Public Health Agency

Protect Life 2 Service Stakeholder Engagement Report

July 2018

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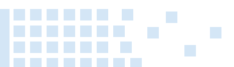


Introduction

1

The Protect Life Strategy was first published in October 2006 and a refreshed Strategy published in June 2012. A formal consultation took place from September to November 2016 with a report published in February 2017 to inform the content of the next version "Protect Life 2 – A Strategy for Prevent Suicide and Self Harm in Northern Ireland 2017 – 2022" (Protect Life 2). The Public Health Agency (PHA) commissioned ***Insight Solutions*** to deliver stakeholder engagement events, not to replicate the 2016 consultation, but to seek views to inform the future procurement of services to implement the pending Protect Life 2. These engagement events were held in each of the Trust areas across Northern Ireland (NI) (See Appendix 4).

The engagement process was to help provide a basis for ensuring that a full range of views are taken into account in determining what and how services should be commissioned and in order to ensure that it meets strategic priorities alongside local needs. The events aimed to acknowledge the extent of the work that is happening within communities in addressing suicide and self-harm, and to help identify gaps and how services can be shaped to address such gaps. Using intelligence from service providers, service users, commissioners and other interested stakeholders will assist the PHA design service specifications for future services to be procured under Protect Life 2 and could prevent delays in procurement after the Strategy is published.

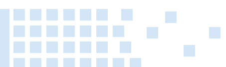
The aims of Protect Life 2 are:

1. Reduce the suicide rate in Northern Ireland by 10% by 2022;

2. Target appropriate financial investment to deprived areas where suicide and self-harm rates are highest.

The Strategy contains 14 objectives (Appendix 1), seven of which are subject to the Protect Life procurement process and can be categorized under one of the three pillars of: prevent; intervene; and support. The remaining 7 require a cross departmental/sectoral partnership approach. The suicide rate in Northern Ireland has remained stable over the last decade at around 15.8 deaths per 100,000 population. Both PHA and the Strategy acknowledge that to meet the ambitious aims of Protect Life 2, working together across government departments and in partnership with other stakeholders from all sectors of society is essential.

Currently £8.7 million is committed to deliver Protect Life 2, £3.5 million of this is ring-fenced for the delivery of the LIFELINE Service and a further £1 million will be invested in concentrated services such as the Self-Harm Registry, media monitoring, prisons, etc. This means that funding of just over £4 million will be going out to tender or will be awarded as grant funding each year over a five-year period.



Methodology

2

Twelve public meetings were held across Northern Ireland (see Appendix 4) - two in each Trust with a third in Belfast area, due to population density and number of interested stakeholders, and three in the western area due to the geographical spread of residents and services.

The events were publicly advertised and the information about the events was distributed by the PHA to all relevant stakeholders including current service providers, commissioners, clinicians, service users, carers and family members. Those wishing to attend were asked to register with the PHA.

A total number of 367 stakeholders attended the public meetings. This included representation from over 125 different organisations including but not limited to service providers; service users; family members; those working in mental health emotional wellbeing/suicide prevention, drugs and alcohol, victim's services, and wider health improvement and community development services.

In addition, from 13th March to 20th April 2018 an online survey was promoted via the PHA website and social media to allow those who were unable to attend the events and any other interested parties the opportunity to share their views.

There were a total number of 36 responses to the online survey.

Following a presentation on the Protect Life 2 Strategy by the PHA, participants were asked to work in facilitated groups to discuss suicide prevention. A number of clearly defined questions were asked of the attendees:

- **What is working well in your area in terms of service delivery to prevent suicide?**
- **What are the gaps?**
- **What more needs to be done to meet the objectives of Protect Life 2?**

Following feedback, attendees were given the opportunity to hear about the proposed training framework and were invited to share views.

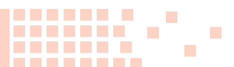
The focus of each event was then directed to suicide postvention. Again, clearly defined key questions were asked. Participants, working in groups, were asked to explore each in turn and provide feedback:

- **What is working well in your area in terms of service delivery in postvention?**
- **What are the gaps?**
- **What more needs to be done to meet the objectives of Protect Life 2?**

In line with the expected outcomes in the Tender Specification the following sections provide an overall summary of the stakeholder engagement workshops including summary of each session and overall summary for all five HSCT areas including highlights of the main points/issues raised at each and whether there were any similarities or differences across localities or the region as a whole. All comments received have been treated equally. This report does not rank or prioritise comments.

Appendix 2 provides the full notes from each of the public events (including anonymous comments received on day of events through comment box) and the online survey as was explicitly required in the Tender Specification.

Appendix 4 contains a breakdown of attendees to the workshop using the parameters agreed with the PHA post contract award.



Common Themes Across all Stakeholder Engagement Events in the 5 Health and Social Care Trust Areas

3

The Section below outlines the common themes across all 5 Trust areas. They have been grouped into Prevention, Postvention and the Training Framework. Individual responses from each Trust area can be found in the Appendix 2.

3.1 Prevention

3.1.1 Building Resilience

Stakeholders across all Trust areas reported that resilience building from an early age is required. Currently it is believed that there is a lack of education around resilience, mental health, self-harm and suicide and it was suggested that Mental and Emotional Health could be introduced as part of the NI curriculum. This, however, would require implementation of support for teachers, youth leaders and, not least, parents to equip them with the necessary tools to help young people build resilience. There was a common view that building resilience and supporting prevention should be part of community development. It was also thought that normalising mental health support services and reducing stigma would encourage more people to seek help and access services. The PHA has run a number of successful public awareness media campaigns, and it was suggested that the use of such campaigns on an ongoing basis was one way in which stigma could be reduced, whilst the awareness and identification of signs and symptoms could be improved across the population.

3.1.2 Better Awareness of Services and Improved Referral Pathways

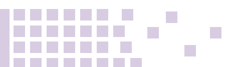
There was some general confusion within communities represented at the events about where to go to get information about services and how to access them. This includes appropriate referral pathways, for example, GP referral or self-referral. There is also a lack of knowledge among service users and those referring into services, e.g. GPs, about the most appropriate service to meet individual needs. Stakeholders believed services could be better promoted in public areas such as youth clubs, GP surgeries and community centres. It was commonly reported by stakeholders that there is confusion regarding the routes of access to services and there is a need for stronger referral pathways in statutory and community organisations. A common recommendation was that a menu of services for each Trust area be developed and that awareness of appropriate next steps for service users be increased, including better sign-posting. This already exists in the form of Mental Health Z Cards with all mental health and suicide prevention services in each Trust area, which suggests that awareness of this resource is low and more needs to be done to promote and encourage its use.

3.1.3 Specific Tailored Services to Meet Need

A lack of counselling services to meet the needs of certain socio-economic groups within the community was identified. It was believed that mainstream counselling and support services should be established to meet the needs of the Black and Minority Ethnic (BME), including multi-lingual or translation services; the Lesbian, Gay, Bisexual and Transgender (LGBT); and rural communities. It was suggested that sustainable investment of funding should be identified to ensure this happens in a consistent manner across all Trust areas. The need for person-centered services which are responsive to specific needs of individuals or groups and those which provide a wrap-around service were advocated. Stakeholders were also concerned about difficulties those with disabilities or living in rural communities have in accessing services. It was suggested that counselling should be offered and provided in a range of formats such as online or at home to address such issues. Other groups which were identified at risk of 'slipping through the net' were men aged 35-55 years old; those affected by the Troubles; those with ASD and Borderline Personality Disorder.

3.1.4 Multi-Agency Approach

A common theme at the events across NI was stakeholders' request for services to be more 'joined-up' with greater connectivity. It was believed that community



and voluntary sector organisations could work in closer partnership with statutory partners and in working together they would strengthen structures, build capacity, better co-ordinate services and reduce duplication thereby increasing efficiency. It was also acknowledged that within statutory organisations there could be better collaboration and cross-departmental working, such as in Health and Education. In developing connected services stakeholders emphasised the need to ensure no individuals slipped through any potential gaps. Frustration was also expressed at the lack of information sharing between organisations and sectors and improvement is essential as this would also lead to more effective referral pathways. In addition, service waiting lists can be long due to high demand. It was suggested that agencies must recognise that a quick, if not immediate, response is essential in many cases and therefore a high priority must be given to implement measures to reduce waiting times.

3.1.5 Community Strength

A community development approach was considered to be of high importance. Stakeholders believed that communities could appoint a "first responder", but in order to do so there is a need for increased resilience for communities as a whole. There were many suggestions to help achieve this, with a focus on the provision of training to equip the community to help those in crisis and increase awareness of signs and symptoms, but also to reduce stigma.

Certain groups in particular were identified that would benefit from this type of training, i.e. community workers who could champion positive mental health. The roll-out of training to community groups, businesses and schools was also believed to be required. A lack of 24-hour support provision (aside from Lifeline 24/7 service) was criticised. The development of drop-in services, community 'safe spaces' or HUBs for people in crisis would be welcome in some areas. Stakeholders also wanted to encourage self-help and increase help-seeking behavior via community capacity and resilience initiatives.

3.1.6 Improved Support for Carers

Based on feedback received through the consultation process, carers feel unsupported and overwhelmed when it comes to supporting a loved one with suicidal ideation. Specific tailored training, counselling and support services were deemed necessary for carers to protect and promote their own good mental health.

3.1.7 Medical Staff

Some stakeholders were concerned about either the lack of knowledge or lack of empathy displayed by GPs who are often the first point of contact of someone with suicide ideation. It was felt that GPs and other first response healthcare staff need to be better trained in identifying and acknowledging the symptoms of poor mental health, in particular suicide ideation and to be more familiar with the range of service options available. It was articulated by some participants that there was a disproportionate reliance on the medical model and that in order to support individuals with mental health difficulties/ in crisis, there should be more resources targeted at training on mental health and suicide prevention and it was felt that increased investment is required by medical staff on the delivery of a more therapeutic model. Some stakeholders suggested that training on the subject should be mandatory for both GP and A&E staff, and others suggested that there should be improved support for medical staff who are providing front line services and dealing with patients with suicide ideation.

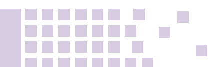
3.1.8 Summary of Key Recommendations for Prevention

- A strategy to help reduce stigma which is well resourced and has community and stakeholder support and engagement
- A strategy to increase awareness of signs and symptoms
- Mapped referral pathways in an accessible format/s
- Provision of training tailored for different sections of the population depending on the needs of the community
- Increase multi-agency partnership and collaborations
- Provision of more drop-in services to support individuals in crisis
- Improved and tailored counselling provision
- Support services for carers
- Increased community capacity and resilience to be considered as part of the Protect Life 2 Strategy
- Early invention, such as an increased focus on building resilience, with children and young people

3.2 Postvention

3.2.1 Longer-Term Solutions

Stakeholders reported that longer-term support work has more impact and there should be less focus on 'short-term fixes' for mental health. Therapeutic support varies and can be for six to eight sessions, however, stakeholders believed this was too short for a lasting impact and counselling and other support services should be offered for a longer duration. It was suggested that more support is required for bereaved families further down the line, and there is a need to follow up with families in the months and years afterwards. One way it was thought this could be done was to link the family with a Suicide Liaison



Officer as a point of contact, support and referral.

3.2.2 Improved SD1 Process

The SD1 form and process was a major topic of discussion at all of the events. Concern was expressed about the timing of the offer of support to the family, the fact the support is only offered to one member of the family, the fact it is a one size fits all approach, and that it does not extend to the families of those who die in hospital or outside of NI. Some declined the process as cold and insensitive with a poor explanation of the process at what is a very traumatic time for families bereaved by suicide.

3.2.3 Better Awareness of and Access to Services

Many people bereaved by suicide are not accessing services as they are not aware of support available or how to access it. Stakeholders recommended raising awareness of these support services by creating a menu of options available and securing a central point of information. This menu of options does exist in the form of Z cards, but awareness of this resource seems limited and needs further promotion. They also believed service providers had a responsibility to promote support groups and other appropriate services. There is a lot of confusion about access to services and stakeholders complained that referral pathways are unclear and this needs to be addressed. Timely, appropriate support with follow-up and 'wrap around' services was stressed as essential for bereaved families. In addition, stakeholders remarked on a 'postcode lottery' in terms of support offered. It was also identified that there is an apparent inconsistency in quality and uniformity of services from Trust to Trust and there needs to be a consistent approach to service delivery regardless of where the individual accessing them lives. Best practice should be shared to help ensure this consistency.

3.2.4 Medical Staff

Similar to the findings regarding prevention, stakeholders encouraged greater sensitivity by medical staff to those who present after self-harming or following a suicide attempt. There is a need for A&E care plans to be carried out and the 'Card Before You Leave' initiative to be used consistently across all trusts. Stakeholders commented that currently there is a lack of consistency of approach from medical staff across the different Trusts. Again, stakeholders believed training should be mandatory for frontline staff and awareness needs to increase so that staff can better signpost to appropriate sources of support. Training not only to medical staff, but also those working in community and voluntary sectors, should be consistent.

3.2.5 Develop Better Support for and Within Communities

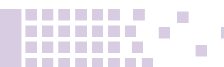
Community attitudes towards suicide were described as often negative and outdated. It was felt that communities needed to receive training on how to support one another following a suicide in the community. The importance of avoiding suicide clusters in communities was emphasized. Some individuals suggested an appropriate Community Response Plan after all deaths, giving the community the support it needs. Community engagement with the establishment and provision of community classes and/or support groups was believed to be beneficial, ensuring people were encouraged to talk openly about what had happened. This was felt to be important specifically for young people. It was felt that minority groups must not be excluded. The importance of practical help, such as neighbours helping with the school run or dropping off groceries to affected families should not be undervalued but encouraged and modelled.

3.2.6 Improved Media Controls

Whilst it was recognised that the current media monitoring and interventions conducted by PHA has been effective, there remains a need to promote best practice when reporting on suicide and self-harm. However, an issue that caused more concern was the impact of social media, especially on young people and the need to control social media content and reach. Stakeholders agreed that stricter monitoring and controls need to be put in place for social media and reactions on social media following a suicide.

3.2.7 Summary of Key Recommendations for Postvention

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



3.3 Training Framework

3.3.1 The Framework Approach and Content

During the presentation and discussion on the Training Framework there was a great deal of support for the menu of approaches to the training. Stakeholders remarked that it was important and beneficial to have a range of different methods of training to assist different learning styles. The flexible approach to training was welcomed with acknowledgment of the different training needs and timescales. Stakeholders reported that e-learning is important, but they stressed that it should not be over-relied upon given internet access issues especially in rural areas in NI and the fact that not everyone has the skill-set to use the internet. That said, to make the training attractive to young people a specific training app could be developed. It was recognised that e-learning could be particularly effective for the lower levels of training. Resilience is a key theme and stakeholders were keen to see it embedded into each step of the training framework. Crisis training was deemed important to give individuals the skills and confidence to support someone who presents as suicidal without having to complete other levels of the training.

3.3.2 Monitoring

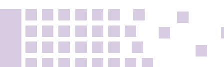
Stakeholders felt that monitoring and evaluation of the training framework was essential to ensure its effectiveness and measure its impact. They were interested to know what planned arrangements were in place and how this would be reported. Comments were also made suggesting that there should be a follow up mechanism put in place to monitor if the training has been utilised by participants, what barriers there were and if support is required in putting the training into practice.

3.3.3 Participation

More information was sought on how accessible the training will be and how it is promoted and offered. Stakeholders sought assurances that the appropriate targeting of participants was demonstrated so that people in rural areas or those who are described as harder to reach, such as minority communities or those whose first language is not English, are offered and can participate in the training in an accessible manner. Ease of access was also discussed with suggestions of localised training options ensuring availability during the evenings and weekends. Those working in the service industries, for example hairdressers and taxi drivers, were described as key recipients for training as they may come into contact with individuals who may be vulnerable and would be in a position to carry out an intervention. It was acknowledged that time and consideration should be given on how to best accommodate participation from these members of the community. Stakeholders supported the plan given that not all the focus was on medical training. But when it comes to training for medical staff they believed incentives may be required for GPs to participate in the training and for them to refer individuals on to other appropriate community-based services. They would also like a clear definition of 'front line staff' and once defined they believed training, including softer skills, for example empathy, should be mandatory for this cohort. Employers are also considered a key group so they may ensure the workplace is a safe environment for those experiencing mental health issues.

3.3.4 Delivery

It was believed by some stakeholders that co-production of the training and co-delivery of it would ensure a well-rounded approach. This co-facilitation could be with members of the community who have lived experience in a peer support style. Stakeholders commented that first-hand experience allows for impact and effectiveness. Some stakeholders thought that longer time periods for delivery may be required to allow for true learning.



Feedback Regarding Prevention and Postvention via Trust Area

4

The section below outlines the discussions within each of the Trust areas. They have been grouped into Prevention and Postvention, acknowledging what works, the gaps in current service provision and suggestions for future commissioning. Individual responses from each Trust area can be found in the Appendices.

4.1 Southern Health and Social Care Trust area

Newry and Dungannon - 13 March 2018

4.1.1 Prevention

It was believed that early intervention and support services to build resilience work well, for example befriending, mentoring and promotion of positive mental health. The importance of good communication between services and multiagency work was emphasised. This cuts across statutory, community and voluntary sectors, with community development approaches linking into key services being important. A number of services in the area were considered to provide good practice and it was acknowledged that there has been more training and people are better equipped with the tools they need to help others and themselves, but there is more to do. The introduction of self-referral to programmes has been massively positive such as Recovery Colleges and the move to 'self-referral' on to programmes has been an important change.

4.1.1.1 Gaps

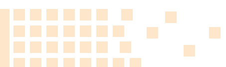
Participants do not feel that holistic services are being offered and there is not good enough links between existing services. Services are difficult to access out of hours and there is a lack of awareness of all services available. GPs are often first point of contact but lack skills and knowledge for appropriate and effective onward referral. Referral pathways need to be extended. Consideration needs to be given to the role of allied professionals, such as school nurses to ensure help is accessed before self-harm begins. Currently it is deemed that there is a lack of the therapeutic relationship in the clinical setting and knowledge of how to develop a "safe space".

Services need to be better at keeping with people on their journey, so that service users are not forgotten after crisis situation but given follow up support. It was also suggested those from deprived communities may have greater difficulty accessing services.

It was felt that much prevention work was being done by services outside of the strategy and there needs to be a mechanism for capturing and reporting on this work, to inform better service delivery.

A recurring theme was the need to destigmatise services, to normalise the looking after of mental health. Suggestions were offered such as "Mental Health MOT" and PHA supported campaigns. This information needs to be given to help people access services and reach out for help before crisis point. It was also believed more information regarding self-care could be provided as not everyone requires service intervention. Many highlighted the risk factor of those recently bereaved as a result of suicide and didn't feel enough is in place or being offered to them to support or look after their mental health.

More is required with young people and parents. The early intervention programme in some primary schools – 6-week programme at P7 on stigma surrounding suicide, mental and emotional wellbeing and self-harm was welcomed and believed effective and similar initiatives were called for across the board in both schools and youth clubs. In addition, it was believed there needs to be more innovative ways to engage parents. It was believed that schools needed more support so that teachers are equipped with resources to identify ill mental health and intervene at a level appropriate to their role.



The models of counselling services provided was questioned, including CBT vs DBT and the need for specific services to meet the needs of certain sections of the community, e.g. ethnic minorities, etc.

4.1.1.2 Suggestions

- Bereavement buddy/champion
- Service mapping exercise showing referral pathways
- PHA Campaign
- Maximisation of social media and Trust website, e.g. to act as one-stop shop for sign posting
- Walk-in centre & out of hours support
- Peer Support workers

4.1.2 Postvention

The short-term work being provided works well, but more is needed regarding long-term services and support. Eight sessions of counselling, for instance, will not provide a long-term solution to pain and grief. There needs to be continued connections with those affected.

There was a discussion around the short-comings of the SD1 form and the timeliness of this and the fact only one family member accepts or rejects support on behalf of other members and the difficulties this creates. There is a recognition that different families and different family members will have different needs. However, referral pathways were believed to be over restrictive and there is a lack of knowledge of services available.

The structures involved were discussed and how complex this can be and the sensitivities involved, such as the role of the police and coroner, registering the death and the difficulties if a death happened outside the jurisdiction. It is important to also consider how a death in hospital is categorised, which can mean a family cannot access support.

There were practical examples of support that can be provided such as weekly check-ins by members of the community or via peer support. Support should be extended to employers of family members to educate them and co-workers. It was thought that many feeling suicidal turn to their church for support and questioned the skill capacity of religious leaders.

There was some feeling that there is a lack of support for those individuals and their families living with someone who has made an attempt to take their own life.

4.1.2.2 Suggestions

- There is a need to change the narrative to reduce the stigma.
- Promotion of alternative therapies – mindfulness, relaxation etc
- Introduction of “healthy websites” for self-harm and associated families and carers
- There needs to be a service in place for supporting family
- Respite care for someone caring for someone who is suicidal
- Greater awareness of available services

4.2 Western Health and Social Care Trust area

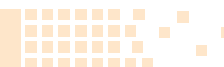
Omagh, Derry/Londonderry 21st March 2018 and Enniskillen, 29th March 2018

4.2.1 Prevention

The Western Trust is an extremely diverse area, having a mix of pockets of rurality and isolation and areas of high population density. Regional organisations working with and across groups and professionals, and plugging gaps, were thought to represent best practice.

It was deemed crucial to work with both the person affected and with the wider family. Although there are many groups working proactively on the issues, the importance of highly skilled people can’t be overlooked, and services must be focused. Training is necessary to raise awareness of pathways and guidelines. Programmes being delivered in schools, such as “promoting positive relationships”, “hope & resilience” and mindfulness were commended, and it was believed there is good communication between schools and the community.

Other positive activity includes community groups and search and rescue groups. Current mental health campaign ‘stickers on heads’ was regarded as positive, however participants believe more of this work should be done. Work which involves hearing from families and survivors - people having a voice - was believed to be very powerful. Community training and peer support were all believed to be having a positive impact.



4.2.1.1 Gaps

The rurality of the area was acknowledged as contributing to difficulty in accessing both services and information. There is a need for connections between isolation/ addictions/self-harm and suicidal ideations and to physically reach out to those isolated or struggling to engage.

It was believed that some service users can fall through the gaps due to the lack of "joined up" co-ordinated services across the board, including community, voluntary, health and education.

It was believed that removing departmental boundaries and a focus on the structure and capacity of service delivery more could be done than the current "myriad of ad-hoc groups". Continuing on the theme, it was believed there should be better communication between first responders and onward referral. There was also frustration that connections and communication between services differed depending on Trust area resulting in a postcode lottery.

Whilst some programmes currently deployed in schools were viewed as good practice it was believed more early intervention in schools is required and there is currently a disjoint between schools and communities.

Waiting lists are regarded as too long, drop in style services with an open door for crisis response ensuring accessibility are necessary, however others believed crisis intervention needs to be residential.

There was an emphasis on training to:

- Promote more face-to face interaction
- Skill up communities, also making them more resilient
- Address gaps in referral pathways
- Impact the 70% who do not access services

4.2.1.2 Suggestions

- Look further afield – internationally for best practice
- Mental Health education integrated as part of the curriculum
- Greater promotion of services
- Consider communication styles of young people and role of social media and opportunity to capitalize this
- Quiet room in A&E

4.2.2 Postvention

It was stated that best practice exists in the North West and this is shared across the rest of Northern Ireland. Services providing a one-person point of contact were believed to work well as it is timely, flexible and allows self-referral. Other good practice examples in the Trust area included the Community Response Plans, multi-agency approaches and inter-agency protocols, Critical Incident Plan authored by GAA as well as specific support groups in the area.

4.2.2.1 Gaps

Again, the issues with the SD1 form were acknowledged and the current review of the form is welcome. In the aftermath of a suicide, communities need to know how to respond, so training and guidelines would be useful. It is not just the immediate family that is affected and support via the family liaison officer should be extended to the wider family, friends, fellow students/colleagues.

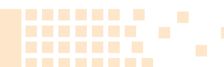
The impact of media and especially social media on young people was discussed with the need to educate parents and teachers in how to manage and respond to this.

It was acknowledged that the offering of support immediately for some families may not be right, and there should be more than one opportunity for families to be offered and avail of support. There is no one size fits all, but more support is required 'down the line' as well as better and more de-briefing for the family and wider community in the aftermath.

Community capacity needs to be built, and consideration should be given to the extension of the Community Response Plan in single deaths.

4.2.2.2 Suggestions

- Community training/guidelines
- Media monitoring/regulation
- Follow-up at interim periods following the death – 3-6 months, up to 1-2 years
- A guide could be left for people to 'opt out' of the support package rather than having to 'opt in'
- Need for a community mental health champion
- Need for a practical, simple step guide to help families following a suicide – including long-term help
- Make it "OK to not be OK"



4.3 Northern Health and Social Care Trust area

Coleraine and Antrim - 22nd March 2018

4.3.1 Prevention

There was a raft of good practice examples working well to help prevent suicide in the Northern Trust Area. Partnership and multi-agency approaches with good connections and communication, underpinned by a community development approach were widely described.

Participants explained that local intelligence informs service provision and there are targeted and specific interventions. Training provision has been beneficial and work to reduce stigma and provide a non-judgemental approach is very important. In addition, the link with non-branded suicide prevention/mental health services should not be overlooked, for example Men's Sheds and sports groups.

4.3.1.1 Gaps

Many participants were frustrated at the lack of awareness by GPs and called on additional training, support and guidance for the profession. They also believed that counselling services should be available in the GP surgery. With regards to hospital, participants believed that vulnerable people are being discharged without adequate or appropriate onward referral. Crisis hubs are required, but not provided by A&E. It was thought that more co-ordination of services would ensure people would be referred according to their priority needs. It was acknowledged that people in crisis are not coming forward.

When people do come forward again the issues of waiting lists and appropriateness of the model of service, e.g. session-based counselling were raised. More should be done on early intervention such as more resilience work, as well as wider consideration of contributing factors such as social isolation, deprivation, drugs & alcohol interaction, and LGBT community issues. A gap was also identified on crisis intervention from the perspective of community and family support, people should be educated on signs and symptoms of poor mental health from early years. The connected community approach needs to be built upon encouraging and using community intelligence.

In addition, questions were raised regarding the monitoring and evaluation of services to ensure we know what is working, how and why. There was some concern regarding consistency of services being offered or delivered due to funding issue. The oversight of professional standards bodies and provision of a small grants scheme could address these issues.

4.3.1.2 Suggestions

- Workplace help and support
- Knowledge of where the services are
- Engage hard to reach
- More campaigns needed
- Consideration of rural isolation – especially older people
- Mental Health App (targeting young people)
- Professionals (GPs, teachers) to receive training
- Mental health discussions part of normal language.

4.3.2 Postvention

Specific services were named as working well in the area of postvention. A local element to these services and existing links seem integral to their success. Intergenerational work was also acknowledged for its effectiveness. In the Northern Trust there is an annual commemoration service to remember all those lost as a result of suicide.

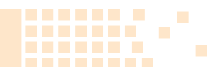
There appears to be consistency in the area with PSNI best practice, regional sharing of approaches around PSNI/SD1 deaths and good communication processes enabling community intelligence systems.

4.3.2.1 Gaps

Questions again arose regarding the SD1 and its timeliness on the offer of support. If this support is rejected by the family member there is then a lack of awareness of support available and therefore people being signposted incorrectly. In addition, it was reported that even when services are known they are too difficult to access or rules have changed, which means some are no longer eligible.

There are gaps in how families are communicated with. This communication needs to happen with those who have been affected to see how services can be improved. More peer support was suggested as the lived experience of suicide ensures empathy, with the caveat and provision of appropriate training and supervision.

There is a huge responsibility for carers to keep their loved one safe, it's important that these people are supported. There needs to be a top-up service or a drop-in service



available as 8 weeks counselling support is short. Face-to-face follow ups are needed to support families more as well as training for communities.

There is an issue of stigma with the acknowledgement that some professionals are still not recording suicide and in addition give consideration around attempt and death five days later.

4.3.1.2 Suggestions

- Educate GPs where to signpost people to
- PHA to share case studies and across border experiences also

4.4 Belfast Health and Social Care Trust area

Belfast (x2) - 26th March 2018 and 22nd May 2018

4.4.1 Prevention

Connectedness and partnerships at local level were seen as important in prevention, including early intervention at community level, cross departmental working, i.e. health and education and sharing information and bringing communities together.

Training was believed to be effective and important in awareness raising, enforcing good mental health, building resilience and stress control which could contribute to self-care. Sign-posting, ongoing support and clients having the ability to progress through services all work well. In addition, wrap around support was said to work well when available.

Family support hubs and bereaved by suicide groups are valued and there is a valid role for peer support in normalising and championing the issues. The Take 5 model, walk in services and immediate "safe-plans" were said to be effective.

4.4.1.1 Gaps

Attendees acknowledged that an early intervention holistic approach is key, however again a significant theme was the need for greater co-ordination and joined up thinking across services. Better connectivity between services was called for. There needs to be better mapping of and stronger referral pathways and information must be shared from statutory bodies. There should be inclusion of the wider community and better training provision.

There is a need for better signposting and ongoing support and more investment into more deprived areas and prevention. Family support was seen as vital, and there was an opportunity to provide services via schools such as mindfulness programmes. There was a belief that 'toxic environments' existed in places such as schools and hospital inpatients which has to be addressed. There were also concerns expressed regarding additional risk factors, such as young people in care and mental health clients in temporary accommodation.

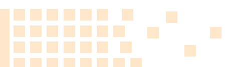
Relationships were seen as key as well as the importance of being heard. To get to this point people need to be encouraged in help seeking behaviour, and they need to know where to go. Community planning is a start but there is a need for better community involvement and resilience building.

There are access issues to specialist services and statutory sector professionals knowing about the services and their access routes. Currently hubs and other effective support mechanisms are being over burdened with nowhere else for service users to go. There is a lack of connection from GP referrals to services.

Services are limited and inconsistent across Belfast. For example, the 'Card Before You Leave' scheme for those being discharged from hospital after self-harm or a suicide attempt was a good idea but is not used across the region. Awareness raising is not getting key messages out and there is a need for more honest conversations to reduce fear and stigma.

4.4.1.2 Suggestions

- Stigma – 'Mental' Illness is a barrier to accessing service. New Terminology - "Emotional/Psychological Wellbeing" - person friendly language
- Community Mental Health Champion – point of contact for access to information, assist trainer and co-ordinate community response
- Campaigns such as the 'Mind Your Head' campaign need sustained and refreshed
- GP awareness-raising should be mandatory
- Community Reponse Plans – the remit of the response plan could be widened to support those who are affected by an individual's suicide attempt



- People in the community should be used and trained – shop-keepers, taxi drivers, bar workers, barbers, hairdressers

4.4.2 Postvention

It was believed that the SD1 process was a good starting point. There are family support groups, psycho-education, creative groups, counselling, complementary therapy all local offering flexibility and community level support. Many of these are community responses developed by people, using community intelligence, it was acknowledged that there is much value in local knowledge.

4.4.2.1 Gaps

Similar to prevention, a holistic approach was called for including a central point for information and the need for GPs to work more with statutory organisations.

Practical face-to-face information is needed, but appointments and waiting times are an issue and it was believed that crisis teams are under resourced. Meanwhile there is a need to continue to support the client waiting on the specialist service. There is a greater role for the community to provide 24-hour support and emergency response in a drop-in setting. There is perceived to be a lack of care for carers, that community support services/ groups are more likely to be based in deprived areas, meaning a gap in service provision for those more living in more affluent communities. There was also believed to be service deprivation in rural areas.

Consideration should be given to the appropriate timing to access services for specific needs i.e. suicidal ideation vs bereavement.

While good changes have been made to the SD1 process, attendees would rather have an 'opt-out' rather than 'opt-in' option as families are shocked and distraught at time of first contact with police officers. Support through this process should be extended to other members of the immediate family. The SD1 process was also described as "cold".

4.4.2.2 Suggestions

- Inform GPs about available services
- General awareness raising of services
- Menu of services
- Community workers/health and wellbeing staff being placed within GPs to refer to
- More education needed in schools on self-harm and suicide
- Awareness campaign on the impact of suicide

4.5 South Eastern Health and Social Care Trust area

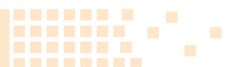
Lisburn and Castlewellan, 27th March 2018

4.5.1 Prevention

A multi-agency approach with improved communication between PSNI, community, voluntary and statutory organisations with improved onward referral linkage and signposting to appropriate services is needed. There is a clear role for community planning in helping all organisations define their role. Early intervention works in schools developing emotional resilience and it needs to be part of the curriculum. Having an early response so people presenting with suicide ideation are identified quickly. This identification can be done via research trends looking at high risk groups and cluster areas.

Flexibility in approach and the ability to provide tailored services using evaluation and feedback from service users and professionals on what works is effective. Having someone local and accessible to connect with and not shying away from tough conversations and situations is a useful resource. Services must be accessible and timely to support people in crisis. Awareness raising through media campaigns to reduce stigma and building resilience are key preventative strategies.

Other services and approaches which work well include Family Support Hubs, Infant Mental Health Strategy with its focus on early intervention, the co-ordinated approach of the Community response plan in response to clusters.



There was also acknowledgment of rural needs with the provision of hubs which are good for signposting/reaching out and the value of peer support.

4.5.1.1 Gaps

There is a lack of consistency across Northern Ireland and this can lead to an increase in anxiety. There has to be better communication and information sharing across community, voluntary and the statutory sector.

Importance of appropriate training for allied Health Care professionals, and the need to be working closer across thematic areas e.g. drugs and alcohol addiction.

There are huge gaps in information provision, it needs to be location specific and accessible, people need to have the right information when leaving one service provider, e.g. A&E, so they feel supported. Members of the community who provide "domestic" services should also be made aware, for example hair-dressers/taxi drivers often need guidance and preparation on where to signpost people that need urgent support.

More to be done to address the specific needs of different sections of the community, for example, middle aged men, ethnic minorities or where English is not the first language.

Waiting times to access services are too long. Services offered/ provided need to be fit for purpose, person centric and consistent. There is too much reliance on the community and voluntary sector.

A lot of the need remains hidden, e.g. in rural and isolated communities and it is important that this is addressed. However, there is still a stigma within communities. There is a need to build resilience within communities via an evidence-based approach. There is a fear of training, a lack of knowledge, complicated referral pathways, even for GPs to navigate.

4.5.1.2 Suggestions

- Should be Recovery Colleges in each Trust
- Tendering process and access to funding has a negative impact on local/smaller projects – how can this be addressed?
- 20% of people deemed 'low risk' died – terminology used to categorise is confusing (low, medium, high risk) – this needs to be addressed
- GP training is a necessity
- Funded interpreting services
- Funded peer-led support groups
- Better evaluation and monitoring of services

4.5.2 Postvention

Community Response Plans were recognised as being effective and were reported as reducing the suicide rate after implementation. Other good practice methods were identified as support groups, counselling, alternative therapies e.g. Men's Shed, practical support and support from funders.

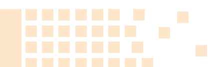
4.5.2.1 Gaps

The same issues as with other Trust areas with the SD1 form came up. Take-up rate for support at time of death is only 50%, so potentially people are not being supported in the aftermath of a suicide. Professor Louis Appleby is leading pilot projects in England in the coroner's court, which on a voluntary basis are offering service of support to family. Could PSNI seek consent at later stage (10 days post) to give family time to acknowledge?

It was reported that resources need to be up to date and there should be better general awareness of services available so as when event happens people are not 'lost'. A 'societal approach' is needed with better connected communities, with practical support offered. Children's rights need to be considered if a parent turns down support, how does that child have a voice?

Again, the issue of a lack of a joined-up report was a common theme in the discussion, that Postvention was not linked or connected, and had no feedback with limited follow up. It was recommended that varied support services are required to ensure the needs of the family and wider society were being met. Special note should be taken of the fact that there is no care pathway for those whose loved ones die by suicide in hospital. Suggestions included peer and family support; consideration of BME communities; Postvention work in schools, all of which need to be timely.

A discussion also centred around the evaluation of interventions, measuring their positive and negative impact and the need for ongoing monitoring of trends to inform service design/delivery.



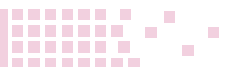
4.5.2.2 Suggestions

- Campaigns need follow up and wrap around services offered
- Could HSCT suicide prevention lead ask for consent instead of it happening at the scene with the PSNI?
- De-stigmatise, remove shame - don't use the word 'commit' – suicide is not a crime
- Target 20-30 year age group – try to talk openly about what has happened
- PHA should seek children and young peoples' views on mental health

Appendix 1

Protect Life 2 Objectives

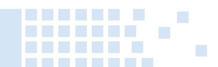
1. Ensure co-ordinated cross government approach to suicide prevention and inclusion in Programme for Government.
2. Provide accessible de-escalation services for those in emotional crisis.
3. Reduce the incidence of repeat self-harm presentation to hospital Emergency Departments.
4. Enhance community capacity to prevent and respond to suicidal behaviour within local communities.
5. Fewer people who are in contact with mental health services die by suicide.
6. Deliver a multi-sectoral training programme in suicide awareness and intervention.
7. Improve awareness of suicide prevention and associated services.
8. Enhance responsible media reporting on suicide.
9. Restrict access to the means of suicide.
10. Enhance the initial response to and care and recovery of people who are suicidal.
11. Improve support for those caring for someone who is suicidal.
12. Ensure the provision of effective and timely information and tailored support for individuals and families bereaved by suicide.
13. Identify emerging suicide clusters and act promptly to reduce the risk of suicides in the community.
14. Strengthen the local evidence base on suicide patterns, trends and risk, and on effective interventions to prevent suicide and self-harm.



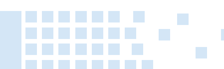
Appendix 2

Notes from Public Meetings and Online Survey Responses

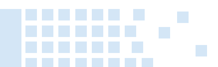
Event	Prevention	Training Framework	Postvention
13.3.18 **NEWRY**	**What works well:** • Early intervention • Community development approach – linking • Multiagency work – connected working • Positive prevention services: befriending, mentoring, multiagency working, counselling, building resilience, schools, club, taking a step back and promoting positive mental health to everyone • SHIP shows the process of referral works – responsive, timely – effective and creates sense of hope (can prevent medicalisation) • Support services at early intervention to build resilience **Gaps:** • Holistic perspective needed • In the area of prevention – many at risk are in a suicidal state due to their own bereavement – bereavement services should be offered to everyone at the "get go" • Service and support at Tier 1 is essential – could come in the form of a "bereavement buddy" or champion in the community – this could be an area of investment • Working in a solutions-focused way together is essential – "sometimes we accept that what has been commissioned is what works, and this is not always the case" • Needs to be accountability/a monitoring committee to account for the Protect Life 2	• Stepped approach – right approach to ensure target audience is ready for training/it is pitched at the right level. • Trainers must be competent in subject in terms of follow up support/safeguarding • Need to ensure co-design of training and training needs to be credible and practical. This needs to be implemented asap • Generally better understanding of training/ suitability to audience needed • e-learning welcomed, power of social media in reinforcing positive messaging • Suggestion of a tier before Step 1 – campaigns and awareness raising • Training to be recognised within CPD • Encourage the concept of building upon, refreshing training etc • Better understanding of different levels and suitability depending on knowledge • Needs to be a support mechanism in place for people who have been trained – checking in with them from time to time • "Steps always sound good, but it comes down to understanding the engagement at each step" • Lack of clarity on what the steps are and what the model looks like • Generally good support for the model • Accessibility to learning is important • Good idea to check in with people after training to see if it has been utilised	• The short-term work is ok, but the long-term work is not good enough • Too much short "quick fix exercises" – longevity is needed • 8 sessions of counselling post-event is not enough • Short term counselling does not work as well • Need to keep connections with people, identifying problems and knowing that problems or times of crisis could re-emerge • PIPs, AMH, Bereavement Support working well (SHIP, Crisis House also mentioned) • Referral pathway needed for ongoing support • More investment needed in self-help materials • SD1 only captures one family member - also may not be time appropriate in terms of being an offer of help • Questions on help needed needs to be a family approach – different families will have different needs, as will different family members • Follow up needed with those who have addressed services but have been discharged • More understanding needed and sensitivity of healthcare staff • Need to promote better attitudes towards self-harm/suicide • Different approach needed towards self-harm than suicide • Better Emergency Department services – on presentation of someone who has self-harmed or attempted suicide there needs to be sensitivity,



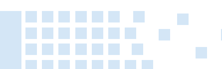
Event	Prevention	Training Framework	Postvention
13.3.18 NEWRY CONTINUED	strategy and to monitor impact • Early intervention happening in Dungannon Primary schools – 6-week programme at P7 on stigma surrounding suicide and self-harm. Similar initiatives needed across the board – more interventions in schools and youth clubs • Much work needs done with parents – barriers in bringing parents together need addressed, need an innovative way of engaging parents • "Much of the prevention is happening outside of the strategy" – "how do tier 1 and tier 2 services support prevention when that is not what they are funded to do?" • There is a huge amount of work being done outside of the strategy, but it is not being reported on – suicide prevention is the core work of many staff, but this is not seen as it is not reported on – "it is reported under drugs and alcohol" leading to "no recognition of the work being done" • One participant felt the Protect Life 2 strategy was "a lot of work and a lot of investment for a poor poor result" (referring to the reduction of 10% by 2022) • Need to normalise support services – 'if you're sick you go to the doctor…teeth you go to dentist' – important to remove the stigma surrounding self-harm/suicide • Importance of language used – positive reinforcement of 'mental fitness' etc • Better connections needed – better awareness of services available • Difficult to access out of hours services for onward referrals • Extremely important to look out for the mental health of those who are bereaved/affected by suicide to prevent a 'viscous circle'	• Should be more information around training, and more motivation to get people to train • Some feel it is a clearer pathway • Need programmes to meet need • Support mechanisms needed for staff • More clarity around parameters and expectations needed • Need age appropriate training for all ages – no need to mention 'suicide' • Training needs to be "credible, not necessarily accredited" – although counterargument suggested "people appreciate an accreditation – people appreciate the credibility and the health agencies etc endorsing training" • Some felt e-Learning would strengthen power of social media • E-learning – same product and reach, uplifting key messages'	correct language used etc • Community response plans put in place including face to face meetings in community, individual/ tailored support – both formal and informal methods • Role of the Coroner's Service Change welcomed • Services for those who die in hospital • Services for people outside UK/NI/ROI • Pressure for justice impacts on those affected • Stigma in rural communities seems to be more pronounced • Acknowledgement that some localities have more services/better networks • Awareness of the individuality of every individual is very important • Suggestion of monthly meetings/weekly coffee mornings as a way of 'checking in' with those affected • Suggestion of a residential to build relationships with people affected by suicide who understand each other • Need for greater employer awareness on how to deal with those returning to work after bereavement (language to use etc) • Process of registering death can be sensitive – may require change • "Are police trained on standards when providing information to affected families?" – greater training within PSNI • Finding the balance between providing information and overwhelming someone is extremely important • Importance in the promotion of alternative therapies – mindfulness, relaxation etc (Nurture Rooms in Belfast mentioned, suggestion of Mindfulness courses in schools)



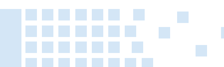
Event	Prevention	Training Framework	Postvention
13.3.18 NEWRY CONTINUED	• - Does everyone know what everyone else is doing? What is out there? Do people know what is available? • Gaps in counselling – needs to be gender specific counselling, counselling for minority groups, travelling community etc • "There is too much focus on CBT and not enough on DBT therapy. CBT focuses on thinking and DBT on emotions – many say they 'were not thinking' during a suicidal episode, because their emotions took over" • Need for specialised counsellors • Need to introduce a 'mental health MOT' "we look after our health and finances etc, but not mental health" • People are not aware of the 'next step' they should be taking – if people don't know they can be helped, they will be more reluctant to ask • It is important that those who do not want to be 'medicalised' can also be seen quickly • Campaigns should be commissioned to help people recognise their own mental health problems • "Communities have a defibrillator to save your life if you had a heart attack on a shop forecourt, but no services in place for those who are at crisis point in their mental health" – feeling that there should be a crisis box or service on hand in communities – perhaps a member of the community trained to deal with crisis • Fear factor needs taken out of talking about mental health and suicide prevention • Carers need to have a voice and be allowed a voice at postvention stage • Feeling that you should not have to reach 'crisis point' before you can receive help – needs		• Introduction of "healthy websites" for self-harm and associated families and carers • Wrap Service/Recovery Colleges available, but needs to be a service in place for family • SHIP referral criteria is very strict – should be delivered much earlier and be more • open – referral pathways are too restrictive. SHIP should be able to take referrals from GPs. Understanding that this referral process is due to strict resource – service must be opened up if more funding granted • MACP – a committee is being established to be able to see young people from 13 years old by GP referral – requires volunteers, training • Need for respite opportunities for those who care for someone who is self-harming or suicidal • 24/7 support



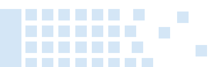
Event	Prevention	Training Framework	Postvention
13.3.18 NEWRY CONTINUED	reframed to properly implement prevention to deliver before people reach crisis • Life MOTs needed – check-ups pre-crisis as routine • Co-production – put community expertise at the planning and developing table. Plan to allow specific areas to be recognised and addressed • Need to look at how self-harm does not become a tragic outcome • Need space and resources for services to develop joint working and experience/expertise so that every contact takes every opportunity to be a good and purposeful contact. Linked strategies, working groups – ensure all services are inclusive and listen to high priority groups • "One important preventative measure would be to have a service in place to provide a life coach to organise a MOT for people in a pressured life, where they might not realise their mental health is in danger until it is too late" **What is needed:** • More social groups at weekends • Recovery clinics • Education of families on signs and symptoms • Training for teachers in schools re early intervention • Recognition of services not protected under or funded by Protect Life • Better connections between services/service providers (multi-agency, making links and working together) • More awareness of services that are available • Mental health awareness "should be a mandatory subject in all schools" and schools "need mental health champions" • "Schools bring in outside agencies and youth		



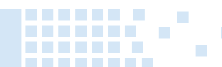
Event	Prevention	Training Framework	Postvention
13.3.18 **NEWRY CONTINUED**	workers who come in, talk and leave no resources – there is no follow up" • Courses available in Recovery College – using people with mental health problems to have a say in the design of services • A card for an individual's purse or wallet to let others know they are in crisis/require support • GP often first contact, but often have little knowledge of charities/public services on offer – more training required • Needs to be groups in the community for the carers of those who are suicidal – support for them in times of crisis or confusion – "people who support need to be supported" – this support is important at the crisis time, but these people need to be followed up on and supported further • Workforces should be equipped to deal with someone who is facing mental health problems • Public information campaigns – preventative messaging and normalising • To look at what else is 'out there' – e.g. Lifemaps • 'Shoulder to Shoulder' – better ways and formats of presenting information – not standard PowerPoint • Needs to be "improved support for someone caring for someone who is self-harming or who has suicidal ideation" • Peer support workers to equip others by sharing their story		



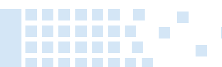
Event	Prevention	Training Framework	Postvention
13.3.18 DUNGANNON	**What works well:** • SHIP, Niamh Louise, Lifeline, Samaritans, Action Mental Health • Samaritans and Lifeline are valuable services, although used for different reasons • Family interventions/Parenting initiatives • There are good initiatives and education around self-harm • Good community and voluntary interventions and work • Accessibility to training has improved – people trained up to deal with issues • There has been more equipping people with the tools they need to help others and themselves • Introduction of self-referral to programmes has been massively positive (Recovery colleges/the move to 'self-referral' onto WRAP programme has been an important change) • Good awareness raising of initiatives, services and conditions **Gaps:** • - Not convinced poster campaigns work – move to digital and social media would be more impactful (print on demand more appropriate, mix of media required, Lifeline business cards do stand out, but other leaflets lost amongst others in waiting rooms etc) • Mental health info/resources should be signed and separated/categorised within public areas such as GP waiting rooms to allow better self-selection • Confusion around access to services – services are out there but how are they accessed/which is appropriate? • GPs need more training and awareness on where to signpost to	• Another level needed beyond – could train service users to be facilitators in some context • Slight gap in stepped approach, but otherwise logical and plausible • Training could be offered in ASIST • Co-produced and co-delivered services/resources – 'lived experience' is valuable so this needs to be used in the best possible way – further role for those with 'lived experience'? • Need for a Recovery College ethos • Needs to be a greater level of integration across all training – cross boarder training, connectedness, needs to also be quality assured • Needs to be more screening on what type of programme or initiative suits a person • When dealing with suicidal clients a 1-1 approach works well, with the creation of a connection being important – more empathy and understanding needs built into the training • Need to address the question "How do I react or deal with someone who tells me they want to take their own life?" • "Need a framework that is not so rigid it doesn't allow for fluidity"	**What works well:** • Bereavement support services are very good, very positive • Niamh Louise and similar services are extremely beneficial • PIPs, CRUSE etc positive – needs to be a specific bereavement support service for the area? • Many people feeling suicidal turn to their church – are religious leaders equipped to deal with this? Noted that Flourish has good resources – wewillflourish.com **Gaps:** • Potential lack of knowledge of support groups noted • SDI form is filled out when PSNI attend scene – this is perhaps insensitive and not the appropriate time – people can tick 'no' for follow up services but how do they change their mind on this down the line? • More access to services for bereaved families is important – all family members are affected differently "from the 4-year-old child to the 60-year-old wife" • 'Major gap' for group of people who do not access services because they didn't 'go through with' the self-harm or suicide attempt • Problem in service users not accessing help – needs to be greater awareness of what is available and how it is accessed • A&E care plans are not being carried through in every instance • Experience so different for each family and this should be addressed in follow-up/direction to services • Community response planning very important – multi-disciplinary grouping to provide support. • Media reporting – need for good practice



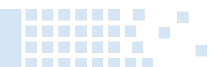
Event	Prevention	Training Framework	Postvention
13.3.18 DUNGANNON CONTINUED	• More promotion around self-care – not everyone needs a service delivered by an organisation • Needs to be a 'hub' or section on website to find information (one member of table did not know PHA stakeholder events were happening until hearing word of mouth). An online hub could be used as a resource to share information on events, resources and initiatives for professionals and service users alike • Trust website has potential for information on services, but it is not maximised – could act as a 'one stop shop' re signposting etc. • Trouble "connecting the dots" – "finding the right service at the right time" • Needs to be much more consideration of age groups other than 'young people • Earlier intervention is essential – referral pathways need extended and those feeling suicidal need access to services before the self-harm stage. Suggestion that this could be delivered through school nurse or through internal school events on 'looking after your mental health', parental programmes and peer mentoring. Referral pathway of SHIP is too strict – suggested referral should come through GP for this programme to open opportunities for access • Those from more economically deprived areas, isolated areas etc need help accessing services • Crisis point care needs extended – development of 'safe spaces' and for people to go to at crisis point • Schools need more awareness training – good work happening but need to equip teachers with resources and information. Suggestion that this could look like a 'menu of services' so teachers know where to go • Better referral pathways needed		



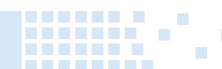
Event	Prevention	Training Framework	Postvention
13.3.18 DUNGANNON CONTINUED	• More bespoke for individuals (foreign nationals etc) needed • “Services need to be better at keeping with people on their journey” – feeling that service users are forgotten after crisis situation is diffused rather than being followed up on or ‘checked in with’ • Need to equip people to be better at “building tools of self-resilience” • Dungannon needs a support service – development of a safe space • Feeling that you should not have to reach crisis point before being referred to a service • “There are TV adverts on recognising STROKE and what to look for – should be similar for self-harm and suicide/mental health” • Difficulty for C+V organisations to know how to identify funding applications – knowledge deficit. • Lack of knowledge around where to get funding • Need for a walk-in crisis centre for suicide prevention • More need for night time support • Therapeutic relationships don’t exist in clinical intervention – need a safe holding place. Development of ‘safe space’ in hours and out of hours. • Need more consideration given to over 60s, those who have lost a lifelong partner, those who have lost a business, rural or isolated		



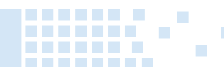
Event	Prevention	Training Framework	Postvention
21.3.18 OMAGH	**What works well:** • SHINE Project - developed into SHIP – regional, works across groups and professionals and plugging gaps. Crucial to work with not just person affected but with the wider family • People now being able to input to the service strategically • There are lots of groups, but the importance of highly skilled people can't be overlooked – focussed is better • Promoting positive relationships programmes in schools (11-18-year olds) • Physically reaching out to those isolated or struggling to engage – promotion of sense of belonging • Connections between isolation/addictions/self-harm and suicidal ideations • Mindfulness (Paws. B) in Primary and Secondary schools is receiving very good feedback – currently delivered by AWARE • Training is useful in that it raises awareness of the referral pathways/guidelines – training delivered directly to communities is important • Drop in style services – open door for crisis response – accessibility **Gaps:** • Rural communities can struggle to access services • Appreciation and acknowledgement of the extensions of funding applications (3-5-year tenders) • Need to look at how young peoples' mental health is managed in other countries • Need research into young peoples' use of social media to inform policies going forward • Opportunities for community and voluntary		**What works well:** • Family liaison – timeliness of the service, flexibility of the service, self-referral • Example of good practice is the 'Critical Incident Plan' within GAA • Family Voices gives a voice to those bereaved by suicide • Bereaved by suicide groups • Community Response Plans • SD1 – although some gaps and currently being reviewed • Reaching out to young people and 'plugging' any gaps on how we communicate to them • Interagency protocols • Cross department approach – e.g. PHA working with DE • Local politicians can have a very positive impact – they should be given training to be used as a positive impact **Gaps**: • Problems with SD1 form • Need postvention training on how to cope and interact in the situation of a suicide – guidelines for communities to respond • Need to stretch the support of the family liaison officer to support friends and wider community • Need more support 'down the line' – who's responsibility is this? • Community response plan – problems arise when other individuals input that results in adverse impact • Managing media reporting – acknowledged educating editors etc. Do we need to regulate this more to increase individual responsibility of newspapers etc? Sensitive reporting by local media



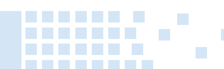
Event	Prevention	Training Framework	Postvention
21.3.18 OMAGH CONTINUED	sectors to meet and connect with each other's services to promote a 'joined up' thinking and prevent a service user falling through the 'gaps' • Essential to build links across gaps. Across families we can see from objectives that cross departmental boundaries must be removed • Need to build structure and capacity in groups – this works better than a myriad of ad-hoc groups • Need to 'skill up' communities • People benefit from face to face interactions – need more of these • Often gaps in referral pathways • If people are trained up they may be more aware of the signs to impact the 70% who do not access services • Need a Tier 1 service to hold onto people in need before referrals to a waiting list – can help de-escalate a situation (Take 5 approach) • Difficulty of knowing the process and services that are available – need more connectivity and awareness • Fear of some working with/talking to people who are suicidal • Need for a flow chart to make the process more transparent • Legislation re paracetamol sales had helped – deaths by paracetamol down as a result – however – stores are breaking this, and people are now using this method again		is required • Some issues regarding consistency of the SD1 could be addressed – this can lead to an uncoordinated response with a number of people/officers arriving • Social media – pressures it adds to young people - parents and adults need additional knowledge and skills • De-briefing after a suicide is very important for family and wider. More of this could be done • There is no 'one size fits all' – need bespoke response based on the individual



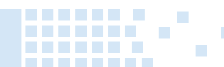
Event	Prevention	Training Framework	Postvention
22.3.18 **DERRY**	**What works well:** • Community groups such as 'Off the Streets' and search and rescue groups • Work in schools, such as 'hope and resilience' programmes • Current mental health campaign 'stickers on heads' • SHIP, Lifeline, Childline • Good communication between schools and community • People having a voice – hearing from families and survivors • Community training, e.g. 'mindset' and mental health first aid • Take Five campaign • Attitudes – less hierarchy, more collaboration • Reduced stigma amongst young people • Community development partnerships • Peer support – School for Hope – model of practice which has been evaluated – Teaching Hope theory **Gaps:** • Mental health education needs to be a part of the curriculum • All sectors need to co-ordinate support/ programmes – education, health, community and voluntary • Media campaigns around suicide very low compared to those on road deaths which are very impactful • Better connections and communication required – should not differ in each Trust area • Need to make communities more resilient or able to respond when they see early warning signs and ensure communities have information available for early signposting even before contact with	• Treatment/intervention needs to be longer • Whole population approach is needed – so you do not have to go through a whole 'procedure' e.g. schools knowing what to do, taxi driver training for ASIST • Can training framework be built around the co-morbidity issue e.g. alcohol, self-harm etc • Training for GPs re mental health/ASIST – this is supposed to happen already and doesn't – should training for 'first point of contact staff' e.g. reception be built into training days • Schools – work put in should be proactive and responsive – early intervention • Need more work on resilience building and coping strategies • Agreement that mixed methods are needed for learning • Needs to be a clear structure/map of who needs what training • A menu of approaches to support individuals could work • More understanding of social media required • Step 3 – enhancing knowledge and skills. If the help doesn't exist, you can't refer. Crisis intervention happens, but in some cases weeks later. Reinforces message that no one cares. Someone in physical crisis would never have to wait so long for help – should be treated like any medical disorder. • Funding can be pulled, and intervention then suffers • If professional help is not available, then the training framework will not work • People in distress need human interaction • Postvention training needs to be addressed. First responders are a huge risk group from suicide	• (One group noted disappointment that there was no discussion on intervention, in light of the aims (10% reduction) **What works well:** • Communication – multi-agency approach for all situations • One-person approach to the main point of contact • Best practice in NW exists and learning is shared to wider regions (CRP) • Community response plans work well post a suicide cluster **Gaps:** • Support only for immediate family, not enough for extended family • Therapeutic support not long enough – only 6 sessions. • Follow up at interim periods following the death – 3-6 months, up to 1-2 years • Offer support immediately after a death – there are currently possible differences in how the support is offered • Medical model – GPs/prescriptions – does not work • Community capacity building – CRP extended in a way to single deaths • Need automatic help for those who are impacted on by suicide – some PSNI staff respond a couple of weeks later and some don't – all members of family should be supported • A guide could be left for people to 'opt out' of the support package rather than having to 'opt in' • Coroner in Australia takes over to offer support and this had been tried in NI but currently not available – it is available when someone dies by car



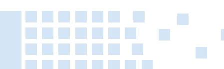
Event	Prevention	Training Framework	Postvention
22.3.18 DERRY CONTINUED	statutory services • Need to educate and promote services (e.g. ASIST training) and promote how to access support easily • Early intervention needed – primary school tools for children to talk e.g. re: ACEs etc/resilience building – equip schools to respond/communities to respond at earliest point e.g. a HUB where a person can 'walk in and talk' • Crisis intervention should be residential • Waiting lists for services are too long (sometimes 13 weeks) • Schools and communities are disjointed – need to be aware of early signs • Access to appropriate services • Services too 'crisis focused' • Access to information • Too many people falling through the system's 'cracks' • Lack of funding • Borderline Personality Disorder – stigma, awareness raising, family support, understanding • First responders need to be able to de-brief key workers – there is currently a disconnect unless this happens – full story not heard. Suicide ideation/ psychosis can cut lines of communication – some sort of revised consent process is needed • We have failed to address the fact that young people have very poor verbal communication skills. They will text before they talk – need to look at modality of talking about suicide – app needs to be developed where young people can access counsellors via text. Counselling is often an obstacle when it is face to face. Samaritans did have an app but because of data issues it had to be pulled. 'Red button' to be built in if suicide is imminent	but are expected to work with those bereaved by suicide – proper training needs to be identified and implemented – must be evidence-based	accident but not by suicide • In WHSCT there are suicide liaison officers who can liaise with family members to offer support – this is then passed to GP within 24 hours. Sometimes families are not ready when support is offered but may need this later. This needs to be a face to face follow up by a trained person – e.g. from own community, as standard • Worry that there are suicides which are not recorded as suicides/suicide related – some support 'missed' • Worry of 'ripple effect' in wider community – increased risk – CRP activated – importance of making sure a CRP is in place – really important to ensure positive outcomes at local levels • A community safe space • Need for a community mental health champion • Need more public understanding of 'behind the scenes' work • Need more promotion of self-care/support • Need for equal support for bereaved parents and siblings • Need for a practical simple step guide to help families following a suicide – including long-term help • 'Does anything work' (mum bereaved by suicide) – resources not there, lots of leaflets, lots of calls but no funding and waiting lists full • Negative feedback of medical/nursing frontline staff • More funding needed for families and PTSD – fundamental needs are not being met with long waiting times for counselling • Not all of the community and voluntary sectors is quality assured – do they meet standards? • CAMHS overloaded as a service and can't cope –



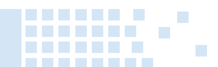
Event	Prevention	Training Framework	Postvention
22.3.18 **DERRY CONTINUED**			saturation is unethical • Need to 'make it ok not to be ok' • Outdated thinking in communities needs to be addressed • Bereaved mum's example – '3 months for children to be seen by services post sister's suicide – fear about speaking about suicide openly afterwards'



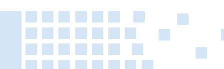
Event	Prevention	Training Framework	Postvention
COLERAINE 22.3.2018	**What works well:** • Partnership Approach (Community and Voluntary) • Multi-agency support service in the Northern Area • Networks in Northern Area • Young Persons Support Project – PHA Funded, Education Authority • Northern Area PLIG – connecting and communication • Emotional Wellbeing Hubs • Bereaved by Suicide Services – PHA Funded e.g. Barnardo's, • Strong emphasis on community development approach • Training available – ASIST, Mental Health First Aid and Bereavement Training • Inclusive local and rural events and specifically targeting men. • Local intelligence informed service provision. • Suicide Prevention Development Officers (SPDO's) in Northern Area • Young men's project • Specific/targeted interventions • SD1 Forms from PSNI – used to inform community network • Nurturing programmes in schools • Navigator programme • Youth service – specific programmes • Street pastors • Early interventions – a cross departmental approach • Supportive family approach – supporting families/ coping skills • Opportunities that bring young people together under a common agenda and getting key messages out there.	• Not all agreed on a stepped approach • Zero Suicide Alliance Toolkit Training • Need to use evidence bases to inform training • Gap in training for GPs and GP Receptionist • Training for "gatekeepers" – train those who have access – make the training work for them although recognition that every one of us are gatekeepers – make every contact count • There needs to be "Increased understanding of suicidal behaviour, its causes and prevalence and provide a range of responses, including guidance and first aid to keep safe the individual experiencing crisis" at Step 1 – raising community awareness around suicide • We need to encourage families to talk about mental health more – years ago we avoided talking about cancer – the big C – mental health needs to be part of everyday language to reduce the stigma • 72% of those dying as a result of suicide have never used the services available – we need to encourage more people to come forward • We need to get information into obvious places – solicitors, banks, funeral directors – the places where people go after the death of a loved one or a relationship breakdown • We need to look at older people and rural isolation too – how do we inform them? • Schools – need to include nurturing programmes as training in schools • There is a need for a public campaign about suicide – it needs to be everywhere – like we have done previously with HIV and Smoking e.g. "Mind Your Head" campaign • How do we collect evidence that the training is effective?	**What works well:** • Suicide Prevention Officers x 3 (PHA Funded) • Danielle Gallagher Suicide Support Co-ordinator • CRUSE – bereavement counselling includes bereavement by suicide • Community response plans – support for communities postvention • Bereavement Support • Schools Support System • Intergenerational work • Localness – local need and local touch • Existing links – Child Bereavement Service through Baranardos • Area very informed and working widely with families and SPDO's on the ground – social workers and advice line • PSNI – LPT's response teams trained in bereavement services and process – leaflets left, and packs handed out now • Consistency – PSNI Best Practice, regional sharing of approaches around PSNI/SD1 deaths • Good communication processes – SPDO's alongside SD1's bringing community intelligence systems in place and working • Suicide Support and Information Service – knowledge of suicide in the area • In Northern Trust there is an annual commemoration service to remember all those lost as a result of suicide **Gaps:** • Lack of awareness of support available and therefore people being signposted incorrectly. • SD1 – does that trigger support being made available – is it at the right time? • Educating GPS to promote where to signpost



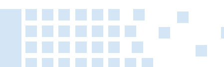
Event	Prevention	Training Framework	Postvention
22.3.2018 COLERAINE CONTINUED	**Gaps:** • GP awareness of services available in the community • Counselling services need to be available in GPs surgeries • Sustainability of PHA funded posts/services and longer-term funding • Cross Dept. communication and roll out of Protect Life 2 • Lack of knowledge about what is happening • What tools are being used to measure impact? • Early intervention • Lack of hospital support – most vulnerable are let go • More co-ordination of services needed to avoid what was described as people being put on a carousel if they are presenting with multiple issues and are not always referred according to their priority needs. • Lack of consistency across NI – geographical postcode lottery. • 20-50-year-old males • Crisis – people are not coming forward • Workplace help and support • Training and service evaluations • Knowledge of where the services are • How to engage hard to reach • More campaigns needed e.g. mask • Rural isolation – especially older people • Mental Health App should be available for children/younger people • Teachers need to be educated in mental health and encourage children to talk about their feelings. • Counselling needs to be available in schools • We need to build resilience in our younger people What works well:	• The training needs to be progressive – not rigid – more flexible approach • Need a widespread campaign to remove the stigma surrounding mental health and suicide • Blending training available which is good • Need to include some basic level resilience training and personal development training so that people have a better understanding of themselves and their own wellbeing • Look at University of Manchester Suicide Bereavement Training	people to. • Need more peer support, lived experience of suicide makes a good peer support worker, however it is very important that they are trained and regulated to “do no harm”. • Problem with follow ups for people in crisis – responsibility of family/carer/community to keep loved one safe • PHA to share case studies and across border experiences also • Raising awareness of workshops • Postvention Support Groups • There needs to be a top up service or a drop-in service available as 8 weeks counselling support is very short



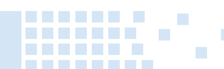
Event	Prevention	Training Framework	Postvention
23.3.18 ANTRIM	• When parents come to group meetings they feel supported – reduces sense of isolation • Training has been very beneficial. Has helped especially in groups dealing with trans issues • Support infrastructure for SAIL is working well for parents throughout NI • Providing non-judgemental approach is very important • There are more groups trying to get the message out • PIPs • Non-judgemental approach • Reducing stigma • Walk-in services • Men/women specific programmes • Involvement in non-mental health/suicide prevention branded schemes/interventions are extremely valuable – e.g. Men's Shed, sports groups etc • Z Cards really useful • Counselling – need early introduction • Employers helping with counselling • Need initiatives to help combat isolation and stress **Gaps:** • GPs/teaching/nursing staff need training on trans issues and how these impact on mental health • Not enough funding for counselling • Need for stability of PHA workforce in area • Professional training needed • Lifeline change in criteria – where do people mid-crisis go for support? Inappropriate focus on process not person in recent months • The link between self-harm/suicide and alcohol needs considered • Waiting list too high for GP on-site counselling	• Training needs have changed in time between old strategy launch – training has had to adapt. Have good evaluation feedback from PHA to adapt training • Frustration that most popular course is often misrepresented in evaluation feedback. Changing staff in PHA can impact on relationships (maternity leave etc) • Training is a lifeline for rural communities – flexibility to get trained at the weekend is important. Need to have trained taxi drivers, hairdressers etc • Access to training very important – not just tier one • GPs need more 'human' basic training – medical model has clouded their perspective • Concern that certain groups would be boxed off against certain 'steps' of training • Sometimes policy and procedure for professionals does not align with training outcomes • Step one is giving information – this is not actually training • Training needs to be integrated with policy and practice. Can do all the training but people can't change what they do (governance, practice etc) • The training that is delivered under contract from PHA etc is only part of what is needed. To do the rest is very expensive to provide resources and recoup costs. PHA need to ensure that recommended programmes are affordable outside of the capacity that they are funded – i.e. where community and voluntary groups need to source funding themselves • Training level 1-2/3 is good • Strategy outcomes ultimately too heavily reliant on volunteers – doesn't acknowledge this	**What works well:** • PSNI have a great training in place now • NHSCT has bereavement coordinators which is a really good model. This is not always available in other Trusts – it is a well-managed service with resources – this is an important resource • Service providers in NHSCT area meet regularly in a peer support forum to build relationships – this works really well and builds trust • Lifeline worked well before thresholds and rules changed • GP on-site counselling works well but not enough resource to flourish • EA in some areas have a bus or opened up community/youth centres • WHSCT Bereavement Support Service and Barnardo's Children's Service provide quality postvention support and have good relationships with community groups and clergy to offer opportunity to link to support at different times • 'Bereaved by Suicide' based in Holywell are a great group **Gaps:** • Confusion around access to services – first responder should know this from the beginning. • Families can be too traumatised at the time to discuss support • SHIP process has made self-harm support more difficult to access – a regressive service • 2-cards too difficult to access • Why is it not possible to roll things out across different Trusts? Should be a level of consistency across Trust areas in service delivery • Service providers in NHSCT area meet regularly in a peer support forum to build relationships – this



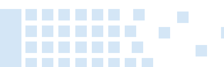
Event	Prevention	Training Framework	Postvention
23.3.18 ANTRIM CONTINUED	services • Emotional wellbeing had potential but inconsistently funded • Some localised examples of really accessible community services but under-resourced and not recognised/known – e.g. safe place to be me • Session counselling model is not useful for suicide and self-harm interventions • Post-code lottery for some services • Family therapy in Lifeline is being stopped • Politics linked to some organisations • More active involvement of professional bodies to support collective and consistent practice/ outcomes • Need for more early intervention • Address benefits/money worries • People have no understanding of signs and symptoms to look for • Introduce employer referral system to counselling • Need to make mental health discussion part of normal language • GPs need to increase medication doses • The term 'mental health' is a problem • People simply do not know what is out there • Pressure of 'making ends meet' • Need a local community focus and ask community what they need • Social deprivation – lack of community – social isolation – all problems • Poverty and isolation are problems – 'like a spider's web' • What is there for younger men if they are not involved in GAA or sports? • Lifeline number should be put into phones • Small grants are important to fund smaller groups which can provide locally tailored services	• GPs could be more incentivised to participate in training and make referrals • Concern at 7 hours timeframe – OCN require 9 hours minimum for one unit • Agree with online approach to improve accessibility • Stepped model options gives a richness and accommodates different learning preferences • Subsidised training for counselling including CPD to support higher calibre of staff – money can prevent good people from progressing • Significant gains to be had from integrating SP training into workplace curriculum e.g. teacher training, PSNI training – should be a requirement in the health and safety/induction • Need to ensure trauma-informed care is included in framework• Need to consider skills required to work with person over longer term – CBT and DBT is the evidence base • Support needed for organisations who have developed their own training to roll-out – pilot and evaluate to build the NI evidence base • Needs to be more support for people to find out what Is available • Training needs managed so whole communities know about it • E-learning not suitable for all • Challenging re capacity/hours • Requires dual support approach to avoid isolation for individuals • Has to be needs based depending on level of support required and to determine how • Need to be appropriately pitched and marketed to avoid people feeling out of their depth and to find the training pathway most appropriate to them	works really well and builds trust • Critical Incident Reviews – practitioners need to be supported in that process especially if independent providers or in community and voluntary sectors • Emotional impact on staff needs to be better supported • Links through police/care hub can be useful in activating localised support to family and friends after death and CRPs • Lack of awareness that postvention support exists or that it can make a difference • Need a more joined up approach e.g. CRUSE training and other providers can contribute to postvention agenda • Therapeutic support is important for rescue workers and volunteers • Issue of stigma – acknowledgement that some professionals are still not recording suicide • Need to be able to work in partnership well at crucial times • Services need to get better at using social media at critical times/incidents • GPs not taking money for GP counselling service • Timeline not long enough – lack of empathy • Should be an opt-out service rather than opt-in for support post-suicide • Consideration around attempt and death five days later • Gaps in how families are communicated with • Communication needs to happen with those who have been affected to see how services can be bettered • Face to face follow ups needed – supporting families more – training for groups and villages etc



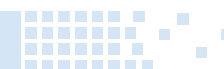
Event	Prevention	Training Framework	Postvention
23.3.18 **ANTRIM CONTINUED**	• Equally, there is a need for neutral options outside local community • Counselling young people through schools is very important – both Primary School and Secondary Schools – this should be normal for everyone and offered to everyone • Retain what is working – there is a lot proving effective re Community Development Approach on RMH and SP through networks, SPDDs and C+V sector. Community led work is pivotal in reducing risk factors. Retain more engagement and inclusivity in all services. To be aware of this whether it is their focus or not to help reduce • Gap identified on crisis intervention – community support and family support – need to educate people more on signs and symptoms of MH from early years • Need hubs – crisis response – not in A&E • Need for community intelligence – connected community approach • Gap in early intervention – more resilience work needed, family support for person at risk • Workplace health is key – local rural construction businesses need to focus on mental health and wellbeing. Staff and colleagues need to be able to identify changes in men's health and interests and be able to spot when a 'man' has not been his normal self so to be able to signpost to relevant services at an early stage	• Has to be mandatory for specific groups of professionals – health, education etc • One size does not fit all – some will benefit from online approach, others one to one, dual – an outcomes approach could potentially facilitate this • Co-facilitation of trainers and those experiencing mental health issues should be considered – peer support • Community navigator needed in NHSCT – who knows about training and services • Agree with whole population training but need to support people to find out what is available • How to do it effectively – need to manage it so that communities know about it • Courses drawn from lived experience – working alongside facilitators – great learning experience	



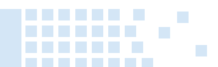
Event	Prevention	Training Framework	Postvention
26.3.18 **BELFAST (FARSET)**	**What works well:** • Self-care • Walk in services • When waiting lists are not too long • Immediate 'safe-plans' and de-escalation • Connections and awareness raising • Keyrings, flyers, 'sport' • Networking and partnership at local level • Sharing information and bringing communities together • Postcode finder of services available • Training – ASIST, Safetalk, Mental Health First Aid • Early intervention at community level • Family support Hubs through referrals • Sign-posting and ongoing support • Cross departmental working i.e. health and education • Peer support (normalising and championing) • Awareness raising – resilience/stress control **Gaps:** • Training in local communities • Target audiences need to be wider • Community support worker needs to be present in all suicide prevention training • Co-ordination between organisations needed • Information needs shared from statutory bodies • Needs to be stronger referral pathways – from statutory to community for people in situational crisis and emotional distress • Hubs are being over-burdened • Lack of connection with causes of suicide • Lack of connection between Government departments • Better understanding required for current services • Gaps/lack of services for people in crisis – problem	• Agreement in principle with stepped approach • Wider framework on training should be available (on PHA website perhaps) • Agree with methods of learning but feel more explanation necessary • Structured approach is important • Need to improve accessibility of online training – limited knowledge of what is there • Air caution on over-reliance of online training • Positive to have a framework but important it is tailored and designed to target those in need • Take stock of what is already available • Concerns around lack of training in suicide prevention for GPs – this is critical – 50% target should be 100% for GPs • The 'everyday person' is not understanding suicide prevention/training • Lack of 'lived experience' reflected in framework • Need to educate people to help them know when you need help and when a loved one needs help – equips individuals and carers to know what to expect • Belfast Recovery College – good model • For 'everyday people' the duration of programmes required needs to be longer • Needs to be flexibility around timings • Some programmes longer than 7 hours • Within steps, target groups and locations should be identified • Use role of peer trainers • Step 1 and 2 need to be accessible and increased focus on population awareness e.g. schools • Ensure trainers are competent in adherence with PHA regulations • Trainers could be a community resource	**What works well:** • Family support groups – NSEW Belfast • SD1 process is a good starting point • Psycho-education for families • Flexibility sessions • Creative groups – counselling, complementary therapy • Local community level support is good – examples in East Belfast – local co-ordinating groups • Counselling services • Talking therapies – on self-harm, bereavement, crisis response **Gaps:** • Needs to be a central point for information • Success stories positive • Joint respect and motivation needed across all sectors • GPs need to know what services are available • People in group expressing how Lifeline has not helped – need practical face-to-face support • Need drop-in services but how to manage the volume of people attending – very high demand • People slip through services – need someone to listen • Appointments and waiting lists are a problem • Different services in different areas • Needs to be a 'menu of services' • There must be an alternative to the police being the first emergency response – what about an ambulance instead – the negative perception of police landing at the door • Crisis teams are under-resourced • Greater role for community to provide 24-hour support and emergency response in a drop-in setting



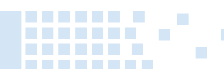
Event	Prevention	Training Framework	Postvention
26.3.18 BELFAST (FARSET) CONTINUED	spreading wider than Belfast • Better connectivity required between services • Lack of adult safeguarding policies in Government departments – i.e. Department for Communities (benefits etc) • Need for better signposting and ongoing support • Need more investment into more deprived areas and prevention • More public general awareness/training needed • Young people don't have understanding • Families support – understanding emotions in family programmes is important • Lack of funding • There are more agencies that support families after suicide than prevention agencies • Needs to be mindfulness in schools • Need to address the 'toxic environments' e.g. school, inpatient unit where others influence individuals • Relationship between client/carer and service is critical • Access issues to specialist services and statutory sector professionals knowing about the services and their access routes • Community Reponses Plans – could the remit of the response plan be widened to support those who are affected by an individual's suicide attempt • Concerns over additional risk factors which young people may be exposed to in care settings e.g. Beechcroft. Young people are being offered alcohol, drugs, being shown pictures of self-harm by other inpatients. Concentration of very troubled people in a setting • Importance of being heard and not being pushed from pillar to post • Need to encourage 'help-seeking' behaviour	• Evaluation needs to be robust • Need accessibility right across Belfast • Stepped approach would have broader impact at correct level for individual needs • Needs to be a 'blended approach' – mix of face-to-face and e-learning • Face-to-face work helps to normalise experience • How will the impact of training be measured? • If need is identified, how will support be offered? • Training and prevention – emotional regulation/ resilience group work in local communities/ targeted areas • PHA training is a great source of CPD for individuals e.g. trained in theories of counselling to add to their skills and knowledge through attending programme of training delivered by PHA • Connecting Service Providers and Training Agency to come together to ensure services and training are matched • Family members/member be offered training opportunity – (early crisis stage) – community level. • Training – face to face works best – more courses and more regular • Ensure strategy document allows for inclusion of new/fresh initiatives – (seen to be working) – ongoing process • Draft Training Framework – There is no point in helping people to learn how to signpost those with mental health problems on to professional help, if that help does not exist. The services are not there. • Training Framework – Resilience is only mentioned in Step 1 – it needs to be embedded throughout all steps. It will require face to face support to deliver, as e-learning will have limitations in building	• Do we know what has worked well, or have any feedback from service users? • Many services, but people do not know how to access them or get referrals • Need for holistic approach • Could we have community workers/health and wellbeing staff being staffed within GPs to refer to • GPs need to work more with statutory organisations • SD1s – very cold and clinical that the person's name is taken out and they are just referred to by a letter • Supporting clients who have been de-escalated while they wait to be picked up for specific intervention – given there are waiting lists. To ensure that this client understands when support will be in place/where from etc and is more likely to continue to engage



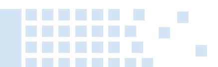
Event	Prevention	Training Framework	Postvention
26.3.18 BELFAST (FARSET) CONTINUED	• People need to know where to go • Too much pressure on GPs and staff • "Stigma "Mental" Illness is a barrier to accessing service. New Terminology - "Emotional/ Psychological Wellbeing" - use person friendly terms. Mental is not friendly – old stigma – mental institutions – mad." • "Joint working – due to lack of resources, Mental Health Services can take services for granted and assume they will provide ongoing support when the service is temporary e.g. mental health client in temporary accommodation up to max. of 2 years. Attempting to deliver planned move on but told nowhere for client to go. Best to evict and make them homeless again. This flies in the face of what we do and puts client at significant risk" • Community Mental Health Champion – point of contact for access to information, assist trainer and co-ordinate community response • Australian model – need to build emotional resilience in children. Family/parental separation is key • Early intervention holistic approach is key e.g. pre-birth in hospitals, schools	resilience skills • Cost analysis for community sector. "I commend all those involved in the development of community/statutory partnership in the delivery of services and training being delivered across the area to date since the development of the WSSIG and delivery of the strategy". • Access to training – meet up at schools (mothers drop off their children), youth clubs, churches, libraries, community centres. Ask people what suits them, offer a creche facility, offer a primer session then follow up with short courses/ extended courses	



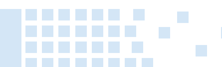
Event	Prevention	Training Framework	Postvention
26.3.18 BELFAST (NICVA)	**What works well:** • More suicide awareness and management training has been available for the whole community – both professional and non-professional • Bereaved by suicide groups are very valued • There is more cross-sector working to provide support locally – e.g. work done to support schools who have experienced the suicide of a pupil • Joined/co-working together as a community • Early intervention • Communication • Enforcing good mental health • Training • Awareness • Follow-ons • Progression in services • Connecting positively with community groups • Take 5 model • Lifeline worked well previously (see below) • Wrap-around support works well when available • Family support Hubs and mental health Hubs • Outreach services **Gaps:** • Not enough prevention services – limited – not consistent across Belfast • Awareness raising is still not getting key messages out – still a need for more honest conversations – still fear/still stigma • Where has the 'Mind Your Head' campaign gone? Needs sustained and refreshed – as much as DOE do with drink driving • Carezone pilot showing gaps, especially in disadvantaged areas – map it – lots of services but it's about joining them up and involving communities – bringing them together with you	• Uncertainty around tendering for training – is this alongside other services? • Not all work is 'training' – awareness raising often done through relationship building • Concerns around e-learning – this could be seen as 'boxed' – an organisation applying to run one particular type of training whereas this is never stand-alone • E-learning not suitable for everyone • Training framework can't be black and white • Holistic approach needed • Community pharmacists are an under-utilised resource • Stepped approach 'the right way to go' to safeguard • Needs to be support built in even at step 1 • Start with awareness then build on for those that need/want it • Target groups need identified by settings too • Think outside the box re targeting for bars/clubs • Ensure follow-up – check if people have used training • Less focus needed on monitoring, more focus on impact (step 1) • Potential for bursary scheme for specialist, in-depth training • Are we going to define/decide who frontline staff are? – teachers, GPs etc. • Need more emphasis on the importance of listening • Involve people, parents and families in shaping training – those with real-life experiences – they seem missing • Understand that conditions differ from person to person • Learn from tragedies and mistakes	**What works well:** • Community responses – developed by people, using community intelligence • Signposting – SOS, counselling, specialist services • Much value in local knowledge • SD1 – some good improvements **Gaps:** • While good changes made to SD1 – would rather have an 'opt-out' rather than 'opt-in' as families are shocked and distraught at time of first contact with police officers • SD1 process including roles, follow-up, linkages need looked at – who is best? When is best? How often do you offer? • SD1 process too long and cold. What to expect/ how long will it take needs to be clearer • Needs to be more awareness raising of services • More education needed in schools on self-harm and suicide • Must be appropriate timing to get into services for specific needs i.e. suicidal ideation vs bereavement • Lack of care for carers • Community based services work more in disadvantaged areas – they seek you out to give or link you in with support. Less community groups in middle class areas – less aware of support • Awareness of support available is an ongoing issue • Landscape is constantly changing due to funding cycles • Drugs and alcohol – big gap – not funded for postvention bereavement support • More talking therapies needed – especially in rural areas • Targeted support to tackle rural isolation



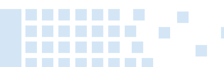
Event	Prevention	Training Framework	Postvention
26.3.18 BELFAST (NICVA) CONTINUED	and empowering them • Lack of connection from GP referrals to services – do they not have the information, or the interest? GP awareness-raising should be mandatory • People in the community should be used – shop-keepers, taxi drivers, bar workers, barbers, hairdressers • Youth services – feel they may not be resourced enough • City-wide services get funding, local services don't but know the young people and know the context and know the area • 6 weeks counselling is nowhere near long enough – needs to be flexible – respond to individual's needs to find root causes (some which are personal but some which will be societal) • Look at the impact of welfare reform • Specialised resources needed in drugs and alcohol – dual diagnosis – combined mental health and drugs and alcohol needs issues • Family views/opinions/experience is vital – need to be heard and listened to for insight • Negativity around mental health• Wrong information being given out • Need posters in all community centres • Need for more signposting • Need for mental health support HUBs • More provision needed for LBGT groups and especially transgender who are 25x more likely to attempt suicide • Important to be able to talk about the issue 'it's ok not to be ok' • Need for a walk-in service • Need for more positive activities in communities • Need more resilience building • Need for more intergenerational work	• Targeted response right across the health service to health professionals • Cascading approach spreads knowledge but not enough being done • Important additional training is directly available to people • Need to empower people to be more confident about signposting, having conversations, talking to people • E-learning good but only on the low level • Importance of refreshers – not just a 'one-stop shop' • Good mechanism for equipping non-professionals/ community groups • The more groups who are made aware, the better • How does the stepped approach work? What does it actually look like? • PSNI need to receive training • "Innovation – look at creative programmes out there – their approach to engage their audience. They know their audience. Need a co-designed programme to engage, connect, empower – capacity. Can leave legacy" • "Information availability – information is power – professionals don't necessarily know signposting or are not trained in those areas. They don't always have the time or emotional wellbeing to deal with very difficult issues. Use volunteers who have these skills already – use them to educate/ train others in communities"	• Targeted responses needed to build resilience in families and communities – especially vulnerable families and the young children/people win those families who have suffered greatly • Finality and stark reality of death – focus of hard hitting campaign • Family support services needed offering practical support – e.g. bringing child to school, linking them to the right services at the right time • Need specialised services, not total reliance on members of the community • Don't dismiss impact and importance of community classes at postvention stage • Barriers around the stigma around setting up a postvention support group • Difficulties connecting minority groups with community • Cross-referral process needs improved • Support needs offered to siblings, partners and children at SD1 process Support groups can prove very useful for individuals; however, the group may be more productive with support e.g. to how it should run • The people who are going out searching for a victim may look distressed on camera (CCTV) and this may take resources away from the people who are in crisis **Concerns:** • "How do young people behave on social media when a friend or relative takes his/her life? Do we know enough? Is something being done to teach them how to manage that? Is this a gap? I realise it would be sensitive, challenging, difficult to get right but it's not going away"



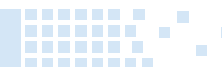
Event	Prevention	Training Framework	Postvention
26.3.18 BELFAST (NICVA) CONTINUED	• Gaps being filled by necessity – model must include community development • More work needed on capacity building – intergenerational in particular – lack of connection between sectors • Need more teachers and parents reaching out • Should be targeting people across businesses • Tendering process may mean smaller groups miss out • Waiting lists too long due to high demand • Statutory services are being flooded by request – people in crisis being signposted by GP to the Hub • Time of GP appointment to service too long • Lifeline worked previously but should be for people in distress/vulnerable as well • Wrap-around services not always available • Need more outreach services – especially in rural areas • De-sensitising in churches – talking openly is important • Community groups need supported to raise awareness • Post-trauma support needed for immigrants coming from areas of war – vulnerable groups need identified and targeted for support • The 'Card Before You Leave' scheme for those being discharged from hospital after a self-harm or suicide attempt was a good idea but is not used across the region • Lack of quality specialist mental health assessment and support out of hours • Lack of informal support networks such as 'drop ins' • Long waiting lists for counselling and therapy • More support needed either by GPs or at Primary Care level		



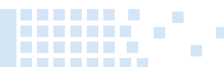
Event	Prevention	Training Framework	Postvention
26.3.18 BELFAST (NICVA) CONTINUED	• Services need to come to people in crisis and not expect them to travel long distances (at a cost) to receive services • Lack of family involvement and recognition of their roles as carers, in identifying risk and contributing to shared care packages and investigations/ recommendations for change • There needs to be a focus on changing our culture to become a more resilient one which embraces healthier behaviours and choices. We understand that this needs to begin at school where mental health should become part of the curriculum. Community Planning processes have been a start but much more is needed in terms of sharing responsibility for delivering support as a package across services in the community and this impacts housing, poverty, education as well as health and social care services. With the growing recognition that suicide is not a problem for 'Health' alone, then money needs to follow and be shared where services will provide the support. Services providing intervention for suicide prevention should not discriminate against users of drugs and alcohol. Suicidality should be seen as a primary problem, not a secondary symptom and service providing mental health support in any sector need to start dealing with it in this way • We should have resilience as part of the education curriculum • Large absence of on the ground services. Lifeline is a service we use and recommend on a weekly basis. Sometimes our service users don't call it but knowing it is there is very helpful. Alternatively, they may call it several weeks after being made aware of it • "Difficulties with young people with additional		



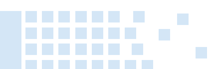
Event	Prevention	Training Framework	Postvention
26.3.18 BELFAST (NICVA) CONTINUED	needs, for example ASD and present as suicidal – ensuring services can understand the best ways to engage/support the young person and that they can take ASD into account without being dismissive" **Concerns:** • How services are funded is a major concern. The community wants to see services provided locally by providers who have a knowledge of local culture and local challenges faced. However, the tender process discriminates against the Community and Voluntary sector in providing these services in favour of larger organisations. As seen from the recent Public Perception Survey carried out by NICVA in 2017, there are high levels of public use and public trust in this sector to provide the support needed. Continuing to provide support services on a short-term basis results in the risk of a diminished capacity to focus on community needs in a stable and understood way. • "How do we engage the 70% of people not known to services? The Type A people who keep problems internal, don't share and will carry out the act. Need to build resilience for people" • "Links to drugs and alcohol crucial – over 50% of people who have taken their life also consumed drugs and alcohol" • "Wider departmental support – anti-poverty strategy needed to prevent – poor living environments, crime, poor health outcomes, poor education, poor employment levels – app pertain to correlate to poor mental health and suicide" **What works well:** • Early response – people presenting with suicide		



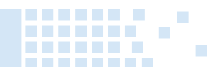
Event	Prevention	Training Framework	Postvention
	ideation to be identified quickly • Having someone to connect with what is local and accessible • Not shying away from tough conversations and situations • Early intervention in schools – developing emotional resilience – needs to be part of the curriculum • Identifying those at risk – including researching trends, looking at high risk groups and cluster areas • Flexibility in approach • Tailored services • Evaluation and feedback from service users and professionals – what works, what doesn't work • Multi-agency approach – improved communication between PSNI, C+V, statutory		



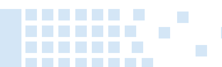
Event	Prevention	Training Framework	Postvention
27.3.18 LISBURN	• Improved onward referral linkage and signposting to appropriate services • Active listening is a good model – 1:1 basis • Lifeline • Easy for practitioners to identify counselling services • Accessible and timely services available to support people in crisis • Action Mental Health • Raising awareness and building resilience • Social Supermarket – Lisburn City Church Food Bank – conversations • CAP courses – 17 churches • SHIP – positive and timely • Media campaigns to reduce stigma and encourage more people to come forward • Mental Health Hubs – increased chance of correct service, timely, including BME groups • Community planning – awareness across all organisations to decide priorities for action • Family Support Hubs – for children and young people • Infant mental health strategy – focus on early intervention • Community response plan – co-ordinated approach – worked well in Lisburn/Ballynahinch in response to clusters • Interagency programmes in schools – increase knowledge of services and access to these (particularly drop-in) • Offering a wide range of services before people reach suicidal stage • Acknowledgement of rural needs – hubs good for signposting/reaching out • Regular support meetings are required for prevention – peer-led support is positive	• Stepped approach to training good but concerns with regards to overlap of existing provision e.g. Recovery College, ASIST, Mental Health First Aid • Mapping of training would be useful – would assist signposting • Step 1 – info available but getting general population to access it can difficult – people can lack motivation to do so for various reasons • More advertising required outside • Staff wellbeing support should be in framework • Clinical staff need training – is this step 4 or where does this sit? • Health professional training is not recognised in the model • How compatible is stepped approach training being offered for BME communities? • People are being trained but then 'move on' – where are they now? How to keep track? • Stepped approach fits well with what is needed on the ground – allows a measured approach • Freedom of choice – e-learning for all staff – approach across the sectors • Develop an app for training – tool needed to assess if you are eligible to get onto 'next level' • Agreed that training must be responsive and not simply a 'tick box' exercise • Good to acknowledge differences in training needs • Good that you can step up if needed • Need to get parity across stages according to need – wouldn't be 25% across all 4 • Step 4 – concerns around e-learning (ASIST) • Funding re staff care depends on organisation and size • Training for all organisations to support staff needed • Post Primary/Primary -we need to be appropriate	**What works well:** • Community Response Plans • Support groups • Counselling • Alternative therapies e.g. Men's Shed • Practical support • Support from funders **Gaps:** • Campaigns need follow up and wrap around services offered • Resources need to be up to date • Better general awareness of services available needed so as when event happens people are not 'lost' • What practical help can be offered by communities? Simple measures like collecting children from school, a 'societal approach' needed/ better connected communities • Children's rights – what if a parent turns down support – where is the child's voice? • No care pathway for those whose loved ones die by suicide in hospital • Take-up rate for support at time of death is only 50% so potentially people are not being supported in the aftermath of a suicide • Could HSCT suicide prevention lead ask for consent instead of it happening at the scene with the PSNI? • Professor Louis Appleby – pilot projects in England – coroners on a voluntary basis offering service of offering support to family – Family Liaison Officer's role in making this wider • PSNI seeking consent at later stage (10 days post) to give family time to acknowledge • Interpreters are very restricted in what they can do



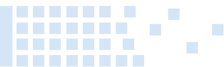
Event	Prevention	Training Framework	Postvention
27.3.18 LISBURN CONTINUED	• Action Mental Health **Gaps:** • Hair-dressers/taxi drivers often need guidance and preparation on where to signpost people that need urgent support • Need consistency across localities in NI – inconsistency can lead to increase in anxiety • Work in Emergency Departments has huge potential – issues around how well staff are trained • Can present when working in other areas – e.g. smoking cessation work then presented with suicide ideation • Social media is a big challenge for young people • Should be Recovery Colleges in each Trust • Need closer working across thematic areas e.g. drugs and alcohol, addiction • Too quick to move people on as we are fearful of situation or not skilled/trained enough to deal with situation • Not enough being done for middle-aged men in SEHSCT area – stats highlighting this group • How do we communicate and share information for service users that move around a number of services – between Community and Voluntary sector and statutory sector • Information on services needs to be available when people leave Emergency Department – people can leave with very little support • Information needs to be location specific• Tendering process and access to funding has a negative impact on local/smaller projects • Information sharing needs to be better • CBYL is positive, but is implemented differently in each Trust	to age/stage • Capacity/numbers/location of trainers	beyond their job role but would like to do more • Lot of support offered at wrong time – too soon and too 'one size fits all' – different • family members need different approaches • Beyond nest of kin – majority these days – unmarried couples etc • SD1 – need a protocol to go back and make the offer of support again • Kinds of support – peer and family support, regular support – again re BME this needs thought through • Role of Lifeline in supporting postvention work – e.g. into schools (youth and community setting) • Query re school's ability to refuse help or intervention – should this be the case? • Evaluating interventions and their positive and negative impact needed • Monitoring trends to inform service design/ delivery – ongoing provision • Too hard to find services or know which services to avail of • Needs to be timely follow-up • Support groups are not well promoted • Carers of patients need signposted • Issues with counselling – consistency, number of sessions, time of access, cost • SD1 process has limitations – need a better mechanism for communication re deaths • Need more funding for support groups • Coaching and alternative therapies need promoted



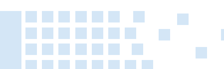
Event	Prevention	Training Framework	Postvention
	• Intervention is limited for specific population groups – e.g. language support needs – Polish community • Translation services are only offered through HSCT services • Too long a time to access counselling services – 13 weeks is too long – 1st 3 days is crucial • 20% of people deemed 'low risk' died – terminology used to categorise is confusing (low, medium, high risk) • Help needs to be offered in a more timely fashion • Counselling/psychology treatment needs to be able to be fit for purpose. Services need to be 'person centred' – responsive to need • Make information sharing better – better collaboration – partnership working needed • Funding • Referral process • GP training is a necessity • Campaign CAP in government departments • Community response plans not activated until 2 deaths identified • Fear around training in communities • Accessibility • Consistency in personnel and volunteers • Flexible adaptive services needed – improve postvention support • Should learn from enquiries • Should be consistency across Trusts • There is a lot of hidden need – e.g. rural areas where people are not getting help • GPs don't know what to say or what to do • Linkages across issues/services • More awareness campaigns are needed – very powerful. Broad/wider approach for 'lightbulb' moments especially at key times of the year –		



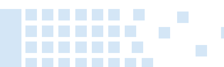
Event	Prevention	Training Framework	Postvention
27.3.18 LISBURN CONTINUED	stigma is still there • Difficulty getting peer-led support groups funded • How do BME groups know who and how to access services • Access to interpreting via C+V services needed by Lithuanian population – PHA funded		



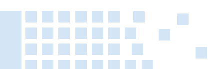
Event	Prevention	Training Framework	Postvention
27.3.18 CASTLEWELLAN	**What works well:** • Need for CBT has been recognised • Trained counsellors providing family support • Men's Shed • Hubs • Community Garden (The Ark) • Steps to Cope programme • Conscious parenting – understanding affects of behaviours in childhood **Gaps:** • Knowledge – lack of awareness • Lack of information locally • GP is main form of crisis support but not always trained • How do we communicate the pathways? • How do we build resilience? Need evidenced interventions that will build resilience • Too much reliance on C+V sector • Intervention at crisis is too late – need more support for everyone to build resilience • Conscious parenting – skills and knowledge needed for parents for support at early stage of life • Need resilience focused projects in schools • How do we reach those who actually need help? • Where do you go for getting help when a family member has attempted suicide? • No linkage between GP, Trust and counselling • Old-fashioned views from GPs are not helpful • GPs lack of specialist knowledge • GP just allocate medication • 'Card before you leave' needs to be given out in every instance – different Trusts are not providing consistent services • LGBT groups not recognised or supported within SE Trust – no localised support	• Each step refers to 'has to get help/support' – this is almost a step in itself • How to ensure the right support at the right time? • What about waiting times? • Has to ensure holistic/person centred referral – everyone is different • It is important that following training and when a trainer is working with an individual and feels the need to refer the individual that appropriate services are • available on immediate referral • Involve interpreters and bilingual people in training – raising awareness about available services • Targeted training for interpreters who are willing to work in a help-line • Designed guidelines on how to get support if needed	• Need support offered for whole family • Suicides linked to losing DLA – needs looked into • No joined-up approach • Don't use the word 'commit' – suicide is not a crime • De-stigmatise, remove shame • Target 20-30 year age group – try to talk openly about what has happened • PHA should seek children and young peoples' views on mental health • Friends and family need better supported • Mentally ill people not supported to get better



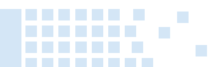
Event	Prevention	Training Framework	Postvention
27.3.18 CASTLEWELLAN CONTINUED	• No link between education counselling services and PHA funded counselling services • Improved resilience needed in schools • Psych-education on different referral options – level of confidentiality, waiting times, which organisation, positives and negatives of all. If you signpost someone to another organisation and it is not right for them, what happens next? How will you know?		



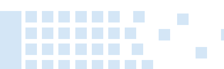
Event	Prevention	Training Framework	Postvention
29.3.18 ENNISKILLEN	**What works well:** • Lots of good work happening – ASCERT, Aisling, Lifeline, Beacon, Oak HLC, Clear, Z Cards, services in Western Trust • Frontline staff • ASIST training • Having confidence to ask a question • Using community infrastructure – GAA etc • Communities being alert • Counselling • Samaritans • Publicity – notice boards, contact details, awareness raising • Flourish • Good amount of services available **Gaps:** • Need to look at the link between gambling and mental health • Need a single point of access (for families and professionals) • Longer term funding required • Needs of rural areas need looked at: transport, communication • Is there enough being done in rural areas? (domestic isolation, transport) • School is the natural environment to deliver sessions – this is where children and young people are together most often • Cross agency working needs embedded in all strategies/interventions • Who is best placed to deliver sessions? (teachers, external facilitators, young people) • Skilling up young people as peer educators may be a success • Information available is not being fully utilised due	• Should be an additional level dealing with someone who is suicidal without having done the previous steps • Look at allocation of funding across groups • Need for quality and monitoring of content• People with lived experience should deliver • Internet access in rural areas is an issue • Need for a clear training pathway – starting with Safe Talk and Mental Health First Aid – overall happy with stepped approach • Need for each step to inform re next step in training for those who wish to progress • Need for organisations to support those sent for training to relate what they have learned to their specific situation • Group e-Learning for GPs and other frontline staff with discussion afterwards (because it involves a shorter time commitment, so it is more likely to be taken up) • Engagement in over 18s – to access training, getting people to attend, how they can identify how to get involved • GPs need to have more input into this process – they are main point of referral – often the first and only contact for individuals • Need to be aware of language – how courses are advertised and presented – who is your target group etc • Targeting individuals/families who aren't attached to groups – how do we target these people for training? • Developing strategies needed for those who have literacy issues • Needs to be mandatory training • Self-care training, staff need to know how to care for themselves	**What works well:** • SOBS (Survivors of Bereavement from Suicide) • SOSAD (Save our Sons and Daughters) • Support groups for those bereaved by suicide • Drop-in support/respite – when the time is right, being with like-minded people, understanding • Darkness into Light scheme • Community support awareness • Churches/schools support • Support of local groups e.g. GAA **Gaps:** • Grief from suicide – need specialised counselling at the right time • Timing of SD1 needs to be better – very individual – ask at different points to allow support • There should be a letter giving with support agencies • People do not know how or who to access • Concern around who is identified as needing support – e.g. unmarried couples, lack of support for long-term partners • PSNI need appropriate support • Activation of Community Response Plan • Ensuring highly vulnerable people are signposted to appropriate services • Social media is a big issue – higher controls on all media needed • Need to look at the Bereaved by Suicide service – their name, who they support, how to access • Some families are not ready for support due to lack of acknowledgement that death was suicide, or due to often negative stigma attached • Possibility of auto-enrolment? • Needs to be more about family and less about service – support groups aren't for everybody



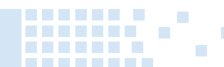
Event	Prevention	Training Framework	Postvention
29.3.18 ENNISKILLEN CONTINUED	to silo working (leaflets, snappy, multi-lingual, tailored approach needed) • Having info in the right places is vital (GP surgeries, Youth Clubs etc) • Need help helping young people identify if they have a mental health issue • Need for workplace awareness raising – how to see the signs • How people access services and the referral process • Transport issues need looked at – people are feeling more isolated • A+E need for a 'quiet room' – staff rely heavily on PSNI • Training for frontline staff – staff don't feel fully equipped to handle people who are feeling suicidal • Waiting time for referral service is too long (12-18 weeks) • Need support for pregnant mothers and new parents – especially in our rural areas – not everyone has access to SureStart or HomeStart • Healthy Living centre models extended • Bring services to people rather than making people go to services • Cross-departmental work is essential • People need better informed about services	• Mandatory suicide prevention/mental health training across a range of undergraduate degrees • Young people not involved in after-school/ weekend activities are harder to reach and more vulnerable • More training for beauty therapists, hairdressers etc • In-House training – OAK going out to organisations at a time that suits them • Online training is not an option in some areas of Fermanagh – rural areas	• Stigma still an issue • Community Response Plan needs triggered after just one death • Need to be the right people around the table at Community Response Plan stage when investigating the 'why' of a suicide (trying to find patterns, prevent clusters) – very difficult to share information due to data protection rules, even though that information could safe lives • Frustration of families re awareness of what support is available • Difficulty with cross-border – some people in Enniskillen/Fermanagh accessing services across the border because they are more helpful or they are more informed about them • Local support organisations – health and wellbeing officers, e.g. GAA are critical in response plans • Breaking the stigma • Fear and ignorance • Insufficient uptake on training • Gaps in services



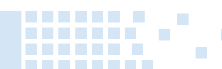
Event	Prevention	Training Framework	Postvention
22.5.2018 BELFAST	**What works well:** • Structure still in place despite lack of government • Community services – people can walk in and get help right away • Lifeline • Passion for suicide prevention is there • SHIP, Protect Life • Recovery college • Take 5 is an idea with great potential to develop and roll out regionally. Needs promotion at strategic level (with consistent message). Tangible, simple and people 'get it' • Local grassroots initiatives i.e. based in setting individual is comfortable in (e.g. sports, Mens Shed, craft, women's groups, youth group etc) • Family support hubs – collaborating at early stage (to support rather than relying on instincts) • Self-care • Good relations and information sharing (within/ between community and statutory)• Talking therapy hubs – alternatives to prescriptions – would be enhanced if linked/had more access to other services at same time • Community events (Take 5, Pop-up Pharmacy) • Increased knowledge of basics e.g. importance of connecting, talking to family and friends etc • Structured programmes for schools • SafeTalk and ASIST training roll out has been very good • Complex service cross-over improving • Taxi watch breaking outside practitioners • Bereaved families work • Beginning 'public places' strategies • Take 5 mental health campaign – ability to identify targeted need • Early prevention – child development, education/	• Everyone does not need highest level, nor is it appropriate for everybody to have • Stepped approaches recognises different levels of capability – better to have more people trained at the right level for them (i.e that will be used by them in their day to day lives) • Stepped approach is safer, gives choice • Will be need for refresher training and reminders of key points of learning • Standards will need measured • What is working in community which could shape and enhance a universal co-ordinated approach • Take 5 is universal – stay focused and don't replicate • Self-mastery is what you want to achieve with a person's wellbeing • Work to skills, untapped potential and talent • Steps too vague to deliberate on • How long does it take to operationalise? MHFA still not updated – be realistic • Integrative approach • Tendering lots is not the way to go – e.g. MH training tender worked out at £30 per person • Spend too much time talking about reviewing and not doing • Access to training courses – need someone to help navigate the range • Okay with stepped approach and methods of learning if it is to be set within a strategic framework. • Difficult to comment on out of context – on its own the approach appears one dimensional – it would need to be part of a multi-faceted strategic framework that would enable training to be targeted (populations / risk factors / areas of deprivation) and focused on outcomes and	• There are good existing models e.g. Northern Trust • Tailored models • Having the autonomy to support people when the lapse/relapse • Having scope to work with people as long as they need • Strength-based approaches – no two families are the same • Time, compassion and love needed • Gendered approaches/understanding • Knowing the person • Being present • Person centred approach – active listening, humanistic, respect what works for them, congruence, body language • Frontline support – e.g. reflective practice, access to complementary therapies etc • Recognition of impact of conflict, socio-economic deprivation, transgenerational trauma etc • Resilience Follow up after completing sessions, check-in clinic? • Family check-ups, family support, family counselling/intervention • Supporting each other • Community response plans • Community intelligence, good connections and sharing information • Good range of support options held within Trust centrally with good working relationships with community, PSNI etc • More responsible reporting by the media – monitored by PHA • Local support groups • Person centred approach – well coordinated locally • Community intelligence and partnership approach to providing postvention support



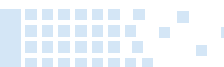
Event	Prevention	Training Framework	Postvention
22.5.2018 BELFAST CONTINUED	curriculum • Training, normalising stress • Experiential learning – community development, upstreaming • 72% not known to services that die by suicide – linking to families, communities, activists • Having quick access to services • Active listening **Gaps:** • Waiting times for people who have chronic pain, depression, anxiety and stress • Connectivity between PHA and BHSCT • Community workers connection to local people • 'CARD before you leave' needs to be given to every person who presents to A+E • Year on year funding means services struggling to keep services and staff with this method • Expectations of funding bodies • Central point for information on all support services needed • Funders need to look at funding criteria • GDPR training for Protect Life • Tendering can kill infrastructure already in place **Prevention Continued:** • Waiting times need reduced further • Staff leaving community working because of instability • Appropriate training for PHA • Alcohol/addiction training • Need to build community resilience – remove barriers to services (childcare etc) • Signposting to other support requires good networking • Lack of awareness of trauma	priorities • The framework should enable the connections to other training programmes (including local programmes); it should set minimum standards and principles. • It should be about more that coordinating the existing training offer – it should enable the strategic direction of resources to achieve the aims of Protect Life 2 • The framework should include an element of research and development (taking account of local evidence, issues and need) • There should be an element of measurement and evaluation built into the framework	• Coordinated approach to bereavement support – recently updated and improved by BHSCT **Gaps:** • Delivery models vary radically • Follow up offers – whose role is this? • Timescales/appropriate source • Support for those connected with actively suicidal person – longterm? • Access issues – information resources, non-core connected groups • Need for community ownership/leadership • CRP – reduced scale, wide range of domino factors • Postvention must include prevention for families/ generational • SD1 process not working to full potential – 2/3 are not marking box for support – immediate trauma might prevent agreement at the time. Need to find a way to get knowledge of available services at grassroots level • Trauma can manifest in different contexts – need to make areas outside of suicide • prevention aware of how to access support etc • Don't prescribe, ask. • Need support for local clubs/organisations • Knowing what is available in each area – database or app on what services are available may be useful • Funeral plans – very elaborate for suicide victims – worrying for young people watching this 'attention' • Need to investigate the methods put into place – 'hot spots' on services available etc • Someone who is hospitalised due to attempting suicide and ends up dying in hospital – when this person dies in hospital it is not recognised or recorded as a suicide – no SD1 form completed



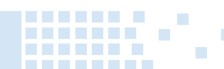
Event	Prevention	Training Framework	Postvention
22.5.2018 BELFAST CONTINUED	• No dual diagnosis for Mental Health and Drugs and Alcohol • Benefits of Take 5 are not known by everyone (simple, applicable) – missed opportunity • Public campaign/settings approach could help with this • No 24/7 crisis service – A+E is not affective • Befriending/social support needed • Pathways in and out of services – co-ordination • Responding to alcohol/drugs • Understanding of substance abuse and self harm • Youth/children and young people – not co-ordinated/evidence based. Need for specific strategy • Emerging social media culture – lack of understanding of impact • Understanding of evidence-based practice/ collecting evidence • SD1 based information not accurate • No follow-up for individuals who self-refer • Reliance on PSNI/families to help people in crisis • No joint commissioning • Targeted training/further development of workforce • High suicide ideation/deaths in the city – leads to fire-fighting locally as no resource for prevention • Disconnect from community development/stat services and processes • Need work to be project funded, serving locally – tendering could potentially undermine work build up over last 15-18 years • Need to genuinely listen to key activists on the ground • C+V bring millions of additionalities to PL funded services • Language barriers – accessing services		• Issues with families 'admitting' suicide was cause of death • Training in hospitals • Structures required – need to be strong • SD1 process needs to be updated (the recommendations of the evaluation carried out need to be implemented) • Training needed on CRP/SD1 process • Variations in resources – relies on 'goodwill' – volunteers, funding etc. Many are not aware of support options • Delays in SD1 receipt and community info • Need support for wider community and other individuals • Communication back to HSC from PSNI following 10 day follow-up • Access to PV services • Communication can be poor and disconnected causing confusion and perception that there is a lack of services in some areas • Insufficient focus on recovery beyond initial support – can • lead to people becoming re-traumatised • Social media, vigils, etc. • Reaching all individuals needing support can be difficult • SD1 process limited – paper based and consent difficult to obtain. • Delays in receipt of SD1s and weekends and holidays can cause further delays in information flow • Need to simplify SD1 process to encourage consent, e.g. PSNI have a card in their notebooks that helps to remind them how to explain the support process • No out of hours service for coordination of



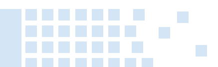
Event	Prevention	Training Framework	Postvention
22.5.2018 BELFAST CONTINUED	• Review research findings for actions and implement e.g. Siobhan O'Neill 2014. Screening in areas impacted by conflict, socio-economic deprivation, high suicides • Wellbeing and resilience strategy needs owned by everyone • Trust community to make strategic decisions re funding programmes etc		bereavement support services • Responding to community intelligence / community needs following a suicide is often done on a 'good will' basis – particularly out of hours



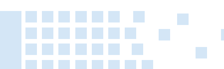
Event	Prevention	Training Framework	Postvention
ONLINE SURVEY FEEDBACK	**What works well:** • 24-hour access to trained practitioner • People being able to talk and ask for help (also to be listened to in a non-judgemental fashion) • Local provision, support and signposting • Lifeline • Connections Programme, SafeTalk, Mental Health First Aid, ASIST • Support for young people/teenagers • Connected services • Primary school support, youth counsellors in schools • The Aisling Centre, Oak Healthy Living Centre, Action Mental Health, Community Family Support Programme • Take 5 Campaign • Bereaved by Suicide Support Projects • Rapid response **Gaps:** • Protocols and pathways must take account of where people live • Appropriately trained people need to be available within reasonable time frames when there is a need including in A+E • Improved communication between agencies is still needed, particularly at local level • Gap remains connecting all services together, where there are different organisations promoting the same things – creates a barrier for people • Implement safe places in all cities and towns with consistent funding across all services • Review regional strategies for implementation of change to improve suicide prevention in both statutory services and C&V sector and also improve implementation times for these changes	- While it is understood that there is no one 'risk assessment' tool or method, there needs to be professionals with some training in risk assessment and possibly the development of new materials. These would be specifically for professionals competent in the use of such tools and with the information they might elicit - ASIST training needs to have a 'top up' option that can be accessed over half a day rather than having to do the full two days another time - This is part of a whole life skills framework that needs connecting thinking – there is not one thing, one issue, one area of life that contributes to poor mental health and wellbeing – but often a whole series of events, issues etc – difficult to categorise into separate training. I find it difficult that this is compartmentalised – however, I also haven't been part of this particular training - Good framework but there should be a schedule for completion within which you need to move up a level - Would be good to offer some recognition to those who complete – gold/silver/bronze etc - Get as many people on the ground who can increase awareness and signposting – you don't have to be an expert to do this. People who can get some training and go back to their clubs/ organisations and give a 15minute awareness session and signpost - Will provide good structure in the community however if there isn't availability of the professional help then the system is letting people down - Steps are an excellent way of tackling the issue of awareness and providing specialised knowledge and skills training. There is a growing need for the population to be aware of the presenting issues	**What works well:** • Training for employers, community leaders, employees, door people, taxi drivers • Recognising clusters • Cohesive support networks • Collaborative working across sectors • Bereavement support groups • PIPS and Anna-Cara model • Wrap around services **Gaps:** • Having access to support from local groups • Trained individuals to explain processes to bereaved family e.g. Community Response process, SD1, Coroner's Process, access to bereavement support packs • Home bereavement support • Improved SD1 process • Timely access to Protect Life co-ordinators • Informed identification of the cause of suicide – better psychological autopsy to identify others at risk and prevent cluster • Co-ordinated approach – C+V • More research around self-harm – does not always infer suicide ideation • Mental health day centres needed • Non-clothed police officers rather than in uniform • Improved access to counselling, bereavement support • More support for carers • Helping families understand that no one is to blame for the suicide • More postvention support for rural communities – timely access to support, working with stat and community organisations • Better identification of vulnerable and at risk



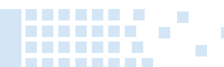
Event	Prevention	Training Framework	Postvention
ONLINE SURVEY FEEDBACK	• More education needed where young people are involved e.g. clubs and schools • More support for young people/teenagers • Need community development approach to community learning • More training to community groups, businesses, schools, agencies e.g. ASIST, SafeTALK, Mental Health First Aid • Need funding for crisis response counselling and support for local groups – can't be provided by just Lifeline • Need introduction of funded wrap-around service for counselling so local counselling service providers are financially supported in the delivery of crisis services • Need to connect with out of reach groups such as travelling community, ethnic minorities, youth not engaged in sport • Encourage post-primary schools to introduce mental health and suicide awareness programmes to their curriculum • More drop-in services in local communities • More consideration for carers who know the behaviours and traits of those suffering mental health problems in their care • Secure accommodation for those at risk • More understanding for links between suicide ideation and crime • Focus on alcohol and drug problems • Better identification of people at risk • More consideration given to men aged between 35-55 years old • More research into links with poor mental health and Troubles legacy in Northern Ireland • Hospital funding – beds etc • More consideration for those with Autism	and have a confidence and ability to intervene and access the appropriate help. The more people who are skilled in the area of identifying mental health issues of concern and those in distress the better equipped we are as a community to deal with and help to address the issue of mental health and suicide. There is a growing need for training at each of the steps stated and it is hoped this will continue to become available to all - Training is an excellent way to raise awareness and inform groups and individuals of the help and resources available to them. ASIST, Mental Health First Aid, Safetalk and B+ are especially popular and extremely informative. Groups also often need to avail of bespoke training packages, bereavement support and general information on services as this is regularly requested - Excellent! The Connections programme does all of the above steps - This is an area I feel needs to be facilitated by those who have experience and working within the field of mental health. This is not a criticism of those delivering the programmes who are not professionally trained, it is so important because people's lives are at risk. We never know the audience and it is always necessary to provide accurate information based on fact and unbiased opinions. The training should be adapted to the attendees and delivered in accordance to the attendees' suitability and understanding - I feel that the entire population of Northern Ireland needs to be pointed in the direction of mental health awareness, not just certain groups and individuals. An attempt is needed to change the public to think differently regarding mental health. What one person can say to you can harm	• Early access to talking therapies



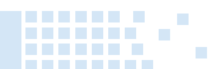
Event	Prevention	Training Framework	Postvention
ONLINE SURVEY FEEDBACK	• Campaigns to break stigma • One organisation which brings together all mental health and wellbeing services for one town or country • Identification of emerging suicide clusters and act promptly to reduce risk • Improved Personality Disorder services • Mandatory suicide awareness/prevention training • More awareness of suicidal thoughts and behaviours • Further training for GPs and medical staff • Less reliance on medication for mental health issues • Bystander intervention training • Waiting times in A+E when PSNI bring someone with suicide ideation to hospital • Waiting lists too long • More support for those with eating disorders	and take away from a lot of good work done by other individuals. Otherwise, I think the steps are drafted well - Training cannot be tendered as a stand alone provision. The whole process needs to be valued from motivating people to attend, the appropriateness of training, the delivery and the follow-up etc. Who delivers is important as local knowledge is needed and an understanding of attendees. Training locally needs to be co-ordinated and there should be a go to person in each area - The stepped approach appears to target all those who are or could be potentially involved with someone who is suicidal or engaging in suicidal behaviours within the community - Sounds good - The LivingWorks model has proved effective to date with a good uptake of ASIST and SafeTALK. Less formalised training/awareness could also complement this model and again be linked to public awareness campaigns e.g. the FAST campaign for strokes. Zero Suicide Alliance – FREE online suicide prevention training is another model which could be considered - I agree with a stepped approach. As a community group we know people may only need and can only cope with a certain level of training. What needs to stay is the flexibility of training providers to run training with the needs of the individual communities in mind. - Up until about 10 years ago there was little or no preventative training at any level on suicide prevention. Thankfully, in the Southern Trust area there are a range of skills based courses provided by PIPS and Action Mental Health. Also,	



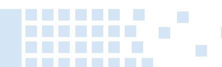
Event	Prevention	Training Framework	Postvention
ONLINE SURVEY FEEDBACK		the arrival of the Recovery College has given scores of vulnerable people with mental health difficulties opportunities to boost self-awareness and confidence. The courses provided by PIPS have been delivered at local community level including areas with high deprivation levels. The Action Mental Health courses have attracted a wide spread of people from all walks of life. The work provided by these organisations along with support from Aware NI have made major advancements in awareness and prevention. The advances made over the years have been slow, but without the Newry Mental Health Forum and Action Mental Health and in more recent times PIPS initiatives like the Recovery College including peer support would not have happened. Another area of support that requires additional resources is the Trauma Service for people affected by the political conflict in the north of Ireland. There appears to be a limited level of support for people who are still dealing with the psychological scars of the Troubles. The north of Ireland has very high levels of Post Traumatic Stress Disorder, but the level of services do not equate with this reality. Staff working in mental health services throughout the Southern Trust at all levels have been supportive of the social model spearheaded through the Recover College and the local Mental Health Forum. I believe there has been an increase in awareness around suicide and mental health generally. However, there is still high levels of stigma about mental health in all spheres of society. I believe resources should be made available to work on this, starting with initiatives at primary school - I believe the strategy will assist with the overall issue, however I do not believe it goes far enough	



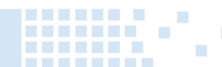
Event	Prevention	Training Framework	Postvention
ONLINE SURVEY FEEDBACK		to try and force an engagement. There is still stigma attached and many people will not self refer - Suicide awareness training and/or Mental Health First Aid training would go a long way to giving people the awareness, knowledge and skills they need to create the above. Workplaces need to be targeted also, as there are a large of people employed and a lot that can be done in the workplace via early intervention - Agree in principle with stepped approach. I think we need to improve our methods of raising awareness for the public – should do some focus groups for ideas? - It is my belief that in NI there exists a massive dearth of training for staff and professionals in relation to BPD. Comments made by untrained staff which can belittle, undermine, offend those with BPD can tip an individual over the edge and lead easily to a suicide. I would like to see the PHA and Department of Health develop proper training by consulting with experts and service users for those working/dealing with BPD individuals. There are far too many people working with those with BPD who do not know the first thing about it, and therefore cannot be trusted to be able to safeguard that person. They could in fact, through their ignorance, do damage. I would also like to highlight the fact that this online survey I am filling in makes no mention of specific suicide prevention training! Why on earth has that been allowed to happen. In the training section, one would expect at the very least – that for suicide prevention training - that actual suicide prevention training features as a number one priority? How could this oversight have occurred? Please address and include this immediately	



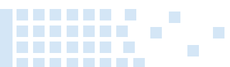
Event	Prevention	Training Framework	Postvention
ONLINE SURVEY FEEDBACK		- The stepped approach will enable provision of training at appropriate levels, the key focus must be on raising awareness across the general population so that people feel confident to seek help - The stepped approach will enable provision of training at appropriate levels, the key focus must be on raising awareness across the general population so that people feel confident to seek help and to encourage help seeking in others. Key to this approach is provision of training which can be delivered in a flexible way to meet the needs of the group and accessibility for the entire population, This will require investment in promotional work to get key messages to members of the public and to market provision of training available for the wider population. Barriers to attendance at training should be considered including childcare support and provision of online and blended training in areas where transport/ childcare may be an issue, bearing in mind internet connectivity for specific areas may present difficulties in itself. All training and trainers must be aligned to and compliant with Quality Standards that are monitored and delivered by appropriately qualified facilitators. It is important also that all commissioned services must assess the requests/ needs of people and implement a stepped training plan and have the capacity to provide support for people after attending training as this often raises other support needs. Critical evaluation of all training is required, the NI population have unique experiences and needs and it is important that we can build the evidence base for what works locally rather than always looking to models which have worked elsewhere. This will have particular	



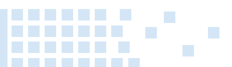
Event	Prevention	Training Framework	Postvention
ONLINE SURVEY FEEDBACK		importance for any services commissioned through innovation funds - Where is the accountability for professional competence to treat mental conditions within professional bodies? How do we know that someone with a doctorate in medicine can effectively treat mental illness? Which requires in my experience the ability to effectively listen and inform. However there are disparatities in diagnosis, treatment and subsequent help. You want to be lucky if you fall mentally unwell. As you may get pills and be left on your own, you may not even receive that. There is no continuity or safeguarding for people accessing professional mental health services. Lock up and electro shock therapies are practiced today. You can be sanctioned and detained and all within the services of a psychiatry & medical model which at times can not agree a diagnosis. My own mother treated by psychiatrists who informed her she was to receive a 'lifetime' of medication, my mother was unable to get up from the sofa as she was over medicated. It was only on my appointment with them, even though she had informed her own psychiatrist, that they reduced her medication, and informed me that she could come of medication, so that was 3 psychiatrists treating one person giving out 3 different messages. Her GP knew nothing about any of this. My mother had been medicated into a stupor, there was no support offered to come off medication. This is actually frightening that this practice is ongoing today. A thorough investigation of psychiatry & medical care is required as a matter of urgency. So perhaps the professionals training needs work too. Training can help us self-care & look out for each other	



Event	Prevention	Training Framework	Postvention
ONLINE SURVEY FEEDBACK		but the Department of Health must investigate & transform the current professional practices which are inadequate. It's a modern day institutional disgrace.. My mother's treatment mentioned above took place and still does within the Belfast Trust - In question three population awareness should concentrate on suicide prevention awareness rather than general mental health. We believe that across the country we can equip gatekeepers to better identify and manage or refer those with thoughts of suicide and systematic training for gatekeepers would contribute significantly to reducing deaths from suicide. It is striking that the seven objectives referred to in this stakeholder engagement seems to get such scant attention in the training framework. As a result, we are concerned that this could result in development and promotion of training that does not directly aim to reduce suicide. It is SDZ's understanding that in the PHA's draft Mental and Emotional Health and Well-being & Suicide Prevention Training Framework that suicide prevention training is only referenced in step 4 of the framework with the emphasis placed on mental health awareness and well-bring. This suggests to us that PHA is not treating suicide prevention as a priority. Caregivers in a wide range of contexts are likely to encounter people with thoughts of suicide. They need specific suicide prevention skills. Some could be trained to identify and refer those with thoughts to someone who can do a full suicide first -aid intervention that keeps the person safe e.g. (safeTALK programme). We need a wide range and large number of people to have these suicide first aid skills. Once trained they can:- identify the signs of suicide; ask clearly and directly; hear the	

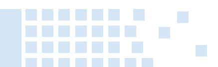


Event	Prevention	Training Framework	Postvention
ONLINE SURVEY FEEDBACK		persons story; help the person to find a turning point and once found the care giver supports it; develop a safe plan and confirm the actions from it. Give the magnitude of suicide and the paucity of appropriate training it is vital that programmes like safeTALK and ASIST and others are urgently made available	



Anonymous Feedback

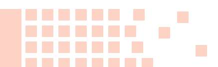
- "Organisations like Mind Your Mate and Yourself should not have to get all their funding from the public – they deserve government recognition"
- "Thank you for the opportunity to respond. For future awareness/consultation it may be useful to look at incidences of suicide in Trusts and Northern Ireland compared to UK region and Europe"
- "Police doctors play a vital role in an individual's mental health assessment during the custody process – it is unclear where their training or understanding of mental health or emotional crisis lies – and they often do not/do recommend assessments"
- "If the most important people (those affected) are included in this process I felt the event was sterile to their emotions and feelings – and clinical"
- "How do you put a price on community development – local approach to prevent suicides? Tendering – does it have to happen? This could put stress and undo a lot of local work"
- "Tender/grant process should recognise the need for all sectors and the key roles they play in this sensitive area of work"
- "Such a huge issue, such a small budget'"
- "Format of the meeting can be very daunting for families bereaved"
- "Getting help for tenders for small organisations. Some small charities have no experience with tenders but have a lot of experience and feedback for programmes and suicide preventions and early intervention"
- "Whilst the process was very informative and helpful, it should have been opened up to members of the public who are or who have had members of their families affected by suicide or suicidal ideation"
- "How Windsor Women's Centre can develop for the future. It is part of the holistic services offered i.e. advice, education, physical health etc. Early intervention is critical. We are concerned about tendering as we have limited capacity"
- "Many community organisations in suicide prevention do a bit of everything – e.g. facilitate, motivate, deliver, build relationships and so on. If the tenders are divided into 'lots' of work, it will break up the importance of fluidity of a community development approach – many organisations unable to tender"
- "Where were the drug and alcohol services in the conversation? Is the penny still not dropping that we need to have direct links to suicide prevention and drugs and alcohol – seems this discussion very much led from a mental health perspective"
- "'First time I have been involved in suicide awareness – some thoughts:
  - Document and share good practice
  - Continually assess learning – is it fit for purpose?
  - No one size fits all
  - Root cause, corrective action – lessons learned – understanding what went wrong – document and correct
  - Share experience – celebrate/communicate success
  - Steps – initiate – develop – enhance – specialist (continuous development)"
- "Any future procurement for services should consider the developments within primary care. 'Multidisciplinary teams' – to include links with the Community and Voluntary sectors."
- "Where was the representation from the 18-30 groups in the community? What are they identifying as what works well and what is not working well?"
- "Have you got feedback from people who have experience of Protect Life intervention? E.g. Community Support Plans"
- "Intervention also should be part of these discussions along with Postvention"
- "Support for suicide prevention is wholly inadequate on every level. My daughter did everything she could to recover from depression. She died 9 months ago. This system failed her"
- "Changing legislation around media reporting in cases of suicide will not affect social media. Reports of my daughter's death were on Facebook before my husband knew she had died"
- "Very positive meeting, lots of good practice in this area"
- "What about some sort of internet (social media?) 'honey trap' – similar to that used to trap child molesters to identify people looking for suicide information"
- "The best way to carry out initiatives is through co-production. Find out what the communities need and tailor training and approach to that. This will optimise the effectiveness"
- "Highlight a huge need for longer term funding commitment for the PHA community development posts – to ensure impact, control and measurement. I am ten years in post – 1st year 3-year contract – 12-month extensions since. Sustainability of services – not appropriate or robust enough to work with future prevention programme and CD approaches"
- "I am one of three SPDOs – I have enough requests for support from stat/C+V sectors for three people in my area!"
- "Thank you for today"
- "As a former civil servant this was the most jargon filled event I have experienced from I retired. I have little knowledge of a direct line to where help lies!"
- "I have great commendation for our services but be humble, we know little about the mind and psychology. Listen to what people who experience suicide know already – tell them about the limitations in services – people know this. Involve the community – use the youth clubs, churches, community groups and meet people where they are'"
- "At an extremely highly emotive and traumatic time people are expected to connect with a statutory, clinical service. One does not know how to communicate with the other – lost in translation'"
- "Time constraints around discussion, particularly around training which was one of context with the importance of the subject"



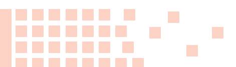
Appendix 3

Stakeholder Attendance List

Representatives of Families affected by Suicide
Action Cancer
Action Mental Health
Active and Healthy Communities Directorate
Addiction NI
ADHD NI
Aisling Centre
Antrim and Newtownabbey Borough Council
ASCERT
Autism NI
AWARE
Barnardos
Belfast Central Mission
Belfast City Council
Belfast Health and Social Care Trust
Belfast Health Development Unit
Belfast Healthy Cities
Big Lottery Fund
Bridge of Hope
CAMHS Drug and Alcohol Mental Health Service
Cancer Lifeline
CAUSE
Centre for Health and Wellbeing
Church of God Shankill
Citizen's Advice (Mid Ulster)
City and Neighbourhood Services
Department BCC
Clanrye Group
CLEAR Project
Collaborating for Change
Derry City and Strabane District Council
Compass Counselling
Contact
Conway Education Centre
Counselling All Nations Services (CANS)
County Down Rural Community Network
CRUN BEE Project (Building Employment through Education)
Cruse Bereavement Care
DAISY
Derg Valley Healthy Living Centre
Derry City and Strabane District Council
Derry Healthy Cities
Diocese of Clougher
Drumalane Mill
East Belfast Community Counselling Centre
East Belfast Community Development Agency
East Belfast Network Centre
EHO
Extern
Falls Women's Centre
Family Voices Forum
Family Mediation NI
First Housing
Giving Life Opportunities to Women (GLOW)
Greater Shankill Partnership
Greater Village Regeneration Trust
Health and Social Services Interpreting Service
Health Improvement Team
Health Improvement, Equality and Involvement Department (DCSDC)
Holy Trinity Centre
Home Treatment Crisis Response Service
Hope for Life
HSC Clinical Education Centre
Inspire Wellbeing
Lenadoon Counselling
Lighthouse
Lisanelly Regeneration Group
Lithuanian Community AMBER
Living Works
Mid-Ulster Association for Counselling and Psychotherapy (MACP)
MACS Supporting Children and Young People
Mental Health Forum
MindWise
Mind Your Mate and Yourself (MYMY)
N&E Belfast Community Wellbeing Service
New Life Counselling
Newry Home Statement Team
NIACRO
NICVA
North Antrim Community Network
North Antrim Community Network
North West Methodist Mission
North West Methodist Mission
Northern Health and Social Care Trust
Northern Ireland Environmental Link
Northern Ireland Fire and Rescue Service
Oak Healthy Living Centre
Oasis East Belfast
Parenting NI
Participation and the Practice of Rights (PPR)
Probation Board for Northern Ireland (PBNI)
Personality Disorders NI
Public Initiative for Prevention of Suicide (PIPS)
PSNI
Rainbow
REACH-out
Relate NI
Relatives for Justice
Riverview House
Rural Support
Sail NI
Samaritans
SASG
SDLP
Simon Community
Sinn Fein
South Antrim Community Network
South Belfast Partnership Board
South Eastern Health and Social Care Trust
Southern Health and Social Care Trust
Space
Start 360
STEPS
Strabane Health Improvement Project
Stronger Together Network
Student Guidance Centre



Tracking Awareness of Mental Health Issues (TAMHI)
The Hummingbird Project
The Primary Care and Talking Therapies Wellbeing Hub
The Rainbow Project
Tyrone and Fermanagh Hospital
Ulster University
Upper Springfield Development Trust
Western Health and Social Care Trust
Windsor Women's' Centre
Wolfhill Centre
Youth Action NI
Youth Education Health Advice (YEHA)
Zest Healing the Hurt



Appendix 4

Schedule of Stakeholder Engagement Events

Trust	Date	Location	Number of Attendees
SHSCT	13 March	Canal Court Hotel, Newry	35
SHSCT	13 March	The Junction, Dungannon	14
WHSCT	21 March	St Columb's Park House, Derry	31
WHSCT	21 March	Silverbirch Hotel, Omagh	25
NHSCT	22 March	Dunsilly Hotel, Antrim	21
NHSCT	22 March	CRUN, Coleraine	20
BHSCT	26 March	FARSET, Belfast	68
BHSCT	26 March	NICVA, Belfast	40
SEHSCT	27 March	Castlewellan Lodge, Castlewellan	16
SEHSCT	27 March	Trinity Community Centre, Lisburn	46
WHSCT	29 March	Fermanagh House, Enniskillen	30
BHSCT	22 May	Park Avenue Hotel, Belfast	21