Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Protect Life Strategy: DHSSPS and Public Health Agency

2 March 2016

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Alex Easton (Deputy Chairperson)
Mrs Pam Cameron
Mrs Jo-Anne Dobson
Mr Kieran McCarthy
Ms Rosaleen McCorley
Mr Michael McGimpsey
Mr Gary Middleton

Witnesses:

Mr Gerard Collins	Department of Health, Social Services and Public Safety
Ms Mary Black	Public Health Agency

The Chairperson (Ms Maeve McLaughlin): I welcome Gerard Collins from the health improvement policy branch at the Department and Mary Black, assistant director of public health at the Public Health Agency (PHA). I invite you to make your presentation.

Mr Gerard Collins (Department of Health, Social Services and Public Safety): Good afternoon, and thank you for inviting us to provide an update on suicide prevention.

You will have received our paper on suicide rates in Northern Ireland, so I will not go into them in any significant detail. However, I would like to highlight that the suicide rate here remains high, at slightly over 16 deaths per 100,000 of population. That equates to 280 deaths per annum on average over the last five to six years. The Northern Ireland suicide rate is the highest in the UK. It is difficult to get exact comparisons because of the recording methods, but the rate is about 11 deaths per 100,000 in England, just under 16 in Wales and between 14 and 15 in Scotland. Scotland has experienced a slow but steady decline in its suicide rate over the last number of years. The rate in the Republic of Ireland is 11 deaths per 100,000, although, if you include deaths with undetermined intent, that goes up to 13. Broadly speaking, we have had for a while the highest suicide rates in the UK and higher rates than the Republic of Ireland.

In view of that, the Department allocates over £7 million annually to suicide prevention. That is more per head of population than any other UK country. The figure does not include significant contributions from mental health services and from other Northern Ireland Departments. In addition, local charities, the community sector and some businesses contribute funding and resources to suicide prevention. It is a welcome development that one or two businesses are starting to allocate staff to suicide prevention and to work in the community and schools sectors in suicide prevention training. It is also important to highlight the fact that the burden of suicide is not equitable and remains

higher in certain areas and among certain groups. As is the case in many other developed countries, three times as many men as women die by suicide in Northern Ireland, and the suicide rate in the most deprived areas is three times higher than that in the least deprived areas. The rate of hospital admissions due to self-harm is four times higher in the most deprived areas than in the least deprived areas. Young and middle-aged males in deprived areas are particularly at risk, as are other marginalised groups, such as unemployed people, people with mental illness, people from ethnic minorities and people with addiction problems. Of particular concern is the early indication that there was a rise in suicide levels in 2015. The recent provisional statistics in the Registrar General's quarterly report show 246 recorded deaths in the first nine months of 2015, compared with a total of 268 deaths for the whole of 2014.

I move on to some progress on actions on suicide prevention. As you probably know, there is a wide range of suicide prevention services in place to help to identify and support people who are in severe emotional distress. They include bereavement support; the Lifeline crisis helpline; community-based counselling; access to psychological therapies; suicide awareness and intervention training; addiction services; self-harm prevention services; and public information campaigns. Significant new developments over the past year include consultation on a new model for the Lifeline service. The Minister is currently considering the Public Health Agency consultation report on the proposed future model and options for the commissioning and delivery of Lifeline. There has been substantial comment on the future of Lifeline. Some of that has been around concerns that Lifeline is coming to an end and will not be replaced. That is not the case: the Lifeline service is to continue but possibly in a different format and shape.

Annual reports have been produced on the self-harm registry, which is fully operational now in all emergency departments. Those reports help to inform policy and service delivery. Allied to that is the roll-out by the Public Health Agency of the self-harm intervention programme, which is delivered through voluntary organisations and is in place across all five trust areas. Furthermore, the PSNI is working with the health sector to continue to refine and develop the sudden death notification system, which provides virtually real-time information on suspected deaths by suicide. That information helps to identify potential emerging clusters of suicide and ensures prompt support for bereaved families. Plans are in place with the PSNI and the University of Ulster to develop specific training for officers on the sudden death notification system. It is also worth noting that other jurisdictions have expressed an interest in establishing a similar notification system in their countries.

An important initiative has been the Churches' initiative, Flourish! Under that initiative, the four larger Christian Churches are participating in clergy training on suicide prevention. The programme helps Churches to address the needs of Church members and parishioners affected by suicide, and the programme is being rolled out across Ireland as part of the all-Ireland work on suicide prevention.

Two major pieces of local research have recently been completed and will be published next week. Both have examined records relating to a large number of suicides and have drawn out the issues around the circumstances of those deaths. The issues identified have included the impact of the Troubles, deprivation, relationship breakdown, the importance of primary care settings for suicide prevention and the need to target people who have had difficult life experiences. The research will contribute to our understanding of prior suicidal indicators and the identification of measures that can be taken to prevent deaths by suicide.

The ministerial coordination group on suicide prevention met on Monday 29 February. A very substantial range of work going on across Departments contributes to suicide prevention, and mental health promotion was highlighted. Some of the significant pieces of work are the Department of Education's iMatter programme, which promotes emotional resilience in pupils. The Department of Education has also been working with the Health Department on developing the Protecting Life in Schools framework to safeguard the emotional health and well-being of pupils. The Department of Culture, Arts and Leisure has undertaken mental health and well-being training through sport and has been engaging with many of the sports governing bodies to ensure that there is training for sports coaches. Work continues with the Prison Service and the PSNI to further develop staff training programmes on suicide prevention and the development of safer custody settings.

A draft of the new Protect Life strategy is in an advanced stage of development. There has been comprehensive pre-consultation engagement with stakeholders, and feedback from that has helped to further refine the current draft of the strategy. The intended focus of the new strategy will be on front-line intervention for people who are in emotional distress and on postvention for meeting the needs of families and friends who have been bereaved through suicide. We are working to finalise the

document and will shortly ask the PHA to develop an implementation plan before going through the formal approvals process in the Department.

We often say that, to reduce suicide in the long term, it is necessary to go upstream and promote emotional resilience. The intention at this stage is that mental health promotion will be addressed under a separate and new action plan that will be developed under the umbrella of the Making Life Better public health strategic framework. This will focus on tackling some of the wider risk factors for suicide and on developing stronger emotional resilience in population groups that face greater risk of suicide currently or in later life. Much of what other Departments reported in the ministerial group will fit into that action plan.

That concludes my update on progress to date. Thank you for your attention.

The Chairperson (Ms Maeve McLaughlin): Thank you, Gerard. What have been the lessons from the original Protect Life strategy?

Mr Collins: The lessons from the consultation feedback and the independent evaluation of the initial strategy are that we need fewer actions. There were 62 actions in the strategy, and it was felt that that, to an extent, dissipated activity across a very wide area. The evaluation recommended that we focus our actions, theme them and group them so that there is a more direct focus on areas such as training and awareness raising. It also recommended an enhanced focus on the primary care setting for suicide prevention and better coordination of activity among groups that deliver suicide prevention services and between the statutory and voluntary sectors.

The feedback from the pre-consultation engagement has largely been that stakeholders want to see most of what we already do in suicide prevention retained. For example, stakeholders want to see Lifeline retained, as well as awareness raising. There have been some calls for more direct public information campaigns around suicide, although I know that the PHA has concerns about being more direct about suicide. When it comes to community support, there is a strong need for and a strong emphasis on retaining the commissioning of suicide prevention services from the community and voluntary sector.

We have also learned that police and custody settings are important settings for intervening in suicide prevention. The PSNI recently noted that very large numbers of people who come through custody are at risk of self-harming. One of the things that we know about suicide prevention is that contact with the justice system is a risk factor for suicide and self-harm. We are also aware that between 28% and 30% of people who die by suicide are known to mental health services, so the need to capture the 70% of people who die by suicide who have not been using mental health services is an important priority. The two most important settings for that are probably primary care services and police and prison services, with community sector services coming in about third.

The Chairperson (Ms Maeve McLaughlin): Look at the figures: every one of those cases is a human tragedy. Would you not agree that, with 268 deaths in 2014 and 246 in the first nine months of 2015, which is 20% higher than in the same period of the previous year, something is fundamentally failing? We cannot honestly say that the Protect Life strategy has worked.

Mr Collins: We cannot say either that it has not worked. As the Northern Ireland Audit Office pointed out some time ago, it is virtually impossible to assess the impact of a single strategy on such a complex issue as suicide. We know that what drives suicide is a lot of the wider social determinants, such as unemployment, poor education, deprivation, addiction and, in some cases, dysfunctional family circumstances. We have said this time and again: to address suicide in the long term, there needs to be a coordinated effort to address those wider risk factors for suicide. Until we make progress in those areas, particularly in relation to deprived areas, and improve the social and economic circumstances of people living in those areas, we will continue to firefight when we deal with people who come to community services who are suicidal.

We have reached a certain pitch. We are quite good at crisis stabilisation, when an individual comes forward to services, but we need to look further upstream to address the social determinants. In Protect Life, we have not to the same extent looked at the longer-term recovery of people who are self-harming and suicidal. We are good at stabilising the situation and work goes on in longer-term intervention, but we need to highlight that at a strategic level. That is something that we intend to do in the new strategy.

Has the strategy has failed? Look around internationally. What we do here is what other countries do. It is what the evidence shows to work. The evidence for what works in suicide prevention is not substantial, and, in properly peer-reviewed evidence, only three or four things are known to be effective. One of those is restriction of access to means, and that is something that we do here. Access to mental health services and sensitive media reporting also work. We do what we know and what the international evidence has shown that we need to do. We do what other countries do.

Our Protect Life strategy has been very similar to the Choose Life strategy in Scotland. Scotland has achieved that steady reduction in suicide rates. There is little that we do that is any different. In Scotland, they put a lot of their success down to awareness-raising campaigns and the fact that they have a huge focus on training in suicide prevention among NHS staff and community gatekeepers. Again, we have that focus here. We may not have reached the same level of coverage in training, but that will continue to be a focus in the new strategy. We have yet to find an intervention that has worked somewhere else that we have not employed here. The alternatives are that we stop doing what we do and find something else, though we have not yet identified what that can be, or we do more of what we do already. To do more would probably require further resources.

The Chairperson (Ms Maeve McLaughlin): How has it taken so long?

Mr Collins: Sorry, Chair. What has taken so long?

The Chairperson (Ms Maeve McLaughlin): Getting from the final stage of the Protect Life strategy to the revised Protect Life strategy. The Committee was told by Michael McBride in 2012:

> *"The independent evaluation of the Protect Life strategy was commissioned in 2011 and is nearing completion ... the new strategy ... will be taken forward from 2014, and we hope to go out to public consultation on that in 2013. The findings to date will be published in full in September."*

That was 2012. Why has it taken us five years?

Mr Collins: We refreshed the Protect Life strategy to run from 2012 until 2014, so it is not correct to say that it has taken five years. We produced a new document for those two years. That document remains current. We had hoped to have the new strategy in place last year. There have been resource constraints. There has also been a very high level of interest in suicide prevention, which means a high level of support work in the Department to deal with correspondence and with participation on various groups. As resource is directed to that, there is less time to devote resource to developing the strategy. We and the population health directorate intend to restructure some of the reporting lines of the day-to-day support work on suicide prevention and carve out time to devote resource to the finalisation of the draft.

The Chairperson (Ms Maeve McLaughlin): Bear with me, but I am sure that people directly impacted on by the issue will not understand the explanation that there were resource implications as being the reason that we could not get a new strategy in place, whether that be in five years or two years.

Mr Collins: That is the reality of the situation. We are a small team —

The Chairperson (Ms Maeve McLaughlin): What resources?

Mr Collins: Staff resources.

The Chairperson (Ms Maeve McLaughlin): You are saying that we did not have the staff resources in place.

Mr Collins: No, I am saying that the day-to-day workload that the Department carries out on suicide prevention has increased. By the very nature of the fact that there is that increase, it has consumed further staff resources. That work tends to be reactive. It cannot be planned. It is demand-led and tends to be very short deadline work. We have to devote resources to progressing that.

The Chairperson (Ms Maeve McLaughlin): How high a priority is it given?

Mr Collins: The very fact that suicide prevention is allocated £7 million by the Department and that that funding, over a number of years, has been ring-fenced shows that a high priority is given to resource allocation to the implementation of Protect Life.

The Chairperson (Ms Maeve McLaughlin): You will appreciate — I know that you have heard this directly — that groups and services trying to tackle the root causes would ask why they have been attempting to do that in the absence of an overall strategy from the Department.

Mr Collins: The 2012-14 strategy is what the PHA continues to work to. As I said, on the basis of the feedback from the consultation, a lot of what we do is what stakeholders want to see retained. Those services are likely to be retained in the new strategy. The PHA develops its annual suicide prevention and mental health promotion thematic action plan. It procures services against that. There is no ceasing of services or ceasing of the commissioning of services. Services continue to happen.

The Chairperson (Ms Maeve McLaughlin): There has been an absence of leadership and an absence of strategy. I go back to the comments, and I do not question Mr McBride's evidence to the Committee. He very specifically indicated to us that the evaluation of the strategy was commissioned in 2011 and was nearing completion. There is a huge gap there. While I accept that it has not been about the absence of services, it has been about the absence of a strategy.

Mr Collins: The evaluation of the strategy in 2011 fed into the update to the suicide prevention strategy from 2012 to 2014. That strategy took account of what the evaluation said. If you look at the original Protect Life strategy and the refreshed strategy, you will see that there are key differences in the strategic actions.

The Chairperson (Ms Maeve McLaughlin): And from 2014 on?

Mr Collins: As I said, it is regrettable that we did not get the strategy produced and published in 2015. We are still working on it. We went through additional pre-consultation engagement to ensure that stakeholders were involved in the development of the new strategy. That has been time-consuming in its own right. Responding to that has been time-consuming, but we want to get the document right. We want to have buy-in to it. We want stakeholders to feel a sense of ownership of the document. That is all taking time.

The Chairperson (Ms Maeve McLaughlin): The key issue in the delay between 2014 and 2016 has been resources.

Mr Collins: Resources and an increased workload, as a result of the general level of political and public interest in suicide prevention and the need to respond to that level of interest.

The Chairperson (Ms Maeve McLaughlin): The key lessons that we expect to see coming out of the new strategy will be fewer actions and an enhanced focus on primary care.

Mr Collins: There is more than that. As to what will be different, we are identifying the focus on primary care and custody settings. One of the big issues that have come up is the data on suicide. We have various databases on self-harm and suicide. We need to start looking at how we can mine those databases more effectively to produce information that gives us further evidence on what is driving suicide and what the local risk factors for suicide are. The focus on data and better analysis of the data will be part of the new strategy as well.

The Chairperson (Ms Maeve McLaughlin): When are we likely to see the strategy?

Mr Collins: We hope to have the strategy approved by the Minister towards the end of the month and out for public consultation around June.

The Chairperson (Ms Maeve McLaughlin): OK. Let me deal with the issue of self-harm in your paper. There were 8,453 presentations as a result of self-harm between April 2013 and March 2014.

Mr Collins: Yes.

The Chairperson (Ms Maeve McLaughlin): It indicates that almost 6,000 people were involved, as some of those cases were repeats. An additional 3,623 cases presented with suicidal ideation. You may not have this information, but how many of those 9,600-plus people received a psychiatric assessment before leaving A&E?

Mr Collins: A full psychiatric assessment? I am not aware of the exact figures. We will have to come back to you on that, if we can even produce those figures. When someone arrives at A&E in emotional distress or having self-harmed, a suicide risk assessment is carried out. If that risk assessment is low, the person is offered an appointment with community psychiatric services through the Card Before You Leave system. If the risk is assessed as medium or high, generally a full psychiatric assessment is carried out and the individual is admitted to inpatient facilities in a lot of cases.

The Chairperson (Ms Maeve McLaughlin): I am probing a bit. Would you suggest or do you agree that there are — I use my words carefully — better ways of fulfilling requirements around psychiatric assessment processes? There is anecdotal information — I am sure that most or all members hear it — about individuals who turn up at risk but then leave A&E departments before a proper psychiatric assessment can take place and, unfortunately, end up back there after a time. Do you have a view on the assessment process in our emergency departments? Is it robust and effective enough?

Mr Collins: We all know that A&E departments are not a great place to be for a person who is emotionally distressed, so the likelihood is that a lot of people will leave before the assessment. It is important that those people are followed up on. I cannot say what the waiting times for assessments are, but I know that the trusts have been working to reduce them, with a specific focus on suicidal patients at A&E. I also know that there has been a programme of training on suicide prevention for A&E staff so that they are aware of the priority of intervening with patients who are suicidal. That is a cascade programme — training for trainers — and part of the broader suicide prevention training process. At this stage, however, I am not able to say anything about the robustness of the assessment.

The Chairperson (Ms Maeve McLaughlin): I am interested in getting the details of what psychiatric assessment took place in the 9,623 cases. Were all those people given a card before they left? Were they followed up?

Mr Collins: There was an evaluation done some years ago of the Card Before You Leave system. By and large, it showed that it was working quite well. I think that there are a few instances in which people will not receive the card. I know that some A&E departments favour a follow-up by telephone as they found that to be more effective. One of the problems with the Card Before You Leave process was the large number of appointments that were not attended. That seemed to come with the territory.

The Chairperson (Ms Maeve McLaughlin): OK. Can you come back to us specifically on the detail that I have asked for? Finally, from me, you talked about other interventions. I know that you attended the all-party group on suicide prevention during the week. Does the Department have a view on the zero suicide model in healthcare?

Mr Collins: We have referred to it in the new draft of the Protect Life strategy and committed to investigating the approach and identifying how it can be adapted for implementation in Northern Ireland. As part of the outworking of that, we foresee the Department setting up, under the strategy, a task and finish group to look at how suicide down to zero has been implemented elsewhere, particularly, as you know, in the Mersey mental health trust, and to see what we can learn from that. There will be differences there from our structures, of course, but we will need to do a business case to determine what we can apply here. If the business case is successful, I envisage a pilot exercise in mental health services in some part of the health sector to trial that approach. That would then have to be evaluated after a number of years. There would be a cost to that, so we would have to monitor the business case.

The Chairperson (Ms Maeve McLaughlin): Did you indicate that that was included in the new Protect Life strategy?

Mr Collins: It had been in the strategy before the event.

The Chairperson (Ms Maeve McLaughlin): I welcome that. I do not think that it is a panacea for all our issues, but it is certainly more than a concept. I am keen to explore how we can shift that to a set of practices, particularly in health.

Mr Collins: We can learn from the Mersey trust, which is starting to shift from the concept and idea of the approach to a practical application of the approach.

The Chairperson (Ms Maeve McLaughlin): Thank you for that. A number of members have questions.

Mrs Dobson: Thank you for your briefing. Given your projected increase in waits for 2015, which we will know in April, are you concerned that the development of the Protect Life strategy has been, as you state in your briefing paper, "slower than anticipated"? Given the questions from and the answers to the Chair, I think that that is an understatement. Ideally, where would you like to have been at this stage with the strategy? You have cited increased workload, among other factors, as having hampered you.

Mr Collins: We would like to have had the strategy out last year and our colleagues in the Public Health Agency working on an implementation plan.

Ms Mary Black (Public Health Agency): May I make a general comment about that? It is less about the strategy and more about the actions that we believe are effective. Even in the absence of the strategy per se, people have maintained important actions that we know will be supportive in suicide prevention. We also know from the international evidence and our local evidence that we have to do this at scale and over time before we will see a reduction in deaths from suicide. As you say, every death is a personal tragedy as well as a cost to us as a society.

In preparation for this meeting, I had a look back at Dr Annette Beautrais's outline of what is effective for suicide prevention. You may remember that she is a world expert who came over from New Zealand a couple of years ago. She says that the population approach is absolutely paramount and that, if you focus only on the groups that are deemed to be at risk, you miss the point. Yes, we have to provide special services and support for those individuals and their families, but we have to have a whole-population approach, and that will require investment over time across all those issues, including public health information. While it looks as though there will be an increase in deaths this year, it is not true to say that we have not made progress in many other areas, including the self-harm registry, the services that are in place, a reduction in stigma and a greater willingness to come forward for services. However, every one of those gains forces you to ask, "What else do we need to do?". That is where we are now.

It is not that the actions that we have taken are not effective. We have some confidence about that, plus we have an independent evaluation that we are stacking up against international evidence, but every one of us has to ask, "What else do we need to do?" and reflect on our learning to date. Part of that involves building the effective actions over time and at a scale where we will see impact.

Finally, I will make a connection with other strategies that are equally important, such as the drugs and alcohol strategy. We know that the minimum unit pricing of alcohol and all those issues are related. We also know that the agency and the trust are placing great emphasis on early years intervention, because building that resilience from very early on will help. We have to do that over time and at a scale, and we have to interrogate the problem consistently, because it is complex.

Those are just comments on the actions that are in play. We still have to look at what else we need to do in the future.

Mrs Dobson: Gerard, you referred very briefly to the community and voluntary sector, and I am interested to find out what links the Department maintains with charities and organisations. I am thinking off the top of my head of Yellow Ribbon, MindWise, the Public Initiative for the Prevention of Suicide and Self-Harm (PIPS), Action Mental Health and Community Links. There are so many fantastic charities and voluntary groups doing amazing work out there. Where would we be without them? What links are you maintaining to ensure that there is that all-important ear-to-the-ground approach when it comes to support for suicide prevention?

Mr Collins: The governance structure for Protect Life has links with the community and voluntary sector built into it . For example, we have the suicide strategy implementation body, which advises the

Department on the direction of the strategy's implementation. That feeds back intelligence from ground level and, on occasion, can and does challenge the Department on the focus of delivery. There are around 40 members of the suicide strategy implementation body, and it meets quarterly. At least half, if not more, of the membership is made up of representatives from community bodies and charities with an interest in suicide prevention. Linked to that, at trust level, we have local Protect Life implementation groups — there is more than one group in the Belfast Trust area — that engage with the community groups that have an interest in suicide prevention in each trust area. The statutory services in those areas are also on the local Protect Life implementation group. We have three or four of those groups for the different areas of Belfast, and they meet quarterly. As well as the main groups, we have a number of subgroups for the implementation of the strategy, including the Lifeline regional steering group and the Bamford Protect Life implementation group, and the charities and voluntary organisations are represented on those.

Mrs Dobson: Engagement is one thing, but they are the ones in our communities, so listening to them and acting on what they say is very important.

Mr Collins: I assure you that those groups are very vocal on those fora. We have, on many occasions, taken direction from the community groups and acted on what they have said. One of the most important groups we have is the Family Voices Forum, which represents bereaved family members. It is by no means the only group that does so, but its progress and feedback on the implementation of Protect Life are standing items at each meeting of the suicide strategy implementation group.

Mrs Dobson: Finally, we all know that our farming communities face real financial problems brought on by a combination of many factors. Unlike in large businesses, the farmhouse table is the boardroom table. If a farmer has mental health problems, it affects everyone in the family. There have been attempted suicides in my constituency and, sadly, actual suicides in other rural communities. As we look to the new strategy, what has the Department done specifically to include measures on farming mental health in order to protect rural lives?

Mr Collins: Mary will probably come in here. The Public Health Agency has been working on the maximising access in rural areas (MARA) project, and there is health screening at farmers' markets. The Department of Agriculture and Rural Development has been a key partner in that.

Mrs Dobson: The MARA project has been superb, but, given the rise, is there anything else?

Mr Collins: Maybe you will give us the details, Mary.

Ms Black: We mentioned MARA, which is a partnership with the Department of Agriculture and Rural Development and identifies vulnerable rural households, carries out a range of checks and then links people into services and supports. That is one issue.

On the broader issue of Protect Life and engagement with the community and voluntary sector, we work through a number of network organisations, particularly in the rural community. The rural community networks are a vehicle through which we work in partnership to engage with rural communities. They have been very effective in two ways: through the small grants programme, which gives very small amounts to very small communities for training, education, awareness raising and various kinds of support; and through the farm families check scheme, specifically identifying farmers and their families. It is highly effective and operates in situations and venues that are more acceptable to the farming community, such as farmers' marts, and refers them to general practitioner and other services and supports. A mental health issue has been identified in a very high proportion of those referrals.

Mrs Dobson: You are aware of the increase as well —

Ms Black: I would not say that we are aware of an increase; rather, we are now aware and engaging. I am not sure that you could say that it is an increase. We have also supported —

Mrs Dobson: Local charities are telling me about an increase. Specifically, Yellow Ribbon is dealing with a large increase in the number of farmers —

Ms Black: I agree with you, but there has been an increase in urban communities as well. What is positive about the rural community is that people now feel more able to come forward and talk about it, even though we know that we still have a stigma issue. Finally on rural communities, we have also supported an organisation called Rural Support, which directly supports the parts of the rural community —

Mrs Dobson: Yes, as a member of the farming community, I am well aware of that. However, given the great need — I am hearing of a massive increase — and the fact that we have just passed a Rural Needs Bill that places a duty on Departments and government bodies to consult on and consider rural-specific issues, I wanted to find out what was in the strategy.

Ms Black: Rural communities are more vulnerable in some ways, as are a number of other communities, so they will definitely remain a focus of attention.

Mrs Dobson: There are no additional measures.

Mr Collins: We will look at that. I mentioned the two major pieces of research that are to be published next week. One, which was carried out by Professor Gerry Leavey of Ulster University, is about understanding suicide and help-seeking in urban areas and rural areas and looking at the differences. His report will produce recommendations that we can look at when drafting the new strategies. Some of the initial recommendations and findings are about the need to support families in rural areas, where there might still, unfortunately, be a higher level of stigma around mental health, and equip them to cope with a family member who is in emotional distress or potentially suicidal. The report will also deal with issues of access to mental health services for rural dwellers and the greater use of primary care services. It will produce findings that will feed into and inform the development of the strategy.

Mrs Dobson: The voluntary sector is reporting a massive increase. At least it is on your radar, and you are acting on it.

Mr Collins: Yes.

Mr McGimpsey: Thanks, Gerry, for the presentation. This is familiar ground for me, so I will not labour the point too much. As you know, when I was Minister, I was frequently asked by colleagues in the Assembly to do more. I used to say, "Tell me what it is that you want me to do. Tell me what we are not doing that you think we should be doing, and we will do it". I did not get many answers.

Is there anything that we do not do right now that you would like to do? You mentioned cutting the number of actions. Many years ago, people used to say, "We need more actions", but the view now is that we do not need as many. Is there anything that we should be doing that we are not doing?

Mr Collins: For me, a couple of big things have come out. One is the need to support families, which I mention in relation to the rural scenario. It happens, but we need to reflect it more at a strategic level. Very often, families care for a family member who is in distress and indicating signs of suicidality. Families are key players, and we could do a bit more to train them, make them aware of the signs of suicide and help to equip them to cope with a family member who is suicidal so that they can respond in the right way to that and to respond when a family member is self-harming. There is huge demand from families to know about that. Usually, when a family finds out that one of its members has self-harmed, there is bewilderment and a lack of understanding of where to go for help. We need to be able to inform families and signpost them to sources of help.

I touched on the need to join up and make more of the different information databases that we have. We need to refine and develop the sudden death notification process because that is our real-time information on what is happening. When we see an increase in suicide, we need to be able to get the data much more quickly to understand what is driving that.

As you know, when there is a suspected cluster of suicides in an area or among a group, very often a community response plan that is already in place is activated, bringing in a number of agencies. There is learning each time a plan is activated and stood down. We could take a step back and learn from instances in rural areas and urban areas where community response plans have been put in place and run for a while. We should find out what had driven a cluster of suicides in one area and what interventions had worked to prevent further suicides. The community response plans are about

preventing a cluster from growing. There is definitely capacity to learn more from what we do in a more structured and formal way and to share that information more regularly.

One of the things that we intend to do that have not been done to date is to look at the serious adverse incident reporting system for suicide and suicide attempts within mental health services. The Donaldson review mentioned that the deadlines for responding to that can limit the quality of information that comes through and that, sometimes, the learning from incidents is retained just within the units in which they took place. We have, through the Regulation and Quality Improvement Authority (RQIA), commissioned guidelines on the audit implementation network to carry out a review of the serious adverse incident reporting system, specifically on suicide and suicide attempts, in mental health services. That will look at whether the system can be changed to improve how it is conducted; the quality of the information that comes out of it; how that information is shared; and how that learning goes on to influence services.

Mr McGimpsey: Is any of that resource-based? Are you constrained because of resources?

Mr Collins: Some of it would require additional resources, and some would not. Some of it is just a change in the way that we do things. If, for example, we just changed our approach to the serious incident reporting system, it might free up resources. Some will require more resources, and some will require a different approach and a different way of looking at things.

Mr McGimpsey: On the issue of gender, age, deprivation, drugs, alcohol and so on and the steps taken on increasing awareness in A&Es and among GPs, the phrase used is "help-seeking", which is the key thing. The first step is getting individuals to seek help. Often, as you said, individuals who are in trouble are not known to services, and a lot of that is down to community-based delivery. Is there more that we can do? I welcome very much the preservation of Lifeline, which has been a very important tool for you. What other steps on help-seeking would you like to put in place? We are talking about mental health, and the jump from adolescence to adulthood is key because the big cluster is among those in their teens and twenties.

Mr Collins: First, we would like to see how we can identify the 70% who do not use mental health services and go on to die by suicide. I touched on that. The big issue is to focus again on primary care because about 50% to 60% of people who die by suicide will have used primary care services in the previous three months. There is also a focus on training for staff in custody and justice settings. We will identify the 70% only if we know who the community gatekeepers are and whether those in distress come into contact with them in those settings. It is important that we continue to train the community gatekeepers: police officers, prison staff, primary care staff, A&E staff, community workers and youth workers, as well as sports coaches, which was a big new approach taken by DCAL. That is a very admirable programme, and we need more of that. We need to keep a continued focus on that training so that people in those positions can identify the signs of suicidality, know how to intervene and know how to signpost an individual to the appropriate services, which might not always be mental health services; they could be community-based services. It depends on the issue that the person faces. They could be family support services. The mental health services route is not always the appropriate one. I see that as an important approach.

Ms Black: When you asked the question, I was thinking of three things. First, we need to reflect on our experience, which is continual. It is important that we continue to do that so that we retain the focus on exactly what we believe will be the most effective actions. I know that there are discussions in Belfast at the minute to start that process. The second thing is investment. Everything that we have talked about is effective, but, if you do more of it and you do it to scale, it will cost more. Therefore, investment is important. Thirdly, some predicators of health and the risk of suicide lie outside of health and social care, so let us get round the table and talk about how we address the issue in communities where young people do not see a future. We are doing that at community level, but do we have sufficient will to create employment and employability opportunities and bring all that work together? There are great examples of that, but could we grow it to scale? Again, the issue of scale, for me, is important, rather than isolated examples of good practice.

Finally, on help-seeking behaviour, public information is very important. We have evaluated the public information campaigns that we have run, and they were highly effective. However, there is a ceiling on the amount that we are permitted to do, and, equally, we need to follow that up with more modern communications by using social media and getting cleverer in how we reach people who are not just vulnerable but can influence their peers. There is quite a lot that we can do with communications, but I go back to scale, investment and working with others, because there is no simple answer.

Mr McGimpsey: The important thing in that answer is that this is not just a health issue; it is for all Departments and all government, including local government. Everybody has to be part of the circle. We used to have a ministerial team: does it still meet and bring all the Departments together? Do the other Departments support this in a tangible way?

Ms Black: Yes, and the ministerial group met on Monday of this week. It is heartening to see the range of actions across each Department. I am simply talking about doing more of that.

Mr Middleton: Thank you for coming along today. The 2015 figures will not be out until the end of this month, but is there any indication at this stage of how they look in the final three months?

Mr Collins: We have no indication. We do not get the final quarter until April, usually. If we extrapolate from the first three quarters, they will not look good. As the Chair said, it looks like a 20% increase. We have sudden death notification figures for 2015, and they indicate 191 suspected deaths. You would think that the sudden death figures should be higher because they cover suspected suicides. However, as I said, the process is still embedding, and we continue to refine it. Maybe not all suspected deaths have been recorded. We will eventually get to the stage at which we can look at the recorded suicides and compare them with the sudden death notification figure for the same year and see the discrepancy, if there is one. Extrapolating would give us a 20% increase and, unfortunately, the highest number of recorded deaths to date.

Ms Black: Last year, there was a reduction, and it is disturbing to see it go back up again.

Mr Collins: We always take a three-year rolling average to iron out variations from year to year, but a 20% increase is fairly significant.

Mr Middleton: No one likes to talk about the statistics because each death is a family devastated and somebody deeply hurt. You mentioned that Scotland had seen a decline in the number of suicides. We have challenges that may be specific to this country, but a lot of the issues are the same across the UK, Ireland and, for that matter, the world. Is there anything that we can learn from what Scotland is doing?

Mr Collins: We have had regular contact with colleagues in Scotland and were involved in the production of the new Scottish suicide prevention strategy a couple of years ago. As I said, what we do, by and large, mirrors what Scotland does. Scotland has, on occasion, put down its decrease to its awareness-raising programmes and a serious focus on training and setting targets for training NHS staff in suicide intervention and suicide awareness. We are already training, and we intend to continue that and up our game. By and large, however, we do what Scotland does.

One area that Scotland may be more advanced in is their statistics on suicide and the contributory factors. It has a very well developed database, the Scottish suicide information database (ScotSID). We need to look at our databases and at how we can combine information more effectively to pick up trends and find out sooner what is driving increases in suicide and which groups and areas are affected. In the round, we need an enhanced focus on training and better analysis, interrogation and reporting of the data on suicide, self-harm and suicide attempts.

Mr Middleton: I agree with what you say about enhanced training, and, as you probably know, a lot of people, including me, have been approached by somebody who is in distress. It can be difficult to know what to do so, if we do not know, we cannot expect anybody else to know. It is about education. Do you think that there should be more emphasis on private employers undertaking initiatives to reach large numbers of people? Obviously, it will not reach everybody, but the more people whom we can reach and educate, the better. There are families sitting round the table when somebody says — it is an unfortunate saying in my constituency — "I'm ready for the Foyle Bridge". I do not like using that line, but it used. It is about how you react to that. What do you say? Do you just dismiss it and say, "Hopefully, they're going to be all right", or do you say, "No, you need help, and this is where you need to go"?

Mr Collins: By and large, being in employment is good for mental health and well-being, but that means being in good employment. If you are in insecure employment or employment that places huge demands on you that you cannot control, that is bad for your mental health and well-being. There is a programme, and our colleagues in the Health and Safety Executive have developed materials that encourage more workplaces to implement standards that have been developed to help

to promote mental health and well-being at work. I mentioned that some businesses were involved. Allstate NI has a team that promotes suicide awareness and intervention in the organisation. They have also come to the suicide strategy implementation body and presented on their programme of delivering suicide awareness training in schools. That group has also offered its IT expertise to help to develop apps on suicide prevention. I would like more organisations to follow that model. There is huge potential if we can get organisations, particularly those with specific expertise such as IT, to come on board and develop interventions on that sort of platform. I would dearly like to see more of that.

Ms Black: Quite a lot of work has been done on the mental health and well-being of the workforce, but I think that you are talking about how you help somebody else. There is a range of training programmes, such as Mental Health First Aid, safeTALK and ASIST, depending on the level required. We are definitely looking at workplace health. The Public Health Agency is in the middle of procuring a service for workplace health, which is precisely on health and well-being as a whole but will include mental health and well-being. There will be increased opportunities as well as those that are currently being explored.

Mr Middleton: That is positive. The traditional ways that people used when they were in difficulty are changing. Traditionally, people might have gone to their minister or priest or spoken to the police. Are you seeing an increase in online services? In my constituency, online counselling services are offered 24/7, allowing people to stay in their home. Sometimes, people would rather remain anonymous and speak to somebody online and say, "Look, I'm having a bit of difficulty. What do I do?". Does anything in the strategy look at that?

Mr Collins: We intend to include a section on new developments in the new strategy, particularly the use of IT and the Internet, to explore where we can go. There is evidence that men, in particular, like the anonymity of the Internet for seeking information on mental health and suicide. Often, the Internet gets a bad press for sites that promote suicide or cyberbullying. However, there is also a very positive side to the Internet; it is where people can get help. Samaritans now provide a lot of help online. ChildLine provides a lot of help online and is seeing a big upsurge in the number of children making contact online as opposed to using telephones. We have to build that into our future approaches. This is the way that it will go, and we have to gear ourselves up to follow it.

Mr Middleton: I have one final issue, which Jo-Anne touched on. Many organisations and charities do a lot of good work. My difficulty is not with the fact that they do good work — they are — but there are a lot of them. A lot of them are doing the same things and fighting for the same funding, and we, the elected representatives, try to support them all. What more can be done to prevent them working in silos and to bring people together? It is difficult, because everybody has their own way of doing things, but we will have to look at that as we try to provide the best service for those who need it.

Mr Collins: I agree. That is what we try to do through the local Protect Life implementation groups, which have the community groups in that area engaged in suicide prevention, so that information and approaches are shared. That can only be good. Mary, do you want to talk about procurement services and so on?

Ms Black: Certainly. Before I do that, let me say that I recognise the problem. In a sense, the strength of the community and voluntary sector is that there is so much diversity, but then there is a potential conflict of interest. That said, I think that there is increasing maturity and willingness to work in coalition. On the new self-harm services that we mentioned, for example, in two of the areas, they are provided by a consortium of five or six organisations at community level. That is very encouraging, and it has come about only because they recognised the value and added benefit that they can bring to the service through that cooperation. However, it is a real problem, and it requires a level of understanding and sophistication for groups to be prepared to do that.

As for the services more generally that we seek to procure, we will procure from the community and voluntary sector as part of the overall shape of the services. We have already procured services for self-harm, as I said, training and vulnerable groups — black and minority ethnic groups, LGBT and Irish Travellers. The next phase of procurement will also look at bereavement services, community engagement and empowerment and facilitation-type services, as well as some others, particularly for young people. Our intention is to make it a procurement exercise to support the community and voluntary sector, but that will require people to come together. The evidence on self-harm is encouraging, but it will not be straightforward in all areas. Inevitably, it means that some people will "win", and others may not. However, the more they work together, the more you will see the strength

of that partnership coming forward in the services delivered and the ability to deliver a stronger service.

Mr McCarthy: Thank you for your presentation and briefing. Most of my questions have been answered, and I just want to make a comment. I pay tribute to all the organisations that are out there. I have a list of them. Despite the fact that they may overlap, they do excellent work in providing facilities and helping you to do your work. However, I am disappointed. You gave us good news and bad news. The good news is that Lifeline is to be retained, which is excellent; the bad news is that you expect a 20% increase in loss of life this year.

Ms Black: Potentially.

Mr McCarthy: Yes, I know. That must be disheartening, not only for you but for the community. Despite all the good work that is going on — you have invested £7 million a year in Lifeline — we could end up with 20% more deaths.

Mr Collins: In this year. We have said — it has been said by experts who have informed us on suicide prevention — that reducing suicide in the long term is a generational effort and that will not be done anywhere in the next one, two or three years. It requires all that upstream intervention to build emotional resilience and coping skills so that people who are vulnerable and experience adverse life events are equipped to cope with those events in a way that does not involve self-harm or suicide. This is a long-term project, programme and strategy, and I think that we are not going to see any significant changes. The increase in the early 2000s had largely plateaued since 2006. It is, therefore, disheartening to see the significant increase in 2015, but we have keep at it and focus more upstream.

One of the positives that I can come out with is that there has been so much research over the last number of years on the fundamental importance of early years and of building mental health and mental resilience in the first three years of life. The PHA has responded to that by producing an infant mental health framework and interventions to improve the life experiences of infants, particularly those in more challenging circumstances. Obviously, it will take a lot of years for that to work through. There is work going on in schools, much more than in the past. There is recognition of the importance of building emotional resilience. That will start to bear fruit in a number of years, but, in the short term, I do not think that we will see any significant reductions.

Mr McCarthy: You said to the Committee — correct me if I am wrong — that insecurity of employment might contribute to suicide. We are in a period of change. In the House recently, we debated zero-hours contracts. Do you know what they are?

Mr Collins: Yes.

Mr McCarthy: That could well be a contributor. If you do not have a full week's work, you will not be able to pay the bills. You have to live, and you may have a family to look after. Zero-hours contracts, if used properly, are OK, but, if they are not used properly, they can contribute to anxiety, possibly leading to suicide and loss of life. There is something to be said for those in authority who operate zero-hours contracts doing that properly and not disadvantaging the ordinary public.

Mr Collins: As I said, employment is generally good for mental health and well-being and for suicide prevention, but that employment has to be able to be termed as "good employment". That means that a person's mental health and well-being are protected in employment and that they have control over their work and some security of work. When employment is not along those lines and there is insecurity of employment, that is certainly a risk factor for poor mental health.

Mr McCarthy: That is very interesting.

Ms McCorley: Go raibh maith agat, a Chathaoirligh. Thanks very much for the presentation. Do you gather statistics for the report on the basis of, for instance, geography, the time of year and social class? I am thinking about directing resources: if you had more focused information, that would allow you to say that certain groups of people are most at risk. I live in Belfast, where the increase in suicide is a huge issue. At the weekend, there were even more deaths as a result of suicide. As we are hearing, it is just set to rise and continue, so I wonder whether it is really being tackled as effectively as it could be.

Mr Collins: I can answer that on two levels in terms of the data. NISRA maintains the data on suicides, and that data is broken down by gender, age group and geographical area, so we have that information. Given that it takes up to 18 months to two years to register a death by suicide, the data will always be a couple of years old, but it is still important. It is from that data, for example, in the Protect Life refresh, that we changed the aim. The aim that we changed to was to reduce the differential in suicide between the most deprived areas and the Northern Ireland average. That was done deliberately to focus efforts on deprived areas where there was a greater incidence of suicide. We have used the data from that perspective. We know from the data that men are three times more likely to die by suicide than women and that that has been among men in the 20- to 55-year-old age group. That has been used to inform the PHA's services and to direct them at males. You will see, for example, that the awareness-raising PR campaigns tend to take place in a male environment. There is one about a boxer and one about a construction worker, encouraging men to seek help because men are much less likely than women to seek help for mental health issues. That data informs and directs where and how services are delivered.

The key thing about instant data is that we do not have that, and that is a problem. If there has been an increase in suicide in a specific area over a short period, that will, hopefully, show up through the sudden death notification system. That system is used by the PSNI, which shares that information with the trusts and the PHA. The PHA looks at that, which helps to determine whether to activate a cross-agency community response plan to tackle the issue in a particular area. We have an ability to respond quite quickly to emerging issues of suicide in an area, and we want to do a lot more about that.

If you were to ask me, for example, what it was that drove an increase in suicide in 2015, I could not tell you much more than that there were more young men in those figures than there has been over previous years. We know that there is now a focus on young men in deprived areas, which had previously been on males in the 20- to 55-year-old bracket. The research into the legacy of the Troubles maintains that the suicide cohort will age because the people affected by the Troubles through post-traumatic stress disorder will carry that, and suicidality will increase. However, the latest figures do not show that; they tend to go against that. You will not take figures for three quarters of a year as a trend, but that came out of the blue at us. We are now back to seeing an increase among young men in those first three quarters. We have limited information to act on as to what happens within a year, and that is where we need to improve our interrogation of the data and our information systems.

Ms McCorley: There are indications that the incidence of suicide among women is rising. We were given statistics recently that indicated that there was an increase in women in Belfast taking their own life. Is there anything to explain why that is happening?

Mr Collins: We do not know. There is a worrying trend. Part of the reason why fewer women die by suicide than men is that women have used less lethal means of self-harm, such as self-poisoning by drug overdose, where there is more chance of a recovery. Men have tended to use more lethal means. We are finding in some of the latest suicides that more lethal means have been used, which is a worrying trend among females.

Ms McCorley: The Committee visited suicide groups last week in north Belfast. It was a group of people who represented all of Belfast, from all communities. They told us that the statistics underplayed the real figures, because they did not include people who maybe died a week after a suicide attempt.

Mr Collins: I think that they were referring to the sudden death notification system, because those figures are included in the statistics if it was death through self-injury —

Ms McCorley: Are you saying that the other statistics are more comprehensive?

Mr Collins: The recorded statistics will always be more comprehensive. The sudden death notification is filled in by the police officer at the scene. Bear it in mind that, when a police officer goes to a sudden death, their first priority is to investigate whether there has been a crime. This is an additional responsibility on them. They complete that form. If there has not been a death — if a person is injured and has been brought to hospital — a sudden death notification form will not be filled in. That may be the data that the local group is referring to, as opposed to the general register data.

Ms McCorley: Those people are dealing with this issue day and daily. You could feel from them the strain of being involved in that sort of work. There is desperation; they feel that they are not supported. There is a lack of strategy and there is a need for a task force. They obviously know that the work has to continue, and they want to do that, but they are firefighting; that is how they describe it. How can you respond to that sort of desperation coming from the people working on the front line?

Mr Collins: Again, it relates back to the point that I made: we have to go upstream and address people's needs before they become suicidal to reduce that volume of firefighting. By and large, firefighting is what we are doing. People are coming into the services in crisis and need to be stabilised. That has a huge impact on the people who deliver those services in the community and in the statutory sector. There is research about the psychological impact on psychiatrists and GPs who lose patients to suicide. That impact is very significant. I have absolutely no doubt that the impact on community workers and volunteers addressing suicide is every bit as significant.

I perhaps should have mentioned earlier that another thing that we are looking at in the strategy, which we have not looked at in Protect Life to date, is self-help and protection for the people who deliver suicide prevention services. The need to protect the well-being of the people who deliver those services was fed back, so we are including that in the strategy. We have a template for that. I mentioned the Flourish! initiative for the clergy. That initiative is not just to equip the clergy to deal with suicide among parishioners, but to keep themselves safe because they are under pressure and dealing with very emotive issues as well. We have a template for delivering support to an important group of gatekeepers, but an element of that support is for keeping themselves well. We can then look at that to see whether we can apply it more broadly.

Ms McCorley: Do you agree that there is a need for more resources for talking therapies and more flexible approaches to that? There is sometimes a one-size-has-to-fit-all approach. That cannot be the case. People get a limited amount of counselling sessions, and that is it. Do you agree that there needs to be flexibility, given the very serious nature of this? If this is a way that works for a lot of people in those circumstances, do you agree that we need to look at more ways of resourcing that in communities where people are living and are so desperate?

Mr Collins: We engage with our colleagues in the Department and mental health services, and those points are raised. Yes, ideally, from a suicide prevention perspective, we would like to see better access to those services and flexible services. That is where we deal with our colleagues in mental health services, who are responsible for policy around those services.

Ms McCorley: Given that you anticipate a 20% rise in suicides, are you looking at a 20% increase in resources to address what, you perceive, is likely to happen?

Ms Black: I cannot speak for the resources side but, when it comes to resources that have already gone in, there are new developments, if we talk of Belfast, such as the health and well-being hubs. The board has put that new investment into the trust, working in partnership with the community and voluntary sector. Those are new services. You are right; service providers feel that there needs to be flexibility, but they are also concerned about duplication. A person may be in obvious need of support, but they could also be a victim and survivor under another programme. There is a need for us all to better coordinate some of that work to help the individual and their family. I absolutely agree with you about that.

The other point that I come back to is about self-care. In Belfast, we are currently piloting a method of support for some of those organisations for their own self-care, and that seems to me to be very important. We are waiting to see how that goes, but we are definitely looking at rolling that out to other areas. The people on the front line can feel it very, very hard at times, and I think that there is a responsibility on all of us to take that on board very seriously. Until now, as is often the case, it has been goodwill that people rely on. This is not just about money but about commitment from those people. It is heart and soul, and you cannot trade on heart and soul. You really have to resource it and support it. We recognise that, and I think that it is an important area.

Ms McCorley: I have one final question. Has the Card Before You Leave initiative been reviewed for effectiveness?

Mr Collins: It was reviewed about 18 months ago, I think.

Ms Black: Yes, I think that it was in 2014.

Ms McCorley: What was the result of that?

Mr Collins: The review indicated that it was working reasonably well, although one of the issues was the high number of appointments that are not attended. There were some instances where people did not get the card, and there was some variation in the service, as was mentioned. I think that one of the trusts preferred to get the phone number of the individual, and it found that more effective. I think that we have to allow for that degree of flexibility. If the trust is finding that it is getting more people to appointments through that approach, I would not stick rigidly with the protocol and say that they must get a card, because the trust was finding that some people were just throwing the card away.

Ms McCorley: You have to go with what works.

Mr Collins: Yes. That was looked at, and I think that some of the learning was taken on board by the trusts that implement the scheme. There will be another review in the future.

Ms Black: We have to look at that continually. If the person is referred to the service and they do not pitch up, how much follow-up is there and how often do you need to do that? Do we need to understand a bit more about why they are not pitching up? It is an area for constant review, particularly if we talk about the zero-tolerance culture, primarily around mental health services but stretching into people presenting at emergency services. That is about making sure that everybody is captured in some way and managed through the system.

Ms McCorley: I think that it is very important to know why people do not attend because I think therein probably lies —

Mr Collins: The national confidential inquiry into suicide has made recommendations for a greater focus on assertive outreach so that, where clients of mental health services miss appointments, that is not just passed on and there is an effort made, particularly at those critical periods, for example within two weeks of discharge from inpatient services. Those recommendations go to the trusts for implementation, and I know that some of the trusts have been working at putting those procedures into place. Again, there is a cost, obviously, to assertive outreach, but we have a process in place through the confidential inquiry to make recommendations of that nature.

The Chairperson (Ms Maeve McLaughlin): I will pick up on that very briefly because I know that Alex wants in as well. The Committee had a meeting last week with the sector and the services, and I stress that it was the community sector right across the entire city of Belfast. They are obviously focusing on the 55 deaths by suicide in Belfast last year alone, which is quite a stark figure. Is there not a need for a particular focus, a particular task force or a particular interdepartmental or departmental approach? I have to say that the groups were quite supportive of the work that had gone on, and there had been a particular interdepartmental focus — maybe that is not the right term — a number of years ago, which seems to have slipped back a bit. I am listening to what you are both saying about moving upstream on the issue, but it is also about following and targeting the need. Is there not a specific case there?

Mr Collins: That point was raised at the ministerial coordination group meeting, and the Chief Medical Officer responded. I am not sure that a ministerial task force, which would be another layer, is necessary. We have groups out there —

The Chairperson (Ms Maeve McLaughlin): Maybe not a ministerial task force.

Mr Collins: I know, but the suggestion was for a ministerial task force.

The Chairperson (Ms Maeve McLaughlin): I am saying that maybe there should be some sort of task force in which all the statutory services are coordinated. The Department would have a leadership role in that, or it could be the Belfast Trust. I am working on the basis of identifiable need on the back of those 55 deaths.

Mr Collins: The Department and the PHA have discussed that. A large number of groups are involved. I was at a meeting in late 2015 about the increase in suicides in north Belfast and the

demand for mental health services. There is obviously something happening there. We are seeing an increased demand for mental health services. People are responding to the need. They are saying, "I have a need here", and using services. We need to know what is driving that increased demand and what is driving increased suicide. There are a number of groups already involved in that. There were groups at that meeting, and there were a number of agencies involved. We need to look at what all the groups are doing and, as Mary suggested, take a step back and see what the learning is from the activation of community response plans. Maybe what is needed here is a large-scale community response plan.

The Chairperson (Ms Maeve McLaughlin): Who leads that? Who drives that focus?

Ms Black: Just before we came in, I was sharing a proposal with Gerard; it was simply an idea and would need to be discussed. Rather than another group, what we need is a think tank to do a large-scale reflective piece of work. At least, that is my suggestion. It would need to be taken to the chairs of the local suicide implementation groups. You may know of the future search programme. You focus, along with politicians, policymakers, academics and community volunteers — all the different stakeholders. It occurred to me that the best approach might be future search or a process like it, which would require in-depth reflection, scrutiny and formal interrogation, but also recognise learning and the things that are going well, and affirm the direction that is required for the future. What I am worried about, if I am absolutely frank, is that another group might actually take energy away from the people who are already there, engaged and focusing their efforts on the task.

The Chairperson (Ms Maeve McLaughlin): I understand that, and I am not suggesting replacing it with another group. I am just saying, in the absence of a strategy and given the increasing number of suicides in Belfast and more generally, that there is a dire need. I understand the future search process; we went through it in Derry as part of the One Plan, but who leads that? How does that happen? Is it the Department? Is it the Belfast Trust? Who does that? What is the process? Is it the PHA?

Ms Black: We have not got to that point. I am very mindful that there are people from both community and statutory services who are already leading the implementation of the Protect Life strategy. I am sensitive about the need to include their view; they may have a different perspective. However, it struck me that an in-depth drill would be helpful and would confirm those bits that everyone is comfortable with and feels are effective, and renew efforts in other areas.

The Chairperson (Ms Maeve McLaughlin): I do not want to get bogged down in that specific issue, but I it is important to clarify who is responsible. Will you come back to us as that thinking is developed?

Ms Black: Yes.

The Chairperson (Ms Maeve McLaughlin): It is important to target the need that exists in view of the stark figures that we are facing. Alex, you have been very patient.

Mr Easton: I will be quick. Thank you for your presentation. From about 2004, suicide rates seemed to be going up and, initially, the Department put that down to better recording of deaths as well as an increase in suicides. We know that is down to various factors such as deprivation, the Troubles and other things. We have trundled along and the figures have been going up and down. There were a couple of years when they were going down, and then they went up again, and then, last year, they went down further than they had been in about five years. Unfortunately, there will be another spike this year, and everybody keeps scratching their heads, looking for factors and wondering how we are going to deal with it.

Is any work being done on the influence of the Internet? I am thinking of the likes of Facebook, Twitter and online bullying. You even get pages where people advocate suicide. Is the Department looking at that as a possible factor in why we are not able to get a steady decrease? Maybe that is a stupid question; I am not an expert. To me, the trend upwards seemed to come when social media started to become a force.

Mr Collins: You can look at it internationally. Scotland has seen a steady decline. England has been reasonably steady. You have to look internationally for that evidence. There is certainly evidence out there that cyberbullying is a risk factor for suicide in the same way as physical bullying is. I do not

doubt that it is a contributory factor. Action has been taken through the Child Internet Safety Forum to try to close down sites that promote suicide. There is a process by which they are notified, but it is very difficult, as you will appreciate, because a lot of those sites are hosted outside this jurisdiction and outside the UK. It is difficult to close them down because they will pop up somewhere else. In the round, yes, cyberbullying is a contributory factor for suicide. There is no doubt about that. Sites that promote suicide make information about means of suicide much more readily available, and those are a worry. Action is taken at UK level to address that. There is no specific evidence that I know of on a Northern Ireland basis about the contribution of those types of sites or of cyberbullying to suicide. Anecdotally, we found that not that many cases have been down to either the honeypot sites or cyberbullying sites, but that is only anecdotal.

Ms Black: It is of general concern that the increased use of social media means that, particularly for young people, there is an increased concern about how they portray themselves in that they are sometimes living through other people's eyes. That can add an additional type of pressure. They might think, "I am not so perfect". It is going on all the time, particularly with photographs. At a general level, as a society, we feel the impact of that kind of behaviour, which is not always in the best interests of our mental health and well-being.

Mr Collins: Mary mentioned Annette Beautrais from New Zealand, who is one of the world's leading suicide prevention experts. She has mentioned legacy social media sites. When a young person dies due to suicide and their Facebook site is still there, there is a tendency for other young people to engage with that site and leave messages on it. The evidence is that that is not a good thing because it diminishes the understanding of the finality of death. You will get text on those sites such as the person "parties on in heaven" or "The legend lives on". That can be very damaging to the understanding of other young people, and it can contribute to what we call suicide contagion. One of the fundamental aspects of the community response plans and the training for clergy and teachers is that parents who have unfortunately been bereaved by suicide are advised to close down their child's social media site.

The Chairperson (Ms Maeve McLaughlin): I have a final point about the experience in Scotland, which has seen a decrease. It seems to have invested more in child and adolescent mental health services (CAMHS) and invested a bit in staff. The most recent figure I saw was that Scotland had 869 staff excluding trainees. What number do we have here?

Mr Collins: I will have to come back to you on that one. I would have to get that from the mental health services.

The Chairperson (Ms Maeve McLaughlin): From your experience and work in that field, has that impacted positively?

Mr Collins: I know that CAMHS has set up crisis intervention teams in each trust area and that, through those, there has been a focus on intervention in terms of social and emotional crisis. I would have to get more detail for you on the volume of services and access times for non-crisis intervention.

The Chairperson (Ms Maeve McLaughlin): Can you come back to us with those figures?

Mr Collins: Yes, I will get those from my colleagues.

The Chairperson (Ms Maeve McLaughlin): OK. Thank you both. The issues have been well aired today. There is an issue about the delay in the new strategy, and there is obviously genuine concern that goes much wider than this room about the 20% increase and what the rest of the year will bring. We want to get the details on the development strategy and some of the other issues that I raised with you. Thank you for your time. We will keep track of how this develops.