resource
 - A more strategic approach to funding is required to support the networks of community partners and embed these services within the framework of health care.
5. There should be a 24/7 crisis response service that can be directly accessed by individuals, families and community organisations - multi agency and multi-disciplinary.
 6. Existing services should be rationalised to create effective partnerships between statutory/voluntary /community workers. New protocols should be developed to ensure co-ordination of services as necessary.
 7. Logging, tracking and long term support for those who have attempted suicide and self-harm.
 8. Suicide awareness training programme for frontline medical and teaching staff on all aspects of suicide including postvention. This should apply to training and education programmes for teaching and caring professions.

A pilot model should be prioritised within North and West Belfast. This would be a centre that could offer crisis response and support for survivors of suicide, suicide prevention programmes, education, training and research, intervention through support and signposting, 24 hr helpline and counselling.

RECOMMENDATIONS FROM THE COMMUNICATIONS AND MEDIA WORKING GROUP

1. Adopt overarching guiding principles in communicating about the prevention of suicide and self harm.
2. Develop a communications strategy in light of the final report of the Task Group.
3. Create a meta directory of support services.
4. Use convenience advertising in support of the strategy.
5. Re-run the Heads Away Just Say advertising campaign.
6. Reproduce the Turn it Around pack for youth workers in North and West Belfast.

Research on the needs of families bereaved by suicide

Introduction

As the work of the prevention of Suicide and Self-harm Task Group progressed, the campaign by families bereaved by suicide to get services and support gained momentum. The subject caught the attention of the local media who reported the experiences of families whose relatives had taken their lives. Reports of families with nowhere to go for help and young people falling between adolescent and adult services were common. There was also a feeling that young people who did seek help were dying needlessly due to lack of resources and commitment to the problem.

A feeling grew across the sub-groups that there needed to be a more scientific recording of experiences, and formalised identification of need. This research is an attempt to respond to these requests.

The research would not have been possible without the willing participation of relatives who had been bereaved by suicide across North and West Belfast.

Methodology

The methodology selected took account of the sensitivity of the subject, and access to interviewees. Initially, focus group work was considered, however after consultation with family support groups, it was decided that issues of confidentiality would reduce the qualitative value of the findings if focus groups were used. The aim thereafter was to carry out a series of around 15 one –to –one interviews with members of bereaved families from across North and West Belfast.

Interviewees

Interviewees were approached by support workers in their communities and asked to take part. Interviews took place in community facilities where follow up counselling would be available, if necessary. Those interviewed were, in all cases, immediate family members – fathers, mothers, sisters, grandparents and partners.

The interviews were scheduled to last for one hour, although this varied according to the experience of those being interviewed. Interviews were based on semi-structured questionnaires designed to encourage participants to raise the issues most relevant to their circumstances and experience. Consent forms were used and interviewees were assured of confidentiality and anonymity.

Bereavement history

Those interviewed had been bereaved for periods of 5 months to 7 years. Initially, a threshold of one year since bereavement had been placed on participants, but there were those who felt they wished to participate in spite of this time limit. In the event, as individual reactions to grief and the grieving process vary, recency of bereavement did not necessarily correlate to the emotional impact of participating in the research. Additionally, there was value to be had in seeing that the gaps in support and services reported by those who were bereaved some years ago were still current.

Findings

Life events and experiences of those who had taken their lives.

Those who had taken their lives had been through a range of life experiences. They ranged in age from 17 to over 40 with some showing signs of physical and/or mental illness before their death and others giving no hint of what was to come. The 17-25 age group did show some common difficulties. Some had a history of self-harm, depression and stress. Problems engaging with school were usual, as were feelings of hopelessness about what the future held and dissatisfaction with their surroundings. Those over 25 were more likely to be married or settled with partners, have children, experience unemployment or hold a criminal record.

Educational aspiration

The families of young men talked of how they had been excluded from school because of behavioural difficulties or lack of resource to meet special needs. Even those who did have ambition were felt to have been held back because of local factors. One "wanted to be a joiner but couldn't get work" and another "had good memory and good reports but in Ardoyne things were against him".

Substance misuse

Substance abuse was a common "coping" mechanism for young men under pressure. Combinations of drink and drugs, particularly cannabis were often used – often to the concern of parents and other immediate relatives. However such habits were difficult to change due to the peer influences involved. Relatives also spoke of how those delivering services were unsympathetic if they knew there was drug use involved.

Suicidal ideation

Once again there was no clear pattern in the group who took their lives having expressed suicidal thoughts. Some did speak of taking their lives and having paranoid thoughts. Others were making plans for the future, from the next night to wedding plans. One young man even discussed another member of the family who took his life wondering "how could he do this to his family?"

Access to services

For those who were aware that their relative had some form of emotional distress, access to services was a major source of concern. Services were either not effective, not appropriate or in many cases, particularly in the case of adolescents not there at all. Families were left struggling with the role of round the clock caring with no respite, support or follow up.

Primary care

General practitioners are acknowledged to be key in access to services. In all cases where GP's were involved families felt that there had been little or no support offered. In cases where families were experiencing ongoing difficulty in coping, there was no evidence of ongoing support or follow up offered. GP's responses to self-harm or mental distress included the use of phrases such as "looking for attention", "pull yourself together", "be a big man" and families have been told that their relatives were attention seeking.

Self-harm was also dismissed as a fad – "all the kids are doing it". One mother said "I spent the last week of his life arguing with him because of what the GP said about him attention seeking". In another case, a GP was too busy to visit a mother immediately after bereavement.

Secondary care

For those who did access secondary care, in some cases in settings such as the Mater, the Royal, and Knockbracken the services were felt in many cases to be unsuitable and unresponsive. Families felt that having "fought" to get help, those admitted had little done for them. In one instance a suicidal young man was given a razor in hospital, although he had being assessed as "being a danger to himself". Inpatient treatment in another case was likened to punishment rather than treatment. Often patients were sent home without a discharge plan. There was also experience of follow up appointments being cancelled by professionals.

Adolescent services

Repeatedly families commented on both the lack of adolescent services and the vacuum in care caused by the transfer to adult services when a young person became 18. Often, although suicidal, young people who wanted help were placed on waiting lists for services.

Counselling

Access to counselling was limited to those who had contact with community services such as Falls Women's Centre, New Life Counselling or PIP's. In all cases where children were bereaved they had accessed counselling either through community services or school. There was no evidence of counselling being offered at primary care by the GP. In one case counselling was offered by the City Hospital after a suicide attempt.

Family Support

Impact on family

There was strong evidence that the families involved were deeply affected by the experience before, during and after bereavement. Families are not being acknowledged as carers while they are caring for someone whose behaviour and suicide ideation is causing concern. The following comments illustrate the extreme stress experienced:-

" I felt I couldn't leave him and we had to watch him all the time"

"we got no respite – we couldn't even get to the support group"

" my father suffered from depression and even passed out when he heard (of my brother's suicide). My mother had to look after him and worry about my brother as well"

"we almost lost my eldest daughter through suicide – the youngest gets neglected"

Bereaved relatives talked about their families being "destroyed" by the experience. Family rifts are common, " the women in the family can talk but when we are all together its not mentioned – we don't know how to talk as a family -we would need help"

Often close relatives go through crisis themselves. One mother recalled "I was at high risk of suicide, I spent six months in bed afterwards. I needed specialist support , but there was nothing" A father tells how " my wife says that a stranger comes into the house – not me".

Stigma

Families mentioned stigma most often in the context of the time of bereavement. It was felt that there was a clear distinction between how people reacted to families at the time of "an ordinary death" and suicide. Relatives feel that people "do not know what to say – they cross the road to avoid you".

Suicide is seen to be a taboo subject and the lack of understanding leads to additional distress and isolation. Men in particular find it difficult to talk about – one said " we feel weak if we can't deal with it". There was a general feeling that the use of role models – maybe from sport or football talking about emotions would help.

There was also some regret that families did not recognise what was mental illness and what was "just part of life". People didn't look for help because they didn't know what was needed or where to go.

Parenting

There was evidence that some parents were clearly struggling to cope. One young mother who lost her son said "I had him at fifteen – I didn't know how to deal with the difficulties when he grew up – classes for parents were all about young children"

Young parents are also at risk – "he was a father at 17 and his partner was younger – the pressure of being a parent was too much with everything else."

Support At time of Death

The shock of sudden bereavement is sometimes added to by the lack of knowledge of what to expect when the emergency services are involved. It is common for ambulance and police services to arrive and swing into action without explaining to families what is going to happen. This is understandable when a crisis response team are trying to save a life. However, it can leave families feeling excluded and resentful.

Issues arising also involved the removal of the deceased's belongings such as suicide notes and mobile phones, which can be important to family members. In some cases, complaints were made about police attitudes and failures in procedures, such as failing to maintain privacy at the scene until family members arrive. One mother wanted to go to the morgue to be with her deceased daughter but found that it was closed.

Sometimes procedures such as the return of clothing can have significant effects on next of kin – one father remarked that his son's clothes looked as though they had "been pulled off him" – causing additional distress.

Formalities

The formal requirements following a suicide often leave families at a loss. Matters surrounding getting a death certificate, the requirement for an autopsy, dealing with the Coroner's office, and post mortem reports may be necessary but families are left without information or advice on what the next steps are likely to be. This can be particularly stressful if insurance companies or mortgage providers are involved.

One relative had to go through the courts to gain access to CCTV footage which proved the nature of her brother's death. This added to the stress of her loss. Close relatives often feel they don't have many rights and don't know where to get answers.

Post bereavement

General Support

Where families got support following their bereavement it came from the few existing community services. Often people needed help but couldn't get it – either because of waiting lists or not knowing where to go. A common source of support was through Jo

Murphy and PIP's. Families were grateful for this, but at the same time acknowledged that this service was not adequately resourced and could do a lot more. Often the support groups have been lifelines to bereaved families. One member said "the support group could do more – it needs developing and structure"

Other services such as CRUSE Bereavement care are unable to respond due to waiting lists. Statutory services often lack continuity and the ability to respond when most needed. One woman recounted – "I only had my family... I waited six months for CRUSE Bereavement care. I was on anti-depressants, having panic attacks and feeling suicidal. I was referred to a psychiatrist and CPN. My CPN went off sick and there was no follow up."

Public events such as the "Tree of Lights" ceremony have often brought people into contact with support services.

Bereaved children

The involvement of children in such a distressing event as a suicide is a matter for special mention. In extreme cases, children as young as five, either sons, daughters or siblings of the deceased have been first on the scene after the suicide. In such challenging circumstances families need expert help. The main challenge is how to explain this to the child, what language to use and in some cases whether to be honest or avoid the painful truth. In some cases children have been told the truth on the street or in school.

In all cases, help was eventually provided to children either through school or families looking for help. New Life Counselling has been accessed successfully, although once again families have mentioned the need for more resources.

Older siblings also need help. There is an identified need for youth groups for bereaved brothers and sisters. On parents told how their son was speaking to other young people at church to prevent what happened to his brother.

The need for support and services

There was clear consensus that support and services were urgently needed to deal with the crisis facing the community. Families feel that there is "not enough being done" and that "something is needed in this area". Services such as PIPS are held up as a lifeline, but not enough. Families feel that they need support 24 hours a day from an emergency response facility or service. There is a feeling of frustration as "people want to volunteer to help, but we are not qualified – we need professionals on board. The community knows how to deal with it, but they need to listen". As one person put it

"We don't want people coming in with their big words and funny accents"

There is also an acknowledgement that more work in prevention is essential. Families feel that there is a need to teach emotional well-being in schools, particularly covering

relationship issues. They also feel that young people need another person they "trust and know" – "someone who will not go to parents"

Summary

The prevalence of suicide in North and West Belfast puts the area into the second highest in Northern Ireland. From the interviews it is clear that the causes are complex, and that more needs to be done in prevention, intervention, and post bereavement support. It is the clear hope of those who took part in the research that the local needs will be recognised in the development of the forthcoming regional strategy and this research will inform any future developments.

Recommendations

These are the key recommendations flowing from the research findings:-

- Further consideration be given to preventative work in the schools and community setting targeted at young people;
- Awareness and education programmes for GP's should be considered aimed at empowering GP's to provide better support for people at risk of suicide;
- Adolescent services should be established urgently to support young people at risk of suicide;
- In-patient services should be more responsive to the needs of people in crisis. Training of A&E staff should be provided to deal with those threatening to take their lives;
- Those admitted to secondary services should be provided with appropriate treatment and discharge plans which are shared with family carers where appropriate;
- Families looking after those at risk of suicide should be recognised as carers and provided with appropriate support and respite to enable them to continue in their role;
- Counselling services should be increased with special access to timely counselling when individuals are experiencing a crisis;
- Family members bereaved through suicide should be recognised as being at risk themselves and follow up support should be offered following bereavement;
- Consideration should be given to parenting support to enable individuals to cope with a young person at risk of suicide;

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- Awareness sessions for emergency services personnel on the special needs of families experiencing attempted or completed suicide should be provided. This could involve those who have been through the experience themselves;
- Information sheets on procedures following suicide should be provided to relatives. This could cover, for example, matters such as return of possessions, the role of the Coroner's office, and post mortems and autopsies.
- A booklet on where to get help following a suicide should be produced and available through, for example, community groups, churches, GP's, emergency services and funeral directors;
- Funding should be allocated to consolidate existing community services, develop counselling services and establish a 24 hour response service with a Telephone Helpline; the service should be community based with professional advisors;
- Special attention should be given to the needs of bereaved children – for example through the provision of counselling and youth groups;

Membership of HAZ Task Group on the Prevention of Suicide and Self Harm

Mr Joe Barnes	Tar Isteach
Ms Mary Black	Health Action Zone
Mr Lawrence Blaney	EHSSB
Mr John Bourke	Probation Board for Northern Ireland
Ms Judy Colhoun	AWARE
Mr Patrick Convery	Deputy Lord Mayor
Mr Michael Doherty	Lenadoon Community Forum
Ms Moira Doherty	New Life Counselling
Ms Harriett Ferguson	Department of Employment and Learning
Ms Evelyn Gilroy	Beechmount
Ms Dympna Johnston	Greater Shankill Partnership
Mr Stiofan Long	West Belfast Partnership
Ms Margery Magee	Health Action Zone
Ms Mimi McAlinden	Investing for Health
Mr John McClure	Irish Church Missions
Mr Dominic McCullough	North Belfast Community Action Unit
Ms Susan McDonald	Northern Ireland Housing Executive
Mr John McGeown	N&WBHSST
Mr Joe McGinnity	CCMS
Ms Bernie McNally(chairperson)	N&WBHSST
Ms Patricia McQuillan	Lenadoon Counselling Programme
Cllr Cathal Mullaghan	Politician
Ms Jo Murphy	North Belfast Partnership
Mr Murdo Murray	North Belfast Partnership
Ms Gayle Nixon	BELB
Mr Mark O'Donnell	Department for Social Development
Ms Joanne Reilly	The Homeless Support Team
Ms Irene Sherry	Ashton Centre
Ms Kathy Stanton	Politician
Fr Aidan Troy	Holy Cross Church
Can Trevor Williams	Holy Trinity and Emmanuel Parishes
Ms Margaret Woods	N&WBHSST
Ms Suzanne Wylie	Belfast City Council

APPENDIX VIII

Membership of Working Groups

Vulnerable Young People Working Group

Emma	Bailie	RADICAL
John	Bourke	PBNI
Mary	Brennan	Ballymurphy Women's Centre
Deborah	Devenney	Ballymurphy Women's Centre
Moira	Doherty (Joint Chair)	New Life Counselling
Kelly	Gilliland	EDACT
Evelyn	Gilroy	Beechmount Community Council
Dympna	Johnston	Greater Shankill Partnership Board
Gerry	Linnane	West Belfast Area Project
Brian	Maguire	Opportunity Youth
Fra	McCann	Politician
Dominic	McCullough	North Belfast Community Action Unit
Susan	McDonald	NIHE
Seamus	McGrenaghan	N&WBHSST
Una	McRoberts	Ardoyne/Shankill Health Partners
Bridgeen	Mullan	PBNI
Danny	Murphy	St Peters Immaculata Youth Club
Bryan	Nelson	N&WBHSST
Joanne	Reilly	The Homeless Support Team
Susan	Semple	N&WBHSST
Bill	Shaw	174 Trust

Schools Working Group

Caroline	Bloomfield	Health Action Zone
Judy	Colhoun	AWARE Defeat Depression
Mary	Creaney	Families Bereaved Through Suicide
Harriett	Ferguson	DEL
Julie	Martin	Contact Youth
Michelle	McCabe	AWARE Defeat Depression
Joe	McGinnity (Chair)	CCMS
Kevin	McKenna	One Stop Shop, Communities in Schools
John	McKeown	DEL
Joe	Morgan	NWBHSS
Angela	Mulholland	NWBHSST
Danny	Murphy	St Peter's Immaculata Youth Club
Gayle	Nixon	BELB
Norma	Patterson	Contact Youth
Susan	Semple	NWBHSST
Neil	Symington	Opportunity Youth

Self Harm Working Group

Mary	Brennan	Ballymurphy Women's Centre
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Deborah	Devenney	Ballymurphy Women's Centre
Moira	Doherty	New Life Counselling Service
Joelle	Gartner	St Louises Comp Coll
Patricia	Jamshidi	St Aidan's Primary School
Joanne	Judge	Psychiatric Nurse
Maggie	Lawrence	Holy Trinity Centre
Gerry	McClelland	Community Counselling
Aoine	McMahon	Threshold NI Ltd
Roisin	Murphy	Opportunity Youth
Mark	O'Donnell	Belfast Regeneration Office
Maria	O'Kane	Consultant Psychiatrist
Brenda	Quinn	Manager - Mental Health
Susan	Semple	Health Care Co-ordinator for the Homeless
Karl	Toohar(Chair)	Self Injury Ireland
Margaret	Woods	NWBHSST

Family Support Working Group

Heather	Adair	Rethink
Joe	Barnes (Joint Chair)	Tar Isteach
Maria	Burke	Ligoniel Healthy Living Centre
Jacqueline	Crossley	
Mairead	Gilmartin	Falls Community Council
Evelyn	Gilroy (Joint Chair)	Beechmount Community Council
Pat	Lynch	AWARE
Geraldine	Magee	N&WBHSST
Carol	McCartan	
Anne-Marie	McClure	Opportunity Youth
John	McClure	Irish Church Missions
Valerie	McConnell	Rethink
Maura	McCrory	Fall's Women's Centre
John	McGeown	N&WBHSST
Denise	McHugh	174 Trust
Jackie	McIlroy	N&WBHSST
Eleanor	McMullan	PRAXIS
Liz	McShane	HEART Project
Angela	Meyler	CAUSE
Jo	Murphy	North Belfast Partnership
Ann	O'Neill	AN Loiste Uir
Catherine	O'Neill	Radical
Jenny	Oliver	Belfast City Council
Amanda	Patterson	New Life Counselling Service Ardoyne
Sharon	Pickering	Politician
Esther	Rafferty	N&WBHSST
Clare	Rogan	Newlife
Irene	Sherry	Ashton Centre
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Gerry	Ward	AWARE
Trevor	Williams	Holy Trinity and Emmanuel Parishes
Briege	Wright	
Margaret	Wylie	Mothers Hope

Communications Working Group

Sinead	Byrne	Health Promotion Agency
Tom	Crossan	Belfast City Council
Colm	Glover	Politician
Tommy	Holland	Frank Cahill Resource Centre
Margery	Magee (Joint Chair)	HAZ
Mimi	McAlinden	Investing for Health
Cara	McHugh	Opportunity Youth
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