Stakeholder Engagement on PHA Commissioned Services for Protect Life 2 Across NI

Pre-Consultation

July 2021

Contents

1.0 Background

Insight Solutions has been commissioned by the Public Health Agency (PHA) to undertake a stakeholder engagement process to help inform how future services aimed at addressing actions within *Protect Life 2 – A Strategy for Preventing Suicide and Self Harm in Northern Ireland 2019 – 2024 (PL2).*

PL2 recognises that no single organisation or service is able to influence all the complex interacting factors that lead someone to harming themselves or, ultimately, to taking their own life and stresses the importance of services, communities, families and society working together to help prevent suicides.

The PHA wish to engage with stakeholders to determine and agree specific commissioning priorities that PHA will support with the funding available and have developed an involvement strategy and plan which outlines how stakeholders with be involved in the process.

This Paper presents an overview of the pre-consultation stakeholder engagement process and findings and will support the PHA develop a discussion paper outlining how the PL2 strategy actions can be delivered This engagement process forms part of the PHA's Personal and Public Involvement (PPI) duty to involve users and builds on previous work completed in 2018.

2.0 Context

2.1 Protect Life 2

Protect Life 2 was published in September 2019. It is a cross-departmental strategy with outcomes which will only be achieved through a co-ordinated response across government, statutory and community level.

PL2 Aims
- Reduce the suicide rate in Northern Ireland by 10% by 2024; and - Ensure suicide prevention services and support are delivered appropriately in deprived areas where suicide and self-harm rates are highest.
PL2 Objectives 1. Ensure a collaborative, co-ordinated cross-departmental approach to suicide prevention; 2. Improve awareness of suicide prevention and associated services; 3. Enhance responsible media reporting on suicide; 4. Enhance community capacity to prevent and respond to suicidal behaviour within local communities; 5. Reduce incidence of suicide amongst people under the care of mental health services; 6. Restrict access to means of suicide; 7. Enhance the initial response to, and care and recovery of people who are suicidal; 8. Enhance services for people who self-harm, particularly for those who do so repeatedly; 9. Ensure the provision of effective support for those who are exposed to suicide or suicidal behaviour; and 10. Strengthen the local evidence on suicide patterns, trends and risk and on effective interventions to prevent suicide and self-harm.

Table 1: PL2 Aims and Objectives

2.1.1 Role of the PHA in PL2

The PHA have responsibility for the implementation of some elements of the PL2 Strategy, and this process is specifically focused on the implementation of:

Objective 4 – *Enhance community capacity to prevent and respond to suicidal behaviour within communities;*

- Action 4.1 – support, encourage and procure community-based suicide prevention services;

Objective 9 – *Ensure the provision of effective support for those who are exposed to suicide or suicidal behaviour;*

- Action 9.1 – providing a consistent, compassionate approach to supporting those bereaved/affected by suicide, including family and social circle.

These objectives have formed the foundation of this stakeholder engagement, with a focus on community-based pre and postvention services. It must be noted that whilst stakeholders were reminded to stay focussed to objectives 4.1 and 9.1, due to the nature and scope of the subject, the conversation did span outside of these specific objectives.

2.2 Previous Work

The PHA started the process of engagement with stakeholders in 2018 by commissioning a third party organisation to deliver stakeholder engagement events across Northern Ireland. There were 12 public meetings held across the five Health and Social Care (HSC) Trust areas as well as a digital survey which could be completed as an alternative or for those who wanted to provide additional information.

The report which was produced as a result of engagement can be read here: https://www.publichealth.hscni.net/sites/default/files/2018-08/PHA%20Report%20Final.pdf

2.3 Building on Previous Work

Since the formal launch of the PL2 Strategy in September 2019, it has been recognised by the PHA and DoH that a more in-depth engagement exercise working with target audiences is now required to help shape the future commissioning of PL2 services within the allocated budget.

Specifically, the PHA required better understanding of whether or not the recommendations outlined within the 2018 Stakeholder Engagement report were still relevant and if further recommendations needed to be considered.

The recommendations outlined following 2018 stakeholder engagement are presented in Table 2:

Prevention:
- Mapped referral pathways in accessible formats - Provision of training for different sections of the community - Increased multi-agency partnership and collaboration - Provision of more drop-in services to support individuals in crisis - Improved and tailored counselling provision - Support for carers - Early intervention, such as increased focus on building resilience, with children and young people
Postvention:
- Consideration given to the number of sessions offered in postvention support services - SD1 process to have an all-encompassing revision - Improve awareness of services through improved communication strategy - Ensure clarity regarding referral pathways and communicate these to key stakeholders and the wider community - Consistent training provided to medical staff - Consistent high-quality service provision across the 5 Trusts, based on shared and best practice - Media monitoring and controls with a new focus to be placed on social media where possible

Table 2: 2018 Prevention and Postvention Recommendations

2.4 Progress Since 2018

2.4.1 Improvements to SD1 Form

Based on stakeholder feedback in 2018, an evaluation of the SD1 process has been conducted with improvements been made to the SD1 process including the introduction of a new SD1 form which ensures support is offered to *all* who have been affected by the death. Alongside this, a training video for PSNI on the SD1 process and bereavement support processes is now shared with all PSNI Officers and incorporated as a module in the Training Academy for new Cadets. Further,

bereavement packs, which includes the Help is at Hand booklet, are provided to all PSNI Officers with the instruction to keep a supply in their patrol folders.

2.4.2 Further Developments

- Development of draft training framework;

- Move to self-referral;

- Implementation of Recovery Colleges;

- Campaigns focussed on raising awareness and destigmatising;

- Further media reporting training and controls;

- Community Response Plans;

It is also important to note that there have been a number of additional reviews carried out at this time which will impact on services commissioned e.g. on the 29th June 2021 the Department for Health published a Mental Health Strategy for Northern Ireland (2021 -2031). The Strategy outlines three themes which underpin a vision of a society which promotes emotional wellbeing and positive mental health for everyone, which supports recovery and seeks to reduce stigma and mental health inequalities. The themes are:

1. Promoting mental wellbeing, resilience and good mental health across society
2. Providing the right support at the right time
3. New ways of working

There are clear links between the themes outlined within the strategy and the objective and actions within PL2 and as such this needs to be considered as we move towards services commissioned.

3.0 Methodology

An 8 week pre-consultation process took place from 15th February 2021 until 11 April 2021. This included a survey which was hosted via Citizen space along with a number of engagement events and focus groups.

Due to COVID-19 restrictions, consultation events were facilitated via Zoom online meeting software. Information in relation to the pre-consultation process was advertised on the PHA website/social media and disseminated via PHA networks/contacts including but not limited to: service providers (statutory and community and voluntary including those currently commissioned and those who are not) service users, community and voluntary organisations, statutory bodies, PSNI and elected representatives. A video was also produced outlining the process which included subtitles.

Tables 3 and 4 provide an outline of engagement and table 5 provides an overview of number of attendees.

DATE	TRUST AREA	NUMBER OF ATTENDEES
Thursday 25th February 2021	Western HSCT	24
Tuesday 2nd March 2021	Southern HSCT	25
Friday 5th March 2021	Belfast HSCT	38
Monday 8th March 2021	NI Wide	22
Thursday 11th March 2021	Northern HSCT	21
Monday 22nd March 2021	South Eastern HSCT	24

Table 3: Engagement Events

30th March 2021	Stakeholder Engagement Session with ethnic minority	NI Wide

	community representatives	
30th March 2021	Stakeholder engagement session with LGBTQI+ community representatives	NI Wide

Table 4: Focus Groups

Engagement	Total Attendees/Respondents
Stakeholder Engagement Events	154 attendees
LGBTQI+ Community Focus Group [1]	5 attendees
Minority Ethnic Community Focus Group[2]	14 attendees
Online Survey (Citizen Space)	99 respondents
Written responses from Membership Based Organisations	3 responses

Table 5: Number of Attendees

Please note, stakeholders were also encouraged to request a focus group meeting/one-to-one video or telephone meeting, in line with the published involvement plan, and were able to submit written/email responses for the duration of the consultation period.

[1] Focus group requested in line with the involvement plan
[2] ibid

3.1 Approach

Stakeholder engagement events (for all events including focus groups) followed the approach outlined in Table 6.

Step	Details
1	Insight Solutions provided an introduction to stakeholders, outlining the aims and objectives of the stakeholder engagement event.
2	PHA provided a presentation giving an overview of background and setting context.
3	Insight Solutions facilitated discussion with stakeholders focussing on: 1: Prevention (2018 recommendations presented to participants) 2: Postvention (2018 recommendations presented to participants) 3: Discussion on the Impacts of Covid-19 4: Potential links/closer partnerships between Protect Life services and Drugs and Alcohol services

Table 6: Approach

4.0 Findings

4.1 Prevention

Stakeholders were asked to consider whether or not the recommendations outlined in 2018 (Table 7) were still relevant and appropriate within community based prevention services.

Recap of 2018 Prevention Recommendations

- Mapped referral pathways in accessible formats
- Provision of training for different sections of the population
- Increased multi-agency partnership and collaboration
- Provision of more drop-in services to support individuals in crisis
- Improved and tailored counselling provision

- Support for carers - Early intervention, such as increased focus on building resilience, with children and young people

Table 7: Recap of 2018 Recommendations

In general, stakeholders held the consensus that the recommendations made in 2018 were still relevant, valid and should remain in any community based prevention model going forward.

The written survey provided quantitative feedback in relation to each specific recommendation which reiterates the validity of the 2018 recommendations, with results as follows:

If these recommendations were implemented do you think they would help prevent suicide?				
	Yes	**No**	**Don't Know**	**Not answered**
Mapped referral pathways in accessible formats	76.77%	4.04%	18.18%	1.01%
Provision of training for different sections of the population	85.86%	5.05%	8.08%	1.01%
Increased multi-agency partnership and collaboration	83.84%	5.05%	7.07%	4.04%
Provision of more drop-in services to support individuals in crisis	94.95%	1.01%	3.03%	1.01%
Improved and tailored counselling provision	95.96%	2.02%	1.01%	1.01%
Support services for carers	89.90%	2.02%	6.06%	2.02%
Early intervention such as increased focus on building resilience with children and young people	91.92%	3.03%	4.04%	1.01%

Table 8: Suicide Prevention

In relation to the specific 2018 recommendations, stakeholders during this consultation expressed the following views:

Mapped Referral Pathways in Accessible Formats

- Clear, understandable referral pathways must be communicated. Many statutory healthcare workers do not know referral pathways
- Smoother referral pathways needed for those transitioning from young peoples' services at 17 years old to adult mental health services. Many young people entering adult mental health services lose a support network which enabled them to cope.
- Many people in crisis do not know how to access support and resources. Further promotion of support services and pathways is needed including promotion of Minding Your Head app. Those in crisis need to be equipped with knowledge on how to ask for help.
- Service users face challenges when trying to re-access support. Support needed to access a service in a timely manner when needed.
- 'No wrong door' approach required where appropriate signposting and referrals are made.
- Information on support must be clear and concise – too much information can be overwhelming for people in time of crisis.
- Awareness raising work needs to accompany changes in mapped referral pathways.
- A one point of access service e.g. Lifeline with a database of links to community providers would help navigate to sources of support.

Provision of Training for Different Sections of the Population

- Acknowledgement by stakeholders of Training Framework as a good model.
- SafeTalk and ASIST training must be more readily available and more easily accessible – demand is not being met.
- Greater cohort of people trained in Mental Health First Aid – enabling people to stay safe within communities.
- Peer training and learning is vital within prevention.
- Dual-diagnosis training is important.
- Training must be accessible to and relevant to all sections of the population including volunteers.
- Need for workplace support including training for business owners/employers and designated mental health champions within staff teams. This should include bereavement support. Employers need to be aware of where to signpost staff who are facing mental ill health.
- Training should be evidence-based and compatible with the Mental Health Emotional Wellbeing and Suicide Prevention Training Framework.
- Improved training needed for communities, especially key community representatives e.g. community groups/committees, sports coaches and those responsible for the welfare of young people.
- Support required for community groups and representatives who have community intelligence and know people in need of help. First response training and understanding of how to help those in crisis is key.
- Importance of community education and wider community training – encouraging everybody within communities to play their role and allow people to feel empowered to help.
- People within communities need to better understand the role they can play in prevention.
- Training should be available on a universal and targeted approach.

Increased Multi-Agency Partnership and Collaboration

- Closer partnerships between statutory and community and voluntary required. Need for linkages between community groups/projects and statutory agencies.
- Wrap-around services critical.
- Multi-agency collaboration must be improved to ensure safety and appropriate treatment. Complex clients accessing services need a more joined-up approach.
- Need to specifically support people with early identification and effective management of self-harm, co-occurring mental health and substance use issues. Models such as PIE and the Doncaster City Council 'complex lives' model could be tested.
- Individuals should be connected into community groups/activities which will help decrease isolation and improve community support.
- Better guidance needed for all staff to understand what information etc can be shared amongst organisations.
- Need for better record keeping amongst services so clients do not have to continually recount their story/trauma.
- MATT initiative which includes PSNI, NIAS and HSCTs is a good model – currently only at weekends but could be expanded. Key to initiative is communication between partners who are first responders to mental health calls and potential suicides.
- Stronger collaboration between Housing, Health, Education etc needed for a holistic approach to care and support.
- Both targeted and universal approach should be considered – changing needs over life-course.

Provision of More Drop-in Services to Support People in Crisis

- Suggestion of outreach workers who go to people in crisis.
- Drop in services will prevent people from presenting at A+E departments.
- Evening and weekend provision is vital – 24/7 access to support when in crisis.
- Mental health ambulances could be introduced to reach those in crisis.
- Crisis Intervention Centres need to expand opening hours and receive funding to support a full staff team.
- Focus on isolation and the impacts of this needed. Need to ensure people are connected into communities and given an opportunity to socialise, learn skills, learn to care for their environment and have pride in local area.
- Suggestion of funded taxi service to bring people in crisis to safety.
- London and larger cities have 'crisis cafes' and other interventions which are non-clinical and non-judgemental . This is something which could be considered for Recovery Colleges.

Support Services for Carers

- View that the mental health needs of those caring for individuals with suicidal ideation are often neglected. Counselling and signposting or other services required for these individuals and their families.
- Must work on developing a 'community of care' so people are enabled to support loved ones in crisis.
- Community respite care needed for carers of those with suicidal ideation.

Improved and Tailored Counselling Provision

- Longer interventions are necessary – 6 week counselling provision is often not adequate to support an individual.
- School counselling services need extended beyond end of school day. Improved access and provision required.
- Timely access to counselling provision is required. Long waiting lists for counselling services result in individuals feeling hopeless.
- Funding required for counselling services to ensure affordability for service users.
- Some stakeholders noted that counselling provision is a 'postcode lottery'.

- Some community-based counselling providers are battling to secure funding, and funding is often short-term.
- Lack of provision for Irish Traveller and ethnic minority communities and LGBTQI+ groups.

Early intervention

- Promotion of positive mental health, encouraging help-seeking, reducing stigma, building resilience should be part of the NI Curriculum.
- Need a focus on health and wellbeing including nutrition, healthy living, healthy relationships and eating and reduction of screen time.
- Young people should be encouraged to set goals and life aspirations.
- Mentoring, coaching, peer support needed.
- Need for a targeted suicide prevention programme for young people.
- Need for better access to CAMHS – more liaison between CAMHS and schools.
- Need for Mental Health First Aiders within schools.
- Suggestion that young people require a suicide prevention programme developed specifically for their age group and needs.
- Trauma informed approach to early intervention is required.
- Work needed to support implementation of Children and Young Peoples' Emotional Health and Wellbeing Education Framework such as support, training and guidance for teachers, youth workers and parents.
- Early intervention work should encompass working across the life course to build resilience/embed wellbeing for children, young people, adults and older adults and include: relationship level, community level and societal level.
- Primary school based counselling provision should be utilised such as the approach in the Colin area of West Belfast.

Other Themes

As well as the above views expressed by stakeholders, the following themes were presented during consultation. These reflect key points which were expressed most frequently with most consensus, and which differ from the recommendations presented in 2018. Please note, these views have been taken from consultation events, focus groups and written survey.

Flexibility and Longer Term Interventions

- 6 week services/interventions are not long enough. Takes time to build rapport and trust with a client with many people not realising their trauma/opening up about suicidal ideation until the end of the provision.
- Need for support to be client-led and time of support assessed by client need.
- Importance of staff consistency within services to ensure best outcome.

Training for Frontline, Medical and Emergency Service Staff and Improved Mental Health Care in Emergency Departments (ED)

- 'Card Before You Leave' must be implemented consistently and put in to practice across the board.
- Need for suicide prevention officer within ED.
- Need for talking therapies within EDs.
- All staff in medical fields must undergo suicide prevention training and be able to recognise signs of mental ill health / potential suicidal ideation e.g. midwives, pharmacists, emergency service staff, GPs etc.
- When an individual presents to ED they are often not referred or signposted to mental health services – must have timely support.
- Need for staff to be trained to understand at risk user groups i.e. pregnant women.
- Professionals need help to react to urgent/crisis situations. Must be trained and equipped with tools and resources to help individual.
- Health professionals must understand the importance of an empathetic approach.
- GPs are often the first point of contact – improved, specific training needed for GPs and more joined-up services to allow referral.
- Mental Health Nurses/Champions needed within GP surgeries as part of Multi-Disciplinary Teams. These workers could also undertake outreach to those within their communities in crisis.

Timely Support/Reduced Waiting Times and Reducing Barriers to Services

- Waiting lists/times are detrimental to those in need. Support is required in a timely manner. Many people on waiting lists cannot afford private

counselling/treatment.

- Immediate assessment of an individual needed and appropriate signposting to avail of correct support.
- Community outreach – local residents and community figures / groups / associations / schools / sports clubs to promote awareness of mental health and act as an intermediator.
- Stakeholders expressed there is currently a waiting list of up to 2-3 years for CAMHs.
- Need to reduce cumbersome paperwork which needs completed by service users – this can be confusing and stressful for those in crisis.
- 3 missed appointments leads to dismissal from service – need to understand that those being supported have chaotic lifestyles and many mental health problems mean they have difficulty maintaining structure and routine. Practical support may be needed in ensuring service users can get to appointments etc.

Whole Family Approach and Parental Support

- Provision of evidence-based parenting programmes at individual, family and community level which have potential to enable trauma-informed approaches and prevent generational transmission of adverse childhood experiences.
- Expansion of specialist perinatal support teams across Northern Ireland.
- Training needed for individuals who work with parents, carers and families to improve access to services and reduction in stigma.
- Helping parents/carers and families see signs of ill mental health.
- Wrap around support to families with a history of trauma/abuse.
- Whole family support for families who have a member who is facing ill mental health and suicide ideation – understanding the impact on other family members and particularly siblings.
- Relational connections – approach needs to be more upstream. Impact of experiences, connections, parenting, childhood experiences to be considered when looking at prevention

Holistic and Therapeutic Approach

- Need to look at 'whole picture' in terms of what is currently happening in the life of an individual needing support – financial issues, relationships, health and social circumstances to determine risk factors and to develop appropriate support mechanisms.
- A full assessment of the service users is needed.
- Prioritise the factor causing greatest concern to the service user and work through the problems.
- Counselling provision and services may not work if an individual is facing wider social or financial issues in daily life.
- Person-centred approach is key with services accessible to a person at a wide range of times to suit need.
- Range of services must come together to help an individual – complementary therapies, community/social groups, befriending, life coaching, social prescribing etc all needed.

Increased Investment

- Stakeholders noted a need for enhanced funding for mental health and suicide prevention support services – statutory and community and voluntary.
- Increased investment into commissioned services would allow for flexibility and enhanced support for service users (e.g. ability to flex up from 6 sessions of counselling to 12 sessions).
- Stakeholders noted that longer term funding of services was key (5-7 years).
- Noted that communities have experienced significant cuts to budgets, personnel and services which has devastated community infrastructure. Retention of locality-based assets important and should be prioritised in commissioning frameworks.

Reducing Stigma

- Need for continued focus on reducing stigma and normalising help seeking for suicidal ideation and mental health.
- Help should be offered through universal services as people find it difficult to ask for support. Offer help and signposting through services such as: midwifery, health visiting, family nurse partnership, school nursing, education setting.
- Increased media campaigns and inclusion of mental health issues discussed in soaps (with appropriate helplines/signposting at end of programmes).
- Language used should be considered – 'mental illness' etc.

Within the written survey, respondents were asked what services they feel will help to prevent suicide, with results as follows:

Services survey respondents feel will help to prevent suicide	
Awareness of suicide prevention through literature, social media, publicity campaigns etc	70.71%
Self-help programmes	63.64%
Advice and support for mild emotional problems	73.74%

Advice and support for social problems	77.78%
Support for lifestyle changes	70.71%
Strategies to deal with anxiety, stress or depression	92.93%
Building resilience	75.76%
Increased knowledge to support others	73.74%
Increased skills to support others	78.79%
Not answered	1.01%

Table 9: Services for Suicide Prevention

4.1.1 Impact of Covid-19 on Prevention Services

Stakeholders were asked to consider specifically the impact of Covid-19 on prevention services, with the following themes garnered:

Blended Service Delivery Should be Retained

- **73.74% of survey respondents said a blended approach of delivery should be taken forward (even post Covid-19 pandemic).**
- Covid-19 has meant service providers have had to offer a range of digital and remote services e.g. text, WhatsApp, Zoom/video.
- Many service providers saw an increased uptake due to digital provision.
- Barriers around digital access must be considered e.g. digital poverty, lack of digital skills, access to smart phones or good internet connection in rural areas.
- Going forward, a blended service delivery should be retained. Mix of face-to-face and digital/telephone methods.
- Should be client-driven and based on client needs.

Stakeholders noted the following delivery methods should form part of any new suicide prevention service (ranked from most popular to least popular method):

Blended approach (all of the below)	73.74%

In-person	71.72%
Video e.g. Zoom, Microsoft Teams, Google Hangout/Meet etc.	57.58%
Telephone	49.49%
Text	44.44%
WhatsApp	37.37%
Web chat	36.36%
Social Media pages or forum	33.33%
WhatApp	0.00%
Not answered	42.42%

Table 10: Methods of Service Delivery

Stakeholders were asked to consider any immediate prevention actions which need to be implemented to support recovery from Covid-19, with the themes below expressed most consistently:

- Increased emotional support and befriending.
- Funding to support young people, especially school-leavers who have faced issues such as exam results, grades not meeting expectations, chaotic school routine, lockdowns.
- Focus on community integration and confidence building when lockdown eases.
- Freephone services for those in mental health crisis and facing isolation - including leaflet drops as a way of signposting to services.
- Specific care needed for elderly and vulnerable people who have faced long periods of isolation through shielding.
- Funding for community and voluntary groups to enable community interaction and service provision.
- Training to ensure employers are aware of effects of Covid-19 on mental health of staff.
- Promotion of physical and mental health and wellbeing through nutrition and exercise campaigns.
- Decrease public health messaging and advertising on Covid-19 – induces anxiety.
- Increased provision and advertising of mental health services.
- Better understanding of 'long Covid'.
- Train service providers and staff on how to handle calls, what to expect post-pandemic.
- Increased bereavement support for those who have lost a loved one.
- Continuation of multi-agency collaboration which has proven effective during the pandemic.
- Provision of a Covid-19 Recovery Plan which includes targeted and resourced actions to address immediate wellbeing needs. Cross-departmental and actions included to address impact of Covid-19 on social determinants of health such as poverty, housing and employment.
- Therapeutic services needed for keyworkers who have been impacted by the

pandemic in their employment.

- Must understand that due to less service delivery/workers 'on the ground' many clients will have lost a key contact – wider community support may be needed for these individuals.
- Training on how to use digital methods of communication e.g. Zoom if they are to continue in service delivery.
- Design, implementation and evaluation of a service supporting the dual nature of mental health and substance use issues.
- Move away from restrictive commissioning of counselling services towards needs-led provision.
- Full societal adoption of building resilience/embedding wellbeing across the life course utilising the Take 5 methodology.

4.2 Stronger Links/Better Alignment Between Protect Life Services and Drugs and Alcohol Services

Overall, there was a general unanimous support for stronger links between drugs and alcohol and protect life services, with the following main points highlighted:

- Need to protect people who are in crisis but also under the influence of drugs and/or alcohol.
- Mandatory drug programmes to help get people off drugs whilst seeking help for suicidal ideation needed.
- Need for improved services where there is a mental health issue as a result of drug or alcohol use.
- Some stakeholders stated that a service user should not have to be sober to receive mental health support. If being sober is required, service user requires a safe space to sober up while ensuring they are protected.
- Need for recovery clinics and rehabilitation centres.
- Need for an overhaul in GP prescribing system to prevent addiction.
- Joined-up, multi-agency approach needed. Reiterates points above re multi-agency working and holistic approach.
- Considerations should be given towards a revision of GP policy not to refer individuals to mental health services where there is drug or alcohol use.

- Reduce criminality/stigma around drug and alcohol use and people may feel more encouraged to seek help.
- Many people are self-medicating with drugs and alcohol to try and treat their mental health issues.
- Central database could be formed for information sharing and ease of referrals.
- Specialist services need to be maintained rather than try a 'one size fits all' approach for people with dual diagnosis.
- Non-judgemental and empathetic approach is necessary.
- As with mental health, suggestion that there should be a drug and alcohol liaison worker in A+E who can signpost to D+A/mental health services before discharge.
- Need to stop dealing with/managing symptoms and address underlying reasons for addictions.
- Greater investment needed in services should this be taken forward. More investment in this at community level needed to bring school health services and community services together.
- Services should work on a universal and targeted approach embedding a health literacy methodology ensuring people can access, understand and implement sustained change.
- PIE and Doncaster City 'Complex Lives' models could be adopted.

4.3 Prevention - Accessibility

76.77% of survey respondents felt that prevention services are not accessible. This was reiterated within discussions at stakeholder engagement events, with main themes relating to accessibility outlined below.

Regional Consistency/Equitable Access to Services

- Stakeholders noted inconsistencies in access to mental health services across Northern Ireland.
- Need for a review of geographic spread of services to ensure all areas can avail of equal access to prevention services.
- Need for a universal approach rather than working on a Trust by Trust basis, however it is important that services working within areas have local community intelligence.

Barriers for User Groups/Considerations for Minority Groups

- Stakeholders outlined a number of user groups who require support accessing services, and who need consideration within prevention services. These include: those with disabilities including hearing and sight impairments, minority ethnic groups including Travellers, those involved in justice system, rural dwellers, those from areas of low deprivation, facing financial barriers, LGBTQI+ community, those with additional needs including Asperger's, ASD and the elderly.
- Some stakeholders noted that the Protect Life Strategy must be underpinned by Section 75/Equality Strategy.
- Some stakeholders noted a lack of specialist services required for helping minority groups and those with accessibility issues.

Irish Traveller and Ethnic Minority communities Minority

- The needs of Irish Traveller and Ethnic Minority Communities, must be considered including translation, cultural understanding and empathy. There is a lot of stigma re mental health within some Irish Traveller and Ethnic Minority communities. Translation services are key and translators must have understanding of mental health issues.
- Many members of Irish Traveller and Ethnic Minority communities need help with online resources.
- Strong Irish Traveller and Ethnic Minority communities representation welcomed on PLIG and other PL2 groups.
- Cultural considerations needed as well as consideration of lifestyle challenges associated with Irish Traveller and Ethnic Minority communities i.e. racism, EU Settlement Scheme, working in low paid jobs, lack of IT skills, working in agri-food sector etc.

LGBTQI+

- LGBTQI+ community face high levels of suicide. Better understanding needed of isolation often associated with being a member of LGBTQI+ community.
- Fear of speaking out about issues as Transgender hormones and operations etc can be cancelled.

- Experience within LGBTQI+ community that service providers often associate mental health issues/suicide ideation with LGBTQI+ identity and this is not always the case. Better training needed for service providers.
- Service providers working with many high-risk clients – need high level of support.
- Wider level of cultural competency needed to help Transgender community. Sense of distrust from the community towards service providers (especially statutory).
- LGBTQI+ affirming spaces are needed.

4.3.1 Improving Access

Stakeholders also expressed concern around potential barriers to access to prevention services as a result of pressures on health system due to Covid-19.

Promotion of Self-Referral and Self-Help

- Need better promotion of self-referral and self-help.
- Encouragement of help-seeking behaviour and habits.
- Many service users concerned around taking first step due to stigma.
- As outlined above, many in need do not know where to go to access service – better promotion of self-help tools and signposting.

Peer Support/Community Support

- Awareness and education at all levels of society to ensure reduction in stigma and ability to signpost those in need to appropriate services.

Publicity and Promotional Campaigns

- Awareness raising is key to access. Promotional campaigns in different formats (i.e. translated leaflets and help services), publicity campaigns relevant to specific groups.

Evidence Based Approach

- Need for a regional strategy to suicide prevention which takes account of different circumstances, locations and communities across Northern Ireland while remaining accessible to all.
- Essential all approaches are driven by evidence.
- Key Executive frameworks including the Substance Use Strategy, the Mental Health Strategy, the Programme for Government and the Anti-Poverty Strategy must be linked and operate according to the factors that influence and drive suicide.

4.4 Postvention

As with prevention, stakeholders were asked to consider whether or not the postvention recommendations outlined in 2018 (Table 10) were still relevant and appropriate within community based postvention services. Specifically, stakeholders were asked whether or not implementation of the 2018 recommendations would lead to a consistent, compassionate approach to supporting those bereaved by suicide.

Recap of 2018 Postvention Recommendations
- Consideration given to the number of sessions offered in postvention support services - SD1 process to have an all-encompassing revision - Improve awareness of services through improved communication strategy - Ensure clarity regarding referral pathways and communicate these to key stakeholders and the wider community - Consistent training provided to medical staff - Consistent high-quality service provision across the 5 Trusts, based on shared and best practice - Media monitoring and controls with a new focus to be placed on social media where possible

Table 11: Recap of 2018 Recommendations

As with prevention, stakeholders held the consensus that the recommendations made in 2018 were still relevant.

The written survey provided quantitative feedback in relation to each specific recommendation which reiterates the validity of the 2018 recommendations, with results as follows:

Do you think that the implementation of the following recommendations will lead to a consistent, compassionate approach to supporting those bereaved by suicide?				
	Yes	**No**	**Don't Know**	**Not answered**
Consideration to be given to the number of sessions offered in therapeutic postvention support	85.86%	3.03%	9.09%	2.02%
SD1 process to have an all-encompassing review	65.66%	1.01%	30.30%	3.03%
Improve awareness of services through improved communication strategy	86.87%	2.02%	9.09%	2.02%
Ensure clarity regarding referral pathways and communicate these to key stakeholders and the wider community	89.90%	2.02%	5.05%	3.03%
Consistent training provided to medical staff	92.93%	2.02%	2.02%	3.03%
Consistent, high quality service provision across the 5 Trusts based on shared and best practice	93.94%	0.00%	2.02%	4.04%

Media monitoring and controls with a new focus to be placed on social media where possible	66.67%	3.03%	26.26%	4.04%

Table 12: Feedback on 2018 Postvention Recommendations

In relation to the specific 2018 postvention recommendations, stakeholders during this consultation expressed the following views:

Consideration to be given to the number of sessions offered in therapeutic postvention support

- As in prevention, postvention services are limited and time-bound. Stakeholders unanimously felt that services should be developed around client need, with ability to be flexible should service user require.
- In child bereavement services the service is not time-bound – allows development of trust.
- Within postvention support, some stakeholders noted there were not enough therapeutic counsellors available for supporting children and young people.
- Service users are being 'shoehorned' into services. Services should be developed round the needs of clients and not vice versa.
- Recognition needed that there is no 'one size fits all' when it comes to counselling/therapeutic support following a suicide.

SD1 process to have an all-encompassing review

- As outlined earlier in this report, there have been improvements made to the SD1 form and process. These changes were recognised by and acknowledged by stakeholders.
- Work and progress was valued but suggestion of further improvements were made. It was highlighted that many people at the scene of a suicide will decline support, and that support needs to be offered again in near future even if declined. Other members of the family may require support but are not always consulted.
- Consideration that people should be automatically opted in for consent and support, with the option to opt out later.

Improve awareness of services through improved communication strategy

- Stakeholders in agreement that information needs to be readily available and accessible to those who need it.
- Communication strategy and promotion of postvention support must take into consideration needs of Irish Traveller and Ethnic Minority communities and those with additional needs including disabilities and isolation.
- Important those who are bereaved by suicide are equipped with resources. People may not immediately be ready for talking therapies but having a list of online, telephone and other resources is important. Suggestion of a bereavement pack which contains information and signposting.

Ensure clarity regarding referral pathways and communicate these to key stakeholders and the wider community

- Importance of ability to access support when needed by bereaved family or individual. Not all people impacted by suicide will want immediate support, but must be engaged with down the line or have a clear pathway into a service.
- Open referral process as in Northern Trust a good model – access never closes.
- Need to have a seamless step-up/step-down way of being able to go through stepped care programme.

Consistent training provided to medical staff

- Some stakeholders feel this recommendation should be widened to 'all staff working within mental health services' to ensure training is consistent across the board.
- Community and voluntary staff and members of communities are often first point of contact for people, there is a need to ensure they are appropriately trained and can respond.
- Support for those who provide care for those who have completed a suicide including first response teams, medical staff, PSNI etc –

Consistent, high quality service provision across the 5 Trusts based on shared and best practice

- Multi-disciplinary Teams could be key to better access to services and provision of postvention support.
- Some stakeholders express geographical differences in services available across the NI Trusts.

Media monitoring and controls with a new focus to be placed on social media where possible

- Need still remains to educate and inform journalists to ensure appropriate media monitoring.
- Need for consequences or legislation.
- Guidelines e.g. Samaritan's should be promoted vigorously.

Other Themes

As well as the above views expressed by stakeholders in relation to the 2018 postvention recommendations, the following themes were presented during consultation. These reflect key points which were expressed most frequently with most consensus, and which differ from the recommendations presented in 2018.

Timely Support/Reduced Waiting Times and Reducing Barriers to Services

- Waiting lists/times are detrimental to those in need. Support is required in a timely manner. Many people on waiting lists cannot afford private counselling/treatment.
- Key worker/suicide support worker may help families and individuals access help when they need it. Will also prevent continual retelling of story.

Peer Support

- Importance of engagement with people who have had similar traumatic experiences/been exposed to suicide.
- Peer support alleviates loneliness and isolation and reduces stigma.
- Some stakeholders noted that in their experience this had been extremely worthwhile, with young people in particular.
- Importance of encouraging peer support and environment of being open and honest – providing people a safe space to continue with their lives through activities and hobbies.

Holistic Approach/Wraparound Service

- Support for children must take into consideration any other support services or statutory services involved.
- Postvention services need to work with an individual and give them the wraparound support they require – support must be based on needs. This may be emotional, practical, financial or a mix.
- Better communication and multi-agency working in a holistic manner may ensure there is no duplication of services.
- Holistic approach will allow for onward referral to community groups and initiatives. Through groups such as walking groups, yoga, Men's Shed etc support networks can emerge.
- Whole family approach to bereavement support in postvention is needed.
- Holistic approach should focus on mental and emotional health and wellbeing as well as physical health and wellbeing.

Trauma Informed Practice/Evidence Based Practice

- Need for connection between trauma-responsive approaches and suicide prevention in postvention support. Those who have been exposed to a suicide need supported.
- Sector should be trauma informed in a responsible way and be trauma responsive.
- Need better understanding and training around the impact trauma can have on a person's life.
- Trauma-informed practice also relevant to prevention and early intervention.
- Need to set targets for suicide reduction particularly amongst vulnerable groups; prioritise action on suicide prevention across government departments and set out clear cross-government processes for implementation, governance and delivery; provide ambitious leadership, resources, guidance and support to enable local policy-makers to put effective plans in place; set out ring-fenced funding for suicide prevention and direct this towards evidence-based interventions that support the most vulnerable groups.

Written survey respondents had the opportunity to state what support was needed for both children and young people (under 18 years) bereaved by suicide in the immediate, short and longer term. Results are presented below in Table 13.

Support Needed for Children and Young people (under 18 years) Bereaved by Suicide	
Immediately (first 3 months)	Help dealing with guilt associated with loss. Reassurance support is there for them when they need it. Talking therapies for at risk younger people (in appropriate setting, not time limited). Community intervention. Multi-agency approach e.g. schools and networks involved to help. Information on healthy coping strategies. Family bereavement support. Dedicated 'support buddy' or key worker for continuity and

	support. Support for peer groups/education settings. Support from bereavement services and other support services e.g. CRUSE, PIPS. Explanation of facts associated with the suicide. Peer support/youth support. For non-verbal children – art therapy, play therapy, sensory therapy. Important to understand children and young people may not be able to express emotions – need time, space and support in formal/informal settings. Individuals need to be made aware of postvention services. Educating children about sensationalism and engaging in this type of behaviour post suicide online/social media. Evidence based approach required i.e. community response plan. Support needed for whole school communities.
In the short term (3 months to 2 years)	Consistent follow ups with young person. Person-centred counselling services (by trained specialist which is not time bound), focussing on trauma, loss, PTSD. Whole family approach – provision of postvention services to family unit. Alternative therapies including play therapy, art therapy, complementary therapies. Continued offers of support. Continued support in school. Promotion of friendships, peer support and mentoring. Continuation of support required by specialist services or ability to uptake support at this stage if required. Bringing young people together who have mutual experiences – friendship programmes, activity programmes, residentials. Ongoing access to information.

	Consistent staff in any service they avail of. Access to online resources. Support during transitions.
Longer term (over 2 years)	Access to counselling (as above). Introduction to support groups/networks. Easing of contact if necessary but with support still maintained (checking in with young person to offer support). Focussing on future aspirations e.g. education, employment, setting goals, personal development programmes. Monitoring by support networks including services, schools, families, friends. Referrals to other services to be made if required.

Table 13: Postvention Support Needed for Children and Young People

Further, survey respondents outlined the support they feel is required for adults bereaved by suicide in the immediate, short and longer term, as presented in Table 14.

Support Needed for Adults (over 18 years) Bereaved by Suicide	
Immediately (first 3 months)	Person-centric counselling service which is not time bound. Support for staying in education/employment while grieving. Access to support groups and bereavement groups e.g. CRUSE, PIPS. Family bereavement support. Financial and practical support e.g. funeral arrangements, childcare. Wraparound support – multi-agency approach. Information and signposting to services, awareness of support groups, community initiatives including leaflets, online resources and information. Key worker/liaison support worker assigned to family. Access to out of hours contact information. Access to creative interventions/complementary therapies.

	Peer support from those who have experienced similar trauma. Liaison person for those affected. Co-ordination of all local stakeholders including community groups – potential establishment of a forum through which these groups can liaise. Awareness of available services is key.
In the short term (3 months to 2 years)	Community support and intervention. Access to counselling and talking therapies (as above). Peer group support. Access and awareness to support services. Integration into community groups, social circles, support groups. Promotion of self-help. Practical support including financial support and advice. Check ins from associated services/service providers and connections. Ongoing support for partners/children/carers. Whole family support. Information on drop-in services. Access to creative interventions/complementary therapies. Continuation of co-ordination of stakeholders including local community groups.
Longer term (over 2 years)	Access to counselling and talking therapies (as above). Promotion of self-care and personal growth programmes. Check-ins from support groups/services. Quick access back into counselling and support services if required. Family support worker to continue to liaise with family. Introduction to local groups e.g. Men's Shed, sports and recreational groups. Person-led support – level of support they require at the time.

	Grief is not a linear process. Continued investment in local community groups – increasing capacity to support and nurture people.

Table 14: Postvention Support Needed for Adults

4.4.1 Impact of Covid-19 on Postvention Services

Stakeholders were asked to consider specifically the impact of Covid-19 on postvention services, with the following considerations outlined.

Blended Service Delivery Should be Retained

- 66.67% of survey respondents want to see a blended approach to service delivery retained going forward.
- As with prevention services, stakeholders feel that postvention support services should retain a blended approach to service delivery. This approach will encompass digital and remote methods of interacting with clients including: text, WhatsApp, Zoom/video call and telephone etc. As with prevention services, stakeholders agree that face-to-face support should never be replaced with these methods, but the service type should be client-driven and based on the needs of the service user.
- There were some confidentiality and safeguarding concerns re communicating with clients via social media etc.

Immediate Support Required as a Result of Covid-19

Stakeholders were asked to consider any immediate postvention actions which need to be implemented to support from Covid-19, with the themes outlined below expressed most consistently.

- Improved training for first responders.
- Increase in face-to-face services i.e. bereavement counselling and postvention support services.
- Review of postvention services – ensuring note is taken of any services which have ceased due to the pandemic (either temporarily or permanently). Further, a review on service users who have disengaged from services if these services have ceased.
- Provision of drop-in support services.
- Covid-19 has highlighted health inequalities which can be responded to through services. Funding may be needed for this.
- Need to ensure longer term funding for commissioned services – services have been agile and responsive to Covid-19 pandemic and longer term funding will allow plans to be put in place for recovery.
- Many families have not been able to experience a wake, funeral, visitors to their homes etc. These families may need specialist support. A therapeutic model could be promoted in which bereaved families could mark the passing of a loved one.

4.5 Stronger Links/Better Alignment Between Protect Life Services and Drugs and Alcohol Services

As with prevention, the postvention discussion homed in on if and how Drugs and Alcohol services and Protect Life Suicide Postvention services should/could work more closely and be better aligned.

Overall, there was unanimous support for stronger links between Drugs and Alcohol and Protect Life services:.

- Need to share information freely between departments (mental health and drug and alcohol). Ensure consent is obtained.

- Services need to come together to provide a holistic support network as services presently work in isolation.
- Adverse incidents often lead to people using drugs and alcohol – closer working between services will ensure prompt response to client needs.
- Clearer referral pathways need developed at the very least between mental health and drugs and alcohol services.
- Suggestion that dual-diagnosis therapists could be placed in A+E departments and organisations.
- Need for rehabilitation accommodation/detox centres where those with substance use issues can recover while receiving help.

4.6 Postvention – Accessibility

Stakeholders expressed concern regarding access to postvention services, with the following themes presented in relation to this.

Waiting Times/Access to Timely Support

- Waiting lists are long and not all service users can afford private support.
- Many services do not operate outside of regular working hours. Evening and weekend provision is required for postvention services.
- Some stakeholders noted there are not enough services to meet demand.
- Need provision and better access to CAMHs and bereavement support as well as in-school counsellors.
- 24/7 access to support needed.
- Primary care workers need to be well informed of community and voluntary services so timely referrals can be made.
- More funding required for services to increase staff team and in turn ability to increase support, based on demand.

Equitable Provision and Availability of Postvention Services Across NI

- Accessibility depends on service availability – people feel excluded, left out and not supported because there are not enough services.
- Availability of services aimed specifically for people bereaved by suicide are limited in some parts of UK and ROI.
- Some stakeholders noted that services were often focussed to Belfast.

Barriers for User Groups/Considerations for Minority Groups

- Similar to the needs outlined in prevention services, stakeholders outlined a number of user groups who require support accessing services, and who need consideration within postvention services. These include: those with disabilities including hearing and sight impairments, ethnic minority groups/members of Irish Traveller and Ethnic Minority communities, those involved in justice system, rural dwellers, those from areas of low deprivation, facing financial barriers, LGBTQI+ community, Traveller community, those with additional needs including Asperger's, ASD and elderly.
- Some stakeholders noted that the Protect Life Strategy must be underpinned by Section 75/Equality Strategy.
- Some stakeholders noted a lack of specialist services required for helping minority groups and those with accessibility issues.

Irish Traveller and Ethnic Minority Communities

- Needs of the Irish Traveller and Ethnic Minority communities community must be considered and information on services must be adapted accordingly to ensure access for these groups.
- Translation services must be available on request with a translator who has knowledge of suicide.
- Map of postvention services needed to signpost to support as well as support using services.
- Many suicides have taken place amongst Traveller community – this can have a knock on effect which should be considered.
- More work to be done in training members of the Irish Traveller and Ethnic

Minority communities so they are educated on where to signpost to and how to offer to support members of their own communities.

LGBTQI+ Community

- Risk of suicide clusters within community – engagement and support is vital for those affected by a suicide within the LGBTQI+ community.
- LGBT affirming spaces are needed within support – cultural competency.
- Communities of interest need to be included in response after a suicide.
- After a suicide of a member of the LGBTQI+ community, support is not always triggered for LGBTQI+ community as family members are often not accepting of their identity. This is a gap and relies on community intelligence. If LGBTQI+ identity is forgotten about in a death this sends a harmful message to the wider community.

Other Considerations/Gaps

- Postvention considerations in services when a suicide has been attempted but not completed – impact on wider social circle. Often this is a gap – an attempt that has not been completed but a massive amount of support still required. Exposure can increase risk going forward.
- Considerations for people in border areas – people who have passed away across the border then SD1 process is not started or people are missed as families/contacts live across the border.
- Need considerations on how to support hard to reach young people.
- Quality standards must be met within postvention services.
- Support for those who have made suicide attempts and are left with injuries e.g. brain trauma.

4.6.1 Improving Access

The following views were expressed mostly strongly in relation to how access to postvention services could be improved.

Easier Access to Postvention Services

- Primary Care MDTs could ease access into postvention support services.
- Outreach work and home visits in informal settings could be encouraged within services.
- Information/contact information for services on any databases/websites/information sheets etc. must be kept up-to-date at all times.
- As outlined above, and in line with 2018 recommendation, stakeholders noted that better awareness of what bereavement support is and how/where it can be accessed is needed.
- Public campaigns on how to better access help and support.
- Suggestion of a designated app for postvention support.

5.0 Next steps

- Carry out an analysis of the consultation responses and map recommendations outlined against other areas of work and current reviews e.g. training to determine gaps / areas of work not currently being addressed and actions within the recently published Mental Health Strategy.
- Develop evidence base for community based suicide prevention interventions and post vention services..
- Development of a discussion papers for both community based suicide prevention services and post vention services outlining options for service development which consider the wider context, challenges, timescales and aims of each service.
- 12 week public consultation process on future service models.