Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Suicide Prevention/Protect Life Strategy

30 May 2012

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

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Members present for all or part of the proceedings:
Ms Sue Ramsey (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Ms Paula Bradley
Mr Mickey Brady
Ms Pam Brown
Mr Gordon Dunne
Mr Samuel Gardiner
Ms Michelle Gildernew
Mr John McCallister
Mr Kieran McCarthy
Mr Conall McDevitt

Witnesses:

Mr Gerard Collins	Department of Health, Social Services and Public Safety
Dr Michael McBride	Department of Health, Social Services and Public Safety
Dr Eddie Rooney	Public Health Agency
Mr Colm Donaghy	Suicide Strategy Implementation Body

The Chairperson: Gentlemen, you are welcome to the Committee meeting today. Michael, I take it that you are taking the lead?

Dr Michael McBride (Department of Health, Social Services and Public Safety): I am indeed, yes. First, I thank the Committee for the invitation to come along and speak to you today. If you are in agreement, Chair, I will make a few comments by way of introduction.

The Chairperson: You sent us a useful briefing paper, and all Committee members have a copy, so thank you for that.

Dr McBride: I hope that you have all received copies of the briefing paper to inform this afternoon's discussion. I think that the invitation is very timely, given the refresh of the Protect Life strategy, which is about to be published, subject to final Executive approval, and given the evaluation of the existing strategy, which is almost complete. We anticipate that that will be published in September.

I would first like to take the opportunity to introduce the other witnesses whom I invited along today. Colm Donaghy is here in his capacity as chair of the suicide strategy implementation body (SSIB) and is well known to Committee members. Dr Eddie Rooney is chief executive of the Public Health Agency (PHA) and is also well known to members. Mr Gerard Collins is from the health improvement policy directorate in my group in the Department.

For today's proceedings, I felt it important that we emphasise that much has happened since the publication of the Protect Life strategy back in 2006. As you will see from the briefing paper, there has been progress across many areas as a result of the strong collaborative work across government, and particularly cross-sectorally, to address the challenge of suicide. Not least among those areas of progress has been the increase in funding to support the implementation of a strategy, which now stands at some £7 million per annum. Despite all efforts and, indeed, despite that work, it is also important to record formally that the suicide rate remains stubbornly high at 15 to 16 deaths per 100,000 of the population in Northern Ireland. I am very happy to discuss some of the rationales and reasons for that during questions.

It is fair to say that we now believe, although we can never be certain, that there was significant under-reporting of suicide prior to 2005. Reorganisation of the Coroners Service has led to a much more robust and accurate system for recording death by suicide, which is very likely to have contributed to the unprecedented increase in the number of deaths by suicide in 2005 and 2006. That had very significant implications for the achievability of the target of a 15% reduction that we set ourselves by 2011. The relatively high rate of suicide is very unwelcome, and every single death is an absolute tragedy. When we talk about the numbers, we need to bear in mind that behind those are individuals who have lost their lives and bereaved families left behind. There will be much talk about numbers today, so it is important that we do not lose sight of the very human consequences and costs associated with them.

It is vital that we have an accurate picture of the scale of the challenge that we face, rather than an under-reporting and, perhaps, under-representation of that challenge. It is fair to say that the bottom line is that we have some 300 deaths a year in Northern Ireland as a result of suicide. That is almost six times the number of deaths as a result of road traffic accidents in Northern Ireland every year. When put in that context, you can see that it is quite a staggering statistic — it is not acceptable. The human and economic costs are significant. Indeed, we sought to highlight those in the refresh of the Protect Life strategy. As I said, as a result of every death, there is a family bereaved and, indeed, surviving family members and friends of the deceased are themselves placed at risk of suicide. Tragically, as members will know only too well from their constituency work, there have been families in which, sadly, more than one individual has died as a result of suicide.

We also know — indeed, the statistics bear stark testimony to this — that suicide is not equal in its impact on society. Its impact is greater in certain areas and among certain groups: the rate is twice as high in deprived areas; males are three times more likely than females to die by suicide; and young males, particularly 15- to 34-year-olds in deprived areas, are a particularly high-risk group, as are other marginalised groups, such as the unemployed, people with mental illness and people with addiction problems. Often, those risk factors overlap. However, each individual suicide occurs in a unique set of personal circumstances — that is an important observation.

Since the Protect Life strategy's launch, the focus has been to put in place evidence-based practice — based on what works — to make effective use of the resource that we have and to begin to address the challenge that we face in the prevention of suicide and self-harm. We know that a significant risk factor is associated with self-harming individuals going on to complete suicide.

In our briefing paper, we outline some of the progress to date. The Lifeline crisis response service has been established. The deliberate self-harm registry is in operation in all A&E departments. In introducing that, we benefited from a close working relationship with colleagues in the Republic of Ireland. Statutory crisis intervention services have been enhanced, and there is now a wide range of community-led suicide prevention and bereavement support services in place, about which Eddie and Colm can provide further details.

There has also been progress in important areas of local research on suicide. It is not just about basing what we do on evidence from international research; we must also base what we do on our learning and research of what works in a Northern Ireland context. Research that examined the effects of the Troubles showed strong resultant linkages to increased mental health problems. The Public Health Agency commissioned research into the experiences of suicidal young men. We have also had a longitudinal study, the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Progress has been made in suicide awareness and in prevention training for healthcare professionals and a range of community gatekeepers, such as youth workers, trade union representatives, community workers, sports coaches and taxi drivers. Indeed, I was particularly encouraged to hear the recent announcement by the Lord Mayor of Belfast that suicide awareness training is to be delivered to all city council staff.

There has also been joint working, one example of which is that between the Department of Health, Social Services and Public Safety (DHSSPS) and the Department of Education (DE). They are collaborating on developing a pupil's emotional health and well-being programme, which includes guidance on implementing Protect Life in schools, the development of suicide cluster response plans for local areas and an all-island public information campaign, which has gone through several iterations and phases of development.

The refresh of Protect Life has drawn on learning from a wide range of sources. They include an extensive review of evidence of best practice worldwide; an evaluation of the various components of the strategy since 2006; experience from the implementation of the strategy; feedback from a formal process of engagement with community groups and the findings of local research, including the Health Committee's 2008 inquiry into suicide and self-harm; and statistical analysis of the suicide trends and patterns in Northern Ireland. I am happy to expand on the process and on the subgroup in SSIB that took forward that refresh of Protect Life.

That learning has identified a number of recurring themes. They include the need for training for front line service providers and community gatekeepers; an enhanced focus on deliberate self-harm, given that such individuals are in the region of 50 to 100 times more likely to take their life; restricting access to lethal means of suicide; further work to reduce the stigma associated with mental ill-health; better integration of service delivery, on which, despite making progress, there remains more to do; and the use of social networking and IT to reach younger people. The need to develop specific rural initiatives was also identified as an important area, as was having a greater focus on males, particularly those from deprived areas.

The long-term goal of reducing suicide rates in Northern Ireland remains. However, the refreshed strategy also sets a new aim of reducing the differential in the suicide rate between deprived and non-deprived areas. We believe that that is where the potential is greatest to make an impact on saving both lives and life years. The new aim is supported by a number of new objectives outlined in paragraph 18 of the paper, which will give a better assessment of the impact of the strategy. If you remember, in this very room, the 2008 Audit Office report questioned using suicide figures as the sole means of assessing the impact of the Protect Life strategy. The new objectives are mostly output-focused, because the refresh will have a span of less than two years, as we are in the process of developing the new strategy. Among the new objectives included are the increased awareness of suicide and mental health issues; increased uptake of suicide prevention and mental health training; and enhanced outreach services, particularly for males in deprived areas at risk of suicide.

The paper also outlines a number of new actions on which the Department of Culture, Art and Leisure (DCAL) and the Department of Agriculture and Rural Development (DARD) will lead. There are actions for mental health services, such as the provision of support in A&E departments and a more assertive outreach to patients who miss appointments. That was a matter highlighted in the report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. The implementation arrangements outlined in the paper remain unchanged. The PHA will continue to have the lead role in implementing the Protect Life strategy. It will be supported in doing so by the Health and Social Care Board (HSCB), trusts, and community and voluntary sector organisations. The suicide strategy implementation body will continue to advise on implementation and will challenge the Department on its policy direction if necessary. The five local implementation groups will remain, and the Family Voices forum will continue to represent the interests of bereaved families.

Our firm intention, as outlined in the briefing paper, is that the ministerial co-ordination group on suicide prevention will meet regularly to provide better and more consistent interdepartmental direction. Since the group last met, back in January 2011, our Minister has had bilateral meetings on suicide with his Executive colleagues in all the key Departments. There has been ongoing and extensive involvement at official level between Departments, particularly on the development of the refresh of the Protect Life strategy. In September, a workshop organised by the Public Health Agency was very well attended. All the key Departments and both the statutory and voluntary and community sectors were represented.

The independent evaluation of the Protect Life strategy was commissioned in 2011 and is nearing completion. Its outcome, together with the review of learning as part of the refresh, will help to form the new strategy that 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. They are that community engagement in the delivery of strategy has been very strong. Work under the Protect Life strategy has reduced the stigma surrounding suicide and raised awareness. There is, however, a need for greater

clarity on roles and responsibilities. Evidence of the impact of Lifeline is needed. There is a need to balance innovation and evidence. The evaluation also identified that there are too many actions. If you remember, the Protect Life strategy had 62 actions, and those need to be reclassified and streamlined. Despite our efforts, it is fair to say that the initial findings of the evaluation suggest that there remains a perception that suicide is a health issue. Therefore, suicide prevention needs to be contained within a wider range of departmental strategies. If we continue to regard suicide as a health issue, we will not address the underlying complex social issues that create the environment in which, tragically, people take their own life. We must continue to work to address that.

There is much scope for further work on the new strategy. As I highlighted in my annual report last year, suicide prevention will continue to be a major challenge, particularly against a backdrop of increasing economic hardship; the high levels of deprivation in Northern Ireland; relatively high levels of mental health and ill health, which are estimated to be 25% greater than the rest of the United Kingdom; and communities coming out of conflict. That is the backdrop and the context in which we will seek to address the public health challenge of suicide.

The Executive have recognised the need for greater cross-departmental working, which will be a priority following the publication of the refreshed Protect Life strategy. Given that 70% of people who die by suicide are not known to mental health services, we need to reach and identify those at greatest risk.

I want to acknowledge that local communities and bereaved families have been to the fore in the development and implementation of the Protect Life strategy, as well as the refresh of the strategy. Colm, in his capacity as the chair of SSIB, and Eddie will vouch for that. They are the experts of experience who have informed the development of the strategy since 2006. Both the implementation of the strategy and gaining of that experience have been hard-earned. Maintaining that commitment will be key. It was key to the progress to date, it will be key to harnessing that energy, and it will be a key priority for the future.

The Chairperson: Michael, thanks very much for that useful presentation. I welcome the opportunity to have this briefing. I am aware that a lot of good work is being done at community and voluntary level in some areas, but I am highly disappointed by the Department's response to the whole issue of suicide and self-harm. You said that the ministerial group has not met since January of last year. That does not send out a clear, positive message that suicide prevention is an issue that the Department has taken on board. You made the point that the Executive have a commitment to greater departmental working, but that is not demonstrated by the lack of meetings. I know that a lot of work is being done at a local level, but if there is no leadership at ministerial and senior departmental official level, that creates a problem. Not meeting and not showing focus does not send a clear message to me and others that this is a serious issue for the Department. I take on board that suicide is not just a health issue, but health must take the lead.

Putting that to one side because I am keen to move on, I have a couple of questions on your briefing. This morning, I met about 10 people to discuss suicide and self-harm, and I wrote to Colm about that. So I have information that is as up to date as possible.

Your briefing paper refers to programmes. There are still problems with the Card Before You Leave scheme, such as people presenting at A&E and being told to for wait six or eight hours. Some are leaving without taking part in the scheme. That great scheme has a positive impact where it works, but it is not happening across the board, and there does not seem to be a uniform approach to it. I think that that is partly because staff are not retrained. Staff are the first line of contact for people attending A&E, so we need to ensure that they are constantly trained in what is available.

I have a few questions, so I will throw them all at you. First, your briefing paper states:

> *"An element of ... funding (£620k) is specifically targeted at areas which experience disproportionately higher rates of suicide."*

I would appreciate a breakdown of how that money is targeted, because I represent one of the constituencies that suffers one of the highest levels of suicide. Other members of the Committee also represent constituencies that suffer high levels of suicide, so that would be useful.

I have worked with some local groups, and it would be useful for Committee members to have a breakdown of who they are because, unfortunately, we are sometimes the first point of contact for families and so need that information as much as anybody else.

Will you give us a breakdown of where the recommendations of the Health Committee's inquiry are sitting and how many have been implemented?

Over the past two or three years, new groups have formed and come up with great ideas. There is a concern that, because the refreshed strategy will be just that — a refresh — those new and other groups will not be able to apply for Protect Life funding.

Finally, when do you hope to launch the refreshed strategy? That will do me for now.

Dr McBride: I think that I have all the questions, Chair. If not, please remind me. The refresh was considered at the most recent Executive meeting and will be reconsidered following ministerial comments at their meeting tomorrow.

The Chairperson: Sorry, what was the first part of what you said?

Dr McBride: The refresh was considered at the previous Executive meeting, and we have received comments from Ministers. It will be retabled at the Executive tomorrow, and, subject to their consideration, our expectation is that it may possibly be approved tomorrow. If so, we will take forward the refreshed strategy at that stage.

Mr Gerard Collins (Department of Health, Social Services and Public Safety): All the comments that went beyond a simple "no comment" were positive and very supportive of the refresh. Indeed, Ministers underlined the fact that other Departments want to be involved in the delivery of Protect Life. We are producing the version 2 paper and hope to get that on to the Executive agenda for tomorrow.

Dr McBride: There is a link between the Card Before You Leave scheme and training, and quite appropriately so. That scheme came from a suggestion and idea that was part of the work of SSIB, which Colm chairs. Indeed, it originated from community and voluntary sector engagement, was taken forward and then launched back in January 2010. That was a relatively short time ago, and it is now fully operational. We are aware of some concerns raised in recent times, particularly about the variability of the scheme's implementation, and the Health and Social Care Board is conducting a review of its efficacy. That review is due to be completed before the end of June 2012, and we will be very happy to advise you in due course of its outcome and any recommendations that arise from it. I will not go into the detail of the scheme, as members will be familiar with how important it is for people who present at A&E departments because of deliberate self-harm or emotional distress. It signposts organisations, provides contact numbers and, indeed, can facilitate a fixed appointment to attend for further assessment as needed.

The Public Health Agency has carried out a review of training programmes, whether on Mental Health First Aid, the Applied Suicide Intervention Skills Training (ASIST) programme or GP awareness training across Northern Ireland. The agency has also worked very closely with the Northern Ireland Medical and Dental Training Agency to enhance the programme for general practitioners in particular. Indeed, it is aligning an action plan as a result of that review, with the aim of further improving awareness of suicide prevention, enhancing training and increasing the ability of healthcare professionals, particularly those on the front line, to signpost individuals in distress and in need to appropriate services. The Health and Social Care Board is also considering novel approaches, such as considering whether front line A&E nurses in particular could be trained and accredited in mental health nursing. That has the potential to enhance the situation. Do you want to add anything on training, Eddie?

Dr Eddie Rooney (Public Health Agency): The training issue emerges from every report, and it is not the surface training. When schemes are introduced, it is important for us to ensure that not only the staff implementing them are trained but that we really get to the heart of the issues. As Michael said, that means looking not only at GPs and other professional bodies but at some of the ASIST training throughout organisations. Both this year and last, we have been involved in the award of certificates to members of the trade union movement. That means that, in workplaces, there are people who are not only aware of mental health issues but feel confident enough, and are equipped, to intervene when those issues arise in front of them. We should not take those people for granted. They are a crucial element of health service delivery, so the training must also be provided at that level. It is a real cultural change for all of us, but training must be multifaceted. We need to provide training across sectors, and that is certainly an area that we will continue to develop.

Mr Collins: One of the new objectives in the refresh of the strategy is to increase the uptake of mental health awareness and suicide prevention training. That will be a major focus over the next two years.

The Chairperson: If the refresh is cleared by the Executive tomorrow, will we get a copy?

Dr McBride: Absolutely. If it is approved tomorrow, we will immediately forward a copy to Committee members for consideration.

Colm, as well as being the chair of SSIB, has, wearing his other hat as chief executive of the Belfast Trust, experience of the Card Before You Leave scheme from a provider perspective,

Mr Colm Donaghy (Suicide Strategy Implementation Body): That is true. Thanks, Michael. As members probably know, the Card Before You Leave scheme came from our local community. The feeling was that people who were very vulnerable and had suicidal ideation turned up at emergency departments but left before they were seen or had a proper appointment arranged for them. The scheme was designed to ensure that, if people did not wait in emergency departments, an appointment would at least be made for them, and they would have that to come back for that. The evidence is that people are most vulnerable in that period of suicidal ideation. Having an appointment and something to look forward to may alleviate some of their pressure and stress. That was the intention of the scheme.

As you probably know, in Belfast, we reviewed and revised the scheme about a year ago, because its implementation differed slightly across some of the provider organisations. In Belfast, we were taking people's telephone numbers so that we could get an appointment to them. As it turned out, not unsurprisingly, some of the numbers given were not the right ones, because people did not want to give their telephone numbers in that situation. We moved to ensuring that, as much as possible, an appointment would be identified before people left.

We have also introduced a 24/7 crisis response in Belfast that is led by psychiatric consultants. Chair, I know that you communicated with me about a particular issue. However, the survey that we carried out last year found that something like 93% of people received our crisis response in emergency departments within four hours, leaving 7% who were not. About 96% were responded to within six hours, but we are reviewing that to see whether we can provide 100% cover. That will not always be possible, but crisis response, allied with the Card Before You Leave scheme, is about trying to ensure that we cover the gap when people with suicidal ideation attend emergency departments.

Dr McBride: Linked to that is the consideration, included in the refresh of Protect Life, that has been given to places of safety. Another issue that arose from engagement with the community was that A&Es are busy places and not the best places for patients who are very distressed, in circumstances such as Colm described, to be assessed. There is always a lot of activity in A&E, and it is a busy environment. That is conducive neither to the sort of assessment required nor to calming, or perhaps de-escalating, an individual who is very distressed. So there has been ongoing engagement, and the Belfast Trust is very actively involved in leading work and engaging with the Health and Social Care Board as to how we might develop models around places of safety working with a range of other voluntary and community sector organisations.

That combination of the crisis response, similar arrangements that have been put in place in other trusts, the review of the effectiveness of the "card before you leave" scheme and the publication of the report on that review in June, and further work on places of safety will, hopefully, begin to address some of those issues. It is a challenging issue, but we are actively engaged on it.

I will ask Gerard to give the high-level breakdown of funding. Colm, you are content to explain how the £620,000 is used to address the areas of greater need?

Mr Collins: The £620,000 was an initiative from the previous Health Minister. It was designed to address pockets of deprivation because of the known association between suicide and deprivation. It is not a huge sum. In recognition that every parliamentary constituency has some pockets of deprivation, it was agreed that there would be a minimum of £10,000 for each parliamentary constituency, and on the basis of that and using a formula based on levels of deprivation, other parliamentary constituencies then receive greater amounts. Not surprisingly, with the north and west Belfast constituencies being the most deprived, that is where the largest element of that funding will go. We do not have a breakdown to hand, but we have a table that we can provide.

The Chairperson: You can send us that breakdown.

Mr Collins: We must not lose sight of the fact that there is another £1·6 million in Protect Life for community-led services and initiatives, plus about £1 million from the Lifeline budget that is subcontracted out, mostly to community groups, to provide counselling support for Lifeline clients who are referred from the service into those community groups. All in all, about £3·3 million of the total package of suicide prevention funding is channelled out towards community groups.

Mr Donaghy: I will give further background on that. It is non-recurring money: in other words, it does not go to the same place every year. It is flexible in the context of the areas of deprivation but also in relation to the rates of suicide that might be there from year to year. The £620,000 was a recognition that there is a differential across our population and geographies in relation to deprivation and its consequential impact on suicide, and that was the reason and the genesis for that funding.

Dr Rooney: Chair, you raised the issue about community groups generally, and we encourage them to come forward. It is not an easy area to bring forward, particularly innovatively, and often the local response requires something new. However, an issue that came from the workshop last year with the community groups was the need to make sure that we maintain high standards, and that is territory where the skill set needed is so important, because the cost of getting it wrong is so important. However, the issues have been raised with me. Next week, I am meeting a number of community groups, including ones that have specifically raised the issue of the difficulty of accessing funding, and it will be an open discussion to hear about that.

The Chairperson: I asked you some questions about the breakdown of the group and the Health Committee recommendations. Maybe you could answer those in writing, because I am keen to allow other members in.

Dr McBride: We can get those to you.

The Chairperson: We are hearing from Antrim A&E after this, so we have to keep to time.

Dr McBride: I appreciate your time constraints.

Mr McCarthy: Thank you for your presentation. I acknowledge the work that has been done on this very tragic subject. It affects us in all our constituencies. I wish you every success in your work ahead. I also pay tribute to the community groups that are engaged in the work. There is a lot of work to be done, but everybody seems to be getting on with it. However, there are still some questions, and I have a few here. Can you confirm your plans for the implementation of the psychological therapy strategy? Do you agree that there is a need for funding for high-intensity workers and professionals with specialist training who could have a real impact in helping people who self-harm repeatedly, and also the more severely ill, as well as the early preventative counselling services?

We talked at length about A&E. Can you assure us that you will fully implement the National Institute for Health and Clinical Excellence (NICE) guidelines on the management of self-harm in A&E departments?

The Royal College of Psychiatrists cite the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness 2011, which found:

> *"of those with a history of mental illness who took their own life in Northern Ireland under the age of 25, 70% had had a history of alcohol misuse."*

Is there anything that you can do to get on top of that?

Finally, what plans do you have to engage support services to reach out to all marginalised, disadvantaged groups — you mentioned that earlier — including the LGBT populations, and to initiate a targeted information campaign that seeks to sensitively raise awareness of the increased risk of suicide among these groups in line with the actions already listed in the suicide strategy?

Dr McBride: I think I got most of those down, but please prompt me.

The first question you asked was about psychological therapies. As you know, we launched the psychological therapies implementation plan, which looks specifically at the provision of psychological therapies as a core component of mental health and learning disability services. Work is ongoing to profile the existing services as they are, to produce an integrated care pathway specifically tailored to the needs of individuals, and to produce regional guides for psychological therapies. Indeed, as was mentioned earlier, there is a recognition of the importance of accredited services and the need for those standards to be consistently applied.

As you may be aware, a computerised cognitive behavioural therapy programme called Beating the Blues, which is recommended by NICE, has been rolled out in Northern Ireland. It is for use in primary care, particularly for the treatment of mild and moderate depression. It has been available to GP practices in Northern Ireland since December 2010, and it is fair to say that the initial uptake has been slower than we expected. There are understandable reasons for that, to do with training and support for GPs in the use of the programme, and those are being addressed. We have also recently extended that programme to include use in prisons, occupational health departments and regional voluntary and community sector organisations. We recognise the key role of those groups, as you mentioned.

You asked about gender identity issues. The refresh clearly recognised the evidence base which showed that certain groups in our community have specific mental health challenges and, indeed, are at an increased risk of suicide. The group that you mentioned is one such group. There is a variety of approaches; it is not just through specific actions in our refreshed Protect Life strategy, but through our sexual health strategy, which the Public Health Agency has been leading on. One of the key core components of that is how we address the stigma associated with individuals in the gay or bisexual community in Northern Ireland, recognising that there is still in Northern Ireland, unfortunately, a significant degree of prejudice, which creates a range of significant stresses, particularly for young people.

Dr Rooney: We have taken a very proactive approach, particularly with the LGBT community. Through the Rainbow Project, we funded 'All Partied Out', which is recently published research into various aspects of the health and well-being of that community. One of the major issues to come out of that report was indeed mental health, but we are also following that up with that community and, indeed, within our own organisation, to tackle these issues.

Dr McBride: You mentioned the influence of alcohol. We know very clearly that there are strong links with alcohol misuse and patterns of alcohol misuse by young people, particularly binge drinking. We know the evidence that a third of young people who are suicidal or take their own life as a result of suicide are intoxicated at the time. We know the effect that alcohol has on lowering inhibitions and on the normal social mores and controls that are usually in place in respect of behaviour. So, the impulsiveness of many of the decisions taken at the time is associated with excess alcohol consumption.

You will be familiar with the fact that the Minister launched the new strategic direction on drugs and alcohol in, I believe, January and that we have been engaging with other Departments, particularly colleagues in the Department for Social Development (DSD), the Department of Education and indeed, the Department of Justice. We have been developing guidelines for parents on addressing young people's drinking behaviour and working with the criminal justice system to ensure that we enforce the regulations around the sale of alcohol, including tests of sales. We have also been working with DSD on the consultation on minimum unit pricing. We are currently doing research on an impact assessment of the introduction of minimum unit pricing.

The Minister has provided strong leadership in addressing the problem of alcohol consumption in Northern Ireland society and is committed to doing that. He has engaged very extensively with ministerial colleagues on the issue. Indeed, that has been the focus of all his bilateral conversations.

Sorry, Kieran; you mentioned a number of other things, but I did not get them all down.

Mr McCarthy: The other one was on A&E and how to make it less distressing for people. You spoke about that.

Dr McBride: There are NICE guidelines, which we endorsed in 2007. There are two sets of guidelines.

Mr Collins: NICE guidance on the long-term management of self-harm was published last year. Earlier NICE guidance on the short-term management of self-harm was published in 2004. The Department is considering both sets. The process is that the Department has to endorse NICE guidance for implementation in Northern Ireland. Once that has been done, the NICE guidance will be put out. There is an expectation that the health and social care system will then implement that guidance. A lot of the recommendations in the NICE guidance on the short-term management of self-harm actually chime with the new refresh; for example, looking at safe areas in A&E is one of the recommendations. As I say, that is very much in keeping with our new direction. A focus on self-harm is extremely important, because it is one of the main risk factors for suicide. So, we are going to focus on that quite heavily. We expect to see the NICE guidance implemented.

Mr McCarthy: Finally, we pay tribute to the work with community groups. You mentioned — I heard this term today for only the second time — community gatekeepers. Who or what are they? That is a new term to me.

Mr Donaghy: Any number of community, voluntary and statutory sector people are community gatekeepers. For example, teachers are community gatekeepers because they have access to children and have an influence on them. Taxi drivers are community gatekeepers because they talk to people on a regular basis. So, a wide range of people are identified as community gatekeepers because of their contact with and influence on their local community.

Dr McBride: It is an important concept, but probably an unhelpful use of jargon in the context of our presentation to the Health Committee. I apologise for not explaining that earlier.

Mr McCarthy: OK. That is fine.

The Chairperson: OK. Another six members want in. I am conscious that the Antrim people are due to come in around 4.00 pm. So, it would be helpful if just one —

Dr McBride: Short answers.

The Chairperson: I will leave it to Eddie. Eddie, you should answer them all.

Dr McBride: Fine.

Dr Rooney: Am I meant to say "thank you"?

Ms Gildernew: Thanks a million for the presentation. I have a couple or three points; I will be very quick.

Mr McCallister: Did you not hear the Chair?

Ms Gildernew: I did, but I have a particular concern about rural provision. I welcome the fact that the rural issue has been acknowledged in the report. I think that that is very helpful. At the minute, there is not the same access to counselling services in rural areas as there is in urban areas. For a lot of people in rural areas, their only access is through school. The school counselling scheme is excellent, but once a young person leaves school, there is no counselling facility. I think that that has to be addressed. That is a point more than a question.

On the issue of high-risk areas for self-harm, I recently came across a case in my constituency involving a young male, whose mother had died, and his relationship with his father had broken down. He went to his GP to seek help and was told that his parent had to be there to refer him. He was underage, he was only 14 at the time, and he was told that his parent had to be there to refer him. I find it very unsatisfactory that the health service was so dispassionate in its engagement with him. He is from a high-risk group. I would like that looked into, because seeking help is a big step for those people. If the help is not then available to them, it can be very damaging to their mental health.

The 75% not known to mental health services is scary, but on the back of yesterday's excellent presentation in the Long Gallery, for which Eddie brought Dr Suzanne Zeedyk over, the fact is that we

can make interventions now that will have an impact on young people 15 years down the line. However, we need to do things now for the 15-year-olds who are at risk at present.

So, we encourage as much early intervention as possible and making investments that have an impact 10, 15, 20 years down the line. We do not get that message across near enough. Karen said yesterday that you are taking an action and making a decision that will not have an impact during your term in office, but that has to be done in terms of leadership and a legacy. So, the early intervention is not focused. The 75% of people who are not known to mental health services probably could have been indicated 10 or 15 years ago if early intervention services had been available. Thanks a million.

Dr McBride: In the style that was suggested, I was going to ask that Eddie addresses the question about rurality. If you allow Gerard to talk for one minute about the wider policy issues on the early years intervention before Colm talks about the specifics.

Mr Collins: There are two major strategies being developed by the Department that have a significant focus on early years. One is the new public health strategic framework that is taking the life-course approach. Pregnancy to age four is one of the stages. The other is the mental health and well-being promotion strategy, which, again, looks at infant mental health and covers pregnancy to age four. So, the upstream interventions come through those two strategies. We agree that early intervention is vital.

On the issue of 15-year-olds and the people who are not in touch with mental health services, we need to find those people who tick all the risk factors for being at high risk of suicide and find where they engage with statutory services and where they engage with community services so that we can then deliver services to build their emotional resilience to prevent them moving into the group of people who are actively suicidal.

Dr Rooney: Michelle, you have hit on the issue that we struggle most with. We are trying to deal with a range of services, some of which are focusing on what is going to happen in the next 30 minutes, and trying to deal with the person sitting in front of you who, for many of our service providers, walked in the door at night. Something needs to happen in that 30 minutes, and it could be the difference between saving a life and not. At the other end of it, we are dealing with something that we can predict a lot of the factors on, and we are having to go to when people are born or before they are born and start setting the foundations. We are trying to do all of those things.

We are also trying to do it geographically. It is true that Belfast has the highest rates of suicide, but not that far behind are Moyle; Strabane; Newry and Mourne, which is Mickey's area; Fermanagh, which is your own area; Armagh; and Craigavon. This is not an urban feature here. One of our challenges is to make sure that the full range of services that can deal with that, and I know you are not saying that it is just counselling, is available everywhere on the basis that that is where the need is.

I am not going to present that it is easy or we are nearly there, but we are trying to get some integration that we have not had before. As Gerard said, there are issues on the strategic front but we are also looking at one-stop shops, which have been piloted and we are now trying to roll up. We try to look at any potential vehicles that we can use that can reach out remotely into those geographical areas and make a difference in there. But to do that, this has got to be one of our cross-cutting themes, regardless of what areas we are looking at. That is really where it is going to. We are trying to move along on every front and make sure that mental health is really up there.

Mr Donaghy: I welcome the recognition of the preventative aspect of the strategy. The strategy was quite deliberately called Protect Life for that reason. It is a societal issue. What will have the biggest impact on suicide in our society are those issues around employment, education and the much wider strategic, interdepartmental issues. I welcome, Chair, your statement that it is not just a health issue, because it is not. The wider governmental and societal response is incredibly important. In the Protect Life strategy, therefore, we highlighted the protective factors within our society that take much longer to bear fruit than some of those issues that, as Eddie and Gerard pointed out, we need to deal with on an ongoing daily basis.

Mr McDevitt: I want to ask you about data. How far have we come on here? For example, can you tell me how many people died as a result of suicide last month in the region?

Dr McBride: Not absolute accurate figures, no.

Ms Gildernew: Sure the coroner has to rule. It is not that easy.

Mr McDevitt: I understand all that.

Mr Collins: What we can tell you is that that data is always provisional until the general registrar report for the previous year is published, which is usually around April/May of the following year. We can tell you the years in which deaths were registered and the years in which deaths occurred.

Mr McDevitt: I understand the constraints, which is why I asked the question. What progress can be made to be able to capture data much closer to real time, because trending is a significant issue here?

Dr McBride: It is. I will ask Eddie and Colm to comment on that. That was the right question, because a key issue that we identified in the new actions is how we get local intelligence, particularly in relation to clusters, so that we can immediately put in place the range of support services that are required where we are, for instance, seeing clusters emerging. That is where we are piloting the SD1 reports in terms of working proactively with the PSNI, for instance, when they are called to a scene where they suspect that there may have been a death as a result of suicide. Trusts will have their own data in relation to suicides. So, we are working closely with local communities, using the SD1 process to ensure that we get on-the-ground, real-time information — at least, provisional information — that will guide the immediate responses. At the end of year, we will get the General Register Office official recorded figures and then the actual figures that occur in-year.

Mr McDevitt: How far are we off being able to have the suspected or provisional data?

Dr Rooney: It is literally a current situation. We have community response plans in place in each of our areas. That is working within 24 hours to get the intelligence in their response and to try to make sure. Sadly, we have seen examples very close to areas represented by you where the need to have a response in place rapidly in order to prevent further suicides in that area is absolutely essential. That is where we are gearing that local intelligence. It is a different issue, Conall, in terms of getting the official statistics aligned. To be honest, we will always be several months, if not years, ahead of the official statistics because we are going to have to be on this. For us, the real issue is making sure that the response that we have is operating on good information. That information is varied, because often the clearest information comes from local communities and those who are closest to local communities and not through the services, although we have a very important role to play, which is all the more reason why we have to strengthen those links. We have to learn. It is a learning process for us. I am not convinced that we have got it right yet.

Mr McDevitt: A huge amount of work has been done to broaden the response to the issue, and so you have many more people involved at all sorts of different levels, particularly at the coalface at community level. I have a question that must be asked, and it is no reflection of the excellent work that goes on at the coalface. How do you ensure that the more people that operate on the front line in volunteer capacity, a semi-professional capacity and a professional capacity are doing so to a standard that everyone can stand over and which gives confidence should something ever go wrong at their end?

Dr Rooney: We are trying to do that by relying on accredited training, and that includes the training of the trainers. We are trying to ensure that we get the highest possible standards — this is where we are dealing very much with international reference points — not simply in terms of the training of the service, but also in the likes of ASIST and Mental Health First Aid, where we are trying to cascade that through into people who are likely to be in situations where they have contact, in the same way as we would like to see the skills of community first aid, in a wider sense, being distributed. The standards issue has been raised by the people who are on the front line as well. They are very keen that we maintain those high standards.

Dr McBride: The Minister has indicated that he is keen to consider how we might further enhance our ability to ensure that accredited services are funded to take forward that work. We will give that due consideration, and the approach with the PHA is taking forward accredited training on evidence-based training models. You will not be surprised to hear that your first question, subject to Executive approval, is the first new action in the action plan that the Executive will be considering.

Mr Wells: Eddie, I attended an event that you ran yesterday. I suggest that all 108 MLAs should be locked in a room and exposed to what I, Michelle and a few others — I think Pam was there — heard. Sometimes, you come out of those meetings not clear about what happened, and sometimes it just hits you between the eyes. Certainly, that was the experience that I had yesterday. The sad message that came out of the meeting was that if you do not have early intervention before the age of three, the die is cast. The most worrying graph that I have ever seen in the Building was shown yesterday by the lady from Dundee University, whose name I cannot pronounce. Maybe you can help me?

Dr Rooney: Suzanne Zeedyk.

Mr Wells: Her graph showed that the improvement as a result of interventions almost stops dead at three, and for the next 18 years you are putting an awful lot of effort in for very little return. As far as suicide awareness is concerned, I often think that it is like trying to catch people falling off a waterfall by standing at the edge of Niagara, rather than being five miles up the river trying to stop them getting off the bank at all. The present criticism of the system is a one point of entry when we really need to get into schools, almost preschool, to try to teach children to come to terms with things that could lead to suicidal tendencies. Do we not need to look at an absolutely fundamental review, based on the evidence that we saw yesterday?

Dr Rooney: Yes, and I believe that fundamental review is what the prevention agenda essentially is about. It is about a shift — based on evidence, as we heard yesterday — to try to have a greater impact for the investment that we are putting in. To reassure you with what we are trying to do — as I say, we have a long way to go on this — looking at the areas where we are putting our efforts in, crisis response is a very important part of it and early recognition of signs and symptoms, building capacity and resilience, which includes early childhood, and all of the effort that we are putting into the very early childhood interventions have got that agenda in mind down the line. The youth and family support empathy in schools is another area that we are dealing with and, indeed, the whole approaches around building stronger communities, and communities that are feeling pride in their community as well, are all providing us with those building blocks, some of which are starting right at the start, because that is where we need to get in. There is always a tension: while fixing the issues and, hopefully, getting them on to a better platform, we still have to deal with the issues that we face today. We are trying to do both. However, I agree entirely that, if we are to have effectiveness in those areas, the more that we invest in effective methods earlier on, the greater the impact on, and benefit to, society will be.

Mr Wells: Yesterday, I heard a stat that it is seven times more expensive to produce the same results once you get past those crucial early years. I have been thinking constantly about what I heard yesterday, and I do not leave the Long Gallery saying that too many times. At present, much of the delivery is by community-based organisations and groups based around a family or community that has suffered a tragic event. I understand that an organisation called, if this is the right name, the Irish institute of suicidology, which accredits and monitors groups that deliver suicide awareness. Are there any plans to create a commonality of delivery through accreditation? I understand that the groups are not averse to that. Are there any proposals to roll that out as part of the strategy?

Dr McBride: The Minister has indicated his enthusiasm for such an approach.

Mr Donaghy: The Irish Association of Suicidology is well known to us in Northern Ireland. In fact, it held its annual conference here two years ago, and I spoke at that. It also produced, with the Samaritans, media guidelines that are widely recognised as a standard that media organisations should try to live up to in the reporting of suicide. The work that you mentioned, Jim, is another strand of work that we will take forward with the Irish Association of Suicidology. People in Northern Ireland sit on the board of that body, so there is a very close link between it and what is happening here.

Mr Collins: There is a mechanism for taking that forward through the all-island action plan on suicide prevention, which is reported to the North/South Ministerial Council at least once a year.

Mr Wells: Will that lead to a situation in which every group is accredited by the association?

Mr Donaghy: I am not aware that that is happening.

Dr McBride: That is an issue for further consideration, and there a number of approaches. We need to ensure that the services provided are evidence-based and delivered by well-trained individuals.

Earlier, Eddie mentioned the importance of ensuring that training is accredited and that the Public Health Agency evaluates training across the range of training provided in Northern Ireland. A further step, and one that the Minister is interested in our exploring, is the delivery of such training by accredited recognised bodies. The suggestion that you made is one such consideration.

Mr Wells: Finally, I go back to Conall's point about the statistics. A series of events in south Down were put down as road accidents. However, it was clear to the average person looking at the circumstances — perfect road, no alcohol or drug involvement — that it was more than just a road accident. How much validity do you give to the statistics? I suspect that quite a few suicides are not being recorded as such, and, therefore, the problem is worse than we perceive it to be.

Mr Collins: It probably is. I came across research that reckons that 15% of accidents involving single drivers could be suicide. When the coroner investigates a death, he has to make a decision based on the probability of evidence, and, if there is not a 51% probability, in the coroner's view, that the death was a suicide or by self-inflicted injury, it is unlikely that the death will be recorded as such.

Dr McBride: It is an important point, Jim. We are confident that, because of the changes in the coronial system here in 2004, the processes for reporting deaths from suicide in Northern Ireland are more robust than they were. They are probably more robust than in other parts of the United Kingdom. In Northern Ireland, the coroner has the discretion to request an inquest, in which case the verdict must be "beyond reasonable doubt" and the only verdict is one of suicide. In England and Wales, the coroner does not have to require an inquest and, in that case, the civil standard of proof, which is the "balance of probabilities", applies, as Gerard indicated. As a result, a number of deaths that would not be recorded as suicides in other jurisdictions, such as England and Wales, are recorded in Northern Ireland. Despite that, Jim, your point is a valid one. We probably do not capture all deaths of undetermined intent. However, in Northern Ireland, such deaths are, if classified by the coroner as being of undetermined intent, currently recorded in our suicide figures. I am sure that there is still a percentage that we do not pick up.

I return to the point made on early intervention. Subject to ministerial and Executive approval, we hope to come to the Committee during the consultation on the new public health framework, at some point after July, to explain how we have incorporated into that framework, as Gerard was saying, interventions from early years right across the life course. That is vital work. The research that you mentioned, which was presented in the Long Gallery, is very compelling, so that must be the direction in which we take forward the new public health strategy. It will then be over to the Public Health Agency to implement. We look forward to the Committee's support in engaging with other Committees, because it is vital that the new public health framework is also considered by Committees across government.

Mr McCallister: I strongly support early interventions. Across the board, in health, education and criminal justice, their effectiveness is well documented. We have talked enough about that here. We need delivery.

Sue and I sat on the previous Committee, which carried out the inquiry. During that inquiry, one of the lessons that we learned from our visit to Scotland was that whatever is done requires robust evaluation, and there must be no sacred cows. Whatever works should be delivered. Are you up for that? Whatever the independent evaluation comes back with — it may be critical of some aspects of the strategy — we should do whatever is proven to have the best effects.

Dr McBride: Let me make a few introductory comments, and then I will call on Colm to comment. Individual components of the current Protect Life strategy have been evaluated as we have gone on: the public information campaigns, GP depression awareness training and Applied Suicide Intervention Skills Training (ASIST), as Eddie said.

You spoke of sacred cows. The rigorous independent evaluation of the current strategy will be published in September 2012. There are no sacred cows: suicide is too important an issue; it is the major public health challenge. We face an uncertain economic climate, and, as I stated in my annual report last year, on the basis of the research, every 1% increase in unemployment translates into something like a 7·9% increase in suicide. Northern Ireland has economic deprivation, communities coming out of conflict and high rates of mental illness. Neither in the priority that the Department and I attach to suicide, nor in the leadership that the Minister has given, are there any sacred cows. We need to ensure that we implement the evidence of what works and make best use of the resource and expertise available to us. As I said earlier, we have experts of experience in the community and

voluntary sector and in the statutory sector. The briefing paper highlights the key initial findings of that evaluation.

Colm, do you want to add to that?

Mr Donaghy: Early on, the Protect Life strategy highlighted what had to happen during the ongoing evaluation of various projects. When those were shown not to be effective, there had to be disinvestment, which is more difficult than investment. That applies when an evaluation is carried out and a particular service area is found to be less effective in supporting suicide prevention. In such cases, those decisions have been taken and will be taken again.

You mentioned Scotland, John. We were conscious that an evaluation of the suicide prevention strategy should not be made too early in the process. If an evaluation is made too early in the process, the measurements are not available to indicate whether a strategy is working. An evaluation involves more than statistics and numbers. The decision to carry out the evaluation five or six years into the strategy was deliberate and means that there will be a measurement of what is working and, potentially, what is not working. There is a commitment in the Department and in policy to ensure that, if something is shown not to work, a decision must be made to cease it or change what we are doing.

Dr McBride: The Minister has had those discussions with his ministerial counterparts. It is about working together. The Minister is clear that he views every Minister around the Executive table as a health Minister. Suicide is a matter for the entire government — it affects all Departments. All Departments can make an impact on the societal factors that result in people in Northern Ireland taking their own lives. There is a strong commitment that we will disinvest in interventions that are not effective and not delivering and reinvest in evidence-based interventions that have an opportunity to deliver. I am very happy to come back to the Committee in due course with the results of the completed evaluation, which will inform the new framework.

In support of Colm's comment, I should say that our reason for deciding to refresh the strategy now was to give it a further period of operation so that we could evaluate it properly and effectively. Indeed, it was the suggestion of SSIB that we refresh the strategy and let it run for a further two years to allow a proper and thorough evaluation. Then, we can use the work on the refresh, along with the thorough evaluation, to inform the new policy. We will link that to the wider work on the new public health framework, such as early years interventions, the life course approach and the new mental health promotion strategy that we will launch for consultation in the autumn. That strategy is about how we build emotional resilience in the entire population and not just in those at increased risk of suicide and self-harm.

Mr McCallister: I am encouraged to hear that, because I sometimes find that government gets wedded to a policy and does not want to let a particular strand of it go. Michael, as you rightly said, this is just too important because of the impact that it has.

Dr McBride: It is too important. We have neither the time nor the resources for duplication of effort or confusion of means.

Mr Brady: Thanks for the presentation. Recently, a community in Newry was bereaved after the death of three young men in their 30s in the space of approximately nine months. I have attended meetings facilitated by Public Initiative for the Prevention of Suicide and Self-harm (PIPS) and attended by social services, the PSNI, etc. The last of those young men to take his life had sought help on several occasions, and the community is aggrieved that it was not forthcoming in the way that they feel that it should have been. Social services are doing their best to address the situation. You talked about accreditation, and a number of young people in Newry have signed up to accredited counselling courses. The difficulty is that PIPS, which facilitates them, is a voluntary organisation and, like many voluntary organisations, struggles for funding.

You also talked about early intervention. The problems will be compounded by the centralisation of the out-of-hours social worker service. That may seem efficient, and it may save money while still enabling people to get a social worker on the end of the phone. However, the difficulty is that, in areas such as mine with a big rural hinterland, the social worker on the other end of the line may well be familiar with the caller through previous contact. That is obviously very helpful, and it needs to borne in mind. It is not all about efficiency and saving money.

Michael, you mentioned how increased unemployment increases the incidence of suicide. Coming down the line is the so-called welfare reform, which is really about cuts. Consider the fact that there will be a reassessment of the approximately 184,000 people here in the North who are on disability living allowance. The figures that we have been given show that 22% of them, quite a large proportion of whom are young people, suffer from mental health problems. It is not about the legacy of the conflict. These are young people who see no future and have mental health problems for various reasons. Also on their way are the single room rent restrictions, which could cause approximately 6,000 people to become homeless. Legislation on underoccupancy will create more homelessness. I wonder whether all of that has been factored into planning. I have no doubt whatsoever that the changes will create rather than solve problems.

Dr McBride: I will pick up on the wider issue of social policy. I will ask Eddie to comment, without going into specific cases, on cluster response plans and identification, which link back to the earlier comments in response to Conall's question. Colm will comment on out-of-hours social services from an operational point of view, if we have time.

The Chairperson: If Mickey is the last person to ask a question, you can do that.

Dr McBride: I hope that you were not showing preferential treatment, Sue.

The Chairperson: No. We are back on track again now.

Dr McBride: You will see that, subject to Executive consideration and approval, the strategy specifically looks at other social policy interventions that recognise the impacts of the economic downturn, particularly on benefits. The Public Health Agency has been working to maximise the access to and uptake of benefits.

The new public health framework looks specifically at alternatives to employment such as mentoring and volunteering, particularly for young people, for whom opportunities for going into paid employment are fewer than previously because of the economic downturn.

Increasingly, we need to look at alternatives to university, because we know about the significant changes in costs associated with university attendance. Indeed, that may, in due course, act as a significant factor in deterring some young people, particularly those from deprived areas, who may have taken up the opportunity to pursue tertiary education previously.

A range of social policy issues needs to be addressed in the context of the new Protect Life strategy, and those will be referenced in the refresh. There is no doubt that the social welfare reforms will present significant challenges, as does the wider economic downturn. We all have a role, across government and in every Department, to work together to address that. That goes back to the Chairperson's earlier comments about the need for the ministerial group to ensure co-ordination across that range of issues.

Mr Collins: The Department has been working with the Department for Social Development (DSD). Suicide prevention and the Protect Life strategy are mentioned in the new DSD NEETS strategy. That needs to be translated into actions on the ground, such as life skills training and emotional resilience building, for young people aged 16 to 24 to improve their employability and employment prospects.

Dr McBride: Eddie will say something about clusters.

Dr Rooney: We must ensure that we provide easy access to the services that are available. However, you pointed to an important dimension, Mickey, which is that the effectiveness of services is, to an incredible extent, linked with local knowledge. That local input must not be lost. The cluster responses and community responses are based on developing that local knowledge, because so much of what guides the right practice at the right time is that local knowledge, which cannot be found on forms or in databases. It is about tapping into the knowledge that has built up in communities over a very long time. We need to make sure that we achieve harmony between those elements. In other words, we must ensure that the services that we provide are effective and can respond rapidly, without losing the input of local knowledge and local presence.

Mr Donaghy: You are quite right, Mickey, that the proposal for the out-of-hours social work service is that it be centralised in Belfast. Currently, Belfast has full-time people working that service. The driver

for the change is not cost, although that is an element. The driver is the national pay and conditions in the Agenda for Change, which has affected payment for out-of-hours social workers. In the other three trusts — the Belfast Trust also provides the service for the South Eastern Trust — there were social workers who were prepared to go on a rota and provide the out-of-hours service as well as doing their day job. However, that is not sustainable. Staff will not be prepared to do the out-of-hours work for us. Therefore, we needed to look at a new model of provision, so the out-of-hours service is being centralised in Belfast and provided by full-time staff. There will still be a local response in local areas, and there will still be people able to respond locally. If the Chair so wishes, we can share with the Committee the proposals for the future out-of-hours social work service.

Mr Brady: I just want to follow up on Eddie's point about local knowledge and local contacts. Some of the social workers to whom I have spoken have a wealth of experience in mental health issues and in dealing with people who are suicidal. There is a real danger of losing all that knowledge. Centralisation will also affect the speed of response: if someone rings Belfast and is referred, that will involve a delay. The actions of an individual with suicidal ideation can be spontaneous, and something can happen in a matter of minutes. Therein lies the difficulty that needs to be addressed. I would appreciate more information.

Mr Donaghy: The principle is to continue to provide a response. If we did not do what we are doing, there might not be a local response at all.

Mr Brady: I go back to Eddie's point about striking a balance.

Mr Donaghy: I understand.

Mr Brady: Thank you.

Dr McBride: I thank the Chairperson and members for the invitation and for the time that we have been afforded this afternoon. We are very happy to follow up in writing on any questions that we did not get the opportunity to address during this afternoon's session.

The Chairperson: At the start of the session, I said that I was highly disappointed by the attitude and approach of the Department. Now, I think that we are on the journey of trying to deal with some of the issues of suicide, self-harm and mental health. After today's presentation, I feel a bit more settled that there is a focus on those issues. Once the refreshed strategy goes through the Executive and we have a copy, we will facilitate a presentation and session on that.

Dr McBride: I am very happy to come back at any stage following that, or after the publication of other reports.

The Chairperson: Interested groups have raised other issues with us, but we will come back to you on those. Thanks very much.

Dr McBride: Thank you.