Just economics

Lost Futures:

Poverty, Inequality and Suicidality in Northern Ireland

SAMARITANS

Conducted by

Eilis Lawlor
Eva Neitzert

Edited by Ellen Finlay

Table of Contents

Table of Figures

Table of Tables

Foreword

Poverty, unemployment, and debt should not cost lives, yet this is the devastating reality for many in Northern Ireland today. Suicide is a tragedy disproportionately affecting the most vulnerable in our communities, cutting short lives and leaving families and communities to grapple with profound loss.

Northern Ireland faces a suicide rate that surpasses not only the UK average but also that of the Republic of Ireland and the EU-27. While much effort has been placed on providing support through mental health services and helplines, these responses often address symptoms rather than the deeper structural causes of suicidal behaviour. Addressing the socio-economic drivers — poverty, inequality, and lack of opportunity — is critical to creating meaningful, long-term change.

In commissioning this report, Samaritans sought to build a clearer picture of the connection between economic disadvantage and suicide. Drawing from in-depth research and lived experiences, this work sheds light on the complex interplay of political, social, cultural, and economic factors unique to Northern Ireland. It offers not only valuable insights but also a call to action: suicide is preventable, and we must all play our part in making that a reality.

Collaboration is key. Governments, policymakers, community organisations, and individuals must work together to tackle the systemic inequalities driving despair in our society. The findings of this report underline the urgency of investing in prevention strategies that go beyond immediate interventions, ensuring that those most at risk are supported, not just in moments of crisis, but through sustained, structural change.

Behind every statistic is a person — someone's child, partner, or friend. By addressing the causes of inequality and building systems of support that prioritise dignity and opportunity, we can move closer to a future where fewer lives are lost to suicide.

Sarah O'Toole
Executive Director
Samaritans Ireland

01. Introduction

Global suicide rates peaked in the 1980s and have been declining since then, reaching a rate of 9 per 100,000 in 2019. [1] The global decline in suicide rates masks stark cross-national differences. For example, suicide rates have been declining in Europe but rising steadily in the US.[2] It is also reported that in the US only 30% of individuals with suicidal behaviour present to medical services,[3] and there is a risk therefore that rates are underreported.

International research has consistently found a relationship between self-harm or suicide and socioeconomic status,[4] [5] [6] particularly unemployment, low education, and low income. These factors have also been found to exacerbate other risk factors, such as relationship breakdown.[7] In addition, suicide rates tend to be higher in low-income communities.[8]

Northern Ireland, has one of the highest suicide rates in the UK[9] and the rate is also higher than the rate in the Republic of Ireland and the average for the EU-27.[10] Previous research, specifically from Northern Ireland, has found that Indicators of disadvantage were strongly related to the risk of suicide.[11] In 2022, NISRA data showed that 31% of all deaths by suicide were in the most deprived quintile.[12]

[1] Saloni Dattani, Lucas Rodés-Guirao, Hannah Ritchie, Max Roser and Esteban Ortiz-Ospina (2023) - "Suicides" Published online at OurWorldinData.org. Retrieved from: https://bit.ly/4hWbaBl

[2] Martinez-Ales, G., Hernandez-Calle, D., Khauli, N., & Keyes, K. M. (2020). Why are suicide rates increasing in the United States? Towards a multilevel reimagination of suicide prevention. Behavioral neurobiology of suicide and self harm, 1-23.

[3] Pescosolido, B. A., Lee, B., & Kafadar, K. (2020). Cross-level sociodemographic homogeneity alters individual risk for completed suicide. Proceedings of the National Academy of Sciences, 117(42), 26170-26175.

[4] Kim, J. L., Kim, J. M., Choi, Y., Lee, T. H., & Park, E. C. (2016). Effect of socioeconomic status on the linkage between suicidal ideation and suicide attempts. Suicide and Life-Threatening Behavior, 46(5), 588-597.

[5] Näher, A. F., Rummel-Kluge, C., & Hegerl, U. (2020). Associations of suicide rates with socioeconomic status and social isolation: Findings from longitudinal register and census data. Frontiers in psychiatry, 10, 898.

[6] Page, A., Morrell, S., Taylor, R., Carter, G., & Dudley, M. (2006). Divergent trends in suicide by socio-economic status in Australia. Social psychiatry and psychiatric epidemiology, 41, 911-917.

[7] Næss, E. O., Mehlum, L., & Qin, P. (2021). Marital status and suicide risk: Temporal effect of marital breakdown and contextual difference by socioeconomic status. SSM-population health, 15, 100853.

[8] Rehkopf, D. H., & Buka, S. L. (2006). The association between suicide and the socio-economic characteristics of geographical areas: a systematic review. Psychological medicine, 36(2), 145-157.

[9] Nisra. (2023) Suicide Statistics in Northern Ireland, 2002 – 2022 https://bit.ly/3EEKhDx

[10] CSO (2019) Suicide Statistics 2019 https://bit.ly/4gEgcBj

[11] O'Reilly, D., Rosato, M., Connolly, S., & Cardwell, C. (2008). Area factors and suicide: 5-year follow-up of the Northern Ireland population. The British Journal of Psychiatry, 192(2), 106-111.

[12] NIsra (2023) Suicides in Northern Ireland, 2022 https://bit.ly/4gFTFUD

In 2024, Samaritans commissioned Just Economics to research the relationship between economic disadvantage and suicidal behaviour in Northern Ireland. This builds upon a previous report, Dying from Inequality, that sets out the evidence linking suicidal behaviour and personal, spatial, and societal disadvantage in the UK. This research aimed to gather firsthand accounts of these relationships with a view to:

1. Betterunderstand the context, particularly the economic, political, social, and cultural factors that are specific to Northern Ireland.

2. Identify effective interventions that target the root causes of suicidal behaviour, especially as mediated by socio-economic disadvantage in all its forms.

The research consisted of:

- a comprehensive literature and review of existing quantitative data
- a policy review of existing suicide prevention strategies in Northern Ireland
- qualitative research that engaged professionals and people with lived experience of economic disadvantage and/or mental health/suicide.

The literature was used to inform the policy review and the primary research and to help interpret the findings. The full review is in Appendix 2.

The report is structured as follows:

- **Part 2 presents the existing data, literature and suicide prevention policy for Northern Ireland**
- **Part 3 presents the findings on economic life**
- **Part 4 presents the findings on political, social and cultural life**
- **Part 5 sets out a series of recommendations**

Box 1 provides an overview of the methodology.

Box 1: Methodology

The research comprised the following:

- Literature, data and policy review
- Focus groups and interviews with professionals
- Focus groups and interviews with people with lived experience

Professionals were recruited through contacts at Samaritans. These included individuals working in the following fields: mental health/counselling, youth work, relationship counselling, gender, poverty, and caring.

Two online focus groups were conducted with a mix of professionals. Additional online semi-structured interviews were conducted with professionals who could not make the focus group dates. A total of 10 professionals were engaged.

Lived experience participants were initially recruited through contacts of Samaritans and then using snowballing. Two focus groups were conducted and additional semi-structured interviews. In total, 13 individuals (2 men, 11 women) were engaged via these methods. Some interviews were conducted via telephone, and some in person, courtesy of the North Antrim Suicide Prevention Network.

Although there was a separate strategy for recruiting the groups, in practice, many of the professionals lived in communities affected by poverty and disadvantage, and their own lived experience came to the fore in the discussions. We have therefore not distinguished between lived experience and professional responses in the findings. This also acknowledges the equal value of both forms of information to the research.

Interviews and focus groups followed a semi-structured approach. This provided participants with scope for exploring the issues that were most pertinent to them, though participants were steered towards economic determinants/intersectionality, where appropriate.

The findings set out in Chapters 4 and 5 emerged organically and closely represent the most significant issues, with the lengthier discussions reflecting the topics covered most extensively. Topic guides for the focus groups and interviews are available in Appendix 3.

Interviews and focus groups with professionals were auto transcribed and notes were taken during the lived experience sessions. These were entered into the data analysis software MAXQDA and analysed for key themes.

Samaritans' internal ethics committee approved the qualitative research with professionals and individuals with lived experience.

02. Poverty, suicide and prevention policy in Northern Ireland

This chapter presents the most recent data on poverty, suicide and its determinants in Northern Ireland. It then reviews existing suicide prevention policies and the evidence base underlining those strategies.

2.1 Suicidal behaviour and mental health in Northern Ireland

Comparing suicide rates across jurisdictions is very challenging, not least due to the time lag in reporting and the fact that annual fluctuations may not be statistically significant (see A1.1.2 for a discussion on this).

It is often reported that Northern Ireland has the highest rate of suicide in the UK. However, a review of statistics by NISRA to standardise them has found that it is slightly lower than in Scotland, albeit quite a bit higher than England or RoI (see Figure 1). The rate for the EU-27 is similar to that of England. The rate in Northern Ireland started to decrease in 2013, reflecting a wider decline experienced across the EU.[13] Unlike other areas, however, it has begun to increase again since 2016.

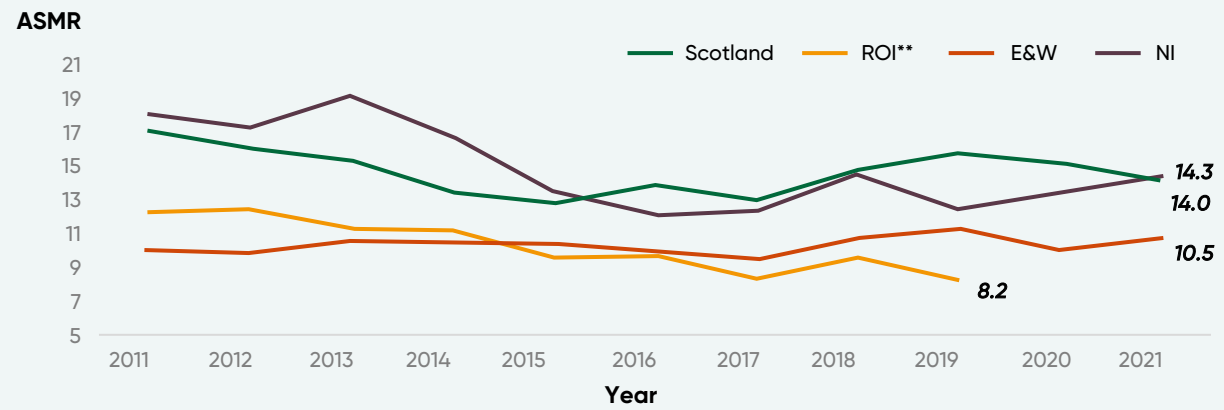


Figure 1: Comparing ASMR suicide rate

Based on available data, Northern Ireland appears to have the highest rate of self-harm in the UK, with an incidence of 20.1 presentations per 10,000 people compared to 11.4 per 10,000 people in England. However, whilst the Northern Ireland data are based on all eight hospitals, the English data are only based on a small number of hospitals and more research on this is required.

[13] Eurostat (2023) Deaths by suicide down by almost 14% in a decade https://surl.li/pbpidp

Another study has found that the self-harm rate in Northern Ireland is over two-thirds (64%) higher than in the Republic of Ireland.[14] The most striking difference in rates was observed among men, with the Northern Ireland rate being 82.9% higher than the comparative rate for men in the Republic of Ireland. Whilst there may be differences in how the rates are recorded, this is unlikely to account for all the differences.

Even taking account of differences in data quality, the pattern in the data points to Northern Ireland having worse (and worsening) outcomes in relation to mental health and suicide ideation compared with comparable jurisdictions.

Northern Ireland has experienced a sustained increase in suicide ideation since 2012/13 (see Figure 2). Increases are particularly stark in under-18s. This group has seen a combined increase (self-harm + ideation) of 76% since 2012/13. The total number of presentations to Emergency Departments for self-harm in 2021/22 was 13,803[15] compared with 12,661 in RoI, although the population of RoI is 2.7 times larger.

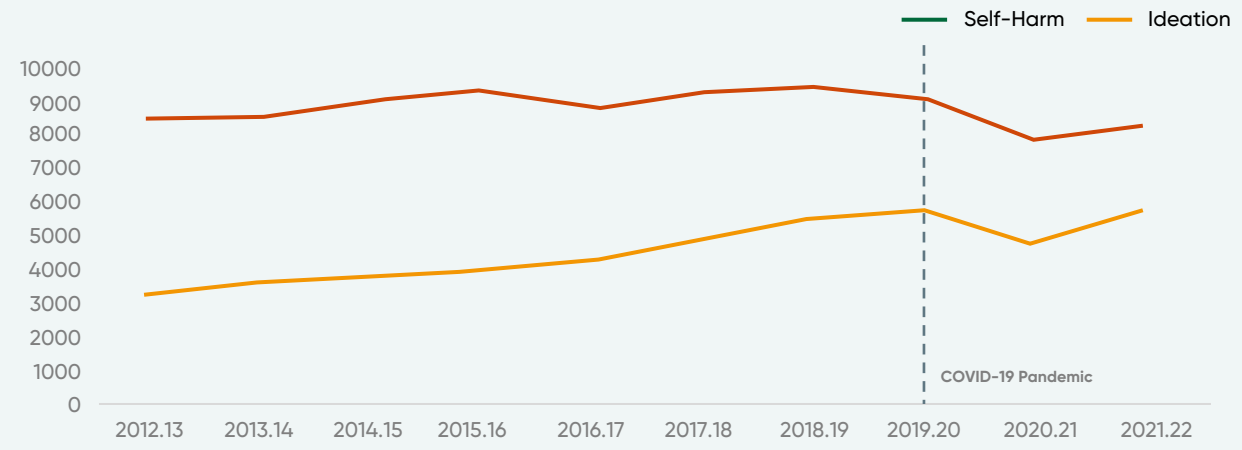


Figure 2: Self-harm and ideation 2012/13 and 2021/22

While the global age-standardised prevalence of mental health conditions has not increased by much in recent years, adolescent mental health conditions are increasing in many countries worldwide, and that growth is occurring most markedly amongst girls. Plausible causes include increased prevalence of bullying behaviour, including online bullying; education-related pressures; shifts in puberty onset toward younger ages; and challenging economic conditions (e.g. lingering effects of the 2008 financial crisis, the Covid pandemic and cost-of-living pressures). The data on youth self-harming presented above is most likely representative – at least in part – of a wider trend of declining youth mental health.

[14] Northern Ireland Assembly (no date) Knowledge Exchange Seminar Series https://surl.li/tczlxf

[15] Public Health Agency (2023) Northern Ireland Registry of Self-harm, 2020/21 & 2021/22 https://surl.li/nragzv

It is not clear whether the incidence of poor mental health is higher in Northern Ireland than in other UK countries, as there are conflicting findings depending on the measures used. Data from the Mental Health Foundation suggest that it is broadly similar (as measured by GHQ-12 and the prevalence rate of severe and enduring conditions).[16] However, a report by the National Audit Office has found it to be 25% higher than in England.[17]

Comparisons with RoI are more challenging, but one study found a higher prevalence of self-reported mental health, higher use of medications and a higher proportion of GP visits for mental health reasons in Northern Ireland.[18]

According to the World Mental Health Survey, Northern Ireland has high rates of post-traumatic stress disorder (PTSD). Trauma exposure resulting from the violent sectarian conflict (1968-1998) (known as The Troubles) is thought to account for this excess.[19]

As well as rates of mental illness, the extent to which it is burdensome for individuals is an important issue to track. In Northern Ireland, mental health issues are the largest cause of ill health and disability in the population,[20] with higher rates of disability benefit claimants than in other parts of the UK.[21]

2.2 Distribution of suicidal behaviour and mental health challenges across Northern Ireland

As is the case internationally (see A1), there is a social gradient in rates of mental illness in Northern Ireland.[22] Figure 3 categorises suicide data by decile in the Indices of Multiple Deprivation (IMD).

As we can see, the number of suicides is three times higher in IMD 10 (the most deprived decile) compared with IMD 1 (the least deprived), and the number of suicides falls as we move from category 10 to category 1.[23]

[16] Mental Health in Northern Ireland (2023) Fundamental Facts. Northern Ireland: Mental Health Foundation; Office of Mental Health Champion.

[17] Northern Ireland Audit Office (2023) Mental Health Services in Northern Ireland https://www.niauditoffice.gov.uk/files/niauditoffice/documents/2023-05/00293490%20-%20Mental%20Health%20Report_WEB.pdf

[18] Health Research Board (2006/8). National Psychological Wellbeing and Distress Survey [data collection]. Version 1. Dublin: Irish Social Science Data Archive SN: 0032-00 http://www.ucd.ie/issda/datasetsintheissda/nationalpsychologicalwellbeinganddistresssurvey/

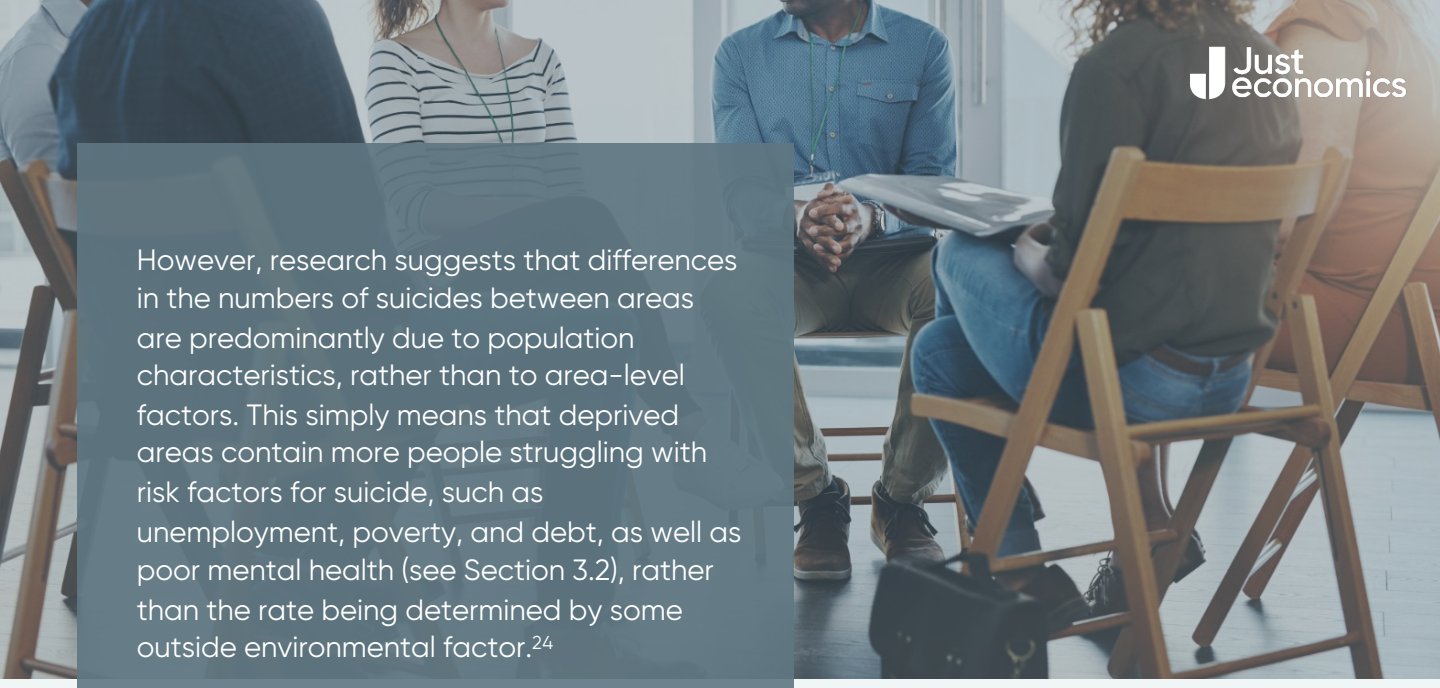
[19] O'Neill, S., Heenan, D., & Betts, J. (2019). Review of mental health policies in Northern Ireland: Making parity a reality. Retrieved October, 11, 2021.

[20] O'Neill, S., Heenan, D., & Betts, J. (2019). Review of mental health policies in Northern Ireland: Making parity a reality. Retrieved October, 11, 2021.

[21] Devlin, A., French, D., & McVicar, D. (2023). Why are Disability Rates for Older Working-Age Adults in Northern Ireland So High?. The Economic and Social Review, 54(1, Spring), 1-28.

[22] O'Neill, S., & O'Connor, R. C. (2020). Suicide in Northern Ireland: Epidemiology, risk factors, and prevention. The Lancet Psychiatry, 7(6), 538-546.

[23] Nisra (2022) Finalised Suicide Statistics in Northern Ireland,2015 – 2021 https://www.nisra.gov.uk/system/files/statistics/Suicide%20Review%20Report%20_Nov%2022_1.pdf



However, research suggests that differences in the numbers of suicides between areas are predominantly due to population characteristics, rather than to area-level factors. This simply means that deprived areas contain more people struggling with risk factors for suicide, such as unemployment, poverty, and debt, as well as poor mental health (see Section 3.2), rather than the rate being determined by some outside environmental factor.[24]

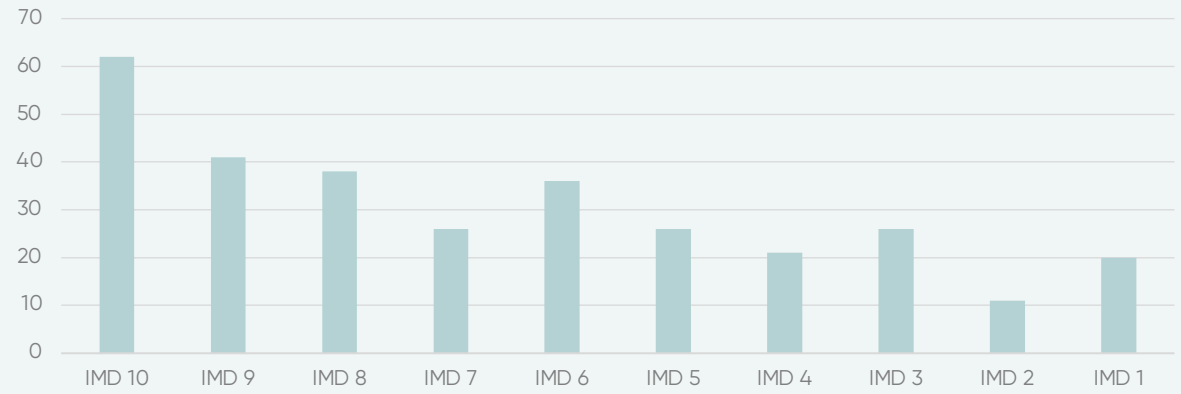


Figure 3: ASMR suicide rate by IMD

Self-harm is also more prevalent among those from more socially deprived backgrounds including, employment, crime, education, health and income, irrespective of area.[25]

In terms of gender, the suicide rate for men is around three times higher than for women, which is similar for each of the UK countries [26] and RoI.[27] The rate is highest amongst those in their 30s, and certain groups are at higher risk, including carers, people with disabilities and health conditions, and LGBTQIA+ people.[28] There are no significant differences in the incidence of suicide between urban and rural areas.

[24] O'Reilly, D., Rosato, M., Connolly, S., & Cardwell, C. (2008). Area factors and suicide: 5-year follow-up of the Northern Ireland population. The British Journal of Psychiatry, 192(2), 106-111.

[25] Griffin, Eve and Bonner, Brendan and Dillon, Christina B and O'Hagan, Denise and Corcoran, Paul (2019) The association between self-harm and area-level characteristics in Northern Ireland: an ecological study. European Journal of Public Health, 29, (5), pp. 948-953.

[26] Samaritans UK (no date) Latest Suicide Data https://www.samaritans.org/ireland/about-samaritans/research-policy/suicide-facts-and-figures/latest-suicide-data/#:~:text=Find%20out%20more%20in%20our%20Understanding%20UK%20and%20ROI%20Suicide,and%2090%20females%20(20%25)

[27]

[28] O'Neill, S., & O'Connor, R. C. (2020). Suicide in Northern Ireland: Epidemiology, risk factors, and prevention. The Lancet Psychiatry, 7(6), 538-546.

2.3 Determinants of poor mental health and suicidal behaviour in Northern Ireland

Research finds that factors linked to mental health problems in Northern Ireland include adverse childhood experiences (ACEs), trauma, poverty, and low levels of education.[29] It is also the case that 41% of suicides had no prior mental health diagnosis. This is similar to what is found internationally (i.e. that mental health is not a proxy for suicide, although it is an important determinant).

Unemployment appears to be a particularly important determinant of suicide in NI: only a third of those who died by suicide in Northern Ireland were known to be in employment compared with two-thirds of those in Scotland.[30] The effect is also stronger for men than women. As well as job loss, financial difficulties such as bankruptcy, debt worries, and business/employment failure are all risk factors, and again, for all these, the effect is stronger for men than women.

It is also noteworthy that the suicide rate has increased since the signing of the Good Friday Agreement (GFA) and that there is an inverse relationship between deaths from The Troubles and suicide.[31] Whilst this appears counterintuitive, there are potential explanations. There is wider evidence – first observed by Durkheim from his analysis of data in the 19th century – that suicide rates are higher in peacetime. This partly contributed to his theory around the protective nature of social integration, which is higher during times of conflict. Subsequent studies have provided further support for this hypothesis.[32]

We also know that 40% of people have experienced at least one traumatic event related to the conflict[33] and individuals who grew up during the worst years of The Troubles are more likely to have experienced multiple traumas and psychopathology.[34]

Conflict may also intersect and complicate other risk factors. One study found that individuals with more than one risk factor were fifteen times more likely to experience suicidal ideation and behaviour. Whilst conflict-related trauma does not appear to have increased the rates of mental ill-health, evidence suggests that it may have increased the complexity.[35]

[29] Mental Health in Northern Ireland (2023) Fundamental Facts. Northern Ireland: Mental Health Foundation; Office of Mental Health Champion.

[30] O'Neill, S., Corry, C., McFeeters, D., Murphy, S., & Bunting, B. (2015). Suicide in Northern Ireland. Crisis.

[31] O'Neill, S., & O'Connor, R. (2020). Suicide in Northern Ireland: epidemiology, risk factors, and prevention. Lancet Psychiatry, 7(6), 538-546. https://doi.org/10.1016/S2215-0366(19)30525-5

[32] Aida, T. (2020). Revisiting suicide rate during wartime: Evidence from the Sri Lankan civil war. PloS one, 15(10), e0240487.

[33] Commission for Victims and Survivors (2012) Troubled consequences: A report on the

mental health impact of the civil conflict in Northern Ireland

[34] McLafferty, M., Armour, C., O'Neill, S., Murphy, S., Ferry, F., & Bunting, B. (2016). Suicidality and profiles of childhood adversities, conflict related trauma and psychopathology in the Northern Ireland population. Journal of affective disorders, 200, 97-102.

[35] McLafferty, M., Armour, C., O'Neill, S., Murphy, S., Ferry, F., & Bunting, B. (2016). Suicidality and profiles of childhood adversities, conflict related trauma and psychopathology in the Northern Ireland population. Journal of affective disorders, 200, 97-102.

Relationship problems are also particularly important in Northern Ireland (a factor in 40.3% of cases in one study).[36] Marriage protects both sexes against suicide, but, as in other jurisdictions, it protects men more so than women, and the risk is elevated for divorced young men in Northern Ireland.[37]

Alcohol dependence was the leading mental disorder associated with suicide in one study,[38] and there is a strong social gradient in alcohol misuse.[39]

Finally, almost a quarter of young people who died by suicide in NI had presented to Emergency Departments with at least one incident of self-harm.[40] This demonstrates the potential for targeted intervention with this high-risk group.

2.4 Poverty and Unemployment in Northern Ireland

In Northern Ireland, poverty rates increased to 18% in 2022/23.[41] Although low compared to other parts of the UK, the rate is higher than in many peer economies, particularly with respect to child poverty.

Moreover, due to the lag in data reporting, these are unlikely to reflect the full impacts of recent inflation and are expected to increase in the coming years.

Although unemployment is at a historic low, Northern Ireland has consistently had one of the highest rates of economic inactivity in the UK.[42] Across the UK, poor mental health has increasingly become a cause of economic inactivity, and there has been an increase in more prolonged/entrenched economic inactivity stemming from mental health problems.[43] More than half of those who are unemployed in Northern Ireland (56%) are long-term unemployed compared with 26% for the UK as a whole. Northern Ireland also has the lowest discretionary income of any UK region.[44]

In addition to cost-of-living pressures, Northern Ireland is transitioning to Universal Credit (UC) from legacy benefits. Prior to the introduction of Universal Credit, the UK

[36] Commission for Victims and Survivors (2012) Troubled consequences: A report on the mental health impact of the civil conflict in Northern Ireland

[37] Commission for Victims and Survivors (2012) Troubled consequences: A report on the mental health impact of the civil conflict in Northern Ireland

[38] Commission for Victims and Survivors (2012) Troubled consequences: A report on the mental health impact of the civil conflict in Northern Ireland

[39] ESRC (2021). Alcohol-specific Deaths in Northern Ireland: Socio-Demographic Analyses

[40] Ross, E., O'Reilly, D., O'Hagan, D., & Maguire, A. (2023). Mortality risk following self-harm in young people: A population cohort study using the Northern Ireland Registry of Self-Harm. Journal of child psychology and psychiatry, 64(7), 1015-1026.

[41] Department for Communities (2024) The Northern Ireland Poverty and Income Inequality report (2022/23)

[42] Stat Wales (2024) Economic inactivity rates by UK country/English region and quarter (seasonally adjusted) https://statswales.gov.wales/Catalogue/Business-Economy-and-Labour-Market/People-and-Work/Economic-Inactivity/economicinactivityrates-by-ukcountryenglishregion-quarter

[43] Murphy (2002) Not working: exploring changing trends in youth worklessness in the UK, from the 1990s to the Covid-19 pandemic https://www.resolutionfoundation.org/publications/not-working/

[44] Ulster University (2022) Illegal Money Lending and Debt Project: Research Report of Findings

already had one of the lowest income replacement rates in the OECD.[45] However, the rollout of UC has been linked to greater use of food banks,[46] debt,[47] material deprivation,[48] psychological distress,[49] rent arrears, rent advice issues,[50] and crime.[51] Families with children have been worst affected by these negative outcomes.[52] For single-parent families, the Joseph Rowntree Foundation estimate that benefit payments covered 68% of their Minimum Income Standard in 2008 and that this had fallen to 49% by 2022.[53]

Northern Ireland is more at risk from these changes to the benefit system, due to factors such as larger families, larger homes, lower levels of childcare support, and higher rates of people claiming disability benefits. In response, the Northern Ireland government has sought to mitigate the poverty-inducing risks of UC by spending between £700 and £800 million to support low-income families.[54] However, as we discuss in the next section, there are still risks that this will ultimately impact poverty rates in the coming years.

2.5 Suicide Prevention Policy in Northern Ireland

The current policy to tackle suicide in Northern Ireland is Protect Life 2. This is described as 'a long-term strategy for reducing suicides and the incidence of self-harm with action delivered across a range of Government departments, agencies, and sectors.'[55] The strategy was first published in 2019 and has been extended in 2024 to run through 2027.

[45] OECD (2022) Benefits in unemployment, share of previous income https://www.oecd.org/en/data/indicators/benefits-in-unemployment-share-of-previous-income.html?utm_source=chatgpt.com

[46] Reeves, A., & Loopstra, R. (2021). The continuing effects of welfare reform on food bank use in the UK: the roll-out of universal credit. Journal of Social Policy, 50(4), 788-808.

[47] Zhong, M., Braga, B., McKernan, S. M., Hayward, M., Millward, E., & Trepel, C. (2023). Impacts of COVID-19-Era Economic Policies on Consumer Debt in the United Kingdom. Urban Institute Working Paper.

[48] Cheetham, M., Moffatt, S., Addison, M., & Wiseman, A. (2019). Impact of Universal Credit in North East England: a qualitative study of claimants and support staff. BMJ open, 9(7), e029611.

[49] Brewer, M., Dang, T., & Tominey, E. (2022). Universal Credit: Welfare Reform and Mental Health.

[50] Hardie, I. (2022). Welfare reform and housing insecurity: the impact of Universal Credit rollout on demand for rent arrears and homelessness advice from Citizens Advice in England. Social Policy and Society, 1-24.

[51] Tiratelli, M., Bradford, B., & Yesberg, J. (2023). The political economy of crime: Did Universal Credit increase crime rates?. The British Journal of Criminology, 63(3), 570-587.

[52] Tucker, J. (2019). Universal credit: What needs to change to reduce child poverty and make it fit for families. CPAG, London.

[53] JRF, (2022) A Minimum Income Standard for the UK in 2022,

[54] Northern Ireland Audit Office (2019) Welfare Reforms in Northern Ireland REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

[55] Department for Communities (2024) Protect Life 2 A Strategy for Preventing Suicide and Self Harm in Northern Ireland 2019-2024 https://www.health-ni.gov.uk/protectlife2

The strategy aims to:

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

As per the tiers set out above, the strategy is aimed at:

- the general public (attitudes, access to means and media reporting),
- targeting at-risk groups (self-harm referrals, screening in substance misuse services, crisis support services and training gatekeepers) and
- postvention support for the bereaved.[56]

In practice, this includes well-being programmes in schools, public awareness, workplace initiatives, training, safety plans for high-risk areas, better prescribing, and postvention. However, it is not clear how the second objective of delivering better services in deprived areas will be achieved, as there is no clear plan to target them towards those areas. Poverty is referenced twice in the strategy: once where it is listed as a determinant, along with unemployment, job loss, and debt (see Table 1).

Individual Level	Relationship Level	Community Level	Society and Health Systems Level
• Previous suicide attempt • Family history of suicide • Chronic pain, debilitating physical illness • Physical and sensory disability • Mental disorders • Alcohol and substance misuse • Hopelessness • Unemployment, job or financial loss, unmanageable debt, poverty	• Sense of isolation and lack of social supports • Relationship conflict, discord or loss • Unstable / unsupportive parent – child relationships • Bereavement	• Disaster, war and conflict • Stresses of cultural assimilation for migrant or ethnic groups • Being LGBT • Discrimination • Trauma, abuse or bullying • Incarceration (particularly in the early stages)	• Access to means • Inappropriate media reporting • Stigma associated with help-seeking behaviour

Table 1: List of risk factors in Protect Life 2 Strategy

What is notable about this grouping is that the economic determinants are listed as operating at the individual level when, in practice, these impacts also operate at the community level. Area-based deprivation is not listed under community level impacts, despite the strong social gradient in risk factors. Presenting risk factors in this way is at odds with the strength of findings on economic determinants in the literature. It also locates poverty and disadvantage within the individual sphere, with the assumption that individuals are responsible for their own economic circumstances.

Later, the strategy acknowledges that suicide will not be addressed by health services alone and that action is needed on the wider determinants, 'including issues of socio-economic disadvantage and inequality that are associated with suicide'.

[56] Department for Communities (2024) Protect Life 2 A Strategy for Preventing Suicide and Self Harm in Northern Ireland 2019-2024 https://www.health-ni.gov.uk/protectlife2

It goes on to list a range of policy areas that will need to be delivered in tandem with this strategy, including early years, anti-poverty, substance misuse, and sexual violence. However, the strategy does not provide any other details on this.

In 2024, a report was published outlining progress against a range of objectives such as delivery of training courses, implementation of crisis response via emergency services calls, media reporting, and restricting access to means. There is evidence of some progress in each of these areas but also problems with how they are reported.

1. The report mainly focuses on outputs (numbers reached with campaigns etc.), rather than the outcomes from those activities.
2. Within that, the outputs are only partially reported upon (e.g. number trainings delivered, without knowing what coverage of the population of stakeholders has been achieved).
3. It does not report on progress toward the high-level objectives of reducing the suicide rate or enhancing services in deprived areas. Although the suicide rate for 2024 was unavailable at the time of publication, the available data indicates a slight increase in the suicide rate since 2019, a 7% decrease in self-harm incidents, and a significant 73% increase in ideation. These findings suggest that the strategy is not on track, particularly given the strong relationship between self-harm, ideation, and suicide in Northern Ireland.

As well as the strategy lacking a joined-up approach, policies in the 'wider areas' are also under-developed. Anti-poverty is a case in point.

The existing strategy was developed in 2016 to run until 2019, at which point it was extended through to May 2022, with the intention to replace it with a new Anti-Poverty Strategy, but this never materialised due to the collapse of the Northern Ireland Executive. In practice, this means that the three-year anti-poverty strategy is eight years old and was formulated before the major events of Brexit, Covid, and the Cost-of-Living crisis emerged.

Protect Life 2 is also dominated by interventions that:

1. Are non-targeted and aimed at the general public (usually education or media reporting)
2. Are targeted at gatekeepers such as teachers
3. Are targeted at those already at risk or in crisis.

A concern with these types of interventions is that they do not benefit from a very robust evidence base. Some interventions, such as helplines,[57] [58] psychotherapy,[59] alcohol restriction,[60] and active outreach have been found to be effective but

[57] Assing Hvidt, E., Ploug, T., & Holm, S. (2016). The impact of telephone crisis services on suicidal users: A systematic review of the past 45 years. Mental Health Review Journal, 21(2), 141-160.

[58] Pil, L., Pauwels, K., Muijzers, E., Portzky, G., & Annemans, L. (2013). Cost-effectiveness of a helpline for suicide prevention. Journal of telemedicine and telecare, 19(5), 273-281.

[59] Brown, G. K., & Jager-Hyman, S. (2014). Evidence-based psychotherapies for suicide prevention: future directions. American Journal of Preventive Medicine, 47(3), S186-S194.

[60] Mann, J. J., Michel, C. A., & Auerbach, R. P. (2021). Improving suicide prevention through evidence-based strategies: a systematic review. American journal of psychiatry, 178(7), 611-624.

there is more limited evidence for areas such as gatekeeper training[62] and public awareness.[63]

In addition, these prevention strategies could be described as *astructural* (i.e. responding to the problem after it has occurred) rather than structural (i.e. changing the underlying socio-environmental forces that are increasing the risk at the population level).

A further limitation of targeted approaches is that, whilst some of these approaches may be shown to work at the individual level, they may not have population-level effects, not least because targeted interventions are not likely to reach the 40% of people who die by suicide but who have not previously engaged with mental health services. Scaling these interventions to the population level would be expensive and inefficient, and the evidence base for population-wide interventions is weak.

2.6 Conclusions

Suicide prevention in Northern Ireland follows a similar pattern to other countries: it focuses on downstream, reactive policies, with a narrow interpretation of risk (i.e. focused on those in mental health crisis). Whilst these policies are important, and some progress is being made in rolling out these approaches, they are arguably a partial interpretation of prevention. Moreover, policy in wider areas, such as poverty, requires new work.

Research shows that the main determinants of suicidal behaviour in Northern Ireland are relationship breakdown, unemployment, poverty, living in a deprived area, adverse childhood experiences, and low educational attainment. A history of mental health problems and/or self-harming is also important, but these intersect with the other determinants.

These are broadly similar to other jurisdictions. However, some are specific to Northern Ireland's history (e.g. trauma), or are amplified relative to other areas (e.g. unemployment). The next chapter will further our understanding of this by exploring these issues from the perspective of people who live and work in Northern Ireland.

[61] Kõlves, K., Chitty, K. M., Wardhani, R., Värnik, A., De Leo, D., & Witt, K. (2020). Impact of alcohol policies on suicidal behavior: a systematic literature review. International journal of environmental research and public health, 17(19), 7030.

[62] Holmes, G., Clacy, A., Hermens, D. F., & Lagopoulos, J. (2021). The long-term efficacy of suicide prevention gatekeeper training: a systematic review. Archives of suicide research, 25(2), 177-207.

[63] Dumesnil, H., & Verger, P. (2009). Public awareness campaigns about depression and suicide: a review. Psychiatric Services, 60(9), 1203-1213.

03. Findings on economic life

As discussed in the previous chapter, only about 50-60% of people who die by suicide have previously engaged with mental health services. Therefore, solely focusing on the delivery and quality of mental health services is a partial (albeit critical) response. The breadth of issues covered in the literature review shows that the determinants of suicidal behaviour are multi-faceted and have relevance across the life course.

To organise the findings, we have followed Stack et al.[64] and split them out into the following domains: economic, political, social and cultural economic life (see Table 2).

Economic life	Political life	Social life	Cultural life	Environment
• Business cycles (recessions) • Unemployment • Underemployment • Job strain and demotion • Indebtedness • Low income • Area-based deprivation • Income distribution	• Social expenditure/safety nets • Minimum wages • Alcohol availability • Left-leaning governments • Domestic violence laws	• Having children • Marriage • Low divorce rate • Separation • Social fragmentation • Religion • Past self-harm • Younger age than classmates • Parental loss • Adverse childhood experiences	• Gender (4:1) • Media reporting/copycat • Gender equality (breadwinner culture and male suicide) • Acceptability of suicide • Alcohol culture (wet vs. dry culture and young males)	• Air pollution • Noise pollution • Second-hand Smoke • Natural disasters • Lithium levels in drinking water

Table 2: Summary of determinants of suicide

The determinants of mental health and the causal pathway between this and suicide are out of scope, as are the environmental factors. Our focus instead is on economic life and on wider political, social, and cultural phenomena that are linked to suicide rates.

This section summarises the findings from qualitative engagement with professionals and individuals with lived experience, as they relate to economic life.

[64] Stack, S. (2021). Contributing factors to suicide: Political, social, cultural and economic. Preventive medicine, 152, 106498.

3.1 Poverty

As discussed in Chapter 2, Northern Ireland is amongst the poorest regions in the UK, with the most recent data showing an increase in both absolute and relative poverty.[65] Interviewees described how financial hardship could lead to mental health breakdowns and suicidal behaviour.

There are higher levels of anxiety and stress in relation to work pressures and financial cost of living increases. Parents must make radical choices in order to provide for their families. So, we're seeing issues in relation to heating, food, that kind of choice needing to be made. We had a case of a family for whom we can provide free counselling but they couldn't afford the bus fare.

There is a larger issue with the emotional turmoil of not having enough money to afford the essentials.

Economic disadvantage leads people to believe that there is no hope for the future and that not living is a realistic choice.

The cost-of-living crisis was described as intensifying people's experiences of poverty:

Gas is still up, electricity is still up, and the money just stays the same….your savings are gone.

My neighbour knows where I work and has been asking for nappies and kid's clothes. One mother told me she hadn't had a family day out in over a year. Kids are losing out and it is difficult for parents to see their kids missing out. Healthy start vouchers do not even cover the cost of infant formula.

Dealing with things like poverty and debt is all-consuming. And so it's very difficult to lift your head out of that situation, to think about any of the other things that government might have policies in place for like, you know, getting into work or training. It feels like it is a total cycle, that it is inescapable from unless somebody is going to say, "Let me help you clear your debts, increase your income".

Across the UK, the Trussell Trust reports a growing mental health need amongst its service users, prompting the establishment of a formal partnership with the mental health charity Mind. While such a partnership has not been established in Northern Ireland, the need remains significant. Originally intended to provide five days of emergency food, food banks are now evolving into hygiene banks and addressing broader needs. Everyone we spoke to highlighted an increase in demand.

We've been overwhelmed by the number of people who present with mental health issues related to finance and financial hardship.

We were repeatedly told that benefits were not adequate and that this was being exacerbated by the introduction of Universal Credit.

[Universal Credit] is driving people into food bank use

[65] Department for Communities (2024) The Northern Ireland Poverty and Income Inequality report (2022/23)

The biggest impact would be to reform the Social Security system, and for us we would raise the floor of Universal Credit to be £120 a week, rather than £91, to more accurately reflect what the cost of a week's shopping is.

Benefits are not enough to meet the essentials, and so that means that people are scrambling around, you know, borrowing off Peter to pay Paul.

Interviewees also noted a more recent phenomenon: a sense that everyone seems to be struggling. As in other parts of the UK, food bank use has expanded to include individuals with average incomes, and has become increasingly normalised. Rather than being reserved for emergencies, food banks have evolved into a regular, albeit informal, component of the welfare system.

I don't know many people who aren't living pay cheque to pay cheque.

The precarious nature of living week to week was highlighted:

I mean we only have to look to last week's news when the child benefits computer system fell over, and families weren't able to get their child benefit paid on time. That's a clear indication of what we have always known: people are living from one week to the next to get their benefit. They have no opportunity. It's such a fine, fine line that they're treading that any glitch in a computer system really throws that family into disarray.

As well as benefit recipients, the working poor were thought to be struggling more than ever:

So, everything's gone up very much. But the wages haven't gone up. So I suppose you've got a combination of people who are working for the same salaries, not being able to afford what they used to before.

I work four shifts a week, cleaning a care home - even though I have a young baby - just to make ends meet. With prices going up, I am under a lot of pressure to work more just to get the essentials. My rent has gone from £600/month to £860/month. It is so stressful because if I get sick and can't work a shift, I won't be able to pay my rent or bills.

It's not the case that getting someone into paid work alleviates poverty overnight and universally, you know, by any means. [Benefits] is a punitive system, which further marginalises those people who need inclusion.

Rural poverty, including amongst the farming community, was also mentioned, as was the East/West divide, and the perception that the East fared better in terms of services and investment.

Because we have such a rural population as well, and I think that always needs to be factored in, and the fact that isolation then plays a big role, and stigma is greater.

If it wasn't for the community and voluntary sector (in Derry) …we're holding the place together

3.2 Debt

An immediate consequence of the increased economic pressures is an increase in indebtedness. This includes those features of Universal Credit that are paid in arrears:

The five-week wait is just an encouragement of debt…the number of women I've spoken to, you know, who are so stressed even about the thought of [it].

Many turn to short-term legal and illegal sources of high-interest finance. This form of debt can further entrench poverty, and there is evidence that it can quickly escalate out of control once payment deadlines are missed.[66] The scale of this type of lending is unknown in Northern Ireland. We do know however that it is the UK region with the lowest proportion of citizens with savings of more than £100.[67]

One type of illegal lending that is unique to Northern Ireland, and was repeatedly described in interviews, was paramilitary lending. Again, there is no data available as to the scale of this type of lending, but there is anecdotal evidence that it is widespread in low-income communities.

Lots of people are using them as money lenders. But there is always a catch. Masked men come to the door if you don't pay up. Their grip on communities is as strong as ever. If something goes wrong people will ring their local community rep, rather than police, in working class areas.

It is so under the radar, people are so afraid to speak about it…but they're seen as serving a need in these areas because people have nowhere else to go, they have nowhere else to get essentials.

When people pass away the debt passes on to their families. I was at a funeral once and they turned up looking for payment from the family.

It was pointed out that there isn't any debt respite legislation that's comparable to what currently exists in England and Wales. Cuts to discretionary supports was also thought to have exacerbated this:

It's half what it was maybe a few years ago. So, you know, you're cutting off access to things that are low cost or no interest, and you're driving people to credit cards. You're driving people to buy now, pay later.

3.3 Poverty stigma

Poverty-induced mental ill-health is partly mediated by poverty stigma. Experiences of poverty stigma are associated with negative self-evaluation and diminished wellbeing as well as mental ill-health.[68] Interviewees told us that the feelings of shame associated with poverty can be as debilitating as the poverty itself.

[66] Ulster University (2022) Illegal Money Lending and Debt Project: Research Report of Findings

[67] Ulster University (2022) Illegal Money Lending and Debt Project: Research Report of Findings

[68] Inglis, G., Jenkins, P., McHardy, F., Sosu, E., & Wilson, C. (2023). Poverty stigma, mental health, and well-being: A rapid review and synthesis of quantitative and qualitative research. Journal of Community & Applied Social Psychology, 33(4), 783-806.

Within the benefit system, people are feeling highly stigmatised because it simply isn't enough to cover, for example, rent. And yes, they may be the working poor, they may be low-income, or they may be people who are job-seeking or economically inactive. However, nobody really should be made to feel that they are an inconvenience for wanting to keep a roof over their head.

… poverty stigma is a huge issue currently and that really takes two forms. There's the day-to-day stigma of living with poverty and what that means but there's also the systemic stigma [where you are seeking discretionary funds or getting emergency food]. You've got to figure out your situation and you are very much made to go cap in hand.

If you want to claim a benefit, even if you want to get your benefits checked, or if you're in debt, there's a massive stigma and massive shame around that.

This was thought to have been exacerbated by political rhetoric relating to benefit cheats, "shirkers" versus "strivers", and how this was being reflected in the reforms initiated under Universal Credit.

It's the hostility. It is a hostile environment for people needing to have the stability of having a roof over your head for you, your family, and what that looks like, whether that's carers, young children or people with disabilities.

Even if you listen to the rhetoric around the two-child limit, you know, a lot of it is about why would we give benefits to people that are just producing loads of children. When you look at what people are expected to live on, there is nobody, nobody that would choose that.

People can have relationship breakdowns, they can lose their job, they can have a mental health crisis. And in those spaces, people need to have a safety net and be properly protected.

As mentioned above, it was also pointed out that a lot of people were unable to work because of health or caring responsibilities, and this is forgotten in the rhetoric around benefits.

People who receive Carers Allowance in Northern Ireland - 15% of that population have had to use a food bank within the last 12 months. I wish it wasn't the case, but there is a massive stigma associated with having to use emergency provision like that.

If you compare unpaid carers, who said that they were struggling to make ends meet, versus the whole care population, that former group is consistently reporting higher rates of things like depression, stress, anxiety.

Seeking help for poverty, debts or mental health was also avoided in some instances because there was a perception that children might be taken into care if the scale of the problem was known about:

People try so hard for their kids, they are really trying so hard but feeling really beat down, you know, they can't go anywhere to get out of the situation they're in and particularly if they're in debt.

The feelings of shame were particularly acute for parents:

You feel so inadequate when you can't give your children basic things that everyone else has. It is so bad for your self-esteem, I know because I have been there.

Children were also very embarrassed by poverty, and we were told that there was significant bullying associated with it. Children who wore donated clothes, or who didn't have the same things as other children were particularly at risk.

3.4 Employment and low pay

As discussed in the previous chapter, the rate of long-term sickness/disability is higher in Northern Ireland than in the rest of the UK and on an upward trend.[69] Northern Ireland is also one of two regions with the highest proportion of low-paid workers in the UK, and median wages are below the UK median.[70]

The growth of low-quality employment was mentioned as a factor, and research shows this is associated with negative health outcomes.[71] Low-quality jobs include those that are "poorly-paid, repetitive, casualised or insecure; requiring of few skills; offering little opportunity for discretion, enterprise and creativity, and which provide few opportunities for progression and development".[72]

Low wages in Northern Ireland have been offset to some extent by lower housing costs, but the latter have been on the increase in recent years.[73]

According to the Trussell Trust, about 2 out of 5 people referred to food banks in Northern Ireland have someone in the household who is in work, which is slightly higher than the UK average. The lack of well-paid jobs was regularly mentioned as a significant strain on mental health:

So for us, there's definitely something around good jobs, but there's also something in between the jobs and the benefits that recognises those who have real barriers to work.

However, one interviewee told us that there was a mismatch between the skills and fitness for work of people and the jobs that initiatives like Invest NI were seeking to bring to Northern Ireland. He believed there also needed to be good quality jobs for lower skilled people, with opportunities for training and progression.

Childcare was identified as a major barrier to employment, particularly for women. It was also noted that children were missing out on the developmental benefits of childcare. In Northern Ireland, as in many countries, childcare participation is biased against poorer children.[74] Lower income communities have less availability and it is often of poorer quality. Unlike in England, there is currently no government-funded

[69] Census (2022) Main statistics for Northern Ireland Statistical bulletin Health, disability and unpaid care

[70] Nisra (2021) Low and high pay analysis https://www.nisra.gov.uk/system/files/statistics/Employee-earnings-NI-2021-S3.pdf

[71] The Health Foundation (2024) Relationship between low-quality jobs and health

[72] McGuire, S., & Keep, E. (2021). Singing from the same hymn sheet? UK policy responses to the NEET agenda. https://ora.ox.ac.uk/objects/uuid:a4e69749-1b1e-40e0-b00e-1fe036ee18ba

[73] Nevin Economic Research Institute (2024) Low-Paid Workers: The Need for Continued Support and the Challenge of Making Work Pay Research In Brief No. 90

[74] Employers for Childcare (2023) Northern Ireland Childcare Survey 2023

https://www.employersforchildcare.org/app/uploads/2023/12/Northern-Ireland-Childcare-Survey-2023.pdf

childcare programme for those aged under 3. The number of universal hours available is lower than in other parts of the UK.[75]

Under Universal Credit, there is an expectation that people will work 30 hours per week, in line with the introduction of 30 hours of free childcare in England.

We're not getting the same initiatives that they're getting in England. They are saying it will be 10 years before our preschool funded places will all be full time. And it does impact upon your mental health… that level of stress. And again, there probably is a sense of stigma as well, having to ask your employer, can I work flexibly? And we know, look, I don't have to tell you, this falls unequally on women.

Families also rely more on informal family care,[76] which, we were told, places pressure on family relationships. Whilst childcare allowances are available, grandparents need to be under retirement age to get the childcare allowance.

My parents are in their 70s. My Mummy has worked since she was 14, I can't ask her to mind my children every day.

Part-time work that fitted with the 16 hours of free childcare was hard to find, particularly outside of the cities.

3.5 Deindustrialisation and area-based deprivation

At the beginning of the 20th century, Belfast was the centre of the global linen industry and home to the world's largest shipyard. Along with the rest of the UK, the city experienced significant industrial decline throughout the century. Between 1962 and 1968, these industries collectively shed about 30,000 jobs, with losses most strongly felt in working class communities. Historical research has demonstrated that these areas of higher unemployment would become flashpoints in the conflict that was to follow.[77] These same areas continue to be the most deprived today.

The legacy of deindustrialisation was raised in interview, particularly by those representing working class Protestant communities, where the shipbuilding jobs had once been.

Deindustrialisation hit East Belfast very hard…Men working in these industries were guaranteed good quality jobs and housing, and they were very tight-knit, close communities where people supported each other…Belfast doesn't get the attention that parts of the north of England get in the levelling up agenda.

In East Belfast, there was always a pathway for men into some sort of employment, and a sense of purpose and social connection that that brings.

[75] Factcheck NI (2021) Childcare provision in Northern Ireland https://factcheckni.org/topics/economy/childcare-provision-in-northern-ireland/

[76] Curristan, S., McGinnity, F., Russell, H., and Smyth, E. (2023). Early childhood education and care in Ireland and Northern Ireland, ESRI Research Series 157, Dublin: ESRI, https://doi.org/10.26504/rs157

[77] Honaker, J. (2005) 'Unemployment and Violence in Northern Ireland: A Missing Data Model for Ecological Inference', paper presented at the annual meeting of the Midwest Political Science Association, Chicago.

With that not being there, and intersecting with a lack of post-conflict 'free for all' in terms of identity, and, ultimately, what does it all mean.

Interviewees also talked about how this intersected with loss of ethnic identity, or purpose associated with the conflict.

If your job's gone and your role that you played in the conflict isn't recognised, all that you have to hold on to, in a way that can't be bought or sold, is your sense of ethnic identity – your Britishness or unionism, your loyalism to the crown or to Ireland. And, if that's all that's left, that can feel like quite a tenuous thing to cling on to, and that's bound to have an impact on your sense of well-being.

The mental health implications of environmental factors that stemmed from an area having high unemployment and deprivation were also raised.

I would like to see more money put into the urban environment, making it feel less hostile, less dominated by traffic more connected, more of a human space.

Fifty years ago, you would have gotten 20 houses into spaces they are now getting 40 houses in to, without the services, or green space being built around them. People need a connection to nature for their mental health.

3.6 Conclusion

This chapter presented the qualitative findings on the relationship between economic factors and mental health/suicidal behaviour in Northern Ireland. The issues that were raised most often were poverty and poverty stigma, debt, employment and low pay, and the legacy of deindustrialisation, area-based deprivation.

These factors are impacting on communities by increasing stress, anxiety, and pressure and forcing some into desperate measures such as unscrupulous lending or unsustainable living situations. A lack of economic resources also reduced people's resilience when challenges arose in other areas of their lives, as we will discuss in the next chapter.

04. Findings on political, social and cultural life

In the previous chapter, we set out how strained economic life impacts the mental health and wellbeing of people and communities. In this chapter, we move on to non-economic risk factors for suicidal behaviours. Whilst these operate as individual risk factors, they also intersect with the economic factors set out in the previous chapter and with one another, as we will discuss. We conclude the chapter with a reflection on some of the assets and strengths that interviewees also identified.

4.1 Conflict

Although the determinants of suicide are largely universal, local factors can also play a role and can help explain elevated rates in some cases.

When asked about circumstances unique to Northern Ireland, all participants unsurprisingly highlighted the enduring legacy of The Troubles. While the conflict officially ended with the signing of the Good Friday Agreement in 1998, its effects remain deeply embedded in Northern Irish society today.

In Chapter 2, we noted the inverse relationship between suicidal behaviour and conflict. Respondents explained this in several ways. First, there was a direct post-traumatic impact on those that had lived through it:

So I would say there has been a real issue in relation to that post trauma, post conflict society that we now have that has impacted on mental health, because people remain very uncertain and very insecure.

One interviewee described this as always living with a heightened sense of anxiety that is difficult to change, even when the source of anxiety is no longer there.

Generations have been parented by people who are at a very hyper vigilant level, whose mental health always sits just at this higher baseline because of the nature of living in conflict. So it is not really just around incident-based trauma, but that lived experience of heightened anxiety.

Second, there were intergenerational impacts:

And it's been interesting because I've been doing this for too long to see how, as young people have become adults and become parents themselves, how those trends have just kind of followed on through.

I think there is a view that, if you go far enough from the conflict, these issues will just resolve themselves, but that does not appear to be the case

Third, there was a suggestion that the conflict may have suppressed suicidal behaviour because aspects of it – such as a sense of purpose, belonging and community, and clear societal role – are protective. This is particularly the case for high-risk groups such as young men:

An odd dynamic of whenever you're fighting, at least you know who you are. You know who your group is.

It is similar to how veterans struggle to adjust to life post-service, they are used to routine and clear authority figures, regular exercise. They also have a sense of meaning, duty, purpose. Paramilitary groups were run on the same model as the army, with drills, regular meetings etc. They would also have a sense of meaning, belonging and male role models.

There were roles that men played in the conflict, whether that was in the security forces, or paramilitary organisations. Once the conflict ended, that would have placed all sorts of strains on a man's sense of identity and belonging, as well as the very practical question of what you do with your time.

We have a very strong sense, sometimes too strong a sense of community, because part of our identity, I suppose, is which particular flavour of community you are part of

Fourth, an interviewee told us that the historical lack of trust in public institutions may be inhibiting help-seeking:

People maybe have trust issues in relation to any supports that can be offered. We still are very much a culture of trusting in people and not institutions. I think that's difficult to break… even in Belfast getting different sides of the city to work together is tricky…we're a bit more still 'villagey' in our in outlook [and] I think that impacts on how we can offer support in places.

Fifth, for those that had been active during the conflict, there was a process of coming to terms with that:

And in this new world, how are people going to judge me? How am I going to judge myself? Because in the old world I can make it OK with myself. How am I going to make it OK with myself to have done those things?

This was particularly the case for people who had left prison after the signing of the Good Friday Agreement. Participants told us that alcohol and drug use became a coping mechanism for this group.

Finally, participants disputed whether Northern Ireland was in fact a post-conflict society.

I think you know the conflict is still in existence but through other means. The fact that none of the structural inequalities that existed before The Troubles have ever been adequately challenged or rectified.

Interviewees also described the strong role that paramilitaries played in some communities: exerting social control and, in some instances, controlling or fuelling the drug trade, and engaging in illegal money lending, all of which have an impact on the wellbeing of communities.

It was noted that the post-conflict arrangements should have anticipated these impacts, and sought to develop an industrial strategy to replace conflict activity with high quality meaningful employment.

4.2 Relationships

As we have seen, relationship breakdown is the biggest determinant of suicidal behaviour in Northern Ireland. Participants told us that families have experienced waves of additional pressures from Covid lockdowns and cost of living increases. This has led to an increase in domestic violence, amongst other things. Interviewees described people trapped in unhealthy relationships.

[Once you realise that it is not] a healthy relationship, how do you get out of it? Especially, when we have a cost-of-living crisis, and we have all sorts of other issues that are feeding into that.

The cost of relationship breakdown was leading to people continuing to live together:

There are a lot of people still together, not for the sake of the children, but for the sake of some level of economic stability.

The impact on the mental health of children from relationship breakdown was also mentioned.

…we see that in relation to a lot of young people now who are school refusers because they have moved to an area that they are not familiar with and to a different school.

Research finds that men are more vulnerable than women to relationship breakdown (see Appendix A2.4), and this was also raised in interviews.

[Relationship breakdown] is particularly difficult for men on low incomes, where they have to try to find a place to live, space for their kids, and pay maintenance. This puts a lot of strain on them and disincentivises a good relationship with their kids. Men can also be disadvantaged in the housing system when the mother has children living with her.

It was also reported that there can be a reluctance to seek help because of the risk of it being taken into consideration with custody.

Another common theme was how social media was changing the nature of relationships.

I heard one researcher say it is the biggest social experiment the world has ever seen, and yet it doesn't have any ethical or moral basis. How people interact in the digital world versus how they interact and build relationships in the real world - there can be a contrast between the two.

I think a large part of that is down to the (social media) companies…they have created a really unsafe space to build relationships. You wouldn't let an adult - not to mention a child - into an unregulated space. Adults can be vulnerable. We can all be vulnerable at any point in time.

I have huge concerns about the role of people's attachment styles and exposure to the Internet in general.

4.3 Gender roles

This discussion led on to gender differences in the risk factors for suicide and how men and women experience poverty. As discussed in the literature (Appendix A2.3), suicide rates are higher in communities with 'breadwinner' cultures. It was pointed out that in working class communities gender roles were often more traditional and there was a greater value placed on masculine identity.

Working class communities have more traditional gender roles and the expectation is that the man is the breadwinner. This creates more pressure.

Prior to my current job, I worked in East Belfast where the suicide rate was growing faster than any other part of the city. I was acutely aware of the mental health needs of working-class loyalist men in particular.

Women, on the other hand, were described as the 'shock absorbers of poverty', and this role was thought to have evolved particularly strongly for women in Northern Ireland during the conflict.

So much of the community activity that sustained neighbourhoods that supported young people, that kept families supported, that thread was carried by women, in a way that was not recognised properly for the role that they played. It was a very practical role, and one that could carry on after the conflict ended. Whereas for men, once the conflict ended, I can understand why that would, you know, place all sorts of strains on a man's sense of identity and belonging and who he is.

We can see this continuation today in data from The Trussell Trust, which shows that nine out of ten attendees at Food Banks are women, and they are more over-represented than in any other part of the UK network.[78] Because of this historical role that women have played, they are seen as less impacted by the stigma of poverty.

There is a stigma for men. My husband lost his job and can no longer work and it has really affected his mental health – that he can't provide for us. I suppose that's about men needing to fit in, needing to have a purpose and needing to be needed. If they don't feel they're needed, they think they've failed.

Women were perceived to have greater access to emotional support, such as friendships and the companionship of their children, particularly during relationship breakdowns. However, this also places much of the burden of poverty disproportionately on their shoulders.

[78] Northern Ireland Anti-Poverty Network (2023) Women and Hunger https://niapn.org/women-and-hunger/

Women get the burden of all this care stuff, whether it's for children or unpaid care, and they do it in the four walls of the house and nobody sees it, or very few people see it. And therefore, it's not a priority. A lot of welfare policies are highly gendered. Women have borne 86% of the cuts, and now they will bear the brunt of the two-child limit and benefit cap.

There are signs that things are changing, however. Representatives of mental health services told us that more men were using their services than ever before. This was a positive sign that help-seeking was becoming more acceptable amongst men. It was noted, however, that men were more comfortable seeking help for addictions, rather than for things like depression, because it is seen as more socially acceptable.

How do we encourage men to go and get tests and support? It's much harder to get men out of the house for those things than women. They will engage with something if they've got a sense of purpose and a sense of attachment to it.

There was a general view from all genders that men should be prioritised for mental health support, and women for economic support.

4.4 Education

Problems in the education system and low levels of education/skills amongst some groups were raised as risk factors in interviews. Research from Northern Ireland finds that inequality based on socio-economic status leads to educational disadvantage for working class children, due to a complex range of material, geographical, social, and cultural reasons.[79] However, where young people can access good quality education, this was described as protective.

Education builds self-worth. It enables people to invest in themselves, learn new skills, meet new people and form new attachments – including with people from different backgrounds – and a lot of those attachments are going to be protective factors.

Academic selection continues to play a larger role in education in Northern Ireland than in other parts of the UK. Evidence shows that socially disadvantaged children are less likely to attend grammar schools, and the type of school attended has been found to be a strong predictor of attainment (and destination after leaving school).[80] Other research finds that academic selection limits intergenerational mobility.[81]

Fair access to education has such an impact on your life chances. There are pockets of areas where people experience a lot of discrimination.

[79] Harris, J., Purdy, N., Walsh, G., Jones, S. and Rowan, A. (2021) Educational Underachievement in Northern Ireland: Review of Research 2021, Belfast: Centre for Research in Educational Underachievement

[80] Burns, S., Leitch, R., & Hughes, J. (2015). Education Inequalities in Northern Ireland. Summary Report.

[81] Devlin, A., McGuinness, S., Bergin, A., & Smyth, E. (2023). Education across the island of Ireland: examining educational outcomes, earnings and intergenerational mobility. Irish Studies in International Affairs, 34(2), 30-47.

There is a big problem with educational underachievement and socio-economic status.

There is also a strong gender gap in favour of girls for both educational outcomes and progression to higher education,[82] which is particularly important given the elevated risk experienced by young adult men.

Over 90% of schools are segregated, and evidence shows that outcomes are diverging along religious identity lines, with a persistent trend of Catholics achieving educational targets and progressing to higher education.[83] In line with earlier discussions, educational attainment is lowest amongst Protestant males on free school meals. Education currently has three systems – Catholic, Protestant and integrated – which one interviewee described as wasteful and inefficient.

I don't think any children should be separated. And I actually think that there's a need to remove religion from education. You can have an ethical education without religion. Those are two completely different things. And when they get tied in together, it becomes quite complicated, and it divides people. So probably try not to do that and build in emotional health and wellbeing, which is just as important as maths and English.

Poverty and mental health problems in the home were thought to inhibit students' ability to engage in school, and poor education was thought to result in low self-esteem and feelings of hopelessness, thereby repeating the cycle of disadvantage.

4.5 Alcohol and drug use

Historically, Northern Ireland had a low prevalence of illegal drugs, such as heroin, compared with the rest of the UK and Ireland. This was thought to be a result of heightened security and a lack of access. However, since the 1990s, there has been a large increase in problematic drug use, as well as drug-related[84] and alcohol-related deaths.[85] Drug and alcohol use were raised often during interviews. Anecdotally, people told us that drug and alcohol use had increased during Covid-19 lockdowns. Substance use was seen as a coping mechanism for people, hence the reason that substance problems affected deprived communities more:

So, we are seeing a lot of people coming through our doors concerned about financial stresses and worries, you know, feeding their kids, putting uniforms on their backs, relationship breakdowns, over all of those types of things. And then they turn to drugs and alcohol, as that sense of hopelessness seems to be justified.

[82] Burns, S., Leitch, R., & Hughes, J. (2015). Education Inequalities in Northern Ireland. Summary Report.

[83] Burns, S., Leitch, R., & Hughes, J. (2015). Education Inequalities in Northern Ireland. Summary Report.

[84] Campbell, A., Harris, J., Wolfe, J., Diamond, A., Mullen, D., & Oteo, A. (2023). Drug Overdoses and Drug-Related Deaths: A Synthesis of NISRA, ED Admissions and Ambulance Service Data.

[85] Nisra (2024) Alcohol-Specific Deaths in Northern Ireland, 2012 to 2022 https://www.nisra.gov.uk/sites/nisra.gov.uk/files/publications/Alcohol-Specific%20Deaths%20in%20NI%202022_updated.pdf

We deal with a lot more issues around drugs than we ever did before. It used to be that alcohol was a big issue. People using alcohol to be able to cope with problems and that was a big driving factor in homelessness, in relationship breakdown, losing your job, and losing your family. Now it's illegal drugs.

The wide availability of a greater number of substances means that the net of people consuming them continues to widen.

Northern Ireland was maybe 10 or 15 years behind the rest of the UK because of the Troubles, but we've got a huge wave of issues with people using drugs. Obviously some people are using them because they're trying to manage emotions, but a lot of it is also opportunity based as well. So, people with no prior predisposition to addiction are becoming addicted because of the addictive nature of the chemicals that they're ingesting.

Sometimes it is not clear if deaths from drugs are overdoses, or from drug-debts that they can't see a way out of. Injecting used to be a barrier for people but is less so now. So, the nature of tolerance and escalation just brings people further and further and further into these zones that they would never have found themselves in before.

4.6 Governance

The Northern Ireland Assembly is the devolved legislature of Northern Ireland (known as Stormont). It was established – in its modern incarnation – in 1998 in accordance with the Good Friday Agreement.

It is based on the principle of power-sharing to ensure that Northern Ireland's largest voting blocs, British Unionists and Irish Nationalists, both participate in governing the region. The Assembly has been suspended on six occasions, some of which have lasted several years. Long suspensions mean that direct rule from Westminster resumes. The problems with Stormont were raised very often in interviews, particularly the slow progress that has been made on policy:

Then in terms of Northern Ireland, we've had real stop start government here, which has meant that there hasn't been a single piece of equality legislation that has been enacted by Stormont. It's always been forced on them by Westminster.

This has been contrasted with Scotland, where novel policies such as child payment have been implemented.

We haven't made full use of our devolved powers here.

This has exacerbated other challenges, such as the pandemic, and the impact of policies considered damaging, like welfare reform.

More fundamentally, however, participants thought that the power-sharing arrangements were not working effectively and required reform. Again, this was contrasted with Scotland's majority system.

Our mandatory coalition here of four parties and an opposition doesn't lend itself well to testing and trying things out.

It's always going to be difficult to get consensus.

The community and voluntary sector, which is very strong in Northern Ireland, was seen as a product of a long history of poor-quality governance.

So, it's a whole ecosystem that is sort of set up in response to government, rather than being supported by it. So, that's not really sustainable in the long term. It's a huge ask of the general public to support people in this way.

We can't keep funding our community development projects in a piecemeal way. The public sector needs to start picking up some of the slack for community development and [mainstreaming effective programmes].

Representatives of the sector also discussed how difficult it was for national (UK or all-island) bodies and, indeed, the public sector, to provide services in areas with very particular histories, cultural norms, and traditions. They highlighted the need to co-produce policy responses with local people.

I think that's particularly important in areas like East Belfast, that has a really specific tradition and unique community…[what works] in Manchester is not necessarily going to work there.

In addition, we were told that cultural identity was still influencing the way in which funding was being allocated, or policies implemented.

There's a legacy from the Troubles, in terms of certain people who maybe hold positions of power within the community, and decisions can be contentious about where funding goes, so, it's about making sure that structures are in place that ensure transparency about how funding is being allocated.

Several interviewees discussed the lack of preventative services and the need for more upstream spending.

We are just creating new adverse childhood experiences every day and we need to be more creative about how we spend the block grant to break this cycle.

If you look at the Indices of Multiple Deprivation, nothing has changed in those in the last 20 years. That is stark evidence that really none of these government initiatives have actually changed anything… if we go back to the pre-conflict era, a lot of the areas are the same as in the 1960s. So, in a way, although The Troubles created a lot of trauma, it also concealed a lot of the issues that needed addressed.

The multidisciplinary nature of this issue was also hampered by the siloed nature of government, which was described as poor at cross-departmental working. So, while poverty sits with the Department of Communities, suicide prevention sits with the Department of Health. This issue, common in other parts of the UK, is more challenging in Northern Ireland because of political instability.

The last Programme for Government that was fully signed off was nearly ten years ago in 2015. The sort of multi-year budgets that you need to try and address these things in the long term, on a cross-policy basis – it's years since we've had one of those.

It was also pointed out that constitutional changes were not actually required to enable policy change (for example on benefits, which are a devolved issue).

If we were willing to pay for it, we could change Universal Credit…it comes down to priorities then, and, unfortunately, the plight of people who are living within the Social Security system, and suffering mental health and a range of other negative consequences, has not been a priority and doesn't certainly doesn't seem to be one for the current administration.

Interviewees also highlighted a culture of conservatism and resistance to change within the Northern Ireland Civil Service. They described instances where politicians would visit and express strong support for their work, but, when discussions involved civil servants, progress would often be hindered, leading to projects being shelved.

But there needs to be something a wee bit more radical with government, particularly civil servants.

4.7 Access to services

Services are a key way to tackle the root causes of disadvantage by reaching communities with preventative support. However, services across the UK have experienced sustained cuts since the austerity programme that followed the 2007/8 financial crisis, and were then further impacted by the COVID 19 pandemic.

Services were described as severely overstretched and unable to cope with the numbers being referred. Gaps were particularly identified in Child and Adolescent Mental Health and areas of disability, such as autism.

[Since Covid] there have been fewer services because they've targeted the key services like nursing and doctors. I'm not disputing that that is required, but that's been prioritised at the expense of other services, which were services in the Community which have not been properly funded.

GP services were repeatedly mentioned, with many people not even able to get on waiting lists.

And, I remember whenever my sister had a breakdown, we were trying to get a doctor's appointment. And they were like, no, you're going to have to try again tomorrow. But we were at such a crisis we said we can't wait. And there was no emergency appointment or anything about the next day either. And it is so difficult when you are full of anger and emotion. They don't take into consideration how much pressure people are under when they come in.

People also highlighted the challenges faced by those under strain, who must then endure long waits for services.

People feel abandoned. Nobody sees me. Nobody values me. There is nobody looking out for me. I've just been left to get on with it on my own.

The lack of services in rural areas was also noted. Participants talked about how worsening public services contribute to this stress when you are on a low income, because you have no alternative option to pay for private services instead.

I was so stressed when my baby was sick and I couldn't get GP appointments for over a week often, even though I kept trying. I can't afford to get a private appointment, and it is just so stressful.

One interviewee also talked about the lack of amenities for young people.

Although it is a housing association, there is no playpark – no communal gardens – no activities for young people. You have to cross a busy road to reach the park, and I can never let the kids out on their own. There are a lot of kids on the street but nothing for them – so the kids are bored and are drawing on walls and getting drawn in to anti-social behaviour.

The community and voluntary sector were described as picking up much of the overspill from these services. However, there was also a sense that the government didn't trust the community and voluntary services to formally deliver these services, even though they are doing it on a day-to-day basis.

4.8 Community strengths and assets

As mentioned above, Northern Ireland has a thriving community and voluntary sector, which has borne the brunt of many of the austerity and welfare reform policies of recent decades.

Our community sector, I think, is a gold mine waiting to be tapped, but only if properly supported.

In addition, people talked about strong communities where people look out for each other. We have already discussed some of the negative aspects of this (i.e. where people are divided along sectarian lines); nonetheless, there are many positive aspects of community in Northern Ireland.

You know, go to any area in Northern Ireland at the moment and there's talk of family fun days being organised for the summer, and some of them do relate to particular cultural or historical things. But, there are a lot of just very generic, very general, family fun days.

Perhaps unlike the rest of the UK, and increasingly RoI, churches still play a significant role in Northern Ireland. These provide free services and activities that are very much valued by communities.

We're very lucky because a lot of the activities are provided by churches, as well as youth organisations like the Guides and Scouts. When you compare the cost of having your child in the Girl Guides to a church-run activity, you can see the difference.

In addition, a strong culture of self-organising social support provides incredible support for mental health and reduces the risk of Isolation (see case studies 1 and 2).

The community and voluntary sector, as well as the culture of voluntarism and informal social support, and the role of churches in providing free access to services and activities, help foster community cohesion and social capital, which are protective against the risk factors for suicide.

Case Studies

Communities across Northern Ireland are finding innovative and grassroots ways to support mental health and wellbeing, often with limited resources.

The following case studies — Glens Wellbeing Group and Willowbreeze Community Anglers — highlight inspiring approaches to fostering connection, resilience, and support within local communities.

Glens Wellbeing Group demonstrates the power of self-organised peer support, creating a safe and inclusive space for women to connect, share, and grow. Meanwhile, Willowbreeze Community Anglers exemplifies how a shared activity, such as angling, can provide men with a therapeutic outlet to address mental health challenges in a supportive environment. Both focus on cultivating social capital and building on the community spirit that exists in Northern Ireland.

Whilst we acknowledge that community-driven efforts can play a vital role in promoting mental health and building resilience, it is important to emphasise that these interventions are not substitutes for public services. Creative solutions such as these should be seen as complementary to, and underpinned by, a public service infrastructure with a strong preventative ethos.

Case study 1: Cushendall Women's Group

Glens Wellbeing is a self-organising group of local people who meet weekly to support each other with everyday challenges and build their mental health resilience. It was started by two friends to fill a gap for a support network in their community.

We were just talking one day and we were saying, you know, there's nothing for us around here, and then we decided that we would start a group.

The group now has 16 members and, whilst the group has an open-door membership policy, it is largely women attending. Some of the women within the group have suffered from personal trauma and addiction, but others are there for friendship, companionship, and to help others.

Everybody knows if somebody's had a bad day. We have a WhatsApp group and we share things on there. So, if something's not good, everybody's there for you

The main aim of the group is an opportunity for women to come together in a space where they feel safe to connect and get support from one another. Group members have also helped each other identify when problems are arising before they escalate:

When I was having a hard time, they told me to take myself to the doctor; they knew I needed help.

They take part in activities that benefit their wellbeing, but also enable them to learn new skills and build up their confidence. Participants pay a small contribution towards refreshments and social activities.

The group is supported by the Northern Area Community Network Suicide Prevention Development Officer, in recognition of its role in reducing the risk of suicidal behaviour. As the group has grown, they have had opportunities to apply for small pots of funding to support their activities. In the past, this has enabled them to run cookery classes and art classes. The group has also provided support to local people that they know are struggling financially and raises money where they see a need for it. The Suicide Prevention Officer (SPO) also directly supports individual group members should they require it.

She [the SPO] is always at the end of the phone if we need her.

Glens Wellbeing Group has also built connections with a local Muslim women's group, in order to better understand other faith groups within their community and promote social cohesion. The two groups have forged a strong connection and have applied for funding for activities with each other.

Case study 2: North Antrim fly fishing group

Previous research has highlighted the social and community benefits of angling.[86] Big Lottery funded a three-year study of the therapeutic benefits of angling for disadvantaged young people. The research found[87] it was an effective way of engaging young people and had direct health and wellbeing benefits, including: opportunities for relaxation, relief from stress, improved physical activity, and access to natural environments. These factors are protective of mental health and support recovery.

Promoting angling as a suicide prevention strategy has also been recognised. In Ireland, the Killinardan Angling Initiative run angling courses for groups at risk of mental ill-health and mental health awareness events, directly targeting suicide prevention.[88]

[86] Thomas, A. B., & Vogelsong, H. (2004). The social benefits of saltwater recreational fishing. In Proceedings of the 2003 Northeastern Recreation Research Symposium. USDA Forest Service (pp. 152-156).

[87] Brown, A., Djohari, N., & Stolk, P. (2012). Fishing for Answers: Final Report of the Social and. Substance.

[88] http://bit.ly/3Qk1nta

Willowbreeze is a community of primarily men, established in 2012, who engage in 'social angling' to promote health and wellbeing. They are mainly active in the Larne area and occasionally beyond. They rent a small freshwater lake near Ballyclare for individual, small-party activities, outreach events, volunteer work parties, and coaching in angling skills/knowledge. They are constituted with a simple governance structure. The committee comprises experienced anglers, some of whom have coaching qualifications, and they offer coaching to members free of charge.

They are a community who have experienced low self-esteem, degrees of social isolation, unemployment, addiction and disability. They use angling activities as the therapeutic backdrop to provide emotional support to one another.

We have focused on the five ways to wellbeing — be active, give, connect, keep learning, take notice — those preventative things. Angling is a great way to achieve all of them.

Members come from various backgrounds, but they particularly identify the need for these kinds of support for men from lower socio-economic backgrounds.

We are both from working class backgrounds and it can be very difficult as a man to open up about your feelings. We see that a lot with young men now, they can't talk to anyone and don't have older role models they can learn from

As well as the direct health and wellbeing benefits mentioned above, there are several aspects of fly fishing which they find particularly suited to the group:

- There is no pressure to speak unless you want to.
- Participants are busy with a shared activity/shared goal.
- It is engaging and fun.
- There is an opportunity to learn a new skill, but beginners can be quickly engaged and get a catch.
- It takes time, and, in between catches, there are opportunities for people to get to know one another and open up if they wish to.
- The escapism it provides can provide people in recovery with a sense of focus and purpose.

I think that really helps people feel safe, secure. They are working with their hands and they are learning how to connect. There's no expectation, people can just be themselves. Some people are just there to fish, but we all keep an eye out for each other.

05. Recommendations

As we have discussed, suicide prevention tends to be conceptualised as a response to symptoms, rather than the causes of suicidal behaviour. In Northern Ireland, as elsewhere, it tends to focus on downstream responses (e.g. psychological treatments, media monitoring, education, helplines and so on).

Despite studies repeatedly calling for a focus on disadvantaged areas and low-income groups,[89] these types of initiatives – either designed to address poverty or targeting low-income groups with high-quality, preventative services – tend not to be included as part of the responses. So, although the 'biopsychosocial model' is widely accepted in suicide research, policy responses are largely focused on the bio/psycho determinants.

We recommend a more holistic cross-cutting policy, that tackles root causes and invests more in disadvantaged areas. This should be based on the principles of the biopsychosocial model of health. It requires a three-pronged approach that includes sufficient wages to foster equality and dignity, the decommodification of essential services, and an adequate benefits safety net.

This chapter sets out some of the areas that could be considered in such a policy.

5.1 Economic life

The main drivers of poverty identified in the research are inadequate benefits, low wages, and the accessibility of childcare. This applies to people who cannot work, such as people with disabilities, and people who are in work, but whose incomes are insufficient to lift them out of poverty. A strong theme from the research was the importance of targeting economic supports at women – or indeed their children.

There is strong support in the literature for the link between an uplift in benefits and a reduced suicide rate, even controlling for confounding variables. It is interesting to note that benefits are protective against suicide even amongst those in work. This suggests that the reassurance of the safety net may be as valuable as its actual poverty-reducing impacts. As discussed in the literature review, many experts believe that more generous welfare is the most important explanatory variable underpinning diverging suicide rates in Europe and America.

[89] Burrows, S., & Laflamme, L. (2010). Socioeconomic disparities and attempted suicide: state of knowledge and implications for research and prevention. International journal of injury control and safety promotion, 17(1), 23-40.

Northern Ireland urgently needs a new cross-cutting, anti-poverty strategy. At its core, that strategy needs to provide for an adequate level of benefits. As well as the mental health impacts, research shows that inadequate income support can increase the distance from the labour market: a further risk factor for suicidal behaviour.[90] [91] There is also no evidence that capping child benefits increases employment, as labour market activity among larger families appears to be particularly 'sticky' in response to reductions in benefits income, most likely due to caring responsibilities.[92]

Benefits policy is devolved, which enables Northern Ireland to develop its own evidence-based system, that has sufficiency and dignity as its primary goals. Because Northern Ireland has adopted policy parity with Westminster on benefits, this would be complicated, not least because it would require a new IT system.

However, given the urgent need to improve the incomes of the poorest communities, there is a strong argument for grasping this nettle.

In the short-term, there is an imperative that the Executive continue to mitigate against the worst excesses of Universal Credit. It should also use the change in administration at Westminster to lobby for a reversal of Universal Credit. The cost-benefit analysis for welfare reform is different in Northern Ireland than at the UK level, as any savings flow to the Treasury but losses affect people in the region. These losses are thought to be greater on a per person basis than in any of the other UK countries.[93]

Table 3 sets out a summary of the policy recommendations under this theme.

Area	Short-term	Longer-term
Benefits adequacy	• Continue with UC mitigations and extend to mitigations for people with disabilities. • Commit to achieving the JRF minimum income standard over time and introduce supplementary rate on a phased basis. • Introduce a targeted child payment, similar to the Scottish Child Payment. • Consider further supplements to groups at-risk of poverty, such as single parents.	• Develop a new Northern Ireland-specific benefits system, that is informed by the evidence on poverty reduction and responsive to local need and context.
Low wages	• Introduce an inequality remit to Invest NI, to ensure a better match between jobs created and the skills available in low-income communities. • Develop a new skills policy for Northern Ireland.	• Develop a more balanced economic development policy that is focused on middle-skill employment and a narrower income distribution. • Develop a 'living wage' economy.

[90] McKnight, A., & Vaganay, A. (2016). The Strength of the Link between Income Support and Activation.

[91] Reader, M., Andersen, K., Patrick, R., Reeves, A., & Stewart, K. (2023). Making work pay? The labour market effects of capping child benefits in larger families.

[92] Reader, M., Andersen, K., Patrick, R., Reeves, A., & Stewart, K. (2023). Making work pay? The labour market effects of capping child benefits in larger families.

[93] Simpson, M., & Patrick, R. (2019). Universal credit in Northern Ireland: interim report. Ulster University. https://www.ulster.ac.uk/lawclinic/research/current-projects.

Poverty stigma	• Inappropriate language by elected representatives regarding benefits should be sanctioned. • The impact of poverty stigma and measures to address it should be included in any anti-poverty strategy.	• Food banks and related provision were developed as temporary emergency response to the Financial Crisis. This type of benefit is highly stigmatised and the longer-term goal should be to eliminate the need for Food Banks.
Debt	• Better consumer protection and regulation of financial products to ensure vulnerable people are protected. • Better monitoring of the behaviour of creditors and investigations of illegal lending. • Greater availability and easier access to discretionary funds for one-off expenses that are distributed in a non-stigmatising way.	• Greater availability of low-cost credit and microcredit schemes (e.g. through Credit Unions).
Childcare	• Work with Westminster to ensure that the 30 hours free childcare is fast tracked. • Universal Credit rules should align with the available free childcare and providers should be paid directly by the State. • Other family-friendly policies, such as paid parental leave, should be introduced in line with countries with the lowest poverty rates.	• Develop a longer-term universal childcare policy, that ensures childcare is never a barrier to work and those on the lowest incomes are not disadvantaged within that system.
Area-based disadvantage	• Any anti-poverty strategy should have at its heart a target to reduce spatial inequalities. These have been shown to exacerbate all other outcomes[94] and to require additional policy measures.	• Develop a more balanced economic development policy that is focused on middle-skill employment and a narrower income distribution.

Table 3: Economic life recommendations

5.2 Political, social and cultural life

Due to the breadth of areas this topic covers, we will not attempt to develop detailed recommendations for each. Table 4 provides an overview of some of the most widely mentioned recommendations from the research.

Area	Short-term	Longer-term
Education	• Increase spend-per-pupil at least to the level in England, and target spending to disadvantaged young people and teaching in disadvantaged schools. • Work with the community and voluntary sector to tackle educational disadvantage, particularly amongst Protestant boys. • Develop better quality post-16 options for young people.	• Remove income and religious inequalities in education by working towards full church divestment and conversion to non-selection.

94

Governance	• Westminster should commission an independent review of the governance arrangements in Northern Ireland to recommend changes that would make it fit for purpose. • The Executive should fully consider the role of the community and voluntary sector in delivering a new holistic suicide prevention strategy that builds on and grows this strength. • Due to the unique history of Northern Ireland, it is especially important to ensure that policies are tailored to the needs and context of local communities.	• A longer-term policy that addresses the health of the community and voluntary sector is required. This should identify the kinds of interventions that are best delivered by each sector and ways in which they can be mutually reinforcing.
Mental health	• Mental health services for men should be prioritised and should be targeted, where possible, at men at risk, such as after job loss or relationship breakdown. • Crisis-intervention (24/7) and homecare packages for people experiencing suicidal behaviour is severely lacking. As well as having better outcomes, these have been found to reduce hospitalisations and be cheaper than standard care.[95] • Trauma-informed care has become the gold standard in public service delivery in recent years. Due to the widespread nature of trauma experiences, much more emphasis should be placed on this type of training, as well as greater availability of counselling.	• Full reform of the mental health services to create a fully accessible service that is based on recovery principles and peer support, as well as high quality medical experience where necessary. This system requires a far greater share of the health budget.
Relationships	• Free relationship counselling, delivered in primary care, should be available to couples that require it, and include access to economic support where necessary. • Fund outreach to men whose relationships have broken down • Create more refuge spaces and provide more funding to women's centres and other women's organisations.	• Greater availability of low-cost housing to ensure that couples are not forced to remain together when relationships have broken down. • Promote a culture of gender equality, where restrictive gender stereotypes are discouraged, and people can safely express their gender identity.

Table 4: Political, social and cultural life recommendations

[95] Murphy, S. M., Irving, C. B., Adams, C. E., & Waqar, M. (2015). Crisis intervention for people with severe mental illnesses. Cochrane Database of Systematic Reviews, (12).

Appendix 1: Methodological challenges

There are several methodological challenges that researchers face when measuring suicide, its causes, and consequences.

Firstly, there is a low base rate of suicide in the population. It tends to be measured in percentage per hundred thousand to account for this. This means that, although every suicide is a tragedy, it is a relatively rare phenomenon, and sample sizes are often too small to analyse robustly. Small datasets in small geographies also introduce strong data protection risks, which is a significant barrier in the context of GDPR legislation.

A second issue is that the nature and quality of suicide recording varies by country. There is no internationally accepted standard for suicide recording, with different norms in place in different countries. In addition, in some countries, cultural stigma means there is significant under-reporting. These factors make cross-country comparisons challenging.

Furthermore, related to the low base-rate of suicide, annual fluctuations in suicide are not appropriate to measure, due to small sample sizes (especially in small areas like Northern Ireland), and three-year averages are required. Therefore, identifying trends requires a long time series. In addition, a two-year time lag is generally required to confirm suicide statistics, as they often require a coroner's investigation. A researcher working on suicide in Northern Ireland today would be working with data from 2019-2022, which means that findings are out of date quickly (underlined by the changing economic and social conditions since 2019).

There are also issues with the appropriateness of dependent and independent variables for a given research question. If considering the relationship between unemployment and suicide, for example, there is a wide choice of variables to use to measure unemployment (unemployment rate, claimant rate, economic inactivity, or changes in these rates) and, indeed, suicide (suicide rate, number of suicides, suicide ideation, self-harm, or changes in these rates). Moreover, many of the most studied determinants – unemployment, poverty, debt, geography and inequality – are all interrelated. It can be difficult to unpack the causal mechanisms, particularly in the presence of the methodological limitations highlighted above. This means that researchers can arrive at contradictory findings depending on the variables, time periods and so on, and causality is difficult to establish. See Figure 1 for potential causal pathways between poverty and suicide.

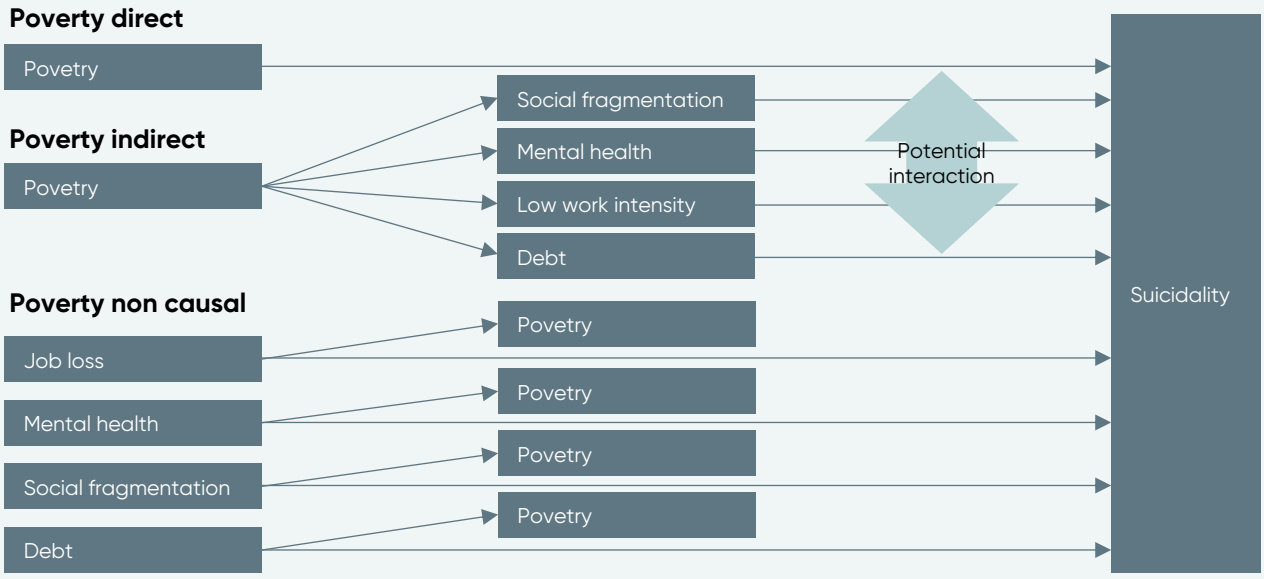


Figure 4: Potential causal pathways for poverty and suicidality

A key critique of Durkheim's work is methodological,[96] as he failed to address the risk of 'ecological fallacy' in his work. That is, he inferred findings on causes of suicide rates to explain individual behaviour. For example, he observed a higher suicide rate in countries with a higher number of Protestants, compared to Catholics or Jews, and inferred that the risk was higher for Protestants. However, this has been undermined by better-designed studies. Ecological fallacy continues to be a risk for suicide research nonetheless, and linking social conditions to individual behaviour remains challenging.

Finally, much of the existing literature comes from the US, where the context is very different (e.g. firearms availability and racial inequality). So, the findings from this literature are not necessarily applicable in a European context.

Despite these limitations, several large meta-analyses and good quality studies have enabled conclusions to be drawn, particularly regarding issues such as unemployment and poverty.

[96] Freedman, D. A. (1999). Ecological inference and the ecological fallacy. International Encyclopedia of the social & Behavioral sciences, 6(4027-4030), 1-7.

Appendix 2: Determinants of suicide literature

Academic interest in suicide has a long history. It is over 100 years since Emile Durkheim first published Suicide, a seminal exploration of the sociology of *suicide*. Since then, it has been a subject of interest across several disciplines, including sociology, psychology, medical science, and economics. This has culminated in a large international literature on the determinants of suicide, and a somewhat more limited literature on prevention strategies.

There are several knotty methodological issues that researchers face when measuring suicide, its causes and consequences (see Appendix 1 for more details on these).

Most immediately, whilst mental ill-health is a leading determinant of suicide, it is sometimes incorrectly treated as a proxy for suicide. In most studies, only about 50-60% of people who die by suicide have previously engaged with mental health services. Whilst the point at which they take their own lives is a moment of crisis, solely focusing on the delivery and quality of mental health services is only a partial (albeit critical) response.

For this study, the determinants of mental health and the causal pathway between this and suicide are out of scope. Our focus is instead on wider socio-economic phenomena that are linked to suicide rates, many of which will also be implicated in poor mental health.

To organise the literature, we have followed Stack et al. and split this out into the following domains:[97] political, social relations, culture, and economic life. We have added environmental due to the growing importance of these issues in the literature (see Table 5).

[97] Stack, S. (2021). Contributing factors to suicide: Political, social, cultural and economic. Preventive medicine, 152, 106498.

Economic life	Political life	Social life	Cultural life	Environment
• Business cycles (recessions) • Unemployment • Underemployment • Job strain and demotion • Indebtedness • Low income • Area-based deprivation • Income distribution	• Social expenditure/safety nets • Minimum wages • Alcohol availability • Left-leaning governments • Domestic violence laws	• Having children • Marriage • Low divorce rate • Separation • Social fragmentation • Religion • Past self-harm • Younger age than classmates • Parental loss • Adverse childhood experiences	• Gender (4:1) • Media reporting/copycat • Gender equality (breadwinner culture and male suicide) • Acceptability of suicide • Alcohol culture (wet vs. dry culture and young males)	• Air pollution • Noise pollution • Second-hand Smoke • Natural disasters • Lithium levels in drinking water

Table 5: Summary of determinants of suicide

Table 5 clearly shows that the determinants of suicidal behaviour are multi-faceted, have relevance across the life course and, crucially, can be influenced by policy.

A2.1 Political

Different political cultures and ways of organising societies have been found to produce different rates of suicide. The most notable factors are the level of social expenditure, the quality of labour market institutions, and the robustness of social safety nets (e.g., social security).

For example, a study of 31 OECD countries found that the greater the social welfare expenditures, the lower the suicide rate, independent of many confounders, including gross domestic product (GDP), income inequality, divorce rates, religious homogeneity, and inflation.[98] Interestingly, an earlier study, which found a similar relationship, also found an effect for confidence in the welfare state.[99]

This links to other research that suggests stress caused by periods of uncertainty (e.g. COVID-19 pandemic, recessions) is the trigger, and that these stresses are aggravated in the absence of safety nets.[100] This means that simply knowing adequate safety nets exist is protective, irrespective of whether they are accessed.

The overall volume of spending on social welfare programmes is higher in Europe than in the U.S., a social fact which has been used to explain the rising suicide rate in America.[101] Scholars have puzzled over the fact that, in most European nations, the rate of suicide has dropped in the 21st century, whereas in the U.S., it has risen by

[98] Tuttle, J. (2018). Specifying the effect of social welfare expenditures on homicide and suicide: A cross-national, longitudinal examination of the stream analogy of lethal violence. Justice Quarterly, 35(1), 87-113.

[99] Yur'yev, A., Värnik, A., Värnik, P., Sisask, M., & Leppik, L. (2012). Role of social welfare in European suicide prevention. International Journal of Social Welfare, 21(1), 26-33.

[100] Fitzpatrick, K. M., Harris, C., & Drawve, G. (2020). How bad is it? Suicidality in the middle of the COVID-19 pandemic. Suicide and Life-Threatening Behavior, 50(6), 1241-1249.

[101] Case, A., & Deaton, A. (2020). The epidemic of despair. Foreign Affairs, 99(2), 92-102.

over 25%.[102] This has led some economists to argue that the decline in European suicide is due to their stronger social safety net.[103] One model found that, adjusting for control variable, if every US state increased per capita public assistance by $45 per year, it would translate into 3000 fewer suicides per year, a decrease of 10%.[104] Indeed, one study found that spending on mental health services was not likely to be as protective against suicide as spending on policies aimed at income growth, divorce prevention or support, and those on low incomes.[105]

A key labour market institution that benefits from some research is the minimum wage. There is some evidence that increasing the minimum wage has an impact, especially amongst young people, those with lower levels of education, and those who experience periods of high unemployment.[106] Another study found that for every $1 inflation adjusted increase in the minimum wage, there was an associated 1.9% drop in suicides.[107] Although this evidence is from the US, where minimum wages are lower or non-existent, the authors argue that the positive outcomes come from narrowing the gap between socio-economic groups, implying that a more equal wage distribution positively impacts on suicide. The authors also argue that there is evidence of spillover effects of minimum wage increases, such that people working at above the minimum, low-wage jobs also benefit.

This links to economic life (next section) and the protection that people have (or perceive that they have) from job loss and periods of recession. As we will see, one of the strongest relationships is between unemployment and suicide, especially for males. However, one study found that this relationship disappeared in Scandinavian countries, where social protection was more robust. This study also found a gradient in effects, which was stronger the less generous the unemployment protection was.[108] Perhaps because of these factors, there is also some evidence that suicide rates decrease when a country experiences a shift to a more left-leaning government.[109]

Finally, legislation has been found to have a significant impact. Here, we look at two: alcohol availability/licencing and domestic violence legislation.

[102] Stack, S. (2021). Contributing factors to suicide: Political, social, cultural and economic. Preventive medicine, 152, 106498.

[103] Case, A., & Deaton, A. (2020). The epidemic of despair. Foreign Affairs, 99(2), 92-102.

[104] Flavin, P., & Radcliff, B. (2009). Public policies and suicide rates in the American states. Social Indicators Research, 90(2), 195-209.

[105] Ross, J. M., Yakovlev, P. A., & Carson, F. (2012). Does state spending on mental health lower suicide rates?. The Journal of Socio-Economics, 41(4), 408-417.

[106] Kaufman, J. A., Salas-Hernández, L. K., Komro, K. A., & Livingston, M. D. (2020). Effects of increased minimum wages by unemployment rate on suicide in the USA. J Epidemiol Community Health, 74(3), 219-224.

[107] Gertner, A. K., Rotter, J. S., & Shafer, P. R. (2019). Association between state minimum wages and suicide rates in the US. American journal of preventive medicine, 56(5), 648-654.

[108] Norström, T., & Grönqvist, H. (2015). The Great Recession, unemployment and suicide. J epidemiol community health, 69(2), 110-116.

[109] Matsubayashi, T., & Ueda, M. (2012). Government partisanship and human well-being. Social indicators research, 107, 127-148.

Alcohol availability is a known risk factor for suicide, especially for males.[110] One meta-analysis of 30 cohort studies found that alcohol use increased the risk of suicide by 1.65 times for males and 1.40 times for females.[111] Another systematic review found that government interventions to reduce alcohol availability had a positive impact on suicide rates.[112] Kõlves et al. distinguish between 'wet' and 'dry' alcohol cultures.[113] A wet culture refers to mealtime drinking (e.g. Portugal), whereas in a dry culture, alcohol was consumed more sporadically, including binge drinking (e.g. Norway). They found that the alcohol/young male suicide relationship was stronger in dry cultures.

For women, stronger domestic violence laws have been found to reduce the number of female suicides,[114] [115] as has greater liberalisation of divorce.[116] There is also evidence that victims of interpersonal violence have a higher risk of suicide, and some evidence that the risk is also higher for perpetrators.[117]

A2.2 Economic life

One of the strongest and most consistent relationships found in the literature is between unemployment/job loss and suicide.[118] [119] [120] [121] A recent meta-analysis found that unemployment increased the odds of suicide mortality and suicide attempts.[122] One US study found that the odds of dying by suicide were 45% higher for unemployed people, after adjusting for other variables.[123] There is evidence both for initial job loss[124] and for long-term unemployment. Findings from one meta-analysis suggest that the risk is greatest in the first five years, and persists, at a lower but elevated level, up to 16 years after unemployment.[125]

Academics have sought to understand whether the observed relationship between unemployment and suicide is causal and, if so, whether it is directly or indirectly causal. This is because unemployment co-exists with other economic phenomena that are also linked to suicide.

[110] Kõlves, K., Chitty, K. M., Wardhani, R., Värnik, A., De Leo, D., & Witt, K. (2020). Impact of alcohol policies on suicidal behavior: a systematic literature review. International journal of environmental research and public health, 17(19), 7030.
[111] Amiri, S., & Behnezhad, S. (2020). Cancer diagnosis and suicide mortality: a systematic review and meta-analysis. Archives of Suicide Research, 24(sup2), S94-S112.
[112] Xuan, Z., Naimi, T. S., Kaplan, M. S., Bagge, C. L., Few, L. R., Maisto, S., ... & Freeman, R. (2016). Alcohol policies and suicide: a review of the literature. Alcoholism: clinical and experimental research, 40(10), 2043-2055.
[113] Kõlves, K., Chitty, K. M., Wardhani, R., Värnik, A., De Leo, D., & Witt, K. (2020). Impact of alcohol policies on suicidal behavior: a systematic literature review. International journal of environmental research and public health, 17(19), 7030.
[114] Beleche, T. (2019). Domestic violence laws and suicide in Mexico. Review of Economics of the Household, 17(1), 229-248.
[115] Rahmani, F., Salmasi, S., Rahmani, F., Bird, J., Asghari, E., Robai, N., ... & Gholizadeh, L. (2019). Domestic violence and suicide attempts among married women: A case–control study. Journal of clinical nursing, 28(17-18), 3252-3261.
[116] Stevenson, B., & Wolfers, J. (2000). 'Til Death Do Us Part: Effects of Divorce Laws on Suicide, Domestic Violence and Spousal Murder. Department of Economics, Harvard University, Mimeo.
[117] MacIsaac, M. B., Bugeja, L. C., & Jelinek, G. A. (2017). The association between exposure to interpersonal violence and suicide among women: a systematic review. Australian and New Zealand journal of public health, 41(1), 61-69.
[118] Platt, Stephen, and Norman Kreitman. "Long term trends in parasuicide and unemployment in Edinburgh, 1968–87." Social psychiatry and psychiatric epidemiology 25 (1990): 56-61.
[119] Yoshimasu, K., Kiyohara, C., Miyashita, K., & Stress Research Group of the Japanese Society for Hygiene. (2008). Suicidal risk factors and completed suicide: meta-analyses based on psychological autopsy studies. Environmental health and preventive medicine, 13, 243-256.
[120] Li, Z., Page, A., Martin, G., & Taylor, R. (2011). Attributable risk of psychiatric and socio-economic factors for suicide from individual-level, population-based studies: a systematic review. Social science & medicine, 72(4), 608-616.
[121] Milner, A., Page, A., & LaMontagne, A. D. (2013). Long-term unemployment and suicide: a systematic review and meta-analysis. PloS one, 8(1), e51333.
[122] Amiri, S. (2022). Unemployment and suicide mortality, suicide attempts, and suicide ideation: A meta-analysis. International Journal of Mental Health, 51(4), 294-318.
[123] Denney, J. T., Wadsworth, T., Rogers, R. G., & Pampel, F. C. (2015). Suicide in the city: do characteristics of place really influence risk?. Social Science Quarterly, 96(2), 313-329.
[124] Milner, A., Page, A., Morrell, S., Hobbs, C., Carter, G., Dudley, M., ... & Taylor, R. (2014). The effects of involuntary job loss on suicide and suicide attempts among young adults: Evidence from a matched case–control study. Australian & New Zealand Journal of Psychiatry, 48(4), 333-340.
[125] Milner, A., Page, A., & LaMontagne, A. D. (2013). Long-term unemployment and suicide: a systematic review and meta-analysis. PloS one, 8(1), e51333.

However, most conclude that it is highly likely to be causal,[126] both directly and indirectly, via poorer mental health, poverty, debt, and so on.[127] Research has also found that labour underutilisation or underemployment is linked to suicide, suggesting that it is not only the absence of employment, but the quality of employment that matters.[128]

This would be consistent with studies that find that poverty and financial anxiety are important mechanisms linking unemployment to increased suicide risk.[129]

This is not to underplay the importance of job loss. One meta-analysis of over 140 studies found that mental health worsens after the loss of a job, and that mental health improves once a person is re-employed.[130] This relationship – and the relationship for unemployment – is stronger for men.[131] We see this especially as we move into the discussion on the business cycle and suicide, where the impacts are again more acutely experienced by men.[132]

During recessions, there are often rapid and large increases in unemployment, and these tend to be associated with increases in the suicide rate.

This was observed in Europe and the US during the recession following the 2008 financial crisis.[133] [134] Again, the designs underpinning these types of studies have been criticised, but meta-analyses of studies using different designs tend to find relationships.[135] In the RoI, the National Suicide Research Foundation estimated that there were over 500 suicides caused by the 2008 financial crisis and recession, and that these occurred mainly in males with underlying mental health problems. This intersectionality shows how cultural, economic, and physical factors can negatively reinforce each other. Another study from England found that few entirely recession-related suicides had ever had contact with psychiatric services,[136] demonstrating again the inadequacy of a sole focus on mental health services.

The role of job loss is, of course, key, but some academics also interpret increases in suicide rates to result from psychosocial stress in populations, which can be brought on by recessionary periods.[137] These stresses can stem from factors such as increased indebtedness, and there is some evidence for an independent relationship between debt burden and suicide.[138] [139]

[126] Blakely, T. A., Collings, S. C., & Atkinson, J. (2003). Unemployment and suicide. Evidence for a causal association?. Journal of Epidemiology & Community Health, 57(8), 594-600.

[127] Oyesanya, M., Lopez-Morinigo, J., & Dutta, R. (2015). Systematic review of suicide in economic recession. World journal of psychiatry, 5(2), 243.

[128] Skinner, A., Osgood, N. D., Occhipinti, J. A., Song, Y. J. C., & Hickie, I. B. (2023). Unemployment and underemployment are causes of suicide. Science advances, 9(28), eadg3758.

[129] Bartley, Mel. "Unemployment and ill health: understanding the relationship." Journal of Epidemiology & Community Health 48.4 (1994): 333-337.

[130] Paul, K. I., Hassel, A., & Moser, K. (2018). Individual consequences of job loss and unemployment. Oxford handbook of job loss and job search, 57-85.

[131] Amiri, S. (2022). Unemployment and suicide mortality, suicide attempts, and suicide ideation: A meta-analysis. International Journal of Mental Health, 51(4), 294-318.

[132] Coope, C., Gunnell, D., Hollingworth, W., Hawton, K., Kapur, N., Fearn, V., ... & Metcalfe, C. (2014). Suicide and the 2008 economic recession: who is most at risk? Trends in suicide rates in England and Wales 2001–2011. Social Science & Medicine, 117, 76-85.

[133] Reeves, A., Stuckler, D., McKee, M., Gunnell, D., Chang, S. S., & Basu, S. (2012). Increase in state suicide rates in the USA during economic recession. The Lancet, 380(9856), 1813-1814.

[134] Reeves, A., McKee, M., Gunnell, D., Chang, S. S., Basu, S., Barr, B., & Stuckler, D. (2015). Economic shocks, resilience, and male suicides in the Great Recession: cross-national analysis of 20 EU countries. The European Journal of Public Health, 25(3), 404-409.

[135] Oyesanya, M., Lopez-Morinigo, J., & Dutta, R. (2015). Systematic review of suicide in economic recession. World journal of psychiatry, 5(2), 243.

[136] Coope, C., Donovan, J., Wilson, C., Barnes, M., Metcalfe, C., Hollingworth, W., ... & Gunnell, D. (2015). Characteristics of people dying by suicide after job loss, financial difficulties and other economic stressors during a period of recession (2010–2011): A review of coroners ' records. Journal of affective disorders, 183, 98-105.

[137] Oyesanya, M., Lopez-Morinigo, J., & Dutta, R. (2015). Systematic review of suicide in economic recession. World journal of psychiatry, 5(2), 243

[138] https://journals.sagepub.com/doi/full/10.1177/00207640211036166

[139] https://www.psychi Rojas, Y. (2022). Financial indebtedness and suicide: A 1-year follow-up study of a population registered at the Swedish Enforcement Authority. International journal of social psychiatry, 68(7), 1445-1453.atrist.com/jcp/persons-debt-burden-are-more-likely-report-suicide-attempt-than-those-without-national-study-us-adults/

Recessions can also increase the rate of poverty, and relative poverty has been found to increase the risk of suicide, even controlling for wider economic development,[140] and this effect is stronger amongst men.[141] Population risk of suicide has also been found to be associated with country-level poverty rates.[142] The same study found that poverty rates were associated with increased alcohol involvement for men aged 45–64 years, indicating a role for alcohol in suicide for this age group.

As discussed earlier, a relationship between social spending and the suicide rate can be observed at the national level. In addition, economists who have studied economic factors argue that the evidence justifies increased government spending on unemployment benefits and debt reduction programmes.[143] One study also found a link between increased per capita spending on active labour market programmes and a lower rate of suicide. The authors argue that the reason underlying suicide rates decreased in Sweden and Finland in the 1990s, when both countries suffered from economic recession, was their robust social protection and active labour market.[144]

Well-designed programmes that aim to reduce the risks of economic hardship would require a better understanding of the groups most likely to be exposed to the negative effects of recession.[145] For example, whilst men are most exposed to these economic phenomena, they are also more likely to benefit from social protections.[146] Research also tends to find that poverty is a greater risk factor for older adults, and prevention strategies for that group could be targeted by income levels.[147]

Finally, living in a low-income community is associated with a higher risk of suicide.[148] Spatial inequalities in health, in general, are well-understood[149] and suicide follows a similar pattern. While there are mixed findings on whether population or area effects are being observed, a systematic review of European countries found that the effect remained even after adjusting for confounders.[150] It has been pointed out that there is a near universal failure to consider equality issues in both academic reviews of approaches to suicide prevention, and the formulation of national suicide prevention strategies.[151] This was discussed in more detail in Chapter 4.

[140] Piatkowska, S. J. (2020). Poverty, inequality, and suicide rates: a Cross-National Assessment of the Durkheim Theory and the Stream Analogy of Lethal Violence. The Sociological Quarterly, 61(4), 787-812.

[141] Choi, J. W., Kim, T. H., Shin, J., & Han, E. (2019). Poverty and suicide risk in older adults: a retrospective longitudinal cohort study. International journal of geriatric psychiatry, 34(11), 1565-1571.

[142] Kerr, W. C., Kaplan, M. S., Huguet, N., Caetano, R., Giesbrecht, N., & McFarland, B. H. (2017). Economic recession, alcohol, and suicide rates: comparative effects of poverty, foreclosure, and job loss. American journal of preventive medicine, 52(4), 469-475.

[143] Mathieu, S., Treloar, A., Hawgood, J., Ross, V., & Kõlves, K. (2022). The role of unemployment, financial hardship, and economic recession on suicidal behaviors and interventions to mitigate their impact: a review. Frontiers in public health, 10, 907052.

[144] Stuckler D, Basu S, Suhrcke M, McKee M. The health implications of financial crisis: a review of the evidence. Ulster Med J. 2009;78:142–145

[145] Mathieu, S., Treloar, A., Hawgood, J., Ross, V., & Kõlves, K. (2022). The role of unemployment, financial hardship, and economic recession on suicidal behaviors and interventions to mitigate their impact: a review. Frontiers in public health, 10, 907052.

[146] Shand, F., Duffy, L., & Torok, M. (2021). Can government responses to unemployment reduce the impact of unemployment on suicide?. Crisis.

[147] Choi, J. W., Kim, T. H., Shin, J., & Han, E. (2019). Poverty and suicide risk in older adults: a retrospective longitudinal cohort study. International journal of geriatric psychiatry, 34(11), 1565-1571.

[148] Rehkopf, D. H., & Buka, S. L. (2006). The association between suicide and the socio-economic characteristics of geographical areas: a systematic review. Psychological medicine, 36(2), 145-157.

[149] Marmot, M. (2017). Social justice, epidemiology and health inequalities. European journal of epidemiology, 32, 537-546.

[150] Cairns, J. M., Graham, E., & Bambra, C. (2017). Area-level socioeconomic disadvantage and suicidal behaviour in Europe: a systematic review. Social Science & Medicine, 192, 102-111.

[151] Platt, S. (2016). Inequalities and suicidal behavior. The international handbook of suicide prevention, 258-283.

A2.3 Culture

Although women tend to experience higher rates of common mental health conditions, such as depression,[152] and have higher levels of suicidal ideation than men,[153] mortality from suicide is much higher amongst men.[154] As we have seen, men are more at risk from important economic determinants.

The so-called 'gender paradox' has been explained in various ways. There is a biological argument that there is a greater tendency towards violence, impulsivity, and lethality in men.[155] It has also been explained by cultural expectations concerning suicide.[156] One such explanation is that men are socialised to adhere to masculine gender norms,[157] which reduces their access to coping strategies, such as emotional support.[158] Support for this theory comes from studies that find that suicide rates are higher in countries with a 'breadwinner' culture,[159] and that higher gender equality and female participation in the labour market have a positive impact.[160] [161]

One study found that norms of self-reliance, discouraging help-seeking, and heteronormativity were particularly problematic aspects of that culture.[162]

Studies on gender equality can vary in findings: some find positive impacts for both genders, others for one gender and some not at all. One study that analysed rates over time found that, as gender equality increased in countries, so too have suicide rates for both sexes.[163] However, as Chang et al. argue, the relationship between gender equality and suicide rates is not static, and can vary by social context and the indicators that are being used.[164] For example, one study found no independent relationship between gender equality and suicide rates in either men or women, but did find that a greater degree of gender equality helped protect against suicidality associated with economic shocks, especially for men.[165]

[152] Zhao, L., Han, G., Zhao, Y., Jin, Y., Ge, T., Yang, W., ... & Li, B. (2020). Gender differences in depression: evidence from genetics. Frontiers in genetics, 11, 562316.

[153] Demuth, A., & Demuthova, S. (2022). Gender differences in adolescent self-harming behaviour. behaviour, 6, 12291-9.

[154] Freeman, A., Mergl, R., Kohls, E., Székely, A., Gusmao, R., Arensman, E., ... & Rummel-Kluge, C. (2017). A cross-national study on gender differences in suicide intent. BMC psychiatry, 17, 1-11.

[155] Shelef, L. (2021). The gender paradox: do men differ from women in suicidal behavior?. Journal of men's health, 17(4), 22-29.

[156] Payne, S., Swami, V., & Stanistreet, D. L. (2008). The social construction of gender and its influence on suicide: a review of the literature. Journal of Men's Health, 5(1), 23-35.

[157] Granato, S. L., Smith, P. N., & Selwyn, C. N. (2015). Acquired capability and masculine gender norm adherence: Potential pathways to higher rates of male suicide. Psychology of Men & Masculinity, 16(3), 246.

[158] Möller-Leimkühler, A. M. (2003). The gender gap in suicide and premature death or: why are men so vulnerable?. European archives of psychiatry and clinical neuroscience, 253, 1-8.

[159] Moore, F., Taylor, S., Beaumont, J., Gibson, R., & Starkey, C. (2018). The gender suicide paradox under gender role reversal during industrialisation. PloS one, 13(8), e0202487.

[160] Chang, Q., Yip, P. S., & Chen, Y. Y. (2019). Gender inequality and suicide gender ratios in the world. Journal of affective disorders, 243, 297-304.

[161] Chen, Y. Y., Chen, M., Lui, C. S., & Yip, P. S. (2017). Female labour force participation and suicide rates in the world. Social Science & Medicine, 195, 61-67.

[162] King, T. L., Shields, M., Sojo, V., Daraganova, G., Currier, D., O'Neil, A., ... & Milner, A. (2020). Expressions of masculinity and associations with suicidal ideation among young males. BMC psychiatry, 20, 1-10.

[163] Moore, M. D., & Heirigs, M. H. (2021). Suicide & gender inequality: a cross-national examination. Sociological Spectrum, 41(3), 273-286.

[164] Chang Q, Yip PSF, Chen Y. Gender inequality and suicide gender ratios in the world. Journal of Affective Disorders. 2019; 243: 297–304

[165] Reeves, A., & Stuckler, D. (2016). Suicidality, economic shocks, and egalitarian gender norms. European sociological review, 32(1), 39-53.

As well as gender norms around help-seeking, women have been found to be higher on protective factors, such as religiosity, parenting/family care, and social networks, and are less likely to own firearms or to use alcohol as a coping mechanism. However, the risk of suicide from alcohol use has been found to be higher amongst women than men, so, although women are less likely to abuse alcohol, when they do, it is riskier from a suicide perspective.[166] Relating again to socialisation, one study from the US found a link between the depictions of firearm use in film and male suicide.[167]

This discussion relates to a wider phenomenon of the cultural acceptability of suicide, which can also vary over time and place. Research from the US finds that expressions of suicide acceptability are predictive of subsequent death by suicide.[168]

There are many explanations as to why religiosity has been found to be protective against suicide. It promotes hopefulness and coping strategies, expands social networks, and provides feelings of integration. It also tends to lower suicide acceptability.[169] A systematic review of the relationship found that religion is not necessarily protective against suicide ideation, but is against attempts, again suggesting that acceptability is a factor.

A recent review of the literature concludes that, whilst it is generally accepted that religion most often serves as a protective factor against suicide across religious denominations, there are aspects of religion that are recognized as potentially representing a risk factor for some groups.[170]

One way in which suicide acceptability is increased is through media depictions. It has been known for some time that mainstream media can increase the number of suicides through particular types of reporting from media accounts (e.g. in film) that romanticise or glamourise suicide deaths.[171] One US study found that reporting of deaths of celebrities by suicide appears to have made a meaningful impact on total suicides in the general population.[172] Research has also found that the media can play a positive role in educating the public about risks for suicide and shaping attitudes about suicide.[173]

The concern regarding 'suicide contagion', highlighted by the above research, has increased substantially in recent years, with the universal availability of smartphone technology and social media use, and access to these technologies by adolescents.

There is growing evidence that cybervictimization is associated with suicidal thoughts and behaviours in adolescents.[174]

[166] McLean, J., Maxwell, M., Platt, S., Harris, F. M., & Jepson, R. (2008). Risk and protective factors for suicide and suicidal behaviour: A literature review. Scottish Government.

[167] Stack, S., & Bowman, B. (2017). Why Men Choose Firearms More than Women: Gender and the Portrayal of Firearm Suicide in Film, 1900–2013. In Media and Suicide (pp. 27-36). Routledge.

[168] Phillips, J. A., & Luth, E. A. (2020). Beliefs about suicide acceptability in the United States: how do they affect suicide mortality?. The Journals of Gerontology: Series B, 75(2), 414-425.

[169] Stack, S. (2013). Religion and suicide acceptability: A review and extension. Suicidology, 18(1).

[170] Lawrence, R. E., Oquendo, M. A., & Stanley, B. (2016). Religion and suicide risk: a systematic review. Archives of suicide research, 20(1), 1-21.

[171] Sudak, H. S., & Sudak, D. M. (2005). The media and suicide. Academic Psychiatry, 29, 495-499.

[172] Niederkrotenthaler, T., Braun, M., Pirkis, J., Till, B., Stack, S., Sinyor, M., ... & Spittal, M. J. (2020). Association between suicide reporting in the media and suicide: systematic review and meta-analysis. Bmj, 368.

[173] Gould, M. S. (2001). Suicide and the media. Annals of the New York Academy of Sciences, 932(1), 200-224.

[174] Massing-Schaffer, M., & Nesi, J. (2020). Cybervictimization and suicide risk in adolescence: An integrative model of social media and suicide theories. Adolescent Research Review, 5(1), 49-65.

A systematic review has found a positive association between various patterns of digital use – frequency of social media use, smartphone addiction, suicide-related social media use, sexting – and suicidality in adolescents and young adults.[175] However, the review also concluded that it was not possible to say whether such patterns confer suicide risk. More longitudinal studies are required in this important area of research. However, it is notable that, despite the emphasis on this topic in the current discourse, it appears less important than factors that have been known about for many decades – if not a century – such as poverty. The potential for social media to be protective against suicide is also discussed in the literature.[176]

A2.4 Social relations

Connection to other people is a fundamental aspect of what defines us as human beings, and a dearth of such connections has profound consequences for our health and wellbeing.[177] Loneliness and isolation are now recognised as public health concerns, as important as smoking and obesity.[178] One aspect of Durkheim's original theory that has held up well to scrutiny is the protective nature of social integration.[179]

This includes strong ties to families and neighbourhoods as well as membership in groups and societies, or what we might today call social capital.

Again, however, the details are more complex. One study of social capital in fifty US states found a strong relationship, but only for white people.[180] Cross-nationally, social capital and higher levels of trust are associated with lower national suicide rates,[181] and this relationship holds when controlling for gender, age, marriage rates, standardised income, and reported sadness.[182]

Social fragmentation is a related concept and has been developed as a construct by sociologists to capture Durkheim's concept of anomy. It refers to the absence or underdevelopment of connections between society and the grouping of certain of its members, and tends to be measured by indicators such as population turnover, voter participation, and the proportion of unmarried people. Research from the UK has found that parliamentary constituencies with high levels of social fragmentation had high rates of suicide, independent of deprivation in the 1980s and 90s, as had those constituencies with the greatest increases in social fragmentation.[183] Other studies of social fragmentation support this.[184]

[175] Macrynikola, N., Auad, E., Menjivar, J., & Miranda, R. (2021). Does social media use confer suicide risk? A systematic review of the evidence. Computers in Human Behavior Reports, 3, 100094.

[176] Macrynikola, N., Auad, E., Menjivar, J., & Miranda, R. (2021). Does social media use confer suicide risk? A systematic review of the evidence. Computers in Human Behavior Reports, 3, 100094.

[177] Holt-Lunstad, J. (2021). The major health implications of social connection. Current Directions in Psychological Science, 30(3), 251-259.

[178] Christiansen, J., Lund, R., Qualter, P., Andersen, C. M., Pedersen, S. S., & Lasgaard, M. (2021). Loneliness, social isolation, and chronic disease outcomes. Annals of Behavioral Medicine, 55(3), 203-215.

[179] Mueller, A. S., Abrutyn, S., Pescosolido, B., & Diefendorf, S. (2021). The social roots of suicide: Theorizing how the external social world matters to suicide and suicide prevention. Frontiers in psychology, 12, 621569.

[180] Smith, N. D. L., & Kawachi, I. (2014). State-level social capital and suicide mortality in the 50 US states. Social Science & Medicine, 120, 269-277.

[181] Helliwell, J. F. (2007). Well-being and social capital: Does suicide pose a puzzle?. Social indicators research, 81, 455-496.

[182] https://link.springer.com/article/10.1007/s00127-009-0018-4

[183] Whitley, E., Gunnell, D., Dorling, D., & Smith, G. D. (1999). Ecological study of social fragmentation, poverty, and suicide. Bmj, 319(7216), 1034-1037.

[184] Evans, J., Middleton, N., & Gunnell, D. (2004). Social fragmentation, severe mental illness and suicide. Social psychiatry and psychiatric epidemiology, 39, 165-170.

However, the current relevance of some social fragmentation indicators have been called into question, for example in a study of Dublin city centre, which had a low suicide rate but also high social fragmentation amongst a young, mobile, and unmarried population. Associations with social fragmentation only emerged in the sub-population analysis (e.g. amongst older people).[185]

Marital status, especially divorce, has been found to have a strong net effect on mortality from suicide, with some studies only finding an effect for men,[186] and others finding it for both genders.[187] A meta-analysis found that non-married men exhibited a greater risk of suicide than their married counterparts in all sub-analyses, but women aged 65 years or older showed no significant association between marital status and suicide. The suicide risk in divorced individuals was higher than for non-married individuals in both men and women.[188]

Whilst it is widely accepted that social support is protective against the risk of suicidal behaviour in young people and later life, there is less research available on adult friendships. However, research suggests that social supports are protective against suicide throughout the life course.[189]

Another key relationship is that of parents and children. Early experiences of physical and sexual abuse, and parental neglect are risk factors for suicidal behaviour in adolescence and adulthood.[190] [191] Parenthood itself is also associated with a lower suicide risk in both men and women, but to a larger extent among women, particularly in parents with two or more children.[192] There are also potential negative impacts. Parents of children with a hospitalized psychiatric disorder, and parents of children who have died are at an increased risk for suicide. In addition, a suicide death of a child increases the risk of parental suicide more than a non-suicide death.[193] Childhood exposure to parental death is associated with suicide,[194] and the effect is much stronger where the death is by suicide.[195]

[185] O'Farrell, I. B., Corcoran, P., & Perry, I. J. (2016). The area level association between suicide, deprivation, social fragmentation and population density in the Republic of Ireland: a national study. Social psychiatry and psychiatric epidemiology, 51, 839-847.

[186] Kposowa, A. J. (2000). Marital status and suicide in the National Longitudinal Mortality Study. Journal of Epidemiology & Community Health, 54(4), 254-261.

[187] Masocco, M., Pompili, M., Vichi, M., Vanacore, N., Lester, D., & Tatarelli, R. (2008). Suicide and marital status in Italy. Psychiatric Quarterly, 79, 275-285.

[188] Kyung-Sook, W., SangSoo, S., Sangjin, S., & Young-Jeon, S. (2018). Marital status integration and suicide: A meta-analysis and meta-regression. Social science & medicine, 197, 116-126.

[189] Kleiman, E. M., & Liu, R. T. (2013). Social support as a protective factor in suicide: Findings from two nationally representative samples. Journal of affective disorders, 150(2), 540-545.

[190] Brodsky, B. S., & Stanley, B. (2008). Adverse childhood experiences and suicidal behavior. Psychiatric Clinics of North America, 31(2), 223-235.

[191] Ports, K. A., Merrick, M. T., Stone, D. M., Wilkins, N. J., Reed, J., Ebin, J., & Ford, D. C. (2017). Adverse childhood experiences and suicide risk: Toward comprehensive prevention. American journal of preventive medicine, 53(3), 400-403.

[192] Dehara, M., Wells, M. B., Sjöqvist, H., Kosidou, K., Dalman, C., & Sörberg Wallin, A. (2021). Parenthood is associated with lower suicide risk: a register-based cohort study of 1.5 million Swedes. Acta Psychiatrica Scandinavica, 143(3), 206-215.

[193] Qin, P., & Mortensen, P. B. (2003). The impact of parental status on the risk of completed suicide. Archives of general psychiatry, 60(8), 797-802.

[194] Hua, P., Bugeja, L., & Maple, M. (2019). A systematic review on the relationship between childhood exposure to external cause parental death, including suicide, on subsequent suicidal behaviour. Journal of affective disorders, 257, 723-734.

[195] Calderaro, M., Baethge, C., Bermpohl, F., Gutwinski, S., Schouler-Ocak, M., & Henssler, J. (2022). Offspring's risk for suicidal behaviour in relation to parental death by suicide: systematic review and meta-analysis and a model for familial transmission of suicide. The British Journal of Psychiatry, 220(3), 121-129.

There is some evidence that the relative age of children in class (younger than classmates) is a factor in youth suicide.[196] It is suggested that the higher incidence of youth suicide in relatively younger school children, may have resulted from poorer school performance, which in turn led to lowered confidence and self-esteem.[197]

Demonstrating a relationship between levels of education and suicide risk is challenging, given that it mediates many important factors, such as employment and poverty. Unlike other determinants discussed in this review, the evidence is somewhat mixed, with some studies finding a positive relationship,[198] and others finding a negative one.[199] However, low educational attainment and school underperformance appear to be linked to an increased risk of suicidal behaviour[200] and poorer mental health.[201]

A2.5 Environmental

A range of environmental factors have been found to be associated with suicidal ideation and mental health generally, and this is a growing area of research. We summarise these here briefly, although future longitudinal studies are required to assess causality.

Adolescents who use tobacco and adolescent girls exposed to second-hand smoke were found to be more likely to attempt suicide in a cross-national study.[202] One study from South Korea found that an increased level of exposure to second-hand smoke was positively associated with stress, depression, and suicidal ideation. Furthermore, stress, depression, and suicidal ideation increased as the level of second-hand smoke increased, after adjusting for variables such as age, gender, education level of the father and mother, school achievement, economic status, inhabitation, and drinking.[203]

Air quality is an important public health challenge and is linked to several chronic conditions, such as cardiovascular and respiratory diseases.[204] It has also been shown to have negative effects on brain structure, leading to earlier onset of Alzheimer's and Parkinson's disease.[205]

There is also considerable evidence to support a link between air pollution and the incidence of depression and suicides.

[196] Matsubayashi, T., & Ueda, M. (2015). Relative age in school and suicide among young individuals in Japan: a regression discontinuity approach. PloS one, 10(8), e0135349.
[197] Thompson, A. H., Barnsley, R. H., & Dyck, R. J. (1999). A new factor in youth suicide: The relative age effect. The Canadian Journal of Psychiatry, 44(1), 82-85.
[198] Phillips, J. A., & Hempstead, K. (2017). Differences in US suicide rates by educational attainment, 2000–2014. American journal of preventive medicine, 53(4), e123-e130.
[199] Pompili, M., Vichi, M., Qin, P., Innamorati, M., De Leo, D., & Girardi, P. (2013). Does the level of education influence completed suicide? A nationwide register study. Journal of affective disorders, 147(1-3), 437-440.
[200] https://jech.bmj.com/content/65/11/993.short
[201] https://www.sciencedirect.com/science/article/abs/pii/S0927537115000068
[202] Lange, S., Koyanagi, A., Rehm, J., Roerecke, M., & Carvalho, A. F. (2020). Association of tobacco use and exposure to secondhand smoke with suicide attempts among adolescents: Findings from 33 countries. Nicotine and tobacco research, 22(8), 1322-1329.
[203] Lee, E., & Kim, K. Y. (2021, January). The association between secondhand smoke and stress, depression, and suicidal ideation in adolescents. In Healthcare (Vol. 9, No. 1, p. 39). MDPI.
[204] Karimi, S. M., Maziyaki, A., Ahmadian Moghadam, S., Jafarkhani, M., Zarei, H., Moradi-Lakeh, M., & Pouran, H. (2020). Continuous exposure to ambient air pollution and chronic diseases: prevalence, burden, and economic costs. Reviews on Environmental Health, 35(4), 379-399.
[205] Gładka, A., Rymaszewska, J., & Zatoński, T. (2018). Impact of air pollution on depression and suicide. International journal of occupational medicine and environmental health, 31(6), 711-721.

A meta-analysis of studies on air pollution found that an increase in ambient particulate matter concentration was strongly associated with an increased risk of depression and suicide, and that the associations for depression appeared stronger for smaller particles, and over a long-term time pattern. Subgroup analyses showed that associations between particulate matter and depression were more apparent in people over 65 years, and from developed regions.[206]

Transport is a major contributor to air pollution, but there is also a growing concern regarding noise pollution and its health impacts. In one longitudinal Swiss cohort study, researchers reported a robust association between exposure to road traffic and railway noise, and the risk of death by suicide, after adjusting for exposure to air pollution and greenness. The effect was stronger for women than men.[207] Similar findings have been found for Madrid[208] and Korea,[209] amongst others. Early childhood has been found to be the most critical period for exposure to environmental pollutants.[210]

[206] Liu, Q., Wang, W., Gu, X., Deng, F., Wang, X., Lin, H., ... & Wu, S. (2021). Association between particulate matter air pollution and risk of depression and suicide: a systematic review and meta-analysis. Environmental Science and Pollution Research, 28, 9029-9049.

[207] Wicki, B., Schäffer, B., Wunderli, J. M., Müller, T. J., Pervilhac, C., Röösli, M., & Vienneau, D. (2023). Suicide and transportation noise: a prospective cohort study from Switzerland. Environmental health perspectives, 131(3), 037013.

[208] Díaz, J., López-Bueno, J. A., López-Ossorio, J. J., González, J. L., Sánchez, F., & Linares, C. (2020). Short-term effects of traffic noise on suicides and emergency hospital admissions due to anxiety and depression in Madrid (Spain). Science of the total environment, 710, 136315.

[209] https://onlinelibrary.wiley.com/doi/abs/10.1002/da.22789

[210] Newbury, J., Heron, J., Kirkbride, J., Fisher, H., Bakolis, I., Boyd, A., ... & Zammit, S. (2024). Air and noise pollution exposure in early life and mental health from adolescence to young adulthood. Jama Network Open.

Appendix 3: Interview guide

Interview guide for individuals with lived experience of economic disadvantage

1. Can you tell me about the area in which you live, particularly experiences in that community of economic hardship, or difficulty in making ends meet (probe around employment, relationships, debt, alcohol etc.)? If you no longer live in such an area, can you tell me about a previous experience?
2. What impact do you think this has on people? In particular, are these experiences linked to mental ill-health and or suicidal behaviour?
3. Have the economic circumstances improved or deteriorated in recent years?
4. How has this impacted on mental health/suicidal behaviour if at all?
5. Is there anything particular to Northern Ireland that is likely to impact on these issues (e.g. experiences of conflict or trauma)?
6. What kinds of supports would help people experiencing poverty, unemployment or financial hardship (probe around benefits, employment and services)?