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Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Suicide Prevention Strategy: Evidence Session with Departmental Officials

17 February 2011

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Jim Wells (Chairperson)
Mrs Michelle O'Neill (Deputy Chairperson)
Mr Mickey Brady
Dr Kieran Deeny
Mr Alex Easton
Mr Tommy Gallagher
Ms Sue Ramsey

Witnesses:

Mr Martin Bell	)	
Dr Maura Briscoe	)	Department of Health, Social Services and Public Safety
Mr Gerard Collins	)	
Ms Madeline Heaney	)	Public Health Agency

The Chairperson (Mr Wells):

Welcome to the Committee. It is a regular experience for some of you. With us are Dr Maura Briscoe, the director of mental health and disability policy in the Department of Health, Social Services and Public Safety (DHSSPS); Mr Gerard Collins from the Department's health improvement policy branch; Mr Martin Bell, who is also from the health improvement policy branch; and Madeline Heaney from the Public Health Agency. Maura, you have been here many

times and know the routine. You have 10 minutes to set the scene, after which I will ask for questions from Committee members.

Dr Maura Briscoe (Department of Health, Social Services and Public Safety):
Gerard will take the lead.

Mr Gerard Collins (Department of Health, Social Services and Public Safety):
Good afternoon, everyone. We want to thank the Committee for the opportunity to provide an update on suicide prevention in Northern Ireland and the implementation of the Protect Life strategy.

I will set the context. Northern Ireland has witnessed a significant increase in suicide in recent years. Particularly sharp rises were recorded in 2005 and 2006, which saw almost a doubling of the number of deaths since the start of the decade. Since then, the trend has evened out at around 15 deaths per 100,000 of the population, which essentially means that Northern Ireland's suicide rates are considerably higher than those in England and Wales and slightly lower than Scotland's.

Somewhat worryingly, evidence suggests that the current economic downturn and the associated rise in unemployment could have a negative impact on our efforts to reduce suicide. Studies indicate that unemployed people are two to three times more at risk of suicide. International research indicates that a 1% increase in unemployment in a country is met with a corresponding 0·8% increase in suicide. That is possibly being reflected in the Republic of Ireland, where the 2009 suicide rate was 24% higher than the 2008 rate. That suggests that the psychological impact of redundancy and unemployment needs to be given greater attention and suitable support measures need to be put in place.

A closer examination of the data on recorded deaths by suicide shows that males constitute three out of every four deaths and the highest prevalence is among men aged 25 to 30 and aged 35 to 49. The priority, therefore, is to encourage a help-seeking culture among men and ensure that services and support are available in ways that they are prepared to use.

The data also shows that suicide is linked to deprivation. On average, the suicide rate in deprived areas is twice that in non-deprived areas. Furthermore, the gap is continuing to widen. Rates have increased overall, but, over the past 10 years, the rate of increase in areas such as

north and west Belfast is almost twice the Northern Ireland average increase. That trend helps to underscore the fact that suicide is a societal issue rather than purely a health issue. There needs to be a broad response to address the issues that contribute to economic and social deprivation.

We need to build the emotional resilience of vulnerable populations generally. Front-line action to care for people who are suicidal will, of course, remain essential. However, we also need to address the underlying issues that contribute to an increased risk in particular communities. In fact, that issue was discussed recently at the ministerial co-ordination group on suicide prevention. I understand that the Executive also discussed the issue recently.

The implementation arrangements for the Protect Life strategy are well established, as they should be after four years in operation. The suicide strategy implementation body advises and can challenge the Department on the implementation of the strategy. Membership of that group is drawn from a wide range of areas, including the statutory sector, the voluntary and community sector and families bereaved by suicide. In addition, the Public Health Agency and health and social care trusts work with local implementation groups to develop community action plans, which are funded under Protect Life. The Public Health Agency leads on the commissioning of regional training, specific pilot projects and awareness raising. The Bamford task force also has a role in promoting mental health and well-being and can advise on suicide prevention actions within the Bamford action plan.

I hope that all members received a copy of the briefing note. It includes a pyramid diagram, which suggests that the bulk of input from other Departments is more effective at the upstream level of promoting mental well-being than at the crisis intervention level, as represented at the apex of the pyramid.

In updating the Committee, rather than go through all the Protect Life actions, we thought that we would focus on some more recent developments. One action is the development of community response plans for potential suicide clusters. Suicide has long been regarded as contagious. Imitative behaviour is influenced by the reporting of suicidal behaviour in the mass media and/or through exposure to suicidal models in an individual social group or local area. Response plans are being developed or are in place in each trust area. The aim of those plans is to ensure that potential suicide clusters are spotted early and that fast, effective cross-sectoral action is put in place to prevent further suicides in a particular area or among a particular group.

Learning from what happened in October 2010 and the January responses to the deaths in the Colin area will further inform the development of those plans.

Lifeline continues to deal with a high level of demand for its services. Over 240,000 calls have been received since the service was established in February 2008, and urgent interventions are required on behalf of 15% of all callers. The rolling programme of all-island actions continues. Applied suicide intervention skills training (ASIST) has been evaluated. A media-monitoring service has been established in Northern Ireland based on the Republic's Headline model. Action on sharing evidence and interventions regarding the impact of the recession on suicide has been added.

Research has recently been published on self-harm among 15- and 16-year-olds in Northern Ireland and on suicidal young men between the ages of 16 and 34. The self-harm registry pilot, which was operational in the Western Health and Social Care Trust area, has been extended to cover the Belfast Health and Social Care Trust area. The "card before you leave" scheme is now operational throughout Northern Ireland. Everyone attending A&E who requires a next day appointment with mental health services has a fixed appointment for the next day.

As we look ahead over the next few months, I can tell you that the Protect Life strategy has been updated to incorporate new evidence and to address the gaps that were identified by the ongoing review of the strategy. The Health Committee's 2008 inquiry findings have also informed that process.

The 2008 Northern Ireland Audit Office report on the performance of the Health Service acknowledges the fact that the suicide rate is:

> "an unreliable indicator of health patterns ... and ... while the relative impact of different strategies on suicide is important for planning, it is difficult to estimate."

We concur with that view. In updating the strategy, consideration is being given to developing intermediate objectives and detailed performance measures that will better measure the ongoing impact of the strategy.

It is anticipated that the refresh of the strategy and action plan will be completed by June 2011. The Minister has agreed to extend the lifespan of Protect Life to 2013 to help to maintain momentum in tackling suicide and to allow for the new actions to take effect. The extension and

update also allow for consideration of initiatives to mitigate the potential impact of rising unemployment. Other revised actions in the refresh strategy will include the identification of suicide hot spots; the promotion of safer prescribing; programmes to enhance the coping and problem-solving skills of those who self-harm; and an additional focus on rural areas. It should be noted that, although evaluation of various components of the strategy has already been completed, overall interim evaluation of the strategy will be undertaken this year.

That concludes our overview. Thank you for your attention.

The Chairperson:

If members are not too annoyed, I propose to bring Sue in first, because issues in the Colin ward were mentioned. This is clearly a north and west Belfast issue in particular.

I want to ask a fundamental question about the reliability of the suicide statistics. On numerous occasions in my constituency, deaths have been totally inexplicable. They are sometimes a result of road traffic accidents. I do not want to be too specific because I do not want to reveal the instances. Let us take the cases of two young men, with no history of alcohol or drug abuse, who are under pressure because of unemployment and whose cars inexplicably hit walls late at night. There is no logical explanation, no mechanical default and nothing to explain why someone would do that on a dead straight road. When that happens, it is put down as a road traffic accident, when in fact there is a considerable degree of evidence that we are dealing with a suicide. How dependable are the figures?

Mr Collins:

Going back some time, there has always been an understanding that there has been under-reporting of suicide figures. That goes back to psychological autopsy research that Dr Tom Foster carried out in 1999, based on 1992 and 1993 figures, when the official suicide rate was around 10·5 deaths per 100,000 of population. His view was based on psychological autopsy, which involves detailed interviews with family members and friends and examining doctors' and GPs' reports. It is a labour-intensive exercise. His recommendation was that the true suicide rate at that time was more likely to be in the region of 12·7. Therefore, the issue has been ongoing for some time.

Over the past few years, Martin has been dealing with the coroner. Can you add to that,

Martin?

Mr Martin Bell (Department of Health, Social Services and Public Safety):

Over the past few years, coroners have been content that figures have been recorded as accurately as possible, within what they can record. The problem is that it depends on the circumstances of a death. If there is an inquest, the cause of death must be established "beyond reasonable doubt". That is the burden of proof. However, in most cases, there is no inquest, unless the family particularly wants it or there are suspicious circumstances. In those cases, the burden of proof is the "balance of probabilities". In such cases, it should be easier, rather than more difficult, to declare a death as a suicide.

In circumstances in which one person is in a car that hits a tree, unless there is additional evidence, it might still be very difficult to state that it is a suicide. It must also be borne in mind that a coroner records the cause of death. Suicide is not a cause of death: it is a classification, which the General Register Office records and holds the details. Therefore, it is possible, in circumstances in which one person is in a car that hits a tree, that that could be a suicide. However, unless there is other collaborating evidence, it is difficult for a coroner or the General Register Office to make any assessment of it.

The Chairperson:

Although there might be some doubt about the actual numbers, are you confident that at least the stats indicate whether the overall trend is up or down?

Mr M Bell:

I am.

Mr Collins:

I am confident of that. The reason for the very sharp increase in 2005 and 2006 is partly due to the move to new coroner reporting, which is more open. That is also reflected in the increase.

The Chairperson:

You say that there is a clear trend between economic deprivation, unemployment and suicide. Does that mean that, unfortunately, we could be facing difficulties? We are in the middle of a recession. It is continuing and, some would say, because of the cutbacks in public expenditure,

there will be more unemployment in certain sectors. I am conscious of the fact that youth unemployment is currently particularly difficult in Northern Ireland. Is there an inextricable link that we just cannot break? If there is more unemployment, can we expect that, sadly, there will be more suicides?

Mr Collins:

International research indicates that that is the case and that there is a correlation between a recession, rising unemployment and increased suicide levels. That does not mean that there is nothing that we can do. We can look at that and at specific issues around unemployment and try to mitigate the adverse impact of unemployment on a person's mental well-being. Efforts to reskill people, get them into jobs and retain young people in education are all important in improving mental well-being and, down the line, having an impact on suicide figures.

The link between social deprivation and suicide is well established. That is not really a surprise when we consider that the risk factors for suicide include unemployment, low educational attainment and, in some cases, family and relationship problems. Therefore, the link is established. In the face of an economic downturn, we need to look at interventions across Departments that can mitigate the adverse impact of unemployment.

The Chairperson:

Unless I am wrong, Sue represents the Colin ward in the Assembly. Is that right?

Ms S Ramsey:

Yes, it falls under the West Belfast constituency.

The Chairperson:

I will let Sue ask next set of questions.

Ms S Ramsey:

Apologies for being late; I was at the Children's Hospice making a donation and did not realise how far away it was. I have a further meeting with the Minister scheduled for 3 March or 4 March to go into some of the details. Thanks for the presentation.

I raised the issue of sudden death notification (SD1) forms with the Office of the First

Minister and deputy First Minister (OFMDFM) two weeks ago. I am concerned that the form seems to be working in some areas, which allows the strategy to kick in, but not in other areas. OFMDFM will talk to the Chief Constable about that.

In the Colin area, we had a great presentation from the Public Health Agency in the Western Trust on its work. To me, much of that work is common sense and seems to be working. However, there are different PSNI strategies, depending on the command area. We need to look at that and get OFMDFM to ensure a common-sense approach.

I am concerned because certain areas, even in my own constituency, straddle two different PSNI command areas. In one area, the PSNI could be proactive, but in the other area, it might not be. There are also areas that straddle two trust areas, two education and library board areas and two council areas. We need to look at that and get a strategy that applies across the board, including in rural areas.

I am concerned by what has been said, because I asked the Minister to call the ministerial co-ordination group on suicide prevention together in October. I am concerned that it did not meet until mid-January. Gerard, did you say that you thought that the issue was raised with the Executive?

Mr Collins:

My understanding is that, at the Executive meeting on 10 February, the issue of cross-departmental co-ordination and input on suicide prevention was discussed.

Ms S Ramsey:

Yes, it was. However, I am concerned about Executive feedback to people such as you, who take the lead on many of those issues.

Mr Collins:

The First Minister and deputy First Minister asked the Health Minister to bring forward a paper on suicide prevention and seek the input of all Departments at a future meeting of the Executive. We have already received that request, but we do not have a date. The request was received only this week, so our Minister has yet to apply. I can see that being followed up, and we very much welcome the support of other Departments in moving the issue forward.

Ms S Ramsey:

It is important that the Committee is also kept up to date.

Before I say any more, it is important to recognise the fact that much good work is being done out there. There have been many interventions in the West Belfast constituency over the past number of years, but there is high media interest in some of the suicides.

The definition of a cluster is another issue. I do not want to go into specific cases, because we have a duty of care to the families of those who have committed suicide. One young fella lived in one part of the West Belfast constituency but spent all his life in another part of the constituency. However, those two areas had different trusts. Therefore, his death and the deaths of three others through suicide in the local area were not deemed a cluster. I am concerned that some cases of suicide do not constitute a cluster. Many people from the Colin area go to school outside that area. Their families and their GPs are outside the Colin area. Therefore, a death by suicide in the Colin area has an impact on the greater West Belfast constituency. However, because that covers two different trust areas, where do those deaths fit in and who says that that is a cluster?

I have some criticisms of the "card before you leave" scheme. The Belfast Trust has just implemented the scheme, so I will not go into it too much. The scheme is not the be-all and end-all, especially in Belfast. Despite the number of suicides in the greater Belfast area, the Belfast Trust was the last to implement the scheme. I want to try to approach the issue positively, because much good work is being done, but I do have some criticisms. I know for a fact that people presenting themselves at hospitals after attempting to take their own lives are being deemed medically fit and released the next day. Those people may be medically fit, but are they psychologically fit? That is a criticism. In those cases, families do not know what to do and are being put on 24-hour suicide watch. It is about how we deal with the medical end versus the psychological end.

We need a change of thinking. Although I welcome the strategy, where is the proactive work? Are we going into schools? Are we targeting younger children? I have had meetings with the Education Minister. Some parents do not want to touch the subject of suicide, which is fair enough, but we need to live in the real world. We need to be proactive and get in there early to give kids the skills for coping in life. The sad fact is that younger people are taking their own

lives because they do not see any way out of their situation or have no hope.

I thank the Chairperson for giving me space to speak. Finally, we need a list of what stage the 62 actions in the Protect Life strategy are at. You talked about a refresh strategy, but we need to know where that is at. We need an idea of how we are changing mindsets. I do not see anything about embracing or protecting life, which Scotland has been very good at. The GAA and the soccer and boxing fraternities have been proactive and want to do something about embracing and protecting life. I do not see that in the strategy. It seems that we are always dealing with suicide when it becomes an issue, rather than getting in there and giving people the tools that they need.

It would be remiss of me not to mention social networking, especially Facebook. You are all aware of what goes on there without my going into the details. We need to be proactive. In fairness, Facebook is up for whatever work needs to be done, because what was said recently on its pages was brutal and stinking. We also need to look at the guidelines around some of the print media, such as 'The Sun'. That paper has been analysed. We know what it did was wrong, but what are we doing about that? Newspapers also have a duty. It does not help kids who have to go to other kids' funerals to see those headlines.

Mr Collins:

I will touch on the cluster response plans, and then perhaps Madeline can come in. Maura will cover the "card before you leave" scheme. I will come back in on the proactive work. Martin will cover the review and the refresh of the strategy. Finally, I will talk about social networking.

We know that suicide clusters can be in geographical areas or among specific groups — for example, school friends. Therefore, clusters do not necessarily occur neatly in a single trust area. On a regional level, the Public Health Agency is working with the PSNI on the roll-out of the sudden death notification form. Essentially, that is the surveillance part of the suicide cluster response to identify early that a cluster is occurring. At trust level and within the agency, notification forms are analysed to find out whether there is a cluster or any connections between deaths. That work is ongoing to develop a regional surveillance system that can quickly identify a cluster so that local suicide cluster response plans can then be activated. That work continues to develop and has been given high priority.

Madeline may want to add more on the work that is being done on the cluster response plans and SD1 forms.

Ms Madeline Heaney (Public Health Agency):

We now have agreement on the plan, and we are working on it with the police. As you said, the different command areas have been an issue. An appointment has been made for that regional role so that the system and forms will be distributed throughout the region. That addresses one of the issues.

We are learning that initial information may not be an indication for cluster responses. We need to do what you suggest: find out where the young person is from and what school or sports group he or she attends. Does the young person have connections in the area? Perhaps his or her family connections are in another area. We need more information to enable us to make better-informed decisions. We may even bring people together who would be part of a cluster response plan simply to gather that information. We may decide that that is not the right intervention and a different one is needed. We continue to examine indications to try to gather as much information as possible. It is the nature of community that family connections can cut across different areas.

The Chairperson:

It is regrettable that the Belfast Trust was the last area to roll out the "card before you leave" scheme. Clearly, that is where a large proportion of the problem lies. Are we content that everybody actually gets a card before they leave? There are indications that people are still being failed by that system.

Dr Briscoe:

I want to reiterate what the "card before you leave" scheme involves. It is important to make the distinction between it and crisis intervention, which Sue, quite rightly, also highlighted. The "card before you leave" scheme is for individuals who are not admitted to hospital, do not require an immediate full mental health assessment there and then and whose risk of recurrence of suicidal ideation or self-harming behaviour is deemed low risk. Therefore, it is for a particular group. There is another mechanism for those who are in higher-risk groups.

It is important that we recognise the fact that the scheme is for lower-risk groups who have been triaged and stabilised in casualty for whatever condition brought them there in the first

place. It could have been an overdose, physical harm, and so forth. They are given a card. We have checked with trusts. It is fair to say that, initially, although some trusts did carry out the scheme, they gave cards that did not include a next day appointment. Based on the information that we have received, our understanding is that all trusts are operating fixed day appointments.

I have a leaflet here on the "card before you leave" scheme from the Belfast Trust. It was updated in December 2010. It clearly states the protocol for how the system works, who should be referred and where they should be referred to. The card provides generic information on which agencies to contact, and so forth. It also includes a fixed appointment. My understanding is that the Belfast Trust has put that in place. That is our most recent information, which we received during the past couple of days.

The Chairperson:

Are you absolutely certain that everybody, particularly young people, who should get the card gets it?

Dr Briscoe:

What I have discussed relates to adults. As regards children —

The Chairperson:

Alex wants to come in on that issue after you have finished, Maura. I just want to give him a chance.

Dr Briscoe:

I described the "card before you leave" scheme for adults. The "card before you leave" for children is a component part of the scheme. Again, our understanding is that the "card before you leave" for children operates in all trusts. Indeed, the Southern Trust has gone one step further in having the child and adolescent mental health services (CAMHS) hospital liaison service, which provides ready access to assessment services through the children's scheme.

Ms S Ramsey:

With all due respect to Maura, it is OK getting all that information, but there is a big difference between young people and adults, and also between 16-year-olds and adults. My concern is that we have come across instances in which young people have met a friend trying to take his or her

own life. They take the friend physically to a hospital, and whether it is a "card before you leave" procedure or an appointment for the following day, the friend is deemed medically fit and released. Therefore, we put a burden on such young people to be with that friend constantly. There is confusion. Where do we take people whom we have just saved, and where do we put them?

Dr Briscoe:

I reiterate that the "card before you leave" scheme is for people who are deemed, following preliminary clinical assessment, low risk. Where there is concern, and people are found to be medium to high risk, they are treated differently. If younger people are medium to high risk, depending on the clinical circumstances of an individual case, they are either admitted to hospital or followed up by crisis intervention teams. Specialist services and crisis intervention teams deliver acute care in the community. It is a mechanism for delivering high-level care. Very often, through the crisis intervention team, people will be visited and contacted a number of times every day.

Ms S Ramsey:

Is that home treatment?

Dr Briscoe:

It is crisis intervention home treatment. Some trusts might call it "home treatment", others "crisis intervention". There is also an interface with recovery teams. We have to be absolutely clear: when we say "card before you leave", we mean something specific. When we are talking about either adults or children who are in a medium- or high-risk group, that is something different again.

I want to draw your attention to a document entitled 'Promoting Quality Care: Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services'. It is an extensive piece of collaborative work that drills down into the assessment process from the screening of risk assessment in mental health and learning disability services, right down to comprehensive and specialist risk assessment. There are aide-memoires attached and tools have been implemented. Indeed, a tool called the functional assessment of the care environment (FACE) is currently being implemented for CAMHS risk assessment. In generic risk assessment in mental health and learning disability services, this is how to do it. That is what

we are implementing through the Health and Social Care Board and the Public Health Agency. It is a very good document.

The Chairperson:

The normal process is for that to be deposited in the Committee office for members to consult. It is a bit bulky.

Dr Briscoe:

It is a big bit of reading. If you want, I will leave it.

The Chairperson:

One copy will suffice. This is a burning issue for some MLAs, but not in other constituencies.

Alex, are you coming in on the "card before you leave" issue?

Mr Easton:

I had not realised that the "card before you leave" procedure is for low-risk patients only. That is interesting.

Dr Briscoe:

In other words, "card before you leave" cases are deemed not to require full mental health assessment or admission there and then. That would put people into a slightly higher risk group. These are people who present with self-harm and some suicidal ideation, who are deemed fit to be discharged as low risk and are then brought back.

Mr Easton:

With regard to the "card before you leave" scheme, can I have a guarantee today that those at low risk are actually given the card in their hand and that it is not sent out in the post?

Dr Briscoe:

My understanding is that the Southern Trust has gone one step further than the "card before you leave" scheme for children in its area. My understanding is that, for adult services, people are given an appointment and a card. The "card before you leave" scheme was a priority for the Department, and it was included in its priorities for action. It is being, and will continue to be,

evaluated, and there will be interim and final reports on the back of its introduction. One has to ensure that the model of the "card before you leave" scheme and its implementation are robust.

Ms S Ramsey:

It is important for the Committee to check that out. The Belfast Trust has made some changes. A young man committed suicide in west Belfast recently, and his appointment came out on the day of his funeral.

Dr Briscoe:

I am sorry; could you repeat that?

Ms S Ramsey:

The appointment came out on the day of his funeral. The card was posted out. You should double-check that. He presented and did not get a card. The card was posted out.

Dr Briscoe:

We checked across all the trusts in preparation for today.

Ms S Ramsey:

It might have changed over the past four or five weeks.

Dr Briscoe:

It might have changed. I do not know that, but we can specifically check that for you, Sue.

Mrs O'Neill:

Thank you for your presentation and for updating the Committee. When the Committee took forward its inquiry, it considered the need for evaluation, and Sue picked up on that point. Your presentation states that there has been no overall evaluation of the Protect Life strategy, but some component parts have been evaluated. Has Lifeline been one of the areas that has been evaluated? Maura might have spoken about that during previous updates on the Protect Life strategy. For organisations that are tasked with delivering and that deal with Lifeline, people are presenting in person at a crisis point. However, because they have not called the Lifeline number, Lifeline is unable to give those people the service. Actually, Lifeline does give them the service, but it is financially difficult. Has there been any review of Lifeline, or what other component

parts of the Protect Life strategy have been reviewed?

Mr Collins:

A review of the north and west Belfast pilot took place sometime after the regional Lifeline was set up. Lifeline is strictly managed with a range of key performance indicators. It took a long time to set up that management project. Martin was very closely involved in that from the start. Information has been gathered to carry out a comprehensive evaluation of Lifeline. My understanding is that the Public Health Agency will lead on an evaluation of Lifeline later this year, and Madeline can confirm that. The contract is up in April, and it could be extended for another year. However, that evaluation will be carried out before the contract runs out and has to be re-tendered.

I have come across a problem whereby some community groups have said that they are unable to refer people to Lifeline. I am not sure how well that has been dealt with, but Lifeline does take third-party referrals into its system.

Mrs O'Neill:

Did it always do that?

Mr Collins:

It has always taken third-party referrals from the start, whether that referral comes from a community group, a family member, a friend or a GP.

Mrs O'Neill:

I will give you a practical example of the experience that such a group would come across. Someone who is obviously in dire need will come in, and of course the group will help and provide the counselling or whatever is needed and signpost that person and do whatever else it can. However, because the person is not referred to the group through the Lifeline 24-hour telephone number, it does not get —

Mr Collins:

That is right. It is the way that Lifeline is established. There are wrap-around support services — therapy and counselling. Over £1 million of the £3·5 million Lifeline funding goes into the wrap-around support services. Contact, which operates the Lifeline service, is required to tender those

services across Northern Ireland. Therefore, they are all tendered out, and community groups as well as Contact provide those services. It can refer only people who come through the Lifeline procedure to those services. If someone turns up at a community group that is not necessarily contracted to provide Lifeline wrap-around support, that group cannot deliver that support and then charge Lifeline for it. It has to be one of the contracted providers.

Mrs O'Neill:

A contracted provider cannot say to someone that that person is in need and that it wants to provide the service but ask the person to ring a phone number first. Obviously, it needs the money to maintain the service. I see that as a weakness of Lifeline.

Ms S Ramsey:

The group can ring while the person is sitting there.

Mrs O'Neill:

Was that always the case?

Ms S Ramsey:

No, not really. It is like a memorandum of understanding on the ground now that if a person comes in, the people who are contracted can ring and do the assessment over the phone. It is a common-sense approach.

Mrs O'Neill:

It is common sense. I am glad that that has changed.

Ms S Ramsey:

That might not be in all areas. I need to check that out.

Mrs O'Neill:

A new programme of training has maybe taken over ASIST. We had identified that the uptake, particularly among GPs, was quite low. Has that improved during the past five years of the Protect Life strategy?

Mr Collins:

That is maybe a reference to the GP depression awareness training that was rolled out some time ago. A total of 50% of GPs participated in that training, and 80% of GP practices were covered. However, that programme has now finished. It was one component of Protect Life that was evaluated. So GPs are still able to avail themselves of any regional training, be it ASIST or mental health first aid, but that particular programme has come to a close.

Mrs O'Neill:

The Committee also considered the availability or lack of talking therapies. Since Protect Life was implemented, have you seen an improvement in the availability of talking therapies for people on the ground? Has there been any analysis of that?

Mr Collins:

Not from our side in Protect Life around the mental health services side.

Dr Briscoe:

As Michelle knows, we produced a psychological therapy strategy in June 2010, and across the comprehensive spending review (CSR) period for 2008-2011, there has been additional service development investment in psychological therapies. From memory, that totalled about an additional £4 million over the CSR period, and of course that will be in the system as we move forward. It is not as much as we would have liked, but we are now trying to embed psychological interventions into the tiered model of mental health and learning disability services so that there is greater access to and greater recognition of the value of psychological therapies. Of course, that includes computerised access to cognitive behavioural therapy, which has been rolled out to all GPs.

A specific group under the Bamford task force is implementing the psychological therapy strategy, a key component of which is embedding it into the different layers. That does not mean that we upskill individuals who are at the front line to have skills in psychological interventions. It goes right the way up to the specialist psychoanalytical and psychotherapy elements. That group has recently been refreshed. It will be led by Dr Paul Bell and will have a number of subgroups, one of which relates to children and psychological therapies specifically and another to workforce development and training. There is a third one, but I have forgotten what that is.

I agree with you that psychological therapies are important, and there is more work to be done on that. It is quite interesting that, on the back of the directed enhanced service in GP practices, the uptake of counselling for depression has significantly increased among individuals with mild to moderate depression. That is what the figures from the Health and Social Care Board indicate. However, you are absolutely right about the fact that there is much more work to be done on psychological interventions.

Mrs O'Neill:

I welcome what you say, and I absolutely agree. However, there still is a culture, particularly among GPs, of writing prescriptions for antidepressants for people who present their symptoms and say that they feel low and down, even though, quite often, simply talking to them would help. We have a long way to go with that, but I hope that we are moving in the right direction.

Dr Briscoe:

There is a directed enhanced service for mild to moderate depression in general practice. Its emphasis is on non-pharmacological approaches to management and recognition. It is about raising awareness, early intervention, anxiety management and sleep management. I suppose that one could argue that there is unmet need there, so early recognition is important, as is access to antidepressants for those who need them.

Ms S Ramsey:

Evidence has shown that we also need to be careful that somebody who has been on antidepressants for 40 years is not taken off them straight away.

Dr Briscoe:

The directed enhanced service is very much in keeping with some of the guidelines from the National Institute for Health and Clinical Excellence (NICE). There are well-recognised professional protocols for the ongoing management of depression, particularly for those who are shown to have recurrent episodes. Kieran would be very familiar with those protocols.

Mr Collins:

Last autumn, the Minister launched an initiative called Fit for Life, Fit for Work, Fit for Change at a GP surgery on the Springfield Road. The initiative helps people who have not worked for a long time and who have depression and anxiety issues to get back into employment by providing

GP treatment and by referring them for fairly intensive counselling and life skills building. We are also keeping an eye on that.

Mrs O'Neill:

Do you have any comments on Sue's point about social media?

Mr Collins:

The Minister is very concerned about social media and has previously raised that issue with Treasury Ministers and with Tanya Byron, who undertook the Byron review, from which the UK Council for Child Internet Safety was set up. The Department has a place on the council, and we intend to have that issue and the issue of children's inappropriate posting on Facebook raised at the next meeting of the council's executive board, which is in March.

We find that a single Department's approaching the Internet service providers to raise those issues it is not as effective as taking a UK-wide approach. That approach carries much more leverage, and to date it has been the best way to address that sort of issue and to have some significant clout with the Internet service providers.

Children spend much more of their life on social networking sites than adults do, which, I suppose, is a generational thing, and they put much more personal information on the Internet. So it is not too surprising that when there is a tragedy in an area involving someone's friend, some children may, without thinking, post information that can be hurtful to the bereaved families. The Department issued a press release on the issue and commented on the fact that we need to get parents to check what their children are putting on the Internet, particularly at these times, and to get the message out that they should not post anything too personal on Facebook.

Mr Easton:

Sue and I asked for an update on the Protect Life strategy. My reason for doing that was a specific case in north Down, which I will obviously not go into. I felt that the system let that person down, because an incident had occurred several weeks previously. I am concerned about the attention that people receive initially. The initial cry for help or initial incident is probably the most vital time at which to try to intervene to help a person.

I visited the Jamie McKee group in north Down, which was set up by a group of friends in

Kilcooley after the death of Jamie McKee. What struck me about them was their lack of knowledge of places to go for help. Are you getting enough information out to community groups, and so on, to advise them of where people can go? Are we taking the right approach when people attempt to take their life initially? I am not a medical expert, but I believe that it is vital to try to help people in the first 48 hours or the first couple of weeks.

The Protect Life strategy has existed for a while. Although it has not been in place for a huge amount of time, I am a bit disappointed that our suicide figures have not gone down to an extent. You mentioned the recession, but the recession has really hit Northern Ireland head on only in the past year or so. I am not saying that there should have been a dramatic decrease in our suicide rate, but I do not see it going down, so I am worried. Is that normal for this stage of the strategy? Can we expect improvements a couple of years down the road? What is the norm?

Mr Collins:

I will come in on the Protect Life strategy, and Maura may want to come in on the system and care.

I will go back to what the Northern Ireland Audit Office said, which is that it is difficult to show the impact that the strategy has on the health indicator that is suicide because there are so many other impacting societal factors. In the refresh of the strategy, we need to develop lower-level performance indicators while maintaining the overall strategic aim of reducing suicide in our society. That is backed up by the Marmot review, in which Professor Michael Marmot said that high-level health indicators are impacted only by a whole range of strategies and programmes right across government. The potential of a single strategy having an impact is quite limited.

We do not know how many lives have been saved by the implementation of Protect Life. That is probably impossible to measure. All that we can say is that there is feedback. Lifeline, for example, occasionally gets feedback from its service users. It receives letters from people who state that they would not be here today were it not for Lifeline. An independent review of the north and west Belfast suicide implementation plan was published in November 2008. It recommended that the only way to show that community-led services on the ground impact on individuals is to have some form of longitudinal study. Someone who has presented with suicidal ideation and receives support from a community-led scheme should be followed up two, three, four or five years down the line to see how well that person is and that he or she is still with us.

Therefore, to measure the degree of impact will take some doing and require some changes to be made. However, it is something that we need to consider when we are producing new actions for the strategy.

Mr Easton:

I know that the strategy helps and that many lives have been saved. However, I am surprised that there has not been more of a drop.

Mr Collins:

We keep working on that. We keep looking at the latest international evidence about what works and what is good practice. We adopt and apply that to Protect Life and to the delivery of existing and new actions. Beyond that, although the performance measures that we established show the impact of the strategy in a real and direct way, it is still extremely difficult to make the link between Protect Life and the overall health indicator that is the suicide rate.

Mr Easton:

What about the information given to groups?

Mr Collins:

Perhaps Madeline could cover that, because a great deal of work is undertaken on the ground between local suicide prevention co-ordinators, Public Health Agency staff and community groups in their areas. That is the fulcrum for community-led action plans to address suicide prevention.

Ms Heaney:

As Gerard said, there are trust-level and local-level implementation plans, and we try to get the information out in different ways. There is a wide promotion of the Lifeline service through posters and cards, and, in each area, posters, credit-card type cards called z-cards and lists of information are provided to groups such as Women's Aid, GPs and specialist services. If there are particular groups or gaps in our provision of information, we will try to pick up on those.

We try to do a great deal of work through community organisations and youth groups, and we also do a great deal of training and skilling of representatives of those groups, so that they are in

possession of the necessary information when they engage with young people. It is those people in the community with whom young people will engage, and it a matter of ensuring that that message continues to be delivered.

Ms S Ramsey:

It is important that we are innovative. Although there are thousands upon thousands of leaflets out there, most people do not need the information until they need it, by which time most places that hold the information are closed. We need to think of other ways of getting the information across, whether through public art or information notices. Billboards in town centres are all well and good, but most of the suicides are taking place outside towns. I am not being critical, because there is a lot of information available, but, as I said, people do not need that information until they need it, and when that happens, they cannot access it.

Ms Heaney:

We are acutely aware of that. We have looked at different methods. In the Colin area, for example, the possibility of creating a wall mural to get the information out was considered. That information needs to be in the community, whether in youth centres, bookies or wherever we think that people might be. We are also considering providing information in rural areas through farmers' markets. As you said, we need to move away from the traditional nine-to-five venues. Other sources of information are the Minding Your Head website and public campaigns on TV and in cinemas that give out the telephone number for Lifeline. We need to keep working on that, because, as Gerard said earlier, where and how young people get their information changes constantly. It is a challenge for us to keep up.

Mr Collins:

Social networking is, potentially, dangerous. However, the other side of the coin is that it presents many positive opportunities to get messages out about mental well-being and suicide prevention.

The Chairperson:

I would like to get this session over by 4.00 pm. Kieran, you are the last Committee member who has requested to ask a question.

Dr Deeny:

Thank you very much, ladies and gentlemen. It is good to see you again, Gerard; I usually see Gerard at social functions at my brother's house.

This serious issue is also of great concern to me, and I participated in the Committee's inquiry into suicide. Last week, I was shocked to read in my local paper that Omagh is up there with the areas that have the highest suicide rates. That is sad and unfortunate. I have been made aware indirectly that, Lifeline has, indeed, saved lives, and the Protect Life strategy has helped. As anyone in front-line practice will tell you, there is no doubt that because of the present economic climate, we are seeing more and more mental health problems. Many more people with anxiety, insomnia, depression and feelings of uselessness are coming through all the time. Those are major issues, so I am glad that we are having this meeting today. We are all here to try to save lives.

Yesterday, I was talking to an individual who lives in Dublin, and he told me that at least 36 taxi drivers there have taken their own life. That is how serious the issue that we face is, and a number of difficult years lie ahead. It is good, therefore, that are talking about this issue.

As a doctor for more than 30 years, I have been called out to sudden unexpected deaths on a number of occasions. The situations to which one is called out are scenes of devastation. In my view, there is nothing as devastating as a suicide. Gerard, you mentioned age groups, and Sue also touched on that. I underlined three parts of your submission: the schools counselling service; emotional health, well-being and empathy programmes; and life skills programmes and coping skills. I think that coping skills are essential, because, in the two instances of suicide with which I dealt, no one — parents, relatives or health professionals — had an inkling that the person was going to do it. Therefore, coping skills are important, and schools need to talk to kids. I hear, time and again, not only in relation to the two cases with which I dealt but from other parents who have lost a young one through suicide, that their children would never have gone through with it had they realised the devastation that they would leave behind. Therefore, we must get through to young people just how valuable they are. You may say that all that must be done in conjunction with the Department of Education, as it must. We have to work together, because suicide is a societal problem. Medical professionals who are called out to those situations become frustrated at repeatedly saying: "If only we had known early on."

You also said that older groups, such as males between the ages of 20 and 35, are at risk. That is borne out by the figures, although I am well aware that young girls take their life as well. You mentioned community-based counselling. I missed Michelle's point about the talking therapies, because I had to leave for a while; nevertheless, we need more of those. During each surgery, a GP sees 20 patients, and talking therapies take time. What is being done in that area? Gerard, you mentioned the Springfield Road surgery. Will you elaborate on what is going on there?

Mr Collins:

Yes. I think that that is Dr O'Neill's surgery.

Dr Deeny:

In primary care, for example, I have 10 minutes in which to deal with a patient and a crowd of people waiting. I may know that the patient does not really need an antidepressant because it is not the treatment of choice for him or her. Therefore, I would like to have quick access to someone working in the community, as would every GP. That is the crux of the problem. Lifeline and the Protect Life regional strategy are extremely worthwhile and have, undoubtedly, saved lives. However, if young people who feel desperate — they have no work and nothing to do — were to be told by their community, family and friends that they are loved and cared for, their lives could be saved. There has to be a community angle, even for people in their twenties.

As we know, men do not share their emotions. The answer may be for them at least to know that the community in which they live cares for them and genuinely wants to help. The question is how to make sure that GPs can access that care. What is being done on the community front for older people, and what is being done in schools?

The empathy programmes and counselling services that you mentioned are vital. Some of the cases with which I dealt involved young people in situations that you or I and other older people would consider life events. Perhaps, being more used to hardship, we would be able to deal with such situations. However, some young people feel that they cannot cope with such situations or major life events. The only solution that they see is to take their life.

Mr Collins:

It comes down to building emotional resilience in young people. In our submission, the lower parts of the pyramid diagram represent promoting mental health and mental well-being. Going

upstream from the coalface of suicide prevention, you see some of the factors that can help to reduce the rates of suicide in the long term. For example, the pupils' emotional health and well-being programme is being developed in schools. That programme is led by the Department of Education with considerable input from the Department of Health, Social Services and Public Safety. I am chairperson of one of the work streams in that programme, which is producing two guidebooks for schools: 'Protecting Life in Schools', and 'A Guide to Critical Incidents'. A critical incident includes a pupil self-harming in school, and the guide shows the proper response. The aim is to have those documents in schools before the summer break. The Department of Education intends to organise a launch day for the principals of secondary schools to create awareness of those documents and of other aspects of the pupils' emotional health and well-being programme. That is extremely important.

The school curriculum emphasises emotional well-being much more these days, which is good. The Department of Health, Social Services and Public Safety's review of health visiting and school nursing identified a clear role for school nurses in spotting signs of emotional distress in pupils and making interventions. Schools are extremely important. A great deal of work is taking place to get in early to build the emotional resilience of pupils and to spot and deal quickly with problems.

Kieran, you mentioned young people who would not have carried through an act of suicide had known the devastation that it would cause. That has come up in conversation before. Previously, the taboo of suicide was one associated with stigma. Although it is right and proper that that stigma is receding, it has been said that we need to try to introduce a positive taboo. We need some creative thinking about what that could be. Is it emphasising for people the devastation that they leave behind? Is it emphasising that suicide means the destruction of more than one life? We need to go back and think of a message that draws people back from suicide. Perhaps "taboo" is not the right word, but some form of positive taboo is essential.

Dr Deeny:

What about coping skills and teaching young people how to deal with situations? Is that part of counselling?

Mr Collins:

Yes, and it is part of the programme in schools that deals with emotional problems, how to

rationalise problems and how to keep problems in perspective. We are going into primary schools with a pilot programme on the roots of empathy. That programme teaches young people, particularly those who may not have been taught about empathy at home, how to manage and restrain their emotions, respect other people and recognise the impact of their behaviour on others. It has been found that primary-school children who are aggressive and bully are often, in later life, at risk of mental health problems and suicide. A bank of research exists to prove that. Part of the reason for that is that those young people cannot develop positive relations with others because they have not experienced empathy.

Similar programmes are introduced at various stages of adolescence and during the teenage years. Some of the work that the Department for Employment and Learning does with young people who are not in education, employment or training (NEET) focuses on developing the life skills to enable them to attend interviews and find employment.

There is, therefore, a wide range of intervention schemes across a wide number of Departments and, similarly, in the Youth Service. In the Department of Health, Social Services and Public Safety, we are trying to develop a cross-departmental promoting mental health and well-being strategy that takes upstream approaches to developing stronger emotional resilience. Our aim is to try to capture what is going on across all Departments. That strategy will be complementary to Protect Life, but it will deal with issues further up the line that can increase the risk of suicide later.

There are a number of programmes for older people, who are more at risk of depression for various reasons, be it poverty, loneliness or just age. So the early identification and treatment of depression in older people is very important. Sometimes, depression is confused with dementia, so they must receive the correct treatment early. There are other programmes, such as promoting active ageing, which try to encourage social networking and social engagement among older people. Those can also help.

Dr Deeny:

The isolation of older people is another issue, but I was talking about those aged between 20 and 35 who have left the school system. You talked about community projects and counselling, but what progress is being made? What about the centre on the Springfield Road, which is something that we need in primary care? I saw a young man a week ago, and I worry about him. I will see

him again pretty soon. He does not want or need medical treatment, but he needs to talk to someone. Most GPs in primary care have 10-minute consultations. When we know that a person needs considerably more input, where do we access that? Is there work that can be done so that we can access that? I think that it should be community based, where people know that they are cared for.

Mr Collins:

Communities know what is needed in their areas, and they know the people in their area. Therefore, more than £2 million of Protect Life's £3·2 million funding goes on community-led suicide prevention and bereavement support initiatives. Let us not forget that, on top of that funding, those community groups bring in more than that again through their own fundraising activities.

Those groups are spread across Northern Ireland. They are part of the local suicide prevention implementation schemes, and they take referrals. People go there when in emotional crisis or despair to receive support, whether that is counselling or alternative therapy. Fit for Life, Fit for Work, Fit for Change is a specific initiative that has been piloted, and we need to look at the outcome of that pilot scheme to see whether that could be rolled out much more widely.

The Chairperson:

I have one final technical point. I visited the Niamh Louise Foundation in Cookstown a couple of months ago, and they were talking about the Protect Life funding. Their issue was not the access to the funding but the fact that the voluntary sector was not represented on the committees that oversee it. They feel that, as a major player in the Southern Trust, their group should have had a chair at the table, as it were. Surely there should be a policy of trying to bring the voluntary sector into the oversight committees to make certain that the money is being spent effectively?

Mr Collins:

The suicide prevention strategy implementation body (SSIB) has very wide-ranging membership, including representatives of the voluntary and community sector. A subcommittee, including voluntary and community representatives, meets once a year to look at the broad allocation of the community support package funding. The recurrent part of that funding, about £1·5 million, goes to the five trust areas on a capitation basis. A further £640,000 is allocated to targeted areas of disproportionate need. Once that funding goes out, local implementation groups, which also

include community representatives, consider the proposals for funding from groups in that area and agree the allocation. Those local implementation groups include trust staff, Public Health Agency staff and representatives of local community groups. So there is quite a bit of community involvement in the decision on how that funding is allocated.

The Chairperson:

Yet, their argument is that one of the main players in the Southern Trust has been excluded from that particular body.

Mr Collins:

That is a local issue. We would need to look into that to see what the position is.

The Chairperson:

Thank you very much for your evidence, which lasted well over the hour allocated and has been very useful. I am sure that this is an issue to which we will, unfortunately, return, because it is ever with us.

After that evidence session, what actions do members feel that we should take on the issue? Is there anything that we need to follow up? There are various issues on which the departmental officials might want to come back to us.

Mr Easton:

As Sue said, it is important to get clarification that everybody receives the "card before you leave" in their hand on the day.

Dr Briscoe:

In light of your comments, we are happy to check again the situation in each trust.

Ms S Ramsey:

May we have an update on the Refresh strategy and a written update on what is happening at the Executive? If they are looking at the issue across all Ministries, it is important that the Department of Education, the Department for Employment and Learning, the Department for Social Development and the Department of Culture, Arts and Leisure play a part. I am concerned that some of the information around young people who are NEET is not all it seems. I sit on the

Committee that deals with the NEETs issue.

Mr Collins:

Would it be useful if we copied the Executive paper to members of the Committee?

The Chairperson:

Yes, it would.

Mr Collins:

When we have a finalised draft of the Refresh strategy, we will be keen to share it with members of the Committee.

Ms S Ramsey:

Will you also send us the information on social networking sites?

Dr Deeny:

We would all be interested in the results of the Fit Futures pilot when they become available. If that turns out to be worthwhile, there is a strong possibility that it will be rolled out across the Province.

Mr Collins:

Certainly, we can provide those results to the Committee. In the meantime, we can share with the Committee a short briefing note on what that pilot involves and where it is taking place. Once it has been evaluated, we can come back to discuss the outcome.

The Chairperson:

Dr Briscoe, will you leave the document that we discussed with the Committee Clerk?

Dr Briscoe:

I am happy to do that.

The Chairperson:

Thank you very much.