Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Protect Life Strategy: Belfast Communities of Interest

16 October 2013

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Mr Roy Beggs
Mr Mickey Brady
Ms Pam Brown
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr David McIlveen
Mr Fearghal McKinney

Witnesses:

Mr Kevin Bailey	North and West Belfast Protect Life Implementation Group
Ms Irene Sherry	North and West Belfast Protect Life Implementation Group
Ms Linda Armitage	South and East Mental Health Community of Interest
Mr Ronan McKenna	South and East Mental Health Community of Interest

The Chairperson: I welcome Irene Sherry, Kevin Bailey, Linda Armitage and Ronan McKenna, who are from the North and West Belfast Protect Life Implementation Group. We have quite a heavy agenda. We have set aside half an hour for this discussion. There will be a 10-minute presentation from you, and then we will move to members' questions. I ask members to be succinct in their questions where possible. This session will be followed directly by a discussion with the Public Health Agency (PHA).

Ms Irene Sherry (North and West Belfast Protect Life Implementation Group): Thanks very much, Chair and members, for having us today. I will clarify one point: Linda Armitage and Ronan McKenna represent the South and East Belfast Mental Health Community of Interest, so this is a joint presentation from communities of interest in north and west and south and east Belfast.

By way of introduction, there have been recent conversations in our groups around incoming tendering with respect to Protect Life services. There is much concern around the need to develop some training to help and consolidate the grass-roots approach that has been happening around suicide prevention not only in Belfast but in all constituencies. Although I understand that groups may have been aware that the indication was that tendering was in the process of happening, it was more a concern that there has not been any direct tender support training available for the groups to provide a sense of equity and a level playing field to enable them to contribute.

The main concern for the groups is that, for the past 10 years, they have been fundamental from an organic, grassroots perspective in helping bereaved families, those with suicide ideation, those who self-harm and, indeed, the broader community with a very emotive issue that has taken a huge toll on the community. However, we want this to be a very positive conversation. I am aware that our colleagues from the Public Health Agency are here and will speak after us. We have an excellent working relationship with them, which we wish to continue and develop. We are here to air some concerns and to look at the process for the way forward. I will hand over to Ronan.

Mr Ronan McKenna (South and East Mental Health Community of Interest): I will set the context. You will have some slides that we have provided. There has been an average of 277 recorded deaths by suicide annually since 2007. That is an increase of 100% in less than 15 years. I know that this Committee tabled a motion in April 2013 and that the Health Minister acknowledged that suicide had virtually doubled in the last decade. In the early part of the 2000s, there were 150 deaths each year but, by 2006, the annual number registered had virtually doubled. The highest rate was in 2010, when there were 313 recorded deaths. As you can see from our papers, 83 of those were in Belfast. We are coming at this from a Belfast perspective.

Unfortunately, despite the best efforts of the Protect Life strategy that is in place, suicide rates remain high. The refreshed strategy that came into play in 2011 will end in March 2014. We are concerned that no new strategy is expected until towards the end of 2014 and that tendering is imminent.

Mr Kevin Bailey (North and West Belfast Protect Life Implementation Group): I will take the Committee through the current challenges that we experience. We come from the community sector, but it is recognised that all sectors are experiencing increasing need across Belfast in relation to suicide. Co-morbidity, multiple presentations and the complexity of individuals presenting not only with everyday life events but with other struggles such as an inability to cope and a lack of resilience are putting increasing demands and pressure on community groups in particular.

There is also a real community fear about the lack of capacity in this scary process of tender and procurement — something that is not really considered to be at all associated with the community sector. Over the past 15 or 20 years, local community organisations have grown organically. Community development has been core to and at the heart of the delivery and outcomes of almost all government health and well-being strategies. One fear is that, going forward, in tender and procurement processes, the community sector will lose out to larger voluntary organisations that are more appropriately resourced, or to consortia that could potentially step in and do, or claim to do, some of that work in a local community setting. Part of our worry and fear about that is that the community itself is best placed to meet that local need and to bridge the gap between strategy at a policy level and local delivery that makes an impact on the ground.

There has been a major strategy for community cohesion and building that up. All sectors have worked hard over the years to develop the infrastructure itself, the cohesion and the partnership working, all of which I am sure you appreciate does not come easy. The competition factor that we would point to in tender and procurement has the potential to unravel that hard work and, in doing so, unravel a lot of work right across the political spectrum, all sectors and local communities. Although community organisations will be impacted adversely by that, ultimately the individual who will be impacted most is the person in need at a time of suicidal risk and crisis.

On the issue of increasing demand, we are more often coming across compassion fatigue. We are not alone in that, but the community sector in particular is experiencing the development of compassion fatigue. Suicide, self-harm and mental ill health are very emotive and emotional topics, and, over the past number of months and years, those difficulties have increased, and we expect them to increase in the future. Indeed, our Health Minister has been telling us that through his statements, as have our service providers. The likelihood and probability of our providers experiencing individuals coming to their door with less need is very small, and that can only increase compassion fatigue when you couple trying to meet individual need with the prospect of tender and procurement.

We have been informed that the Business Services Organisation (BSO) is advising some of our statutory partners that they cannot get involved in organising or funding tender procurement training. So, although we recognise and value its input, there is a gap in how we can meet the current demands and how the community sector can be ready, using the community-development approach with measurable outcomes, given the timescale.

I will give you an example where the current process works really well. The sudden death forum is part of a regional policy, and the community responses are also regionally developed and led by the

board and the PHA. Part of that process involves ensuring that we respond immediately when a death occurs in the local community. The community sector and individuals who live in those communities are essential to that functionality. Our partners in the statutory sector say that that cannot happen without community involvement. The community has a sense of the issue of contagion and how to contain it. Without that input, we could potentially be facing much larger issues around contagion in local communities.

There is also the fear that the tender and procurement process will focus largely on supporting programme delivery. Currently, we need to have programme delivery and infrastructure, and we need a staff team, organisation and resources to meet that need. There is a fear — an unquantified fear, because we are not sure of the specifications — that tender and procurement will focus not on infrastructure and programme delivery but solely on programme delivery, which then puts an additional risk on local organisations.

Finally, there is the concept of security of funding to allow delivery to the population. Most of our organisations experience annual funding or short-term funding for around six months, depending on what comes out of slippage money, year on year. As demand increases across Belfast and, indeed, regionally, local organisations will struggle to meet that demand. Although the community sector in particular has been in conversation with its statutory partners around increasing funding and increasing longevity of funding, it does not want to do that at the risk of not receiving any funding through tender and procurement processes.

We recognise, folks, in coming here today, that we want to set the context and set out our current challenges, but we also want to offer some possible solutions to this process; it is not all negative.

Ms Linda Armitage (South and East Mental Health Community of Interest): I have five points to present. First, it is critical that the tender and procurement processes are aligned with the new Protect Life strategy and, secondly, that there is provision for immediate interdepartmental support to resource tender and procurement training. All the current and future commissioning of services should follow evidence-based practice. Communities need support to show and to evidence that. People often fear change, but, if the local communities were properly supported, they would welcome the future commissioning direction with a focus on improving local residences, emotional well-being, building resilience and reducing suicide.

Thirdly, we ask that the Health Committee host focus groups with Protect Life providers and other community of interest groups. Fourth is the need to endorse the diversity of service and needs across communities, including in the tender specifications. We want to stress that there is a real willingness and, indeed, an appetite across Belfast for the community, voluntary and statutory sectors to deliver together. There is a requirement to offer diverse services to meet growing needs in this city, and those diverse needs require a locality-sensitive approach to be embedded in community development. That is very important. Communities have expertise on what works locally. They have a local knowledge, and we feel that this is essential when developing the future specification. The Department has highlighted the fact that one expectation for the final strategy would include building on existing strengths such as strong community engagement. However, imminent tendering could jeopardise that expectation. Fifthly and lastly, we want to see a review of the functionality of the Suicide Strategy Implementation Body by the end of the year.

The Chairperson: Thank you for your presentation. I do not need to reiterate the support of this Committee for the really valuable work that you all do. It is important to recognise that the process of developing a community suicide response came from the community; I know that from my constituency. The community is where the ethos and roots of the programmes came from, and it is essential, therefore, that the community is aligned throughout this process.

It is of concern that we hear how a new process around procurement could impact on the vital work that is happening. You have been very honest about the good working relationship between you and the PHA, and probably the Department. We need to develop that. What is the key mechanism that would allow that to happen now? You talked about recommendations, and one was about the alignment of the tendering with the new strategy. Is that the central plank that needs to be put in place?

Ms Sherry: Yes; that definitely needs to take place. I am conscious that our colleagues from the PHA have worked very openly with us to try to move to a process of tendering. The difficulty comes when we look at the barriers to communities engaging, because they feel that they do not have the

resources to get them up to speed on the tendering process. Therefore, it is critical for us to have some mechanism whereby, parallel to the new strategy coming out, a process is put in place to ensure that capacity is built up in communities around tendering and training.

I am aware that, across constituencies, there are groups that feel that the current funding mechanism has not allowed new groups to develop. I fear that that could damage the community cohesion that we have, so I totally take on board that that could possibly be a fear from the Public Health Agency. Alongside that, there needs to be some mechanism whereby that can be looked at but, centrally, whereby training and development can happen specifically around tendering and procurement. I know that the PHA has been doing some training and is developing training around the specifications that have been drawn up around counselling, complementary therapy, and so forth.

We are focusing specifically on tendering and procurement because the fear is that, if you go into a process of tendering, which can be for up to five years, the local groups do not feel that they have the capacity, and they will lose the opportunity to go into that. In Belfast, to give one example, there are 20 groups that are funded under Protect Life. That is not to say that those groups are all receiving core funding. They are not. Many of them are just receiving money towards a service delivery aspect, so we need to consolidate that. Because groups are getting money under Protect Life per se, it involves them in the decision-making processes and in the critical work around suicide prevention in the city and across other constituencies. We cannot afford to lose that when we are faced with increasing numbers of suicides and presentations of self-harm.

The Chairperson: If the procurement process were to proceed now, in the absence of the new strategy, what practical impact would it have?

Ms Sherry: I think that it could have a very negative impact, because groups feel that they are not ready for it. Those that will be ready for it are the broader and bigger voluntary and regional groups. That would have a knock-on unsteadying effect, causing fear in communities.

Mr Wells: Your statistics show that about a quarter of all suicides in Northern Ireland are in Belfast, yet it has about one sixth of the population. Suicide rates seem to be higher in Belfast than in the rest of the Province. From your local community background, are we any further on in identifying, first, whether there is definitely a cluster of suicides in north and west Belfast, as is often quoted, and, secondly, identifying why Belfast seems to have a much higher rate than other parts of Northern Ireland?

Mr Bailey: The concept of a cluster and contagion can be defined simply by one attempt of suicide that is likely to impact on another individual's likelihood of inflicting self-injury. There are massive amounts of data and research, not so much locally, but certainly nationally and internationally, which points to why a person might attempt suicide. North and west Belfast have economic and social deprivation, and there is an inability to seek help. People are disconnected from their friends, family and community, and feel a burden upon themselves. Those are often put forward as the main factors. People are also being exposed to suicide, either through a previous attempt by themselves, or from a community perspective. Those factors go into making up the contagion and the clustering.

How you align suicides according to geographical location, age range and the space and time in which they occur, compared with what you would normally expect in, say, a six-month period, goes into factoring whether a number of suicides is noted as a cluster. Certainly, in Belfast, we have seen a number of those, as we have seen in other parts of the Province, over the past number of years. The community response plan is trying to counteract that.

We know, loosely, why people will attempt or complete suicide, but getting to the individual root cause of why an individual has done it is very difficult. A study was completed in 2011 in which 36 men who had attempted suicide were interviewed about why. One reason given was the inaccessibility of services that met their needs. They felt that they could not get services or that the services that they knew about were not accessible to them. You could argue that there are lots of services. Belfast is not short of services, but the problem is the inability to seek that help and to receive it in a timely fashion.

Mr Wells: Those factors were present, even more so, in, say, the 1970s, when we had even worse economic deprivation and the Troubles very much on our streets. What is noticeable in the statistics is that suicide rates have increased dramatically since the 1970s; in fact, they were increasing during the 2000-2007 boom. We were probably never as strong economically as we were then, and there was

much more employment. Why is this such a recent phenomenon? The latest statistics are even higher than those you quoted. I think that the figure is over 300. It seems strange that we have had this rapid increase over the past decade.

Ms Sherry: We have a much better recording mechanism for suicides. I think that that is one contributory factor: we have more accurate numbers. Since the time of the conflict, the age of people who have attempted or completed suicides has increased from the mid-30s right up to 50s, 60s and 70s. We have seen that from the introduction of the SD1 process. When the previous strategy came out in 2006, there was massive concern about youth suicide. Fortunately, a focus was put on that, and a lot of work was done. Now, we are trying to work with people between 25 and 50 for whom disconnect from interpersonal relationships is a big factor, particularly in Belfast. A recent research survey showed that individuals between 25 and 50 had the fewest interpersonal relationships. The same group presented to mental health services for common mental health problems and also had the highest number of suicides.

Mr Brady: Thank you for your presentation. Are you saying that if the tendering process as it is envisaged goes ahead, it could adversely affect smaller groups? There are many smaller groups doing very good work in my constituency. You talked about the accessibility of services. It is about prevention but, then, of course, there is the unfortunate aftermath for families, including counselling and all that is involved. Are you saying that larger groups that may not be as accessible may get the money and smaller groups may suffer?

Jim made a point about the stats. Not all deaths by suicide are recorded as such, and the figures can be completely skewed. It may be that, as you say, the inaccuracy of the stats is becoming more apparent. There is a fear that smaller groups, which are accessible in communities, will suffer if the tendering process goes ahead.

Ms Sherry: That is definitely the fear. It is the one thing on which we are pressed to try to get your help and support. We need the consolidation of those small groups: for every £1 that may be given by the Department, £20 comes back in the form of the voluntary contribution from people who cover weekends, bank holidays and holiday periods. That is critical for us.

That is not to say that the groups are absolutely saying no to tendering. In one sense, there would be more flexibility in resources and more resources for groups, but the difficulty is in getting groups to collaborate. It takes time to do that because there is legal documentation. How do you get the small, organic groups in different constituencies to come together?

Mr Brady: Many those groups do a lot of voluntary work, but they need resources. There are also people who have experience with close relatives of the trauma that suicide brings to the wider community as well as to individuals. That is why it is important that those groups are maintained; otherwise, you get a disconnect with larger groups. I am not saying that they do not do a good job, but there is sometimes a disconnect because they are not as accessible.

Ms Sherry: Absolutely. Many of those involved contribute their time. As we sit here, it is not that we are paid as suicide prevention workers. I am a community member; I work voluntarily on the issue of suicide. However, as you said, there are many people across the city, and in other constituencies, who are involved because of a personal loss that has brought them to a point where they want to help and support families and friends in similar situations.

Mr Gardiner: Thank you for your presentation. Have you made contact with other organisations like your own outside Belfast? Do you operate solely in Belfast?

Ms Sherry: The truthful answer is that I have had conversations with some groups with a common interest in working on suicide prevention and with victims and survivors. We would have had conversations about concerns that are shared by people who work with victims and survivors about moving to a commission-based service. This morning, I was at a meeting at which I spoke with groups from different constituencies, from Derry, Tyrone, Armagh and so forth. Although I have not spoken to them in an official capacity, we get a sense that they have a similar concern.

Mr Gardiner: I represent Upper Bann, which includes the Lurgan, Portadown and Banbridge areas. Do you know of any organisation like yours that operates there?

Ms Armitage: I am not sure. I know that other networks, such as the Healthy Living Centre network, do not hit County Armagh. People will be interested in the community response plan, because it is very local. The local knowledge is there, and people have enquired about it. I am not sure whether there is a particular group in and around that area, but —

Mr Gardiner: I think that it would help you if you could get that established and have groups in various counties all pulling together to get financial gain out of it all.

The Chairperson: The Public Health Agency might be able to give us more detail on that. It is a valid point, because, ultimately, it is about consolidating what is already there.

Mr Bailey: There is a realisation in the community sector. There is a mature conversation to be had. The community sector is aware that there are things that it is better placed to do, things that the statutory sector is better placed to do, and things that the voluntary sector is better placed to do. That conversation has to happen on an open, honest playing field. There is a fear in the community sector that it is not ready and that it is not aware of the potential opportunities coming down the line. If it is properly resourced, that fear could be alleviated while we maintain the excellent work being done across each of the sectors and bought into by local people.

The Chairperson: Sorry for cutting across you, Sam.

Mr Gardiner: It is quite alright. I want to encourage them.

Mr Beggs: You mentioned how individuals who are bereaved as a result of suicide can be motivated to try to address the issue locally. I have seen it in my constituency. One individual organised a meeting in Carrickfergus town hall and brought all the relevant organisations together to try to empower and better inform people. The statutory agencies could not do that. If they called a meeting, probably very few people would turn up. I value the community input in this area. What attempt has been made to enable the community sector to make a collective bid? I would have thought that that would be a very powerful bid if it could be structured in that way.

Ms Sherry: Conversations have been happening among groups across Belfast about forming collaborative relationships. That is the right thing to do, and we should encourage it. However, even if you got the 20 groups in Belfast together, they would not necessarily win the tender. If, for example, we made a mistake by omitting something from a tender specification, we would just be removed from the tender process. Although collaboration is important — we are working to get people to collaborate — it does not remove the difficulty that we could damage what we have built organically at community level.

When you go in for a tender, you have one lead partner. Therefore, regardless of whether you get 10 groups in a collaborative relationship, the resource will go to the main partner. So although they may deliver the service into a different locality, the resource does not necessarily follow it.

Even getting a small amount of money makes groups feel part of the jigsaw and that they are engaging in the process. Whether they got £5,000 or £10,000, they were brought into the process, with the sense that suicide is everybody's business and that everybody has a role to play. That is where the difficulty would come.

Mr McKinney: I have more of a comment than a question. It strikes me that there are two value processes — a procurement process that is designed to provide; and the process that these groups and others are engaged in — and that there appears to be a clunk between the two. Is there anything that the Committee can do to decrease the time pressure? Perhaps that is for the discussion with the Public Health Agency in the next session.

The Chairperson: We will reflect the groups' five recommendations directly to the Public Health Agency. Rest assured, we are about making sure that there is no dilution of the vital work that is being done. The Committee will look, within our remit, at how we can help to bring about those conversations to consolidate the work that is being done. If there are issues around tendering in the absence of a new strategy, they need to be looked at. We need to align the processes.

Mr Brady: My comment follows on from Roy's point. It would make sense for groups to come together. However, the nature of the voluntary sector and the community sector is that their

effectiveness is embedded in their own community and in having local knowledge and acceptance in their community. The bureaucracy around tendering and applying for funding makes it almost impossible for some of those organisations, because they waste so much time and energy. As one who worked in the voluntary sector for a long time, I know that you chase your tail all the time. You spend half your life looking for funding when you could be much better employed doing what you are supposed to do, and therein lies the difficulty. Small groups embedded in communities are extremely effective in the work that they do. They need to be commended, and you should be commended for the work that you do. It is important to say that.

The Chairperson: Folks, thank you for your time and detail. We will take your recommendations to the Public Health Agency and come back to you. We want to be part of finding a solution to support your work.