

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

Please use this questionnaire to tell us your views on the draft strategy.

Please send your response by **Friday 4 November 2016** to:

phdconsultation@health-ni.gov.uk or to

Health Improvement Branch
Room C4.22
Castle Buildings
Stormont Estate
BELFAST
BT4 3SQ

I am responding as... *(Please tick appropriate option)*

a member of the public;

a professional / practitioner working with people affected by suicide

(Please specify which area / sector)

Health and Social Care

Education

Justice

Other*(Please specify)*;

on behalf of an organisation, or

Other.....*(Please specify)*;

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ANY OTHER MATTERS

Q10. Please provide any other comments or suggestions that you feel could assist the development and delivery of the Strategy.

Comments:

Introduction

Established in 2006 by the renowned trade unionist and human rights leader Inez McCormack, the Participation and the Practice of Rights (PPR) organisation works to support marginalised people and groups to use a human rights based approach to make change on the socio-economic issues which impact their lives. We currently work with people affected by unemployment, changes to social security benefits, people living in poor social housing and those who are homeless as well as those impacted by suicide and self harm. Our methodology was recognised in 2012 by the UN Office of the High Commission for Human Rights as a good practice example of how communities can claim their rights. In 2013 Mary Robinson, former UN High Commissioner for Human Rights and former President of Ireland, described PPR's work as "the way in which human rights work should be, but isn't, done".

Since 2006 we have worked to support mental health service users, carers and families bereaved through suicide in their work to improve mental health service delivery. This work began with a group in Belfast – the Belfast Mental Health Rights Group, whose campaigning work resulted in the adoption of a new appointment system for those in mental health crisis visiting A&E departments – the Card Before You Leave. This work has now grown and involves a range of groups impacted by mental health who campaign to make improvements – known as the Mental Health Rights Campaign. We will not be making detailed analysis to be made of all aspects of this consultation, rather on the basis of our work we are contributing to this consultation and are making specific comment on Objectives 1,2,4 and 6 -10 ('Postvention').

Human Rights Standards

The role of government generally in the delivery of health related services, specifically, is to respect, protect and fulfil the right to health. This duty is clearly identified in international law, notably article 12, of the International Covenant on Economic, Social and Cultural Rights (ICESCR), to which the governments of the United Kingdom and Ireland are signatories. Article 12 states;

"The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health"

This is interpreted as the right not only to "timely and appropriate" health care, but also to underlying determinants of health, including water, sanitation, food and health related education and information.¹

The United Nations Committee on Economic, Social and Cultural Rights, which is charged with monitoring state compliance with ICESCR has identified that the obligations regarding the right to health, extend to ensuring that healthcare is accessible. For example, General Comment 14 issued by the Committee in 2000 states;

¹ CESCR General Comment 14, Para 11

“...health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.”²

United Nations Committee on Economic, Social and Cultural Rights has made recommendations specific to the right to health in its examination of the United Kingdom and Northern Ireland in June 2016. The Committee recommended:

“The Committee urges the State party to continue its efforts to guarantee the effective implementation of the mental health legislations in all jurisdictions of the State party and to ensure the accessibility, availability and quality of mental health care, including for persons in detention.”

While governments are under a duty to ‘progressively realise’ the right to health, some elements place an unconditional and immediate obligation on the state, including:

“To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them.”³

Notably for our work and this consultation, the UN underlines the importance of participation of groups in decision making around the way in which the right to health is given effect. Essentially, people affected should have a say.

“Under international human rights law, the right of individuals and groups to participate in decision-making should be an integral part of all the policies, programmes and strategies intended to implement the obligation of States parties.”⁴

General

We note with concern the level of suicide rate in northern Ireland, despite 10 years since the introduction of Protect Life. The rate of suicide has decreased in all other regions of the UK except here, where it has increased. The consultation document notes (p55) that the feedback from pre-consultation and workshops indicated Protect Life worked reasonably well, yet with suicide increasing we must question how well it has achieved its aims.

PPR would like to highlight the link between mental health, suicide and deprivation. While this is noted to some extent in the consultation document, it is not adequately explored or explained – nor are there concrete recommendations or actions for how this will be addressed. Rather the approach seems to a general, rather than targeted, approach. A stated aim of Protect Life 2 (PL2) being to ‘reduce suicide rate and narrow gap between rich and poor areas’. PPR questions how this aim can be achieved without increased, and targeted, funding.

In addition, we note with concern that while Protect Life 2 highlights the links between mental health, suicide and deprivation/poverty, it is the same administration that is enforcing welfare ‘reform’ (cuts) and austerity (i.e. public sector job loss). A real approach to reducing suicide and improving mental health must begin with reversing these cuts and ensuring an adequately funded, and humanly operated system of social provision.

² (2000) United Nations Committee on Economic, Social and Cultural Rights, General Comment 14, paragraph 12(b)(i)

³ CESCR General Comment 14, para. 44(d)

⁴ CESCR, General Comment No.14, para 54

Additionally, while the consultation document does note some of the concerns about increased use of online services in preventing suicide and self-harm, it doesn't address about those who can't access computers/internet due to age, language, resources – despite these being groups most at risk of suicide.

Funding

PPR and the MHRC have recently raised the issue of lack of balance of funding for mental health compared with physical health. Currently, while mental health accounts for approximately 25% of health cases it currently receives only 8.5% of the health budget. The Mental Health Rights Campaign group sent an Open Letter to the Health Minister calling for funding of mental health services in line with need. The letter was signed by over 600 mental health service users, their families and carers from across Northern Ireland, as well as endorsed by 30 major mental health charities, professional bodies including the Royal College of Psychiatrists, Bamford Mental Health Research Centre University of Ulster, Action Mental Health, CAUSE Carers Foyle, Contact, Cruse Bereavement Care in Northern Ireland, Mindwise, East Belfast Counselling, UNISON, Northern Ireland Association for Mental Health (NIAMH), New Life Counselling and Praxis Care as well as academics Professor Colin Harvey, Professor Siobhan O'Neill and Professor Brice Dickson.

Despite a 20-25% higher prevalence of mental health problems in Northern Ireland than in other jurisdictions of the UK, investment in mental health services is between 10-30% lower than per capita spend in England. Research has also highlighted that between 2008 and 2014 the actual spend on mental health by all Trusts has been around 25% less than that proposed.

In light of this, the letter calls for 25% of the recent additional £72 million received by the Department of Health to be allocated to mental health services, and for progressive steps to be taken to ensure that a proportionate share of health funding goes on mental health.

Their call for funding parity has been echoed by the United Nations. Under international human rights law the Northern Ireland Executive has a duty to ensure that everybody has the right to the highest attainable standard of health, including mental health. Yet in June 2016 the UN body charged with monitoring the government's compliance with this duty expressed concern "*at the lack of adequate resources provided to mental health services*".

The Minister for Health Michelle O'Neill responded stating that mental health was one of her key priorities and that she looks forward to '*tackling issues in relation to the funding of mental health, development of new services, improved delivery of those services, and genuine and meaningful involvement of service users at every stage*'. She goes on to say that she is '*delighted that mental health is being given such a priority in the forthcoming Programme for Government, and moving towards parity of esteem- making progress to the point where mental health gets its fair share of time, effort, attention and resources*' is a concept she is committed to. The Minister also indicates that she will respond in detail to the issues raised in the Open Letter.

More recently, in the Department of Health's report 'Health and Wellbeing 2026 – Delivering Together', the Health Minister states that her department is "*committed to achieving a parity of esteem between mental and physical health to ensure that we are tackling the true impact of mental health on our communities.*"

Recommendations

In line with the 10 Objectives laid out in Protect Life 2 (PL2), PPR has the following recommendations if these Objectives are to be achieved. These recommendations are expected to complement other efforts laid out in PL2. Only those areas most relevant to PPR's work are commented on; lack of comment on other objectives/areas does not imply approval.

Objective 1: "Fewer people who are in contact with mental health services, die by suicide".
Objective 2: "Reduce the incidence of repeat self-harm presentation to hospital emergency departments."

General Practitioners Role

Throughout the consultation document is noted that high number (72% of people) are not in contacted with mental health services in the 12 months before they die by suicide. It also notes that GPs are overall the main source of contact for people for mental health in general, and specifically that the last medical professional most people have contact with before attempting suicide is their GP (p30). In the consultation document recommendations (p70), 'gatekeepers' (which include primary health care professionals) need to be trained in spotting risk of suicide and self harm.

In the Department of Health's recent report 'Health and Wellbeing 2026 – Delivering Together', the Health Minister notes that "Primary care is the bedrock of our health and social care system and provides around 95% of the care people need throughout their life", and she pledges more funding for mental health interventions in primary care.

Recommendations (re Objective 1): Appropriate funding and training of GPs regarding mental health. To implement Health Ministers recommendations regarding GP multi-disciplinary teams in recent response to Bengoa. We echo the calls made by BMA Northern Ireland in their recent 'General Practice in Crisis' [report](#), including recommendations on increased funding and especially the call for "Immediate resources to fund an expanded and comprehensive primary care team to reduce and relieve GPs workload, including mental health practitioners, health visitors, advance nurse practitioners, physiotherapists and physician associates."

Card Before You Leave

In 2008, the Belfast Health and Social Care Trust, published research carried out by Mr Evan Bates entitled "A report on patterns and trends in the use of hospital services in Northern Ireland." This research analysed patterns and trends in the use of certain hospital services during the period 1998/1999 and 2006/2007, taking account of geographical area, age, gender and economic deprivation. It concluded that deprived communities disproportionately access health service through an A&E setting whereas their more affluent neighbours are more likely to access healthcare provision through GPs.⁵

The Card Before You Leave is an appointment card scheme which provides a follow up appointment for people who present at A&E at risk of self harm or suicide who are not admitted and who do not receive their psychosocial assessment then and there. The scheme was launched across Northern Ireland in January 2010 and its aim is to prevent

⁵ Belfast Health and Social Care Trust (2008) "A report on patterns and trends in the use of hospital services in Northern Ireland."

people falling through the cracks by leaving hospital with nothing.

In 2013, following a positive HSC Board evaluation of the scheme, a further recommendation was made that Trusts should consider the use of a 'duplicate card' for carers who attend A&E with a patient so that they too have access to the information about the date and time of the follow up appointment. This evaluation also noted that on average, 160 people per month receive a Card Before You Leave appointment card.

The Belfast Mental Health Rights Group and PPR have been involved in the campaign for and the implementation of the scheme since its inception. In 2015, the BMHRG withdrew from the Self Harm Working Group, the body charged with implementation of the scheme, because of concerns that their participation was not meaningful.

Current concerns regarding the implementation of CBYL

- **November 2015: PIPS organisation are reporting to PPR that many people are leaving the Mater Hospital A&E without a Card Before You Leave appointment card.**

PIPS said;

"We have had some of our clients who have been in A&E and also being seen by the mental health team leaving with nothing. The following week or weeks getting a letter stating they did not attend their appointment with a psychiatrist and they need to go to their GP to get a new referral"

- **August 2015: [Self Harm Working Group Visits to Ulster, Mater and Altnagelvin Hospitals A&E Departments.](#)**

The report from the visits confirms many of the concerns that the group has raised; for example, delays in sectioning under the Mental health Order in all Trusts visited, duplicate cards not being given out in Belfast Trust, issues with communication/recording patient details in Belfast Trust/family Guides not being given out in Belfast Trust etc. Additionally, information regarding the sectioning process was not properly displayed at the Mater.

- **Summer 2015: [Data received under FOI regarding the implementation of the CBYL in different trust areas highlights gaps in monitoring and implementation.](#)**

Information received under Freedom of Information request from each of the Trusts paints a worrying picture about the scheme's implementation. Inconsistencies in data collection regarding the scheme's operation across the Trusts are clear. Additionally, where information is collected it evidences persistent problems with people not receiving an appointment card and instead receiving a follow up phone call. To put this concern in context, information received from the Belfast Trust indicates that in 2014-15, of the 874 people referred to the Card Before You Leave system, only 57 received a fixed appointment. A further 341 were offered an appointment by telephone. Critically, 417 people in need of a follow up appointment but who had refused care could not be contacted by telephone. The very people this scheme was designed to protect are being allowed to slip through the cracks.

The Public Health Agency's own evaluation of Protect Life highlights 'Improving hospital emergency departments' as an area which needs particular attention (p54). Additionally, PL2's pre-consultation findings highlighted this as a gap which needs addressed. The 'Twelve points for a safer service', produced from the findings of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NICISH), noted with concern missed appointments/contacts with services and highlighted the need for follow up

after patient discharge which should take place within 7 days. The implementation of NICISH findings in England and Wales reduced suicide.

Recommendation (re Objectives 1 & 2): CBYL has been recognised by the Trust/HSC as having power to reduce risk of suicide, and therefore if properly implemented would help both Objective 1 and 2 to be achieved. Yet, there remain ongoing issues with how CBYL information is recorded. This would need prioritisation and resources. It is vital that resourced system is implemented, which is monitored so that there is annual increase in successful implementation.

Objective 4: “Enhance the initial response to, and care and recovery of, people who are experiencing suicidal behaviour and to those who self-harm.”

General Practitioners

As stated previously, the PHA’s own evaluation of Protect Life highlights GP role in suicide prevention as an area which needs particular attention (p54). Their own pre-consultation highlighted the need to address gaps in primary care and for “greater recognition that GPs have a critical role in preventing suicide” (p56). The Health Minister has recently stated that “Primary care is the bedrock of our health and social care system and provides around 95% of the care people need throughout their life”. While there is a high number of people (72%) having no contact with mental health services in the 12 months before they die by suicide, it is equally the case that for many of same people their GP is the last health professional they have contact with. The PL2 consultation document has highlighted how GPs need to be trained to recognise signs of risk of self harm and suicide.

GPs are most often the first point of contact for people with mental health problems, but too often they are not working as they should. An issue that is regularly brought up by mental health service users, their families and carers is the lack of timely and appropriate services provided by GPs for people who present with mental health problems.

GPs are often the first point of contact for people in this situation and so are well placed to ensure that people receive the right help at the right time. This is particularly the case in areas of social deprivation where the rate of mental health problems in the most deprived areas (30%) is double the rate in the least deprived areas (15%). Unfortunately, as borne out by human rights monitoring conducted by the Mental Health Rights Campaign, too often this is not what happens in practice.

In 2015 58% of people surveyed indicated that waiting times to see GPs were unsatisfactory or very unsatisfactory, while less than half (41%) felt that their GP had offered them the most appropriate type of care.

During late spring/summer 2016 PPR worked with a number of mental health groups across Northern Ireland to explore in more depth the specific issues that exist with accessing timely and appropriate help from GPs. Workshops were held with various groups including CAUSE carers group in Foyle, STEPS in Draperstown, SAM88 in Cookstown and the Belfast Mental Health Rights Group.

Among the issues raised by people were difficulties getting an initial appointment, difficulties in rural areas with getting an out of hours appointment when experiencing a mental health crisis, lack of privacy in reception areas, not enough time for appointments, lack of expertise among GPs in relation to mental health and no mechanisms for patient participation. Difficulties with getting an appointment were raised by all groups.

The lack of expertise in relation to mental health was also frequently raised. People felt strongly that among the specific training in relation to mental health that GPs should be required to have undertaken was the Applied Suicide Intervention Skills Training (ASIST).

Many of the problems identified by patients, their families and carers are readily acknowledged by GPs themselves. [A survey commissioned by the Royal College of GPs in 2015](#) shows that nearly three quarters (72.5%) of adults in Northern Ireland believe that GP waiting times are at crisis level. Two thirds (64.8%) of people surveyed were not able to book an appointment with within the same week. The poll found that patients in Northern Ireland have the longest GP waiting times.

GPs have highlighted the need for a major overhaul of how GP practices deliver services to patients, including people presenting with mental health problems. Among other recommendations put forward to the Health Minister, the [British Medical Association](#) has called for primary care teams to be expanded to include mental health practitioners.

The [Health Minister's response](#) to the Bengoa Expert Panel's recommendations on reform of the Health Service, '*Health and Wellbeing 2026*', recognised that primary care is the 'bedrock' of the health and social care system, providing as it does 95% of the care people need throughout their life. It sets out a commitment to increased investment in GP services with more funding for mental health interventions in primary care. As all the proof of the pudding will be in how this vision is delivered upon.

Recommendations (re Objective 4 – as with Objective 1): Appropriate funding and training of GPs regarding mental health. To implement Health Ministers recommendations regarding GP multi-disciplinary teams in recent response to Bengoa. We echo the calls made by BMA Northern Ireland in their recent 'General Practice in Crisis' [report](#), including re funding and especially the call for “Immediate resources to fund an expanded and comprehensive primary care team to reduce and relieve GPs workload, including mental health practitioners, health visitors, advance nurse practitioners, physiotherapists and physician associates.”

Postvention Objectives (6-10)

The consultation document highlights that there is “significant effort into seeking and negotiating help for a family member” following a suicide. The PHA's own evaluation of Protect Life highlights clear pathways of postvention support as an area which needs particular attention.(p54) Suggestions from pre-consultation to were address gaps, and recommended the “better sharing of information”, and called for a “reduction in time” between death of family member and receiving support,

For those affected by suicide, proper post-bereavement support can be vital to improving their mental health, and so decreasing the likelihood of further suicide.

However, PPR and the MHRC have identified several ways in which the current bereavement support model is falling short. We identified the problems as:

- difficulties in referral,
- lack of information on support available,
- lack of referral for those who die in hospital, and
- time delays in receiving support.

The Current Process for SD1

Information received by PPR in March 2016 relating to the Belfast Trust in response to a Freedom of Information request, showed however that in 2014, 41 SD1 forms were received and 25 requests for support were made. In 2015, 55 SD1 forms were received and 30 requests for support were made. **Overall just over 50% took up the offer of support through the SD1 process.** This does raise concerns that families are not receiving support given the associated risks.

A range of issues with the SD1 process were highlighted by the group from their own experiences. For example, families have raised the issue that this support is offered just after the death, when they may not be in a frame of mind to accept it. In addition, families report that when asked, the PSNI could not always explain the type of support on offer. Also, police and social services can be perceived negatively in some communities in Northern Ireland and thus people might not want to take the support. Indeed research advises for a careful approach following suicide noting “the secondary trauma investigations can cause”⁶. Finally, there is no current process akin to SD1 where a family member attempts suicide but later dies in hospital, and therefore families are missing out on support referrals.

Research carried out by the Mental Health Rights Campaign shows that bereaved families have trouble accessing support and having access to information about what services are available. **Surveys showed in 2015 that 100% of carers highlighted access to information for someone in mental health crisis as being problematic/core issue for them.**

Support group members from both SOS and SAFE Together felt that the PSNI could not identify the support that was on offer, and this was a factor in not giving permission to receiving support.

Focus groups with families bereaved by suicide in Belfast further elaborated on the nature of the problems post bereavement. One group member explained how it is difficult to know if you need help so close in time to the bereavement as it is such a traumatic time. Next of kin are usually asked this by a police officer about whether they want support within a short period of time of the death.

Even when families take up support, there are time delays. Support should be offered in 48 hours. However, very few people get this.⁷

Deaths in hospitals

Family members also raised the issue of lack of post bereavement support when an individual dies in hospital following a suicide. There is no SD1 process of support referral, as PSNI guidelines do not mandate them to investigate deaths in hospitals (even suicides) except in exceptional circumstances.

Suicide is recognised as being particularly difficult on families, and that the bereavement from this is unique to other forms of death. Given the mental health implications and increased risk of suicide, extra measures are needed. While deaths in hospitals following a suicide present unique difficulties, being in the hospital setting before deaths means that

⁶ ‘A death like no other’

⁷ One worker noted that out of 12 families she worked with, only 3 had received support within 48 hours.

Trust polices on End of Life Care, which:

“identifies bereavement care as a key part of palliative and end of life care,”⁸

allow the Trust the opportunity to start the support process as soon as is possible/suitable, giving the family extra resources to cope.

However, while staff are able to provide some information of where to go for help, as with deaths in the home this is not enough. Group members have identified the need for a referral process, and as with the recommendations for the SD1, that this process be automatic.

Recommendations (re Postvention Objectives 6-10): PL2 lists “Further development and evaluation of SD1 process” as an ‘action’. The work of MHRC with the support groups strongly calls for the need for a system of automatic referral for bereavement support. Below are some suggestions for how this could happen. The current SD1 process could be amended to be in line with the Victim Support model of automatic referral unless the family actively declines. For deaths in hospital, a system mirroring (but not necessarily linked to) the SD1 process, amended to be automatic, would be in line with HSC Bereavement objectives. Finally, automatic referral to the coroner’s office as a place to manage bereavement support has been proposed by the group and has found success in other jurisdictions.

Automatic referral to bereavement support through SD1

The current model for referral to bereavement support is not working sufficiently well for families. Data released through FOI showed that in 2014 and 2015 almost 50% of families were not opting for referral when the police were completing the SD1 forms. As we have stated, many families have shown how that the offer of support is coming too soon and that police often cannot fully explain what is on offer.

Yet families do want support, and thus have suggested automatic referral to be used instead. This could simply mean PSNI officers informing families that their details are being passed on. As with other automatic referral services, families can state they do **not** want support at the time, and can opt out at a later stage.

Making SD1 an automatic referral would bring it in line with support offered to others who have been through a traumatic experience – namely victims of crime.

If you have been a victim of a crime,

*“The police will **automatically** pass your details to Victim Support NI and other criminal justice organisations, so you can be offered information on additional services (including support services). They can advise on medical support or alternative accommodation should this be required as a result of the crime.”⁹*

Further to this the PSNI Victims Charter states that:

“You are entitled to have the police pass your details to a victim support service provider (unless you object) so that you can be offered information on what support

⁸ “Living Matters; Dying Matters: A Palliative and End of Life Care Strategy for Adults in Northern Ireland” March 2010 Department of Health www.ncpc.org.uk/sites/default/files/8555_palliative_final_0.pdf

⁹ ‘Information for victims of crime’ Department of Justice p2 (<https://www.justice-ni.gov.uk/sites/default/files/publications/doj/information-for-victims-of-crime.PDF>)

services, including specialist support services, are available to you. You do not have to use these services.”¹⁰

The automatic referral to support services may potentially raise data protection issues. However, within the Trust’s Current Family Support Guidelines¹¹ regarding SD1 referrals, it already emphasises the importance of keeping families information private, and requires that staff only using persons initials when Family Support Plan is forwarded to community representatives involved. Additionally, as we are arguing that the PSNI extend their automatic referral used in Victim Support to the SD1 process, they can use their already developed data protection methods here.

The Data Sharing Code of Practice, which covers activities such as police passing on information and GPs sharing patient information with a hospital, emphasises that:

*“under the right circumstances and for the right reasons, data sharing across and between organisations can play a crucial role in providing a better, more efficient service to customers in a range of sectors – both public and private.”*¹²

The Code also highlights situations:

*“of when, or whether, it is acceptable to share information without people’s knowledge or consent or in the face of objection”.*¹³

Given the noted effects of poor or delayed bereavement support following a suicide, introducing automatic referrals will help Trusts meet the Protect Life objectives of **all departments playing a pro-active role in determining actions in support of suicide prevention.**

Automatic referral for deaths in hospital

An additional area in which bereavement support was not meeting families’ needs was around deaths in hospitals following a suicide attempt. Group members stated that the choice of support referral (for example through the SD1 process) when a death happens outside of hospital was not open to them. The Trust guidelines around sudden death and bereavement in general would support the introduction of an automatic support referral process, in line with our above proposed changes to SD1. Because the PSNI only rarely investigate deaths in hospitals (even suicides),¹⁴ the Trust will need to create their own automatic referral policy (but can be modelled on SD1).

Our suggestion is situated in general bereavement guidelines, which notes that the majority (three quarters) of deaths in Northern Ireland are in a hospital setting. It also notes the seriousness of sudden/violent deaths. Therefore it is highly problematic having no clear systems/guidelines for automatically linking families into post bereavement support if their

¹⁰ Victim Charter Summary, A Charter for victims of crime, Understanding your entitlements and the support you can get Department of Justice p8 (https://www.psnipolice.uk/globalassets/advice--information/victim-support/n-i_victims_charter_summary.pdf)

¹¹ Trust’s Current Family Support Guidelines, VG Guidelines Comm’ Pathways, December 2014, Belfast HSC Trust, obtained in Freedom of Information Request (12 Feb 2016)

¹² Data sharing code of practice, Information Commisioners Office, May 2011, p4 (https://ico.org.uk/media/for-organisations/documents/1068/data_sharing_code_of_practice.pdf)

¹³ Data sharing code of practice p7

¹⁴ Memorandum of Understanding. Investigating patient or client safety incidents (Unexpected death or serious untoward harm): Promoting liaison and effective communications between the Health and Social Care, Police Service of Northern Ireland, Coroners Service for Northern Ireland, and the Health and Safety Executive for Northern Ireland. (www.hscbereavementnetwork.hscni.net/wp-content/uploads/2014/05/memorandum-of-understanding_investigating_patient_or_client_safety_incidents.pdf)

loved one dies in hospital following an attempt to take their own life. Current guidelines say bereavement support should start even before death – this is possible with people coming in after suicide attempt. While Trust guidelines have many positive aspects such as informing families of help available, as with the SD1 process this needs to be automatic (unless the family expressly opts out).

Allowing for deaths in hospital which follow a suicide attempt to be put through an automatic referral process will allow Trusts to fulfill current HSC Bereavement Care policy (2009) aims. This policy stresses the need to

- *“improve the quality of care delivered in the Health and Social Care services for family, friends and carers of people who are dying*
- *create a holistic, co-ordinated approach to bereavement care, which applies during the ‘journey’ of bereavement (i.e. prior to, at the time of, and following the death).”*¹⁵

And to heed by these principles:

- *“Communication, information and resources: That people who are dying and those who are affected by bereavement will have access to **timely, accurate and consistent information***
- *Working together: That good communication and co-ordination will take place within and between individuals, organisations and sectors,*
- *Arrangements for immediate support should be in place when death is sudden or due to traumatic circumstances”*¹⁶

Families of people who enter hospital after a suicide attempt also should avail of bereavement support as soon as possible, and not necessarily only after their family member passes away. This will help fulfil Trust policies on End of Life Care which:

*“identifies bereavement care as a key part of palliative and end of life care.”*¹⁷

Automatic referral to coroner’s officer for bereavement support

Support group members highlighted the positive experience they had of the role the coroner’s office played in bereavement support. Suicides must be reported to the coroner’s office¹⁸. This includes deaths in hospital. A Memorandum of Understanding (MOU) between the PSNI, HSC and the Coroners’ office states that

*“There is a general requirement under section 7 of the Coroners Act (Northern Ireland) 1959 that any death **must** be reported to the coroner if it resulted, directly or indirectly, from any cause other than natural illness or disease for which the deceased had been seen and treated within 28 days of death. [...]For example[...]; deaths associated with the misuse of drugs (whether accidental or deliberate); any apparently suicidal death; [etc]”*

Therefore, as all suicides should be reported to the coroner’s office, this provides an opportunity for them to be involved in overseeing the bereavement support. This model has worked in other jurisdictions.¹⁹

A recent piece of research examined a similar model which works successfully in Australia. In the Coroner’s office for New South Wales the forensic counsellors (social workers):

¹⁵ Northern Ireland Health and Social Care Services Strategy for Bereavement Care pp 4-10

¹⁶ Northern Ireland Health and Social Care Services Strategy for Bereavement Care pp10-14

¹⁷ Living Matters Dying Matters A Palliative and End of Life Care Strategy for Adults in Northern Ireland March 2010 www.ncpc.org.uk/sites/default/files/8555_palliative_final_0.pdf

¹⁸ Coroners Service for Northern Ireland, Courts NI ([https://www.courtsni.gov.uk/en-GB/Publications/UsefulInformationLeaflets/Documents/Coroners%20Service%20for%20Northern%20Ireland/Coroners%20Service%20for%20Northern%20Ireland%20\(HTML\).htm](https://www.courtsni.gov.uk/en-GB/Publications/UsefulInformationLeaflets/Documents/Coroners%20Service%20for%20Northern%20Ireland/Coroners%20Service%20for%20Northern%20Ireland%20(HTML).htm))

¹⁹ Developing Psychoeducation Bereavement by Suicide Groups (Australia & New Zealand) Anne Embury, The Rank Foundation, 2014

“make initial contact to the next of kin within a day or two of the death being reported to the Coroner, providing psychosocial support and information about the autopsy and the Coronial process.”

“The team work with the Coroner’s office and police to facilitate supported access to post mortem and Coronial reports, and viewing the body.”

As the forensic counsellors, who provide information, support and counselling to families in the aftermath of suicide, are part of the Coronial system, they can contact the next-of-kin immediately following a death to provide support, working alongside Police. While there is a high rate of complaints re bereavement in the UK, a team which was the focus of a study reported:

“that they have never received a complaint about their proactive approach from anyone contacted immediately following a death.”²⁰

These recommendations came from work following 3 focus groups with people bereaved by suicide including the Belfast Mental Health Rights Group (BMHRG), the Safe Together Group and Survivors of Suicide in Spring 2016 on the issue of post-bereavement care. They identified from their own experience the Sudden Death 1 (SD1) Form as a key measure that should be improved. Subsequent research, discussions with key support workers with in-depth knowledge of the impact suicide has on a family, and the mental health system also pointed to a need for change in this area.

In summary:

- An automatic referral for the SD1 process. An automatic referral policy already exists with Victim Support and so the principles (and solutions to obstacles such as data protection) can be applied here.
- A newly formulated referral process comparable to an automatic SD1 referral process for deaths in hospital following admission following a suicide attempt.

If our above recommendations are implemented, it will help Protect Life 2’s Postvention Objectives (Objectives 6-10) to be achieved. These recommendations will strengthen the Department for Health and its agencies’ human rights obligations, especially in regards proactively protecting the right to life by putting in measures to prevent suicide.

**Please return your response questionnaire.
Responses must be received no later than 5pm Friday 4 November 2016
Thank you for your comments.**

²⁰ *Developing Psychoeducation Bereavement by Suicide Groups pp9-10*