HSC Public Health Agency

Suicide Prevention – Protect Life
Ministerial Workshop
28th September 2011

1. Background

The Minister for Health, Social Services and Public Safety, Mr Edwin Poots MLA, asked Department officials and the Public Health Agency to organise a workshop to support the implementation of the Protect Life Strategy and to consider what further action is needed in order to tackle the high level of suicides and self harm in Northern Ireland. The event primarily provided an opportunity to explore the views and perspectives of the community and voluntary sector. Community & Voluntary (C&V) organisations funded through the NI Suicide Prevention Strategy "Protect Life – A Shared Vision" (DHSSPS 2006) were personally invited to the workshop along with key representatives from the Department of Health, Social Services and Public Safety (DHSSPS), the Public Health Agency (PHA), the Health & Social Care Trusts (HSCT), the Health & Social Care Board (HSCB) and members of the NI Executive Health Committee.

In total, there were 118 participants, 54 from the statutory sector and 64 from the C&V sector. A full list of attendees is detailed in Appendix 1.

2. Programme

The purpose of the workshop was to consider what more should be done to reduce the increasingly high levels of suicide in Northern Ireland. (A copy of the programme is provided in Appendix 2)

The event was chaired by Mary Black, Assistant Director of Public Health, PHA. The proceedings were introduced by Dr Eddie Rooney, Chief Executive PHA, who set the scene for the morning's discussions. Mr Colm Donaghy provided an overview from his experience as Chair of the Suicide Strategy Implementation Body (SSIB). He shared the need for society as a whole to respond to the challenge of suicide, rather than focusing only on the contribution of health and social services. Dr Carolyn Harper, Director of Public Health, outlined the pattern of suicide and self harm and the range of actions being taken, together with others, to address the issue. She charted progress and highlighted the need to do more. (A copy of Dr Harper's presentation is provided in Appendix 3). The Minister, Edwin Poots MLA, provided a personal perspective and an overview of what was required from his Department and other organisations. He affirmed the existing efforts as well as his willingness to seek additional measures that would prove effective in reducing levels of suicide. The Minister confirmed his commitment to addressing this challenge.

3. Group Discussions

The workshop focused on six key areas which had emerged over the years and through evaluations. These were:

- ❑ Connections with related issues such as drugs & alcohol use
- ❑ The role and impact of social media & communications
- ❑ Access to services
- ❑ Early intervention & building emotional resilience
- ❑ Support for families and carers
- ❑ Standards, such as those for counselling and training.

Within each of these broad headings, a number of issues were addressed including evidence of what is most effective, vulnerable groups, any gaps and what else needs to be done.
Below is a summary of the main points raised on the day. (Detail of all responses is provided in Appendix 4).

General overall comments:

- More integrated and collaborative working between government departments and sectors, including statutory, C&V, education, pharmacists, housing etc.
- A Strong emphasis on the need to link with GPs/primary care.
- Public Information campaigns are required (this was mentioned in most topic areas), including the need to avoid 'glorifying' suicide and handling messages with sensitivity.
- A sustained focus required across the life course.
- There is a need for further research locally to understand more about what works.
- Need to focus more on vulnerable/ at risk groups, while also covering the whole population.

Connections with related issues such as drugs & alcohol use

- Concerns were raised about amalgamating the strategies.
- A very broad risk group – can affect anyone in any situation – cannot take a 'one size fits all' approach.
- Need for culture change in relation to alcohol consumption.
- Important interrelationship of the issues – service providers need to be more aware of the links and other services available
- Important to adopt an holistic approach.

The role and impact of social media & communications

- Need to address impact of social media sites e.g. bullying, as well as using social media and other online forums to provide information.
- Security concerns for individuals and the need to 'block' sites.
- Better information required on recognised websites, particularly on services available.
- Use of social media to support people e.g. after care.
- Public information campaigns have been helpful, and clear, and language is important.

Access to services

- Need to improve access to services.
- More focus on crisis response.
- Frustration about what works and hard to reach services.
- Need for A&E staff training on services and family support.
- Need for evidence based services.
- Need more than Card Before You Leave for signposting to services– emphasised the need for physical handing over from one service to another.
- Care pathway to be clearer.

Early intervention & building emotional resilience

- Reduce stigma.
- Share resources and learning.
- Need for long-term funding to better plan services.
- Need for links with education to have mental health within the curriculum.
- Support for parents and families.

Support for families and carers

- Stronger support needed within A&E (quiet room/liaison worker).
- Support for bereaved parents.
- Examine the evidence (example used SHINE) at reducing rates.
- Better signposting and referrals for services with a family focus.

Standards such as those for counselling and training

- Need for accredited framework (BACP/IACP).
- Need for consistent approach across different providers, better coordination.

- Ensure services are regulated and monitored effectively.
- Need to include GPs.
- Competency as well as qualifications should be considered.
- Support mechanisms and a need to ensure that adequate standards are implemented.

4. Summary of Key Themes

- Importance of maintaining and expanding sensitive public information campaigns as part of an integrated strategy and action plan.
- Focus on service interfaces and the need for stronger connections and handover between providers.
- The need for a family focus and personal support for referral and engaging with services.
- Action needed using social media as part of an integrated approach.
- The need to secure funding on a longer term basis for community providers.
- Better coordination, monitoring and accreditation of counselling and other services.
- Better integration with primary health care and GP services.

5. Conclusion

There was considerable reflection during these discussions about areas of need and future direction. Mr John Compton, Chief Executive of the Health and Social Care Board, outlined key issues which had emerged from debate: the need to retain focus on the individual and family; the need for better coordination of services at all the levels; and the commitment of the Board to examine how best services could address the gaps identified.

Mary Black concluded the event with a commitment to forward a report of proceedings and to use the findings to help shape the future direction of the strategy. Immediate action will be for the Minister to consider feedback from the event and determine next steps. She thanked participants and speakers for their ongoing commitment and contribution to the day.

6. Evaluation

There were 60 evaluation forms submitted to the workshop. In general, the response from the evaluation forms was very positive with 90% stating that the event met their expectations. See Appendix 5 – Evaluation outcomes.

Appendix 1 Participants

F = Facilitator
NT = Note Taker

Present:

Table 1

Edwin Poots, MLA	Department of Health, Social Services and Public Safety NI
Dr Michael McBride	Department of Health, Social Services and Public Safety NI
Dr Andrew McCormick	Department of Health, Social Services and Public Safety NI
Dr Eddie Rooney	Public Health Agency
Dr Carolyn Harper	Public Health Agency
Mary Black	Public Health Agency
Colm Donaghy	Belfast Health & Social Care Trust / SSIB

Table 2

Topic: The Role and Impact of Social Media & Communications

Colin Fowler (F)	IPHI – Mens Health Forum
Brendan Bonner (NT)	Public Health Agency
Stephen Wilson	Public Health Agency
Arthur Cassidy	Yellow Ribbon Campaign
Margaret Mulholland	Northern Health and Social Care Trust
Denis Paisley	Old Warren Partnership
Gerry Bleakney	Public Health Agency
Leanne Mulholland	Public Health Agency

Table 3

Topic: Access to Services

Norma Patterson (F)	Contact
Martin Bell (NT)	Department of Health, Social Services and Public Safety NI
Kenneth Reid	Mayor of Dungannon
Joy Hammond	Northern Health and Social Care Trust
Anne Mooney	Department of Health, Social Services and Public Safety NI
Stephen Bergin	Public Health Agency

Table 4

Topic: Early Intervention and Building Emotional Resilience

Denise Doherty (F)	CWSAN
Gerard Collins (NT)	Department of Health, Social Services and Public Safety NI
Mary O'Hagan	Community Development Health Network
Anne McLarnon	Colin Community Counselling
Colin Loughran	Action Mental Health
Joe McKane	FASA
John McAllister, MLA	Health Committee
Pat Lynch	Aware Defeat Depression

Table 5

Topic: Support for Families and Carers

Eleanor Jordan (F)	Windsor Women's Centre
Denise O'Hagan (NT)	Public Health Agency
Anne Townsend	CRUSE Bereavement Care
Issac Andrews	Respect Project
Catherine McBennett	Niamh Louise Foundation
Dympna Johnston	Shankill Partnership Board

Table 6

Topic: Standards such as those for Counselling and Training

Karen Collins-Neill (F)	New Life Counselling
Aidan Murray (NT)	Health & Social Care Board
Walter Ferris	PIPS Upper Bann
Maxine McFarland	Holywood Family Trust
Lorraine Craig	Carrick Woman's Forum
Chris Totten	Public Health Agency
Angela McPoland	Public Health Agency

Table 7

Topic: Connections with related issues such as drugs and alcohol use

Liz McArdle (F)	Youth Action
Gary Maxwell (NT)	Department of Health, Social Services and Public Safety NI
Brendan Cassidy	Samaritans
Nicola Greer	CRUN
Anne Bill	FASA
Seamus McCabe	PIPS Newry & Mourne
Gabrielle Nellis	Public Health Agency
Hilary Parke	Public Health Agency

Table 8 – merged with other tables

Table 9
Topic: Access to Services

Danny Power (F)	HEART Project
Maurice Devine (NT)	Department of Health, Social Services and Public Safety NI
Audrey Allen	Action Mental Health
Trisha McQueen	East Belfast Group
Malachai O'Hara	Rainbow Project
Bill Halliday	Mindwise
Muhammed Sartaj	Department of Health, Social Services and Public Safety NI
Colin McMinn	Department of Health, Social Services and Public Safety NI
Bryce McMurray	Southern Health & Social Care Trust

Table 10
Topic: Early Intervention and Building Emotional Resilience

Monica McCann (F)	Barnardos
Siobhan Sweeney (NT)	Public Health Agency
Naomi McCay	Public Health Agency
Gordon Crozier	The Link
Susan McCrory	Falls Women's Centre
Eva Koemer	MACS Supporting Young People
Kathryn Bell, MLA	Health Committee
Bridie Sheridan	Youthlife
Lisa McElherron	NICVA

Table 11
Topic: Support for Families and Carers

Noelle McConnellogue (F)	ZEST Healing the Hurt
Molly Kane (NT)	Public Health Agency
Sinead McIlvenna	Lighthouse
Siobhan McGuckin	Korum Centre, Strabane
Maura Sharkey	Family Voices Forum
Marie Crossan	CAUSE
Nuala Quinn	Southern Health & Social Care Trust

Table 12
Topic: Standards such as those for Counselling and Training

Shauna Houston (F)	CLEAR
Seamus Mullan (NT)	Public Health Agency
Francine Curran	Lenadoon Counselling Project
Joe Conlon	Holy Trinity Centre
Michael Cairns	Family Voices Forum
Irene Sherry	Bridge of Hope
Mary Black	Public Health Agency

Table 13
Topic: Early Intervention and Building Emotional Resilience

Justine Brown (F)	North Belfast Partnership
Mark McBride (NT)	Public Health Agency
Patricia Magee	WAVE Trauma
Amanda Pollock	NACN/CRUN
Sharon Dickson	Lisburn YMCA
Jo Murphy	Lighthouse
Gota Maircella	Public Health Agency
Kevin Bailey	South Eastern Health & Social Care Trust

Table 14
Topic: Early Intervention and Building Emotional Resilience
Also discussed funding

Carrie Montgomery (F)	Contact
Josephine Devlin (NT)	Department of Health, Social Services and Public Safety NI
Stephen Barr	Opportunity Youth
Jeff Barr	Koram Centre
Pauline McMullan	Lisburn YMCA
Phillip McTaggart	PIPS
Fiona Molloy	South Eastern Health & Social Care Trust
Myra Redmond	Department of Health, Social Services and Public Safety NI
Maire Cairns	Family Voices Forum

Note – tables 15-17 merged with other tables.

Table 18
Topic: Connections with related issues such as drugs and alcohol use

Gary McMichael (F)	ASCERT
Madeline Heaney (NT)	Public Health Agency
Owen O'Neill (NT)	Public Health Agency
Mary Catherine McGuinness	WAVE
Albert Hewitt	Charter NI
Joanie Brown	Kilcooley Community Allotments
Briege Wright	Falls Womens Centre
Craig Cook	React
Peter Bohill	Belfast Health & Social Care Trust

Also in attendance

Ronan Henry	Press office, Department of Health
Lisa McAlister	BBC
Maeve Hully	Patient and Client Council
Amanda O'Carroll	Public Health Agency
Anna Morrison	Department of Health, Social Services and Public Safety NI
Dr Giles Aldworth	QUB (trainee)
Bernie McNally	Belfast Health & Social Care Trust
Al McComb	Belfast Suicide Awareness Support Group
Ann Mooney	Department of Health, Social Services and Public Safety NI
Dr D McAleavey	QUB (trainee)
Nuala Cullen	Southern Health & Social Care Trust

Appendix 2

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Suicide Prevention Strategy – Protect Life
Ministerial Event with Community & Voluntary Sector

Wednesday 28 September 2011
Kings Hall, Belfast

PROGRAMME

Chair: Ms Mary Black, Assistant Director of Public Health, Public Health Agency

9:00 am	**Registration, Tea/Coffee**
10:00 am	**Welcome** *Dr Eddie Rooney, Chief Executive, Public Health Agency*
10:05 am	**Suicide Strategy Implementation Body** Mr *Colm Donaghy, CE Belfast HSC Trust, SSIB Chair*
10:15 am	**Context for the Workshop** Ms *Mary Black, Assistant Director, Public Health Agency*
10:20 am	**Public Health Agency** *Dr Carolyn Harper, FFPH, Executive Medical Director/Director of Public Health, Public Health Agency /*
10:30 am	**Minister for Health, Social Services and Public Safety** *Mr Edwin Poots, MLA, Minister for Health, Social Services and Public Safety for Northern Ireland*
10:35 am	**Group discussions**
11:35 am	**Feedback from group discussions**
11:50 am	**Observations on the Day** *Mr John Compton, Chief Executive, Health & Social Care Board*
11:55 am	**Closing Remarks and Next Steps** *Ms Mary Black, Assistant Director, Public Health Agency*
12:00 pm	**Close**

Appendix 3

Dr Carolyn Harper

Director of Public Health, Public Health Agency

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Content

- Organisational roles
- Trends & patterns
- The approach
- Funding
- Challenges & how we might address them

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Organisational Roles

- DHSSPS & other Departments – set policy
- SSIB – advisory & scrutiny role
- HSCB (inc LCGs) & PHA – commission services
- Providers (statutory, C&V) – provide services

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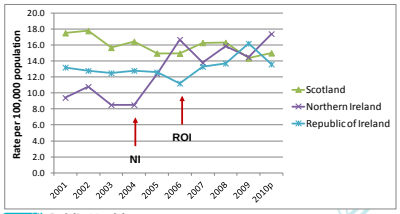
Registered suicide rates per 100,000 pop, 2001-2010p
NI, Scotland & ROI



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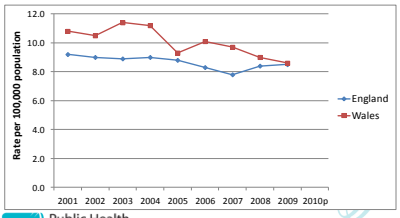
Registered suicide rates per 100,000 pop, 2001-2010p
England & Wales



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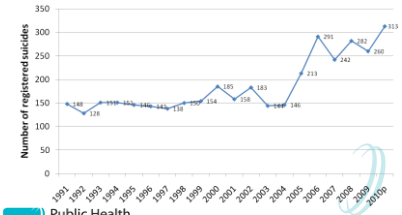
Number of registered suicides in Northern Ireland, 1991-2010p



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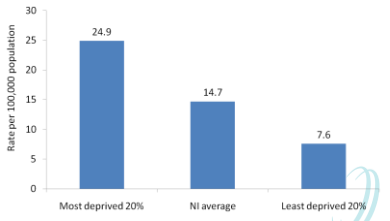
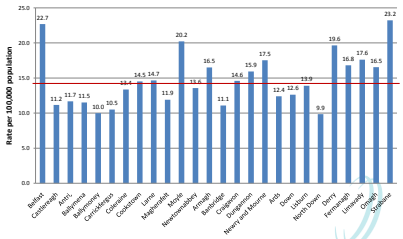
Inequalities within NI
Registered Suicide rates per 100,000 pop, 2005-2009



Public Health Agency

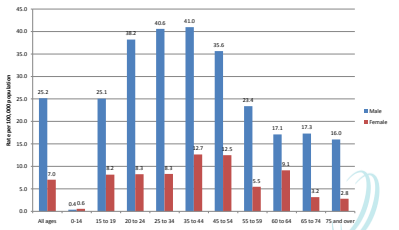
Rate of suicide in Northern Ireland by LGD, 2006-2010p



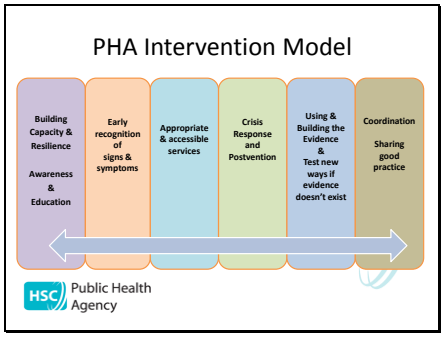
Public Health Agency

Suicide rates in NI per 100,000 (5 year rolling average 2006-2010p by Local Government District (5 year average presented to maximise robustness of data).

NI rate of suicide by gender and age, 2008-2010p



Public Health Agency


PHA Intervention Model
Building Capacity & Resilience
Awareness & Education
Early recognition of signs & symptoms
Appropriate & accessible services
Crisis Response and Postvention
Using & Building the Evidence & Test new ways if evidence doesn't exist
Coordination
Sharing good practice
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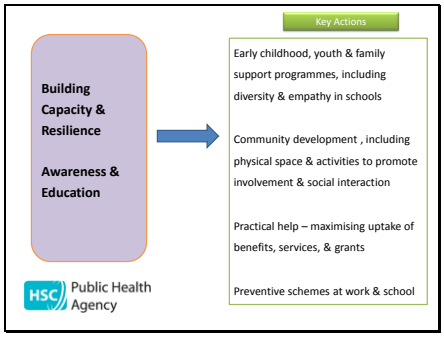
Key Actions
Building Capacity & Resilience
Awareness & Education
Early childhood, youth & family support programmes, including diversity & empathy in schools
Community development , including physical space & activities to promote involvement & social interaction
Practical help – maximising uptake of benefits, services, & grants
Preventive schemes at work & school
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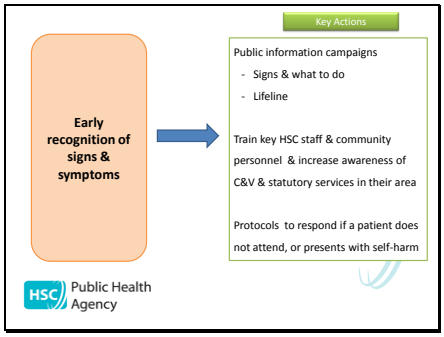
Key Actions
Early recognition of signs & symptoms
Public information campaigns
- Signs & what to do
- Lifeline
Train key HSC staff & community personnel & increase awareness of C&V & statutory services in their area
Protocols to respond if a patient does not attend, or presents with self-harm
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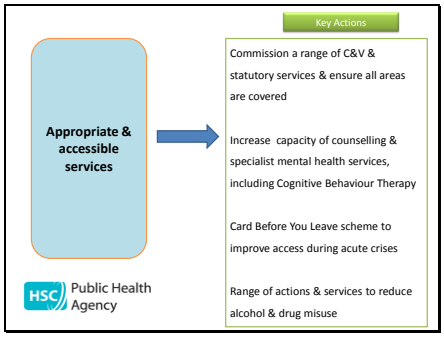
Key Actions
Appropriate & accessible services
Commission a range of C&V & statutory services & ensure all areas are covered
Increase capacity of counselling & specialist mental health services, including Cognitive Behaviour Therapy
Card Before You Leave scheme to improve access during acute crises
Range of actions & services to reduce alcohol & drug misuse
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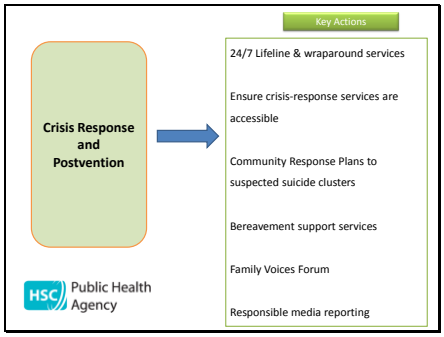
Key Actions
Crisis Response and Postvention
24/7 Lifeline & wraparound services
Ensure crisis-response services are accessible
Community Response Plans to suspected suicide clusters
Bereavement support services
Family Voices Forum
Responsible media reporting
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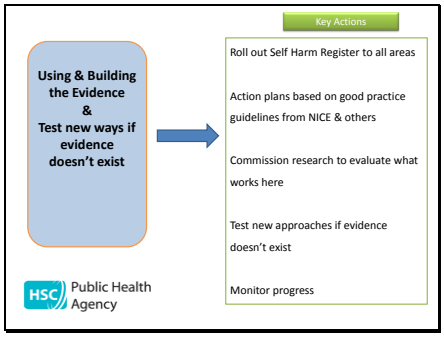
Key Actions
Using & Building the Evidence & Test new ways if evidence doesn't exist
Roll out Self Harm Register to all areas
Action plans based on good practice guidelines from NICE & others
Commission research to evaluate what works here
Test new approaches if evidence doesn't exist
Monitor progress
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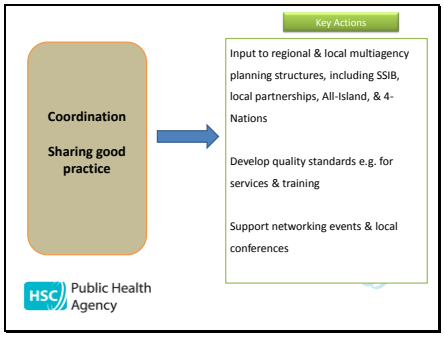

Current Funding

- 2010/11 funding for mental health services £231.8m
- Mental Health Promotion Funding £900,000 annually
- Protect Life funding £6.7m annually (including Lifeline)

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Much Still to Do

UNICEF Report Child Wellbeing 2007

Country	Rank out of 21 Developed Countries on 6 Domains
Netherlands	1
Sweden	2
Ireland	9
US	20
UK	21

unicef

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What Else do we Need to Do?

- Within health & social care
  - Scale & intensity – programmes need to be at a scale & intensity that makes a difference
- In other sectors
  - Unemployment – mitigate its effect & create employment
  - Education & Youth setting – rounded preparation for life or mostly an academic focus?
  - Alcohol – introduce minimum unit pricing
  - Neighbourhoods – should be clean, looked after & safe – responsibilities of property owners
  - Shape the culture – inclusive, more equal, vibrant, unified

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What Else do we Need to Do?

- Be clear & focused – on actions that make a difference
- Be constructively critical – look at the evidence
- Be brave – be prepared to stop doing some things if they are not effective
- Be connected – work together across sectors

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Responses in Full **Appendix 4**

Below is the responses recorded by the note takers for each topic:

Connections with related issues such as drugs and alcohol

1. Outside of your organisation/project, what has been working well and what could be improved?

Table 7 responses:

- Dealing with relationship breakdown
- How to deal with those not engaging
- Back to Work Schemes – No Short-term fix, Link up
- Partnership working works well
- Breaking down silos and using resources
- Sometimes lack of trust between C/V Sector and Statutory sector
- PHA – Need for greater transparency – Recognises input of C/V Sector
- Linkages with MH & Suicide
- Worries around amalgamating strategies
- Bottom up approach needed
- Need for separation of strategies

Table 18 responses:

- Increased programmes yet numbers still going up, but maybe would be even higher without additional activity. Maybe we are "seeing" more and more "openness". Is there a risk of glorifying deaths – murals, facebook etc makes it ok to do it.
- Connection to alcohol – most do not take alcohol intending to die. Are lower rates in areas of higher investment, impact of employment.
- Need to target higher risk groups better. Difficult to get people to engage it.
- Vulnerable people- often handle multiple issues but service providers don't always make connections to greater risk of suicide, e.g. If service for one issue, e.g. Debt / D&A etc.
- Need connections beyond health and education – housing etc.
- Need better working together.
- Primary Care: often need referral into services but GPs reluctant to refer or accept referrals from C/V groups.
- Vol groups often have people at greatest risk.
- Ex prisoners support groups doing good work.

- Questions why rates are increasing despite the increase in services. Concerns that suicide may be glorified especially among young people through facebook. There are more support networks in areas where suicide rates are low. Need to target males most at risk – feeling that we don't do this well.

Reponses from feedback forms

- Clear standards-roll out regionally.
- Partnership is working.
- Crisis response, protect life resources centres have worked well.
- Not enough support for people affected by economic downturn.
- Connectivity across departments/VCS.
- Training and awareness at 'grass roots' level-need resources directed more to this area, to improve community ownership of the issues and help members feel they can address drug/alcohol misuse problems and mental health concerns themselves.
- FASA, MH and AA, education and learning.
- Joined up working.
- More should be done to help ex-combatants integrate into their community.
- The One Stop Shop service for young people has increased access to Drug and Alcohol services by reducing stigma, adult One Stop Shop should be able to do the same.
- Recognition that there is a link with Drugs and Alcohol.

2. Are there any communities/groups/individuals that are particularly vulnerable within this topic area?

Table 7 responses:

- Young people – issues re: paramilitary's and debt
- Relationship issues (30-40%)
- Recently bereaved
- Those young people not engaged in community
- Those not involved in sports
- Carers & Givers – Emotional support for very sensitive, emotional resilience
- Areas of deprivation
- Transition stages
- Those recently made unemployed (or long term employment)
- Those accessing benefits

Table 18 responses:

- Drug & Alcohol issues
- Unemployed
- Those with multiple issues / vulnerabilities
- Poor education.
- Young people – schools
- Those with relationship problems
- Those who are referred and do not attend or only attend once / twice.
- Home based services need to address the wider health services with clients. Services tend to focus on just the presenting issue. Very important issue – need to build connections with housing, benefits and employment. Majority of people who commit suicide have issues with employment and debt.
- C/V sector have issues with linking in with primary care. Trusts would like to be in a position where C/V services can refer directly to the Trust Mental Health services.
- Services should go into schools giving young people information.
- Loyalist ex prisoners are a high risk group.
- Unemployed males
- Young people experiencing broken relationships
- High link between alcohol and suicide. Need for outreach to people with alcohol problems. This needs to be developed more because of the degree of non attendance with people who have drug and alcohol issues.
- 80% of people who have committed suicide have been in touch with a GP in the last 6 months.
- Women prisoners are high risk groups. They should not be in prison if they have major mental health problems.

Responses from feedback forms:

- Young men.
- Trauma from the conflict.
- Threats from paramilitary organisations putting young people and some older men at high risk.
- Debt-to paramilitaries /young people and also due to economic decline, unemployment/ lack of aspiration.
- Young people and relationship breakdowns.
- Individuals in middle adult hood, who have unemployment problems/living in deprived areas.
- Individuals living in rural areas-social isolation.

- Young people with dept, those that are threatened by paramilitaries, relationship breakdowns, recent arguments. Young people at weekends under pressure to take drugs and alcohol from peers, unemployed.
- Estranged youth, those living away from home.
- In my area of work, I feel that many loyalists ex-prisoners and ex-combatants feel that they don't fit into the community and then turn to drink and drugs which leads to suicide.
- Males in the economically active phase of life who reside in deprived areas.
- Hazardous alcohol users and drug users that are not connected to services.

3. Are there any gaps within this topic area that need to be addressed?

Table 7 responses:

- Short term fixes
- Tendering issues – competition between C/V Sector
- Commissioning not Tendering
- Learning from Protect Life to input to Mental Health Strategy
- Learning from Scotland – Embedded with Mental Health
- Balance of Approach
- Need for Family based approach to services
- Use of alcohol
- Debt
- Relationships
- Paramilitary
- Outcomes from Troubles
- Lifeline roaming charges
- ALL Island approach to Lifeline
- Issues re: drugs – Local CAT Team.
- Need a local service re: Drugs
- Outreach re: Crisis points – Young People and Suicide – Mobile Support
- Reaching Out to Rural Areas
- Education to schools – Consistency

Table 18 responses:

- People need to have better access to a wider more holistic range of services. Services need to be able to facilitate this. Need to stop services passing clients on from one service to another.
- Need to reduce the stigma against alcohol / drugs.
- Gap in support services for people leaving prison.
- Leaving A&E – people need more than a card, should be helped access services.
- Other agencies, especially housing services need to have a broader health focus.
- Multi-agency approach to support clients.
- Culture of drinking needs to be challenged, widespread misue.
- Place of safety – is it a gap? Currently exists in Leeds. Managed by C/V sector. Run by service users for self harm.
- Holistic one stop services for adults.
- Need to support people in a more holistic manner focusing on health and wider issues.
- Need better connections with Primary care and referral pathways.
- Connections better different services eg. Debt / Mental Health
- Links to education and schools
- Wider links with D&A outreach work
- Those in prison system – sometimes people put in prison when actually need mental health support and when come out of prison – what support? Adult one stop shops? Current services are for 15-25 year olds.
- Referral routes into services need to be more flexible.
- Information sharing needs to be better between services.
- Attitudes of A&E staff – are they a barrier to going to services.
- A&E may not “risk assess” someone who has alcohol.
- Improved working with Housing Executive
- Domestic Violence – Multi-agency approach in place – why not same for suicide?
- How to support people before in crisis
- Alcohol – culture
- Is place of safety a gap? Different understanding of what this is or might be.
- Need more holistic advice services for adults – not just health based. Signposting and joined up services

Responses from feedback forms

- Staff and volunteers need to have knowledge about how drugs and alcohol may contribute to risk and how to give advice and encourage access to support.
- Drug and Alcohol agencies should be encouraged to consider suicide prevention as a core role.
- A more holistic approach to support e.g. signposting to employment/ training/ benefits advice agencies to improve earnings and reduce deprivation.
- The main gap is to help ex-combatants; helping them before they turn to drink and drugs.
- Safe places for those with drug and alcohol issues especially at weekends maybe provide safe places.
- Drug and alcohol education progress are not enough, more youth to work with youth.
- Safe places for young people.
- Mentoring/peer mentoring for young people and also at risk of drug and alcohol misuse and abuse, looking at the separate issues within rural and urban areas.
- All Ireland roaming charges for Lifeline-should be free.
- Detached outreach- in rural ideas, i.e. Street Safe
- Safe place-Although I am aware of potential scoping exercise to identify a model-this is really welcome.

4. Are there other areas which need to be addressed?

Table 7 responses:

- Greater integration needed for all related issues
- Peer mentoring / bullying
- One size doesn't fit all (Rural / Urban Issues)
- Not Just a health issue
- Positive Messages – From everywhere – Integrated Response.

Table 18 responses:

- Male stereotyping – don't show feelings etc
- Why some areas have different rates to others – disadvantage is a major issue.
- Support organisation's need to think more holistically.
- Is there tendency to focus only on individual mental health issue
- Relationships and break up etc
- Most Important: Support people – not just in crisis but holistic and all factors that impact on life.

Responses from feedback forms:

- Short term funding-does not give stability
- Competing VCS agencies against each other with tendering- is destabilising the CVS and resources to communities-change to attitude to secure the assets we have got rather that ineffective tendering that causes displacement and destabilisation of not only the services but those people who are at risk, who don't know how access services.
- All-Island approach to suicide prevention, due to problems reaching border areas.
- Adult information and Advice Centre (One Stop Shop.)
- Pre crisis support e.g. counselling for anxiety and depression in community based provision.
- Building emotional resilience.
- Better communication between SU and C groups.
- Better trust between groups.

Other general comments from feedback forms:

- More training could be done with ex-combatants in a wide range of topics, this will help prevent suicide.
- Build resilience by introducing means of encouraging a forward thinking culture rather than reflecting on negatives like unemployment.
- Government Departments/services/CVS need to stop promoting negativity, i.e. there is no money, we are in a recession, need to start to promote positivity, resiliency, we can cope.

Role of Social Media and Communications

Table 2 responses

1. **Outside of your organisation/project, what has been working well and what could be improved?**
    - Clarity on the definitions -it's the tools /mechanisms that the public can communicate on the issue.
    - Note there are positive and negative aspects, promotion/opportunities but the risk of contagious/copy cat
    - Facebook concerns/evidence of contagious, related issues of bullying etc. Need for regulation.
    - Need to encourage non-virtual communication, need to encourage people to be realistic.
    - Concerns on privacy laws.
    - It provides an opportunity for surveillance and identifies individuals who post these emotions and are at risk.
    - We need to make sure that information sites are more accessible, easy to use, content and signposting.
    - Link to early intervention and encouraging young people to communicate to people.
    - Need to take account of technology changes and the greater use of mobile technology/phones.
    - Need to use software development to make information more accessible across various internet tools e.g. Youtube etc.
    - Need to link to education curriculum e.g. GCSE in Suicide Behaviour, Education Training Resources.
    - Need people to teach people here to communicate better on a personal level.
    - Need to consider how the media reports/advertising ranges around the issue.
    - We need to improve media monitoring to include websites not just the newspapers/TV

2. **Are there any communities/groups/individuals that are particularly vulnerable within this topic area?**
    - Rural communities/farmers in particular.
    - Ethnic minority groups were English is not their first language.
    - LGBT chat rooms.
    - Chat room monitors need to be trained/awarded.
    - Use of weekly texts 'feel good messages'.

- People with mental health problems-needs clarity on the appropriateness of the messages/ethical considerations.
- In terms of PR campaign needs are separate positive mental health issues and separate suicide issues.
- Message-Suicide is selfish-need to be non-judgemental. The message has to be in language that focuses on the consequences.
- Protect life/life is valuable positive message-'your head is away, just say'.

3. Are there any gaps within this topic area that need to be addressed?

- Mobile unit going to those young people/communities who won't go to centres.
- Policy makers need to consider the consequences of their decisions e.g. Gay Blood Donor ban reinforces stigma.
- Connectedness at a strategic level and local. Need to link closer issues like drugs and alcohol, social health and suicide.

4. Are there other areas which need to be addressed?

- We need to get a grip of how we can use social media, and how this can be regulated. The issue of I.T security blocks HSC bodies.
- Need to focus on hard to reach-give local groups the resources and information to support them.

Other comments

- Need to encourage people to communicate verbally and not depend on virtual, face to face contact has to be promoted.
- Broader security issue-'need to look out for each other.'
- Social media is a fact of life-need to keep in touch and use appropriately, how do we get information to people-this is the way in.
- Awareness of what the consequences are, avoid glorification.

Access to Services

1. **Outside of your organisation/project, what has been working well and what could be improved?**

Table 3 responses:

- Community Mental Health Teams: more timely response and multi-disciplinary.
- Lifeline Follow up
- Generic MH Services good at targeting middle aged people ie, via GP etc.
- MH Promotion in sports club etc (Wellbeing promotion good)
- Crisis response home treatment teams.
  How could be Improved
- More research to causes: medical, lack of BZ, Deficiency?? Biological issues.
- Communication – assessment of patients views and HSC view
- Greater younger person focus in MH Service – more tailored.
- Services focus too tight: need to link in with C/V Sector Providers and MH Promotion work to stop "revolving door" syndrome.
- Utilise local knowledge via existing local service providers (social capital).
- Public Information Campaign
- Lifeline to form part of Trust Delivery Plan, i.e. Children calls.

Table 9 responses:

Three Distinct Areas

- Prevention
- Crisis Intervention
- Aftercare & Support
- First expression of disappointment re: context – should have been more focus on specific vulnerable groups.
- Local knowledge re: potential clusters but no action taken. Card Before You Leave has not worked for young people (East Belfast).
- Colin area – felt that speed of cluster response was slower than expected but has had positive subsequent impact in terms of establishing linkage and coordinated action.
- Prevention and early intervention should be targeted.

- Concern regarding connectedness of everything across the wide range of stakeholders and the massive challenge of enhancing this – need for local rather than regional action.
- Process re: getting into A&E is good. Big issues is training of A&E staff. Need to enhance communication between A&E AND Mental Health. Identify revolving door people who self harm for example. No clear cut guidance regarding management of alcohol (drug abuse in A&E). Unclear about the purpose of the self-harm registry
- Real key issue is to do prevention – but how can we address long-term outcomes / impact not a vote catcher – we are reactive across the board. Highlighted no other departments involved in today's proceedings (further clarification provided from the chair re purpose and invitation to the event)– e.g. Education. ASIST Training should be compulsory. Five churched in Ballynahinch have pulled together and developed a social club for young people – excellent response.
- Cultural Psyche – "brings things to yourself" – how to we change this. Also issue re: media etc talking about profiling suicide.
- Need to be more innovative how we reach those that are hard to reach. Lifeline generally working well – free 24 hr crisis response.
- Across the spectrum and across services – from promoting mental health, early intervention, crisis management, identification cluster responses, HSC, Vol/Community groups, education, clergy, police.
- Surestart;
- CBYL;
- Assertive Outreach;
- Managing Non-compliance DNA etc
- Early in-life interventions
- SAIs
- Self Harm Register
- Joined up approach
- Sharing best practice – the evidence base
- Roots of empathy
- FNP
- Public Information Campaigns

Responses from feedback forms:

- Immediate A&E crisis works well but things then seem to fall apart.

- An example of what really worked was the followed up approach and response to the Colin Area issues. This response extended beyond boundaries and hours-what we can do when we think outside the box.
- Crisis response care home treatment teams and CAIT teams - great to have them, need to be more linked up formally with lifeline for hand over. Likewise A&E and mental health discharge systems need to have hand over to lifeline built in.

2. Are there any communities/groups/individuals that are particularly vulnerable within this topic area?

Table 3 responses:

- Young Males – MH services lack sufficient focus
- Ethnic groups – Big issue in Dungannon area
- Farmers
- Police
- Dentists

Table 9 responses:

- Lesbian, Gay, Bisexual, Transsexual due to discrimination. Criticism that these groups are not well targeted. Who is representing BME groups/ Prisoners at this event?
- How do we provide access to services in respect of the increasing social morbidity – debt, unemployment etc – they don't fit into categories – how do C/V sector reach out to these people (who don't use services – GP / Education etc need to step up to the mark here). C/V Sector are key in this with regard to capture and support these individuals – but concerns regarding funding to these groups. Can't continue on a goodwill basis. Need to further develop local joined up partnerships.
  Vulnerable Groups
  - Self Harm
  - Young People
  - Males
  - Older People
  - Prisoners
  - Debt
  - Alcohol / Drugs
  - Mental Health
  - Using A&E
  - Unemployment
  - Rural

Responses from feedback forms:

- Young men do not often engage with face to face services or are seen to be non treatment compliant – we need to find a strategy to engage them – need to connect with the person and their family and experiences. Older people get forgotten about then sometimes.

3. Are there any gaps within this topic area that need to be addressed?

Table 3 responses:

- Reduction in MH funding
- Lack of connectivity between Statutory and C/V Sectors

Table 9 responses:

- If we are a small region we should know each other – why are we not doing local partnerships better – across agencies for example.
- The issue of disconnect is key and we are not doing this well enough.
- Frustration and uncertainty that even with evidence, facts, figures we still don't have the answers. We still don't know what works – this highlights the crucial need to target early in life interventions (eg.FNP) where there is clear benefit to long term positive outcomes in context of health, mental health, social morbidity, criminality etc. Do we have an evidence base in relation to suicide in this context.
- The key message through this is that we have done lots of good / short-term / reactive things. They may work in the context of preventing suicide locally but the upward trend (overall) still exists. Perhaps to stop the upward trend there needs to be a mindset that public health suicide prevention will only create a positive downward trend by targeted preventative action – particularly for those groups we know as vulnerable.
- Not just access – also about skills / competence
- Hard to reach, refusal of service, DNAs
- Impact of Capacity Legislation
- Focus given to learning in context of Mental Health.
- (NCISH) – what about other 70%.
- Public Perception
- Access criteria in Mental Health
- Managing social problems (relationships, finance)
- Cross jurisdiction work

Responses from feedback forms:

- More innovative services less rigid more flexible, accessible, appealing, less judgemental and labelling.

- Yes the Minister talked about “joined upness” and connectivity. No-one seems to be seriously addressing this issue. Also the gap at the 5 church initiative “the edge” in Ballynahinch as an example.

4. Are there other areas which need to be addressed

Table 3 responses:

- Need for less stigmatised and more responsive and joined up / connected services (both stat and c/v) which reach out to people at times of crisis and which utilises local knowledge and services where available.

Table 9 responses:

- Adverts / medic – need to draw out the issues – such as “I’m gay” “I’m terminally ill” “I’m in debt”.
- Teachers not equipped / resources to build in emotional resilience into the curriculum.
- How do we examine those cases who died by suicide but who were not dealt with via SAI Mechanism – we don’t learn from this.
- Social Capital Development
- NB: We didn’t get the opportunity to discuss After Care Services but in context of Access to services this is vital.

Responses from feedback forms:

- Formal agencies and training for police and ambulance on assessing rights and A&E having an agreement to receive assessment (if available) from lifeline and refer back to lifeline on discharge. Exit and entry points need to be supported by the lifeline service.
- Funding – urgently. Increasingly we are dealing with “contracts”. Managers rather than professional staff who are in danger of destroying existing services and will not develop “up stream” preventative services.
- Long-term funding, more strategic, less competitive, very useful event.

Early Interventions and Building Resilience

1. **Outside of your organisation/project, what has been working well and what could be improved?**

   Table 4 responses:
   - Development of Colin area Early Intervention Strategy & Colin "Health for All".
   - Roots of Empathy
   - Surestart (but see below)

   What could be improved?

   - Efforts to support employers to keep people in work when they show signs of mental distress and/or become mentally unwell. Use/promotion of services such as CareCall, promotion of healthy workplace policies.
   - Efforts to reduce stigma associated with mental illness. Provide training for employers on this issue.
   - Ability/willingness of schools to signpost to community-based mental health support services.
   - Teacher training on emotional resilience. Who is training the teachers to deliver emotional resilience skills. Cascade training doesn't work.
   - Joined up working.
   - Takes too long to roll out successful local programmes regionally.

   Table 10 responses:

- PHA campaigns have worked well. Best use of media is to direct to where can get help.
- Better joined up approach. E.g. communities of interest, facilitated by Colette Rodgers.
- Sharing information and best practice.
- Just because services are available does not mean they are accessible, e.g. stigma attached.
- Idea of a full services school- big gap-more holistic approach.
- Need to do something now.
- Need safe space-local community-put professional in community with local workers.

- Strong connection needed between local community workers and professional mental health-need to work in tandem.
- Sharing resources but these are under resourced.
- Number of beds decreasing-need to research respite centre.
- Need to look at Lifeline-could it be more flexible-what it delivers-24hour building-emergency.
- Lifeline should work in partnership with other organisations
- Families-parents and teachers as well as young people.-area under sourced.
- Often by luck who gets services-because of the nature of funding-so many 'pots'.
- Life skills versus academia, often affects who school will allow in to deliver services.

Table 13 responses:

- Early Intervention & Building Resilience
- Fit for All
- Steps for Life
- Roots of Empathy
- Aggression targets children who have shown bullying threats, delivered in schools in Belfast P5. 3 programmes, different age groups – being rolled out over other areas outside Belfast.
- N Belfast – Parenting Programmes
- WAVE TRAUMA – 10 Week programme
- YOUTH STAR – Trauma programme – Building everyday resilience for young people. Also WAVE have other programmes and support families.
- Tackles unresolved issues - helps young people being bullies.
- Moyle Area – lack of informal / formal programmes. Links with Key agencies e.g. working with youth leaders – brings in parents when youth cause problems. Keep rural communities at forefront.
- Kevin Bailey 'Bouncing Back' to increase resilience, mental health staff, health visitors can use with clients. There is also a youth version.
- TATI – Mental health / sex Health Southern area recently.
- What is resilience – public don't understand concept – we do not use language public can relate to.
- Need to pass on from generation to generation. We put services into address symptoms not the root causes.
- 'Take 10' Pharmacy developed – Belfast Primary schools

- A holistic approach is needed – need tools and resources to deal with.
- We have good services but they are not always used when needed – used only in crisis.
- SHARP Programme – programme in all secondary schools in Eastern area. Alcohol, Training pack for training teachers. Parents involved through homework sent home.
- There is good practice, e.g. Early years – we don't need to always reinvent the wheel.
- 'Just Say No' campaigns – did they work??
- Public Information Campaign
- Strengthening Families

Table 14 responses:

- More long term funding required in order to sustain services longer term
- long term funding essential in order to retain experienced staff – at the moment groups unable to offer permanent contracts
- Funding should be directed to those areas experiencing higher rates of suicide
- Funding should be tailored to meet the need within each local community
- Funding should be directed to specific issues effecting a local community
- Need more resilience building programmes in schools
- Teachers not always fully trained to deliver programmes -best to have an fully trained person from outside the school environment delivering the programmes in schools
- Resilience building programmes in schools should be intergrated as part of the school curriculum and given the same priority as lessons –this would help remove the stigma associated with mental health illness
- Good quality training required for all including voluntary workers working outside normal office hours

Responses from feedback forms:

- SET roll out of Positives Steps- MH and EW being programme- increasing self esteem, confidence, asking for help, making contribution, valuing self and others-30 orgs training and delivery.

- Referral from MH for those who don't meet MH threshold for treatment, but still need MH support and those at the end of treatment-follow up support and care.

2. Are there any communities/groups/individuals that are particularly vulnerable within this topic area?

Table 4 responses:

- 14 year olds (see below), unemployed people, people recently made redundant, people in stressful work places
- Unemployed and socially disadvantaged young people - particularly young men (who are a difficult group to reach)

Table 10 responses:

- Life skills versus academia again not all schools will allow services in. Almost don't want to admit there is a problem.
- Emotional resilience- whole family take everyone on board- particularly those bereaved by suicide.
- Need for more postvention work with these bereaved.
- Community can be last place for early intervention.
- Increase in referrals from primary schools.
- Presenting with anxiety issues.
- Young people experiencing unemployment and poverty.

Table 13 responses:

- All People – at all stages of life
- More support is needed earlier – also focus on 14/15 year age group
- Young men – some bullied by paramilitaries
- Ex prisoners – now have loss of identity
- Unemployed
- Single parents
- Mental health issue
- Rural and Urban
- Parents with Disabled Children.

Table 14 responses:

- Children not of school age, primary school children and parents
- more resilience building programmes needed in primary schools

- resilience building programmes needed in nurseries e.g. Tattered Teddies programme, Bounce Back programme

Responses from feedback forms:

- Isolated teenage males
- Parents
- Parents of disabled children
- Rural dwellers-isolated from formal and informal services, who are generally more insular and less vocal. Give them a community resource to connect to opportunities to engage around health. Connect people who are particularly vulnerable. Connectedness=resilience. Poor connectedness= poor resilience and suicide
- Older people and suicide–most likely to die from suicide attempt than other particularly older men.
- Early intervention for all, not just early years interventions across life span.

3. Are there any gaps within this topic area that need to be addressed?

Table 4 responses:

- Surestart provision is not wide enough.
- Health Visiting seems to focus exclusively on the mother & baby. Fathers need to be brought into the visits & be engaged with.
- Lot of young people seem to take poor lifestyle choices - such as drugs, alcohol, unsafe sex (all of which can be detrimental to mental health) - at around age 14. Much of this is through peer pressure. They need better role models and preparation for facing these pressures from about P7 onwards. This should include efforts to prepare families to deal with emotional pressures that come with the onset of adolescence.
- GPs always absent from workshop events such as todays. Make mental health promotion/community engagement part of GPs continuing professional development and include it in the GPs Quality & Outcomes Framework. GPs seem to be outside of the loop on suicide prevention under Protect Life.
- Local mental health/suicide prevention contact points in GP surgeries.

Table 10 responses:

- How do we promote local services

- Connectedness from medical services to local services-how people are treated-people have barrier with medical services.
- Resource local communities to respond at early stages
- One stop shop for all ages-joined up with community-flexibility in terms of hours can be based in community building.
- Need to look at funding long term build on-not one-off or short term –need to be more long term.

Table 13 responses:

- Peer education, programmes tailored for different age groups
- More input from ELBs
- Youth service workers stretched to deliver courses. The culture does not include addressing emotional issues. The focus is on physical activity.
- WAVE – Young men bullied. Gap between strategy and ground level. There is no one to turn to.
- Gap to bring evidence to reality. Need to give correct information to individuals.
- Realisation that people respond differently and have programmes that suit them that they know about.
- There are less 'protective' communities.
- Lack of consistent / sustainable funding.

Table 14 responses:

- More research e.g. longitudinal study into the causes of suicide
- more partnership working
- Mentoring support for trainers and people working in the area of suicide prevention –clinical support for people working in the field of suicide prevention is essential

Responses from feedback forms:

- Targeting those who don't go to youth groups or who don't turn up to school.
- Older people and suicide.
- Women aged 35-50.

4. Are there other areas which need to be addressed?

Table 4 responses:

- Standardisation of pre-school provision in terms of quality - private/voluntary sector provision lags behind state sector/DE provision in terms of quality.

- Early intervention is not just about intervention in the first 3 years of life, it's about early intervention across the lifecourse and particularly at known points/transition of vulnerability such as starting school, moving to secondary school, leaving school, becoming unemployed, retiring, divorce, etc.
- Development of "community maps" at a very local level that identify handful of who can look out for people who are at risk and who can intervene on suicide prevention/mental health promotion - e.g. pharmacists, GPs, Youth Workers, Teachers - and then ensure that these people receive the relevant training. Statutory services should commission local community groups to pull together these "community maps". Similar to Neighbourhood Watch schemes.
- Wraparound services provided by Lifeline need to be evaluated quite soon and revised in light of evaluation findings.

Table 10 responses:

- Quality of relationship with community and medical professionals-joined up approach-support to community sector to do that.
- Support for these working on this issue on the front line-many on short term contracts-some volunteer, no funding.
- 'fit for purpose
- How can you plan for long term if money in 'year' applying every year-losing staff-retraining.
- Delivering together on an equal basis.

Table 13 responses:

- Programmes targeted towards younger people
- We need a constant drip feed
- Need to communicate in a modern way – smart phones, modern media
- We need to involve young people more
- Target others through young people to parents
- Not necessarily about more programmes but having programmes that link and are timely
- New parents need to care for themselves and they need support also in parenting programmes.

Table 14 responses:

- More cross departmental working
- Need to stop duplication in departments
- To promote cross community groups working together -funding criteria needs to be looked at because the way it is at this time

groups are reluctant to refer clients to other organisation for support because they will lose the funding for that client

Responses from feedback forms:

- Teaching of good coping mechanisms
- Emotional resilience needs promoted at a scale, intensity and in a language that the individual, family and community get-not as a concept/definition but describe it in a practical steps/way with visuals of a good peer (all ages) who demonstrates good emotional resilience and use this as a campaign, we need to raise competence on this.
- Mental strength may be a more easily understood term than emotional resilience.

Additional comments:

Table 4: Community pharmacists can be the first to spot post-natal depression. They should be encouraged to do so & trained to signpost the mother to local sources of help.

Table 10: Very difficult to be strategic when we have having to cope with short term funding. Need long term funding-will help to keep skills in sector.

Table 13: Language used to communicate information around emotional resilience – needs to be less conceptual. Needs to be practical, visual, real and local. Culture change about asking for help and supporting behavioural change. Peer support young people to be part of the process.

Table 14: It should be noted that most of the discussion in this group was centred around current funding arrangements and how this needs to be reviewed to promote more community groups working together and the need to keep experience staff in posts longer term to prevent losing their expertise within communities.

Support for Families and Carers

1. **Outside of your organisation/project, what has been working well and what could be improved?**

Table 5 responses:

- Attempts to control media reporting of individual suicides felt to be working well
- PSNI system working well – offering to pass details to Health Services so support can be offered. If families say no at this stage it needs to be reoffered e.g. when post mortem results being given to family and when coroner deals with family.
- Within their organisations: Felt that the process used by Greater Shankhill Reference Group was valuable i.e. First responders- then open up a centre within the community to provide support and provide family packs to signpost people.
- People giving up free time to help – commitment.
- Issue of bereavement becoming less taboo was felt to be a positive step.
- Card Before You Leave- good idea but appointments take too long. Family need support in the intervening period until appointment.

Could be improved

- Provision of a range of types of intervention for those bereaved as not all people will want same. Counselling not wanted by some families. Other services e.g. complementary therapies to help de-stress often more acceptable.
- Need more co-ordinated provision of bereavement support.
- Often plethora of support offered in unco-ordinated manner and families may not be accepting of need for support.
- Need a family liaison worker to offer and co-ordinate support from range of providers.
- Increased availability of other practical supports to bereaved families e.g. childcare etc particularly at time of death.
- Need separate private waiting area in A&E. People who self harm have long waits and are often abused by other patients when waiting. This is also a NICE recommendation.
- Need more continuity of care when in statutory services.
- Need support for C&V sector staff who are often traumatised when dealing with people at risk.
- Everyone should ask about risk and know how to respond.

Table 11 responses:

- Identifiable gap for supporting bereaved families, development of Hope, Heal and Help programme to support families. Families seen as a group. Group members can decide what they need. Psycho education very important – not just talking shops.
- Support groups for bereaved parents very important – all support groups give families opportunity to let off stress, feel safe, supported without judgement. How do we support families that don't want support or don't know how to get it? Need community liaison suicide support officers.
- Different family members may react in different ways- have had different relationship with family member who has died. Some people may never access support. Like idea of process – path to move through different stages.
- If can put into place policies which already exist. Person centred planning to provide range of services to let people know what is there.
- One Stop Shop doesn't fit all.
- Scale and intensity of programmes important. Invest in what is there not novelty. Need to ensure programmes are effective. Abandon services that are not working. Families need to be able to move on.

Responses from feedback forms:

- SHINE project –clinical evidence based effective services/interventions, family support services (Individual counselling and family support programme) delivered in the Western Board. Rapid response for Clients who have been admitted to hospital following serious incident of self harm/ attempted suicide who are referred to voluntary counselling service before discharge from hospital and will be seen in community (counselling service) within 7 days. This is backed up with family support services to keep the whole family not just the individual who has self harmed/attempted suicide but the family.
- Efforts to deal more appropriately with suicide from the media perspective e.g. Samaritans who have done some work to stop the media glare and whip up fear in communities.

2. Are there any communities/groups/individuals that are particularly vulnerable within this topic area?

Table 5 responses:

- Bereaved families and friends
- Ex-combatants – see below.

Table 11 responses:

- Support groups good and work well for adults. Groups of young adults adolescents don't fit into this model and children.
- Deaf community vulnerable
- Rural communities – isolation – people want privacy, don't want others to "know their business".
- People with dual diagnosis – MH & Alcohol – difficult to meet needs
- Support for young men and families
- SHINE Project in West has reduced rates in West – linked to those admitted to hospital seen within 7 days.
- Need to target individuals and make sure help is there when people directed. Vulnerable groups growing as a result of recession / change in benefits.
- Hard to reach groups – local free paper inset information in paper. Change in rules on housing benefit. Need other departments linked into this. Research in the young men 18 – 35 years. Need informal support, sports etc. Peer support important.

Responses from feedback forms:

- Young men and siblings parents who are at a higher risk.
- Deaf community
- Rural community

3. Are there any gaps within this topic area that need to be addressed?

Table 5 responses:

- C and V sector overwhelmed and unable to cope with volume of referrals and people signposted by GPs. There are long waiting lists.
- Need more strategic longer term funds to develop services.
- GPs are asked to decrease prescribing but are not providing an alternative.
- Need to involve children in campaigns and ensure tested with children-must be sensitive e.g. An anecdote: one child was repeatedly being told that he needed to be the man of the house now when he felt he didn't want to.
- Develop resources for dealing with children bereaved.

Table 11 responses:

- Socio-economic downturn, long-term unemployed, areas of deprivation.

- Increase in alcohol abuse and mental health problems. Alcohol needs to be addressed
- Safe houses, places of safety for A&E. Need for all A&E staff to have programmes such as ASIST.
- A&Es need calm areas for people at risk of self harm, mental health
- Need mental health staff working in A&E?
- Users and carers views need to be central to service development and design.
- Resources are needed back services and provide services.
- DNA service users need to ensure appropriate support and follow-up.
- GP in particular in developing and being involved in services.

Responses from feedback forms:

- Tracking people at risk from point of entry into the service and exit (follow up) long term services where needed
- Address impact of alcohol in SH/suicide.
- Government to address cheap alcohol and easy access.
- I.D client who have attempted suicide to trace if they have been seen or not. I.D vulnerable families.

4. Are there other areas which need to be addressed?

Table 5 responses:

- Reports from one organisation that people who have been involved in activities during the Troubles who are experiencing mental health problems are finding that when they present for help they feel they are unable to obtain the support they need. They are often offered medication and being told by health professionals and counsellors that if they make a disclosure it has to be reported and so are not able to discuss their problems. Anecdotally this has resulted in a number of suicides as ex-combatants are struggling to come to terms with their role in the Troubles. Need to build support for C&V sector who are attempting to provide support to these groups- often traumatic for the listener who provides the listening ear.
- Need to ensure wide stakeholder involvement e.g. Funeral Directors.
- There was support for Public Advertisements as discussed by Minister but not shock tactics. Needs to be very sensitive.

Table 11 responses:

- Cost effective services – c/v / statutory need to learn from each other – lack of communication between all sectors. Mapping of all C/V services and Stat – Information for all collate and keep up to date so as to be used by those who require it. Use electronic system.
- Prevention of suicide needs to be focused on – not so much focus on after the incident occurs.
- Easy access to services. Current S/E downturn impact on individuals who are vulnerable cannot be stressed enough.
- C/V and Stat services must work closely together in a joined up manner. Evidence based services available. Replicate what works. Ensure services being delivered meet the needs of service users and that they are effective, efficient and cost effective and work across departments.

Responses from feedback forms:

- Hurt individual=hurt families and holistic integrated approach through the provision of services in effective partnerships between both statutory/voluntary and community sector who deliver quality assure cont. Effective services.
- Accountability and responsibility of all government rep/stat sector, com/vol sector to ensure effective service that meets individual and family needs.
- Dept/PHA needs to collate existing evaluation of community/voluntary and statutory sector to ensure they are working before they continue to be funded. Responsibility /accountability

Addition comments from table 5:
Need for cross departmental funding for family support workers to provide support to:

a) People with serious mental illness and their carers.
b) Individuals who self harm and their families.
c) Families after suicide.

Standards such as those for counselling and training

1. **Outside of your organisation/project, what has been working well and what could be improved?**

Table 6 responses:

- PHA SAI Review revealed the lack of an accredited framework for counselling based on any DHSSPS Guidance. Draft Guidance was not issued therefore there is no regulation of the standards for counselling which has a statutory authority in Northern Ireland. As a consequence of this there is a variation in counselling practice and indeed concerns that this variation leads to poor practice in some cases. There is therefore nothing to stop an individual or group setting up as a counsellor with little training or experience.
- Training standards are crucial and the field is very crowded with "so called counselling qualifications" which may or may not be adequately accredited or have necessary professional supervision or placement time on the course.
- The Training for individuals needs to be backed up by a safe governance framework for counselling activities. Adoption of BACP or UKCP standards or equivalent would be only acceptable to commissioners of services. It should be seen as a vocation not just an academic qualification.
- Define more clearly what counselling is and is not e.g. befriending has a valid role but it is not counselling.
- GP training and awareness of emotional distress could improve earlier pick up and earlier intervention. GP's awareness of counselling needs to be improved.
- Better co-ordination of the various counselling services; it is partly competitive and therefore not delivering the best service as a total contribution to meeting need – there is overlap and inefficiency as a result.
- A Mental Health support service (statutory or C&V) in GP surgeries was one suggestion that could actually be delivered in the surgery or close by in a time of distress.
- Men often present at GP with other symptoms when there is an underlying emotional or distress issue which needs to be given time to be discovered and met by a local wraparound service almost immediately.

Table 12 responses:

- There is recognition in the sector that standards need to be improved. Groups are prepared to move on this.

- There is a lot more working together than years ago, but there are still people working outside the process who need to be brought in.
- Some organisations, ISO, Investors In People etc, so still a recognition that there's a need to improve.
- Need to build liaison with other groups in the sectors.
- It's one thing having policies, but are they just lifted and cut and pasted from other organisations – implementation and monitoring needed.
- Know your limits, niche and expertise.
- Specialise – funders need to gate-keep the services that are provided – more regulation. Approach this from a mutual support perspective, not an auditing function – what are your org requirements, support needs etc.
- Too much decisiveness in the sector, not only in groups but also in the commissioning of services.
- Need for regulation of consistency of people who are inspecting the services provided.
- Need for standards, protocols on use of social networking by groups.

2. Are there any communities/groups/individuals that are particularly vulnerable within this topic area?

Table 6 responses:

- All at risk – Public Health approach but particular groups are young men and older men. The approaches to contact need to be not health service focused and led they should be community led and based in places and activities where people are.
- B & ME & Traveller communities are not well represented in demand for services. This needs to be met by greater outreach activity and wraparound focused on primary care.
- There is still a taboo on not only suicide but on the wider mental health range of conditions.
- Men will attend services that are designed for them whereas GP and associated primary care seems to them to be "female" oriented. So services need to outreach into male environments, clubs.
- Services need to be delivered outside conventional 9 – 5 hours and need to be answered and delivered by people not answer phones with push button 1 etc
- The Criminal Justice interface is also important to reach difficult and at risk groups – e.g. better connections with Police in Police

Stations/Custody Suites where many people come to attention first.

- Youth Services are crucial to reaching young people in dangerous "out of hours" settings in local communities. More formal linkages, maybe employment, better training for recognition of problems and onward referral to local, already known and co-working services where equipped to respond.
- Services need to overcome the reluctance to go into areas not traditionally and at times which we are comfortable with.

3. Are there any gaps within this topic area that need to be addressed?

Table 6 responses:

- Primary care should be where the front line services are accessible → not through an intermediary with waiting lists or going to secondary care or A&E.
- Financing for this new way of working is required. Some of this can be made available through efficiency in doing the right thing not the wrong thing where money is being spent. Existing community settings could be used more not new buildings.
- There is also a need to make efficiency work within the C&V system. There are still too many services not operating in a joined up way often in the same small local areas.
- Training for GPs in practice now is needed but also much more widely in prequalification training for not only GPs but also teachers, youth workers as well as the more obvious other health care professionals.
- Department of Education and OFMDFM – counselling standards for education and for the victims sector should be looked at for lessons to be learned before we try to develop a new set.

4. Are there other areas which need to be addressed?

No specific response provided from either table.
Other general comments received from Table 12

- Awareness of Standards
- From those not involved in groups – lack of awareness of standards. Seem to have a lot of courses for people on the front line, but do they have the time to do it?
- Would like to pose the questioner: how many know what they are doing could be better.

- Lot of groups wasting time chasing funding and red tape.
- The place is full of knowledge, research and expertise – just get out there and deliver,
- ASSIST – A lot of individuals completing this have lost loved ones from suicide – should this be the case- should there be a detachment. It was rolled out to those who would participate and volunteer. Qualify this with the fact that people did have to go through training and interviews, but not assessed for suitability in all Trust areas. Need for consistency and a support mechanism for trainers.
- Lack of monitoring for training programmes
- Any group can provide training by booksoe on-line resources and roll it out. No control over it. Need for monitoring.
- Evidence base needs to inform the placement, location and context of training.
- Need to challenge the industry / business that has developed around suicide.
- ASIST Training should be provided by people who are recognised – not just those who volunteer.
- Need for governance of standards in counselling.
- Families find the business / industry language very emotive and challenging. See all the groups and agencies talking common sense and doing good work, but needs to come down to into community.
- Qualifications are not enough – staff should be quizzed more on their expertise in the area of suicide. Trusts / PHA should ask for people to be registered and also have completed x hours of CPD.
- Need for organisations to identify their niche and expertise and stick to that. Do not profess to be more than what they should be.
- In other areas of work there are registers – you need to be on these to be able to practice your training / counselling.
- Too many organisations trying to do bits and pieces of everything rather than specializing. This means the staff don't have the specialism, expertise etc – and management do not have control over governance.
- Need to take away the dependency mindset from C/V Sector – Should be about delivery.
- Victim consultation at minute on Minimum Standards Framework for Victim/Survivor Services. The issues are interconnected also to drugs and alcohol. Would this create different sets of standards depending on who your funders are?
- Non-recurrent funding climate has a significant impact on staffing and reinforce service delivery.

- Need for more professionalism
- Need for Support
- Work with competences
- If policies are adopted by organisations, are they implemented?
- Accreditations important, but with it comes a need for monitoring and support.
- Similar to victim sector – Lot of the families are involved, need to monitor this.
- Needs to be support for organizations to adopt appropriate standards and enable people to recognise their expertise to work within their competency.

Topic not stated on feedback form

General comments from feedback forms:

1. **Outside of your organisation/project, what has been working well and what could be improved?**
    - Sd1 Form, Family Liaison officers but family liaison worker in the community.
    - Sponsored day care need lots more family support / money.
    - Mental health Protect Life – building now

Appendix 5 –

Evaluation

Suicide Prevention Strategy - Protect Life Ministerial Event with C & V Sector Wednesday 28th September 2011 Kings Hall, Belfast

		Personal Invite	From Colleagues	Other - Please Specify
1	**How Did you Find Out About This Event?**	35	20	Family Voices Forum
				Taster Week - PHA
				Circular email from COI
				PIPS Upper Bann
				Organisational request to attend

2

	Yes	No	No answer
Did this event meet your expectations?	54	4	2

Comments:

- Opportunity to be involved in more than one topic
- I didn't feel that the voluntary sector at our table was being listened too, the facilitator wanted to focus more on the positive work being done - how can there be change?
- Good opportunity to refocus - however many of the issues have been discussed before - with the same outcome-be brave-implement changes needed.
- Much longer event than anticipated- Good approach - Minister Poots staying in the room and sitting on the discussions exceeded my expectations
- The short time allocated to the event was good - short and sharp.
- It was very short.
- Good cross section of viewpoints - healthy discussion - good to meet other co-workers in suicide prevention
- Truncated discussion
- Focus was very much on statutory sector, e.g. No community, voluntary or family speakers
- Hard to say, it's always a case of what happens next, as opposed to enlightening discussions

3 Was there anything which would have been helpful that was not included in the event?

- No except maybe for QUB Research into suicides amongst males.
- Other groups could have been invited to bring flyers for their services
- We could write down our own options, I feel that there was a different agenda at our table which would include 'Pats on Backs'.
- Other sectors/professions/depts/agencies at least minimally represented
- More discussion time or smaller groups so all can contribute
- More time for discussion
- Possibly some GP representation
- A copy of Dr Carolyn Harpers presentations in the packs would have been very helpful
- Showcasing opportunity of existing services
- Longer time
- More time - full day to discuss topics - we are the people on the ground and are the voice of service users
- Representation from cross-departments
- Would like to have seen a group work discussion focusing on the wider determinants of health and health inequalities
  and their relationship with mental health promotion and Protect Life Strategy
- A ministerial Q+A or panel. Opportunity to input into all themes
- What Next? Actions? Next Conversation? Who else outside this sector will be having this conversation? Will we hear what they have to say? How do we make the links?
- A short overview of each organisation represented would have been useful
- A bit more time
- Possible time for question + answer from key speakers
- More time for discussion

- I know that other statutory depts were not invited but I think it would have been useful for them to hear the issues that were discussed across most of the themes
- More time to speak to individual representatives from Statutory sector
- Other parties besides health
- An obvious misconception that suicide prevention focuses exclusively on counselling. There are a raft of phychological therapies available by Chartered Physcologies which have high efficacy roles. Counselling often opens up a can of worms they cannot close.
- More personal story telling to capture peoples' minds
- Always need more time to develop discussion
- Benefit to be gained from having other Departments available for 'joined up' discussion and representation from Primary Care
- Difficulty to only having opportunity for one person to represent our organisation as would have preferred to have representatives at other group discussions
- A community speaker, more time for discussions - was community involved in the organisation of the event/programme?
- Other agencies/depts to discuss more collaborative interventions

4. How would you rate the following aspects of the event:

	Very Poor	Poor	No Strong Opinion	Good	Very Good
Event Location			7	26	27
Event Length	1	6	2	28	23
Event Organisation			3	21	36
Venue			7	25	28

Comments

- Room was a bit noisy and hard to heard other participants at the table but that was possibly the 'buzz of activity' and hard work in the room

5 How would you rate the event in terms of the following

	Very Poor	Poor	No Strong Opinion	Good	Very Good	No answer
Information Provided		2	5	35	18	
Delivery Style		1	2	27	29	1

6 How would you rate the event overall	Very Poor	Poor	No Strong Opinion	Good	Very Good
		1	2	29	28

If you rated the event poorly, please explain why?

- I found that important points raised in the group discussion were not raised at the feedback. I felt the facilitator shared his views rather than the group.
- More time given to subject

7 Do you have any suggestions for improvements to this event?

- I think other agencies i.e. NIHE, Education should have been invited
- I found it very rude that everyone from the statutory sector at our table were using their blackberrys, which shows the disconnection to how they feel towards suicide prevention - ban phones on tables.
- Other sectors/professions/depts/agencies to be at least minimally represented
- Some evidence of what works in other countries/what are the key differences - our high rates? - Not just describing them alongside some locality profiles of age, social factors etc.
- Although this was targeted at C & V it would be useful to link with ELBs further as they have such a valuable role to play
- More time + smaller groups
- Perhaps review in one year what has happened as a result of it
- Could maybe have a longer workshop next time - some good discussions were cut short due to

lack of time

- More of them, accountability
- I feel that in general GPs are the missing link in this process - future GP involvement / linking would be useful
- Keep mental health promotion/suicide prevention on the agenda- It needs to be more than a moment-a sustained, coordinated approach to interventions/support is necessary - across the life cycle
- GP's and Pharmacists to be present- Maybe representatives from Pharmacy/GP Locality Partnerships. More background on what is already being provided in each area
- Succint map/directory of programmes per Trust area
- Possibly rather than PHA chairing the conference to let the C&V sector present the conference with anecdotal evidence rather than the statistics we are so already aware of.
- The opportunity to network beyond the tables to others present in the room - post session
- Very interesting morning
- Longer time spent for discussion
- Thank You - we talk about joined up working - have done for years but in reality the C&V sector struggle on short term inadequate funding. What message are we giving to clients in our agencies?
- We dont have the money to continue this programme translates into hopelessness for the client that service providers dont care- and contributes to suicide rates increasing
- It would be good to provide delegates with an overview of the event including reference points of statistical data and content of presentations and key points from group discussions
- Q+A Panel Session - Rotating workshops to input on all themes
- Either longer time or follow up
- List of significant dates in this sector/area of work coming up - create an info/diary network. List of publications/research - current and where available
- Follow on event in one year to update/movement/planning to develop ideas
- Less importance given to meaningless buzz words and emphasis on creating effective strategies

- It was good to have a short focused event. It was well organised and paced appropriately. Definitely felt listened to.
- Follow up within 3 months
- Please ensure future funding is delivered and provided to effective services not just comm/voluntary sector but statutory
- Critical you need to bring together all those who work independently of each other in voluntary agencies to avoid duplication, share expertise and support each other.
- This should not be a 'one off' event- should be the beginning of a series
- Appreciated the input of the Minister and his willingness to share his personal experience and to engage with individuals at the tables
- An action plan following the event, follow up with participants and other groups
- It would have been good to be able to speak to the Minister afterwards - personal contact - no substitute
- Follow up with clear actions outlined