Area-level implementation of Connecting for Life

Connecting for Life

Findings of a Survey: Local CfL Action Planning

Monitoring & evaluating the implementation of C*f*L

December 2017

Background: Strategic Goal 2 of *Connecting for Life* (C*f*L), Ireland's national, coordinated, multifaceted strategy to reduce deaths by suicide and self-harm 2015-2020, focuses on improving local communities' capacity to prevent and respond to suicide. Fundamental to this goal is the design and implementation of multi-agency suicide prevention action plans at an area level, aligned with the national strategy (C*f*L Action 2.1.1). The *Connecting for Life Donegal* Action Plan was the first area-level C*f*L suicide prevention action plan to be completed (in 2015); the strategic planning processes applied in Donegal have been replicated and/or adapted to the varying contexts across the country over the subsequent 24 months.

In July 2017 the Monitoring & Evaluation (M&E) Team in the HSE National Office for Suicide Prevention (NOSP), as part of the evaluation of the implementation of C*f*L, invited all stakeholders involved in C*f*L area-level planning /steering groups to take part in a survey and share their reflection on the process to date. This document summarises the key findings from this survey.

This paper summarises the findings from a survey of key stakeholders involved in C*f*L area-level suicide prevention strategic action planning.

2 Resilient Communities

Key points:

- Over a two year period (2015-2017) the C*f*L area level suicide prevention action planning process has mobilised more than 500 stakeholders across multiple sectors, throughout the country, to focus on building communities' capacity to prevent and respond to suicidal behaviour.
- In June 2017 all key stakeholders (n=336) involved in the C*f*L area-level planning/steering groups (n=17) were invited to take part in a survey and share their reflections on the process to date. The planning/ steering groups were at different stages in the development of the area-level action plans e.g. 7 groups had completed the process and had a published plan, while 10 groups were actively engaged in the planning process. The response rate was acceptable at 43% (n=145).
- The evidence indicates that area-level C*f*L strategic planning groups (while varying in scale and composition) were very effective in engaging a broad range of stakeholders and the strategic planning processes were well managed, with active, meaningful stakeholder participation. To this end, they have helped to secure buy-in and support for the work of suicide prevention across the country, and have laid the foundations for effective implementation of the national strategy at an area-level.
- There is also preliminary evidence of increased collaborative working (at an area-level) as a consequence of the C*f*L planning processes.
- While most respondents had confidence in their (emerging) area level C*f*L action plan (seeing it as realistic & achievable) approximately two thirds of respondents (64%) were of the opinion that sufficient resources were 'not available or only somewhat available' to implement the plan.

HSE Feidhmeannacht na Seirbhíse Sláinte Health Service Executive

Background

Connecting for Life (C*f*L), Ireland's National Strategy to Reduce Suicide 2015-2020, sets out a vision of an Ireland where fewer lives are lost through suicide, and where communities and individuals are empowered to improve their mental health and wellbeing.

The bottom-up approach to the implementation of C*f*L happens at an area-level, through local strategic plans. **Action 2.1.1** of the C*f*L strategy requires that "*consistent multi-agency suicide prevention action plans*" be implemented "*to enhance communities' capacity to respond to suicidal behaviours, emerging suicide clusters and murder suicide*". These plans are the responsibility of the HSE Mental Health Division and should "*be aligned with HSE Community Health Organisations (CHO) structure, Local Economic and Community Plans and Children and Young People's Services Committee's (CYPSC) county plans*".

Obtaining a clear picture of the development of these strategic plans and monitoring how well these plans are being implemented will allow for a more confident link between C*f*L and any observed changes in population level outcomes. At the outset, it was envisaged that 21 local suicide prevention action plans would be developed across the nine HSE CHO Areas. The planning process commenced in 2015 with this in mind. However, as of October 2017, there will be 17 plans developed; some areas which were initially planned to be single-county level plans transpired into two-county plans and some into CHO level plans. At the time of writing (December 2017) 12 of the 17 area-level C*f*L action plans have been launched.

Method

All stakeholders involved in C*f*L area-level planning/steering groups (i.e. 336 individuals across 17 C*f*L local action planning groups) were invited to take part in a survey and share their reflections on the process of building local support for suicide prevention and of developing the action plans. Following a review of the literature the M&E team in the HSE NOSP designed and tested the survey. The survey focused on stakeholder perspectives on;

- the composition & workings of their area-level planning/steering group
- the strategic planning process & their role therein
- the extent to which the (emerging) area-level plan is (being) informed by local need, and fits the local context
- the buy-in and support secured
- an assessment of their level of collaboration with other stakeholders on the planning/ steering group (using the Levels of Collaboration Scale[1]).

The survey was circulated to relevant group members via email with a Survey Monkey® link by the NOSP's Monitoring & Evaluation function. The response rate was acceptable, but low. For the purpose of analysis, 145 survey responses were deemed usable; the valid response rate was therefore 43%.

Table 1 Survey Responses	(n)	%
Valid responses	(145)	43
Incomplete responses	(82)	25
No response	(109)	32

Due to the varied response rates **(TABLE 2)** it was not possible to provide area-level survey feedback. **(TABLE 3)** gives a breakdown of the organisation type which survey respondents represented on the planning groups. **(TABLE 4)** presents a thematic analyse of the qualitative data on respondents' perspectives on the strengths, limitations and challenges of the C*f*L area-level planning process.

Key Findings:

The **C*f*L area-level strategic planning groups** are important vehicles to engage a wide network of stakeholders in the work of suicide prevention. At the time of the survey (July 2017) there were 17 C*f*L strategic planning groups engaged in or having completed the planning process; two groups had yet to convene (and plans in two areas were under review).

- The scale and composition of the area-level strategic planning groups varied enormously the largest comprised of 54 key stakeholders representing 25 sectors developing a multi-county C*f*L action plan. The smallest group consists of 7 key stakeholders, (all HSE) developing a C*f*L plan to work across two-part counties.

- While membership of a strategic planning/steering group depends on local context, one-in-four (25%) respondents were of the opinion that the voices from relevant sectors were '*not at all*' or '*only somewhat*' represented on their C*f*L planning group; examples of missing voices included HSE Primary Care, General Practitioners and

[1] Preliminary analysis of data indicates that engagement in the C*f*L planning process has significant improvements in stakeholders' levels of collaboration. This will be explored in more detail at a later date.

coroners. That said, the vast majority of respondents (90%) were reported that members of the C*f*L the planning /steering group were 'substantially'/'almost entirely' engaged, interested & motivated. (Figure 1).

- In many instances the voices of a broader range of stakeholders were brought together in Working Groups; 82% of respondents reported that the outputs of Working Groups informed the work of their C*f*L strategic planning group. In addition, the vast majority of respondents were of the opinion that the C*f*L area-level strategic planning group was informed by community consultation (82%).

Strategic planning is often criticised for taking too much time, and costing too much. However, at its best it is a proactive process focused on making things happen, rather than letting them happen. Area-level strategic planning processes are crucial to establishing direction and focus, and facilitating an intentful and targeted approach to suicide prevention at a local level, aligned with the national strategy. The evidence indicated that the **C*f*L area-level strategic planning processes** are/were very well managed.

- Most respondents reported that meetings were (substantial/almost entirely) well chaired (95%) and well resourced (90%) with a full-time Resource Officer for Suicide Prevention coordinating the process (93%) and open and transparent decision-making (89%). (Figure 2).

- The majority of survey respondents felt (substantially/almost entirely) that their **role in the CfL area-level planning process** was clear (83%), that their time was not wasted (87%), that their voice was heard throughout the process (87%) and that they were involved in decision making (84%). (Figure 3). However, it was acknowledged that it was a slow process which can make it challenging to maintain momentum.

"Locally I think that the overall time from the start [of the planning process] to now has been far too long"

Any **area-level strategic plan** should be needs based, evidence informed and tailored to the local contexts. Survey respondents in areas where the planning process was completed (n=7)[2] rated the composition/workings of the planning groups and the level of buy-in and support higher compared to respondents in areas where the planning process was still underway.

- Most survey respondents were of the opinion that their **area-level C*f*L strategic plan** (substantially/ almost entirely) has an appropriate geographical scope (89%), was informed by the evidence of 'what works' (89%) and data on prevalence (90%). (Figure 4).

- The vast majority of stakeholders (95%) reported that their area-level C*f*L plan was also (substantially /almost entirely) aligned with the national strategy and fits with existing initiative in the area (87%). (Figure 5). It should be noted that the HSE Mental Health Division has invested resources into ensuring this alignment.

- Given the requirement that the area level C*f*L plans be aligned with the national strategy, the degree to which they are able to address (unique) issues in the local context, was raised as a concern.

"The main concern I have with the process is that the end product will not reflect the local situation as the National Office can accept or reject actions and indeed the local Strategy"

The area-level C*f*L strategic plans are separate from their implementation; implementation is an intentional process (of making it happen) that proceeds through stages and extends over time. It matters because it improves outcomes and builds capacity. Unrealistic goals and/or lack of focus and resources are some of the key reasons why strategic plans fail to get implemented.

- Most respondents were of the opinion that their local C*f*L strategic plan was (substantially / almost entirely) realistic and achievable (85%), and clearly specifies the actions different partners have committed to implementing (93%). However, one-in-four respondents felt that their local C*f*L strategic plan did not have a well-connected champion.(Figure 6).

- Most stakeholders reported (79%) that there was (substantially/almost entirely) an implementation team in place to drive the local C*f*L strategic plan and that they had access to the expertise necessary to help with implementation of the plan (73%).

- However there were concerns about resourcing; approximately 2-in 3 respondents (64%) were of the opinion that sufficient resources were not available or only somewhat available to implement. (Figure 7).

[2] Across the 7 areas with completed C*f*L suicide prevention action plans, a total of 166 stakeholders were contacted, 72 completed the survey i.e. 43%

Lessons Learned:

- Developing area-level C*f*L suicide prevention action plans have been shown to be effective in mobilsing communities around the issue of suicide prevention. But this work takes time and resources; more specifically it requires the time and commitment of some of the most highly paid and highly experienced people across a range of sectors. The time required needs to be acknowledged particularly in a time bound national strategy like C*f*L.

- While an important output from C*f*L the area-level planning processes are the suicide prevention action plans, the outcomes for stakeholders (organisation, community, individual, and partnership) capacity are noteworthy.

- The development of area-level C*f*L implementation plans (rather than action plans) clearly mapping out how the national strategy would be implemented in the local context, would have secured the necessary stakeholder buy-in and support efficiently and effectively, and would have facilitated a considered, and more timely move into implementation.

- Monitoring and evaluation support should have been made available from the outset across all area-level planning processes. Thereby facilitating the collection of high quality data using standardised instruments that could not only identify needs and inform planning at an area level, but could also have facilitate comparisons across areas, and the establishment of baselines against which to measure change.

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Table 2: Connecing for Life (C*f*L) area-level suicide prevention action planning groups

CHO Area	Connecting for Life Plan	Status of Planning Process July 2017	Planning Group Members			CHO Response Rate
			N Contacted	N valid Responses	Response rate	
CHO 1	**Donegal:** Suicide Prevention Planning Group (SPPG) was set up in to oversee the process (n=24). They were informed by; • Engagement Working Group (EWG) (n=12) • Information & Research Working Group (IRWG)(n=8)	**Planning process complete** (County Plan published July 2015 & being implemented)	25	9	36%	**38%**
	Sligo/Leitrim: A Cross County Steering Group (n=24) was set up to oversee the process; They were informed by county working groups • Sligo Working Group (n=21) • Leitrim Working Group (n=17) and; • Consultation process (6 public meetings, on-line survey)	**Planning process underway** (Cross-County plan being drafted (published October 2017)	24	3	12%	
	Cavan/Monaghan: C*f*L Steering Committee was set up to oversee the work (n=27)	**Planning Process complete** (Cross-County Plan Published June 2017)	27	17	63%	
CHO 2	**Galway/Mayo/Roscommon:** C*f*L Steering Committee was set up to oversee the process (n=29). They were informed by; • HSE Working Group (n=16) • Engagement Working Group (n=28)	**Planning process underway** Cross-Counties Plan being developed (to be published 2018)	29	18	62%	**62%**
CHO 3	**MIdWest (Limerick, Clare, Nth Tipperary):** A Suicide Prevention Steering Group (SPSG) was set up to oversee the process (n=54). They were informed by; • Engagement Working Group(EWG) (n=12) • Information & Research Working Group (IRWG).(n=9)	**Planning process complete** (Cross-counties plan published April 2017)	46	30	65%	**65%**
CHO 4	**Kerry:** The Kerry Suicide Prevention Planning Group (SPPG) was set up to guide the process (n=13). They were informed by; • An Engagement Working Group (n=13) • Information and Research Working Group (n=11)	**Planning process complete** (County plan published May 2017)	15	2	13%	**14%**
	Cork: The Cork Suicide Prevention Planning Group (SPPG) was established to lead out on the work (n=28) They were informed by • Engagement Working Group(EWG) • Information & Research Working Group (IRWG)	**Planning process complete** (County plan published July 2017)	28	4	14%	

CHO 5	**South Tipperary:** South Tipperary Suicide Prevention Planning Group' (SPPG) established to develop a plan (n=18). They were informed by the workings of • A Consultation Working Group (CWG) (n=6)	**Planning process complete** (County plan published April 2017)	18	9	50%	**33%**
	Waterford: A process was undertake to amalgamate county & city • The Social Inclusion Measures Working Group (SIMWG) of Waterford County Development Board engaged consultants to conduct public consultations & stakeholder interviews • A Prevention Interagency Working Group (SPIWG) oversaw the developed of Waterford City Action Plan for Suicide prevention in 2007; this plan was reviewed following a series public consultation & interviews with key stakeholders • Following alignment of the Waterford City & County Councils (in 2014) the city and county action plans for suicide prevention were merged into one strategy Connecting for Life Waterford	**Planning process underway** (County plan published September 2017)	26	5	19%	
	Wexford: Plan under review	**Under review**			-	
	Carlow: Carlow Suicide Prevention Planning Group was set up to oversee the planning process (n=25).	**Planning process underway** County Plan being developed (to be published 2018)	25	9	36%	
	Kilkenny: Suicide prevention action plan published 2014 pre CfL -	**Under review**	-	-	-	
CHO 6	**Dublin South East, Dún Laoghaire & East Wicklow:** A Steering Group consisting of HSE representatives was set up to oversee the process (n=7)	**Planning process complete** (Cross counties plan published March 2017)	7	1	14%	**14%**
CHO 7	**Dublin South Central:** A multi-agency steering group was established to lead out on the work (n=11)	**Planning process underway** Plan will be published 2018	11	1	5%	**11%**
	Kildare/West Wicklow: A multi-agency steering group was established to lead out on the work (n=18)	**Planning process underway**	18	4	22%	
CHO 8	**HSE Midlands Region: (**Longford /Westmeath, Louth/Meath, Laois/Offaly). An Oversight Group was established to lead out on the process (n=11). .	**Planning process underway** To develop a Regional Suicide Prevention Action Plan	11	7	64%	**68%**
			8	3	38%	
			9	9	100%	
			9	6	67%	
CHO 9	Dublin North, Dublin North Central: The Steering Group to guide the process was established in August 2017	**Planning process had not commenced**	-	-	-	
			336	137		

**Of note:*

- *The total number of responses to the survey was 145, however 8 respondents did not identify for which plan they worked as part of, but were still included in the overall analysis of results*
- *At the time of survey, four planning groups were surveyed within CHO 8 as it was envisaged that three separate plans were to be developed within CHO 8; now it is a CHO plan*
- *At the time of survey, CfL Wexford was under review, hence findings from members of this planning group were not included as part of this survey*
- *There is a slight discrepancy in some of the numbers of the steering/planning group members as listed in the published plans, and the number originally provided to NOSP by ROSPs for the survey to be circulated to*

Table 3: CfL Area-level suicide prevention planning group membership by organisation

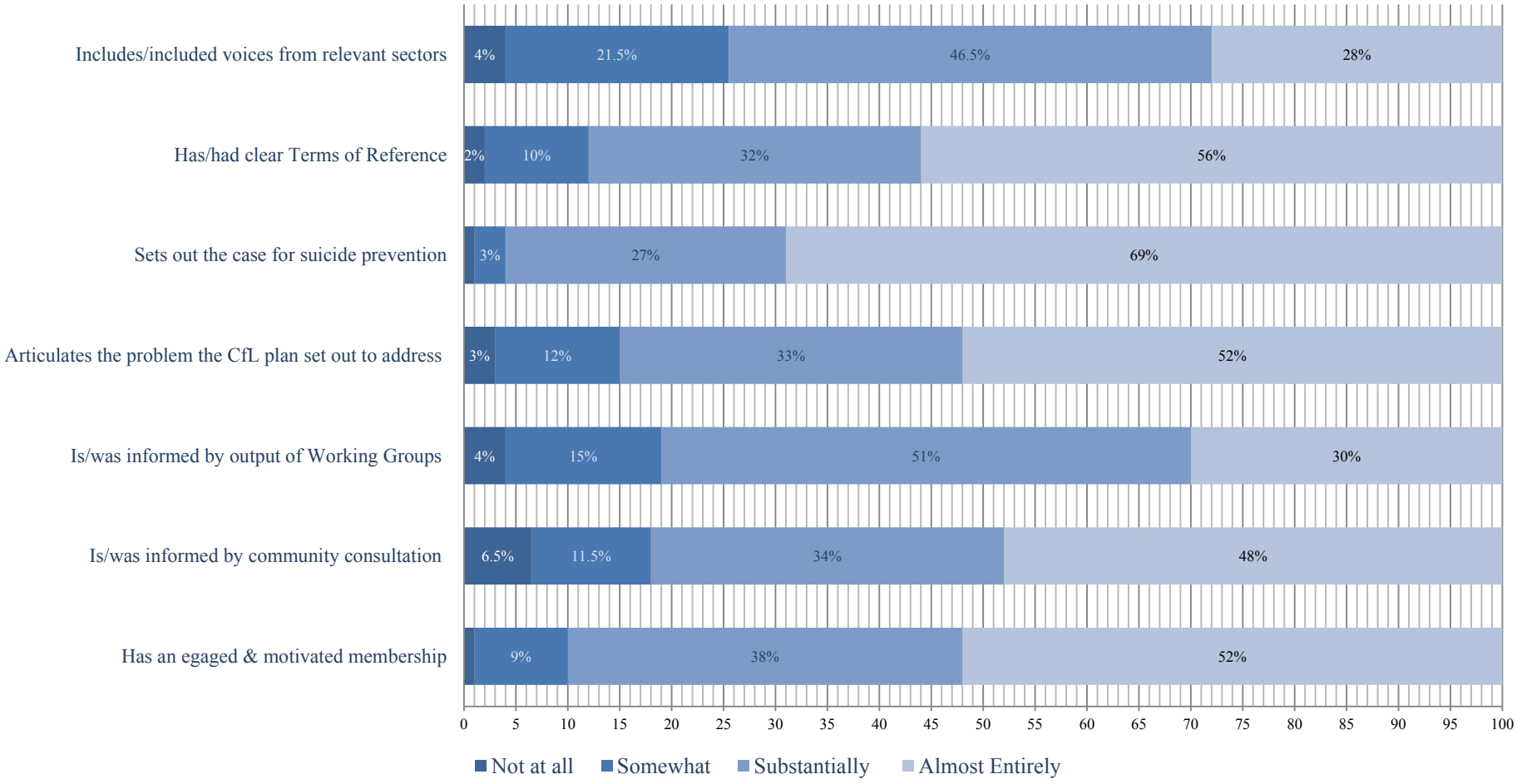
Organisation/Representative Group	Number		Response Rate
	Contacted	Responded	
Arts Organisation	1	0	0%
Bereavement Support Group	5	4	80%
Community Development Programme	11	3	27%
Coroner	6	1	17%
CYPSC	3	3	100%
Elected Representatives (local counsellors)	2	1	50%
Education Training Boards	13	3	23%
Family Resource Centres	7	3	43%
GAA	1	0	0%
Garda Siochana	20	13	65%
GP	4	0	0%
HSE Acute Hospital Division	5	2	40%
HSE Adult Mental Health Services	14	12	86%
HSE CAMHS	5	2	40%
HSE Chief Officer	3	0	0%
HSE CHO Mental Health Lead	6	3	50%
HSE Health & Wellbeing	14	6	43%
HSE Mental Health Service Users	2	2	100%
HSE Mental Health, including ROSPs	40	17	43%
HSE Primary Care	12	4	33%
HSE Psychology	9	1	11%
HSE Public Health	8	3	38%
HSE Social Inclusion	20	9	45%
Local Authority LCDC	30	17	57%
Local Development Company	14	8	57%
Local Drug & Alcohol Taskforce	4	0	0%
Local Public Participation Network (PPN)	6	2	33%
Local Press/Radio	2	2	100%
NEPS	4	1	25%
Person bereaved by suicide	1	1	100%
Person with lived experience of suicide	3	3	100%
Sports Partnership	3	1	33%
Traveller	1	1	100%
TUSLA	17	5	29%
Youth	19	8	42%
Other	21	4	19%
Total	336	145	43%

Table 4: Thematic analysis of qualitative data

Theme	Sub-themes	Indicative quote
Strengths of the CfL area-level planning process	Diverse membership	"It was an excellent group to work with, a diverse range of people representing different sectors who were very committed to the entire process"
	Leadership	"Really excellent Chairperson and strong commitment from her and the staff to process - ensuring all voices were heard … Highly inclusive"
	Scale of the work	"The number of organisations and individuals involved in this piece of work was very impressive and gives complete validation to the exercise"
	Committed members	"A very motivated and active group who had great interest in the steering group and everyone's views were articulated"
	Well-coordinated	" [The ROSP} did great work, organising and motivating the committee and keeping us involved in the process!"
	Laid good foundations	"I believe that the relationships, based on personal interaction which has build trust and understanding, developed as part of the planning process have assisted in the implementation"
Limitations of the CfL area level planning process	Buy-in	Could have had more buy in from Education sectors No GP buy in or representation No /HSE Primary Care Representation"
	Representation	Very disappointed that CAMHS are not sitting around the table..."
	Community engagement	"Community engagement/consultation meetings were not well attended; may have received a better turn out if we offered something more to encourage people to attend, e.g a talk on mental health, suicide prevention or managing stress etc"
	Skills deficit	"I think research/information skills were a bit in short supply so the onus fell on a small number of people." "The facilitator was not the right choice and this has left community feeling a bit isolated"
	Strategic Thinking	"Lack of focus, time, discussion and resources on implementation of the strategy…….its implementation will be challenging"
	Innovation	"A lot of it is already in play. Little innovation apparent as yet"
Challenges of the CfL area-level planning process	Structural	"The main concern I have with the process is that the end product will not reflect the local situation as the National Office can accept or reject actions and indeed the local Strategy"
	Volume of Work	"The planning process was focused, however could easily have been jeopardised due to large amounts of information which required validation, processing in order to ensure the Plan met the requirements as laid down in terms of reference"
	Vision	"The whole process was challenging in terms of articulating what was going to change in the counties… there was no promise of additional resources and the deep concern re the level of MH service in the Counties, clouded many of the conversations….
	Managing expectations	"It was difficult during the process to manage a wide variety of services all with their own needs"
	Maintaining momentum	"The length of time to get decisions was also difficult and held things up"
	Enabling participation	"Most of the participants were HSE employees…, they were acquainted with each other and with the language that goes with these roles! It took me awhile to catch up .. I would have felt more comfortable in a small group, which could then report to the large group!"
	Resourcing	"Many actions within the plan are dependent on resources - while many of the partners committed to delivery of actions within their existing resources, government policy - in the youth and community sector particularly - will, I suspect, impact on the organizations' ability to deliver"
	Reach	"Some high risk groups were difficult to reach - due to lack of local community supports, e.g. limited LGBTQI supports, Traveller supports, etc."

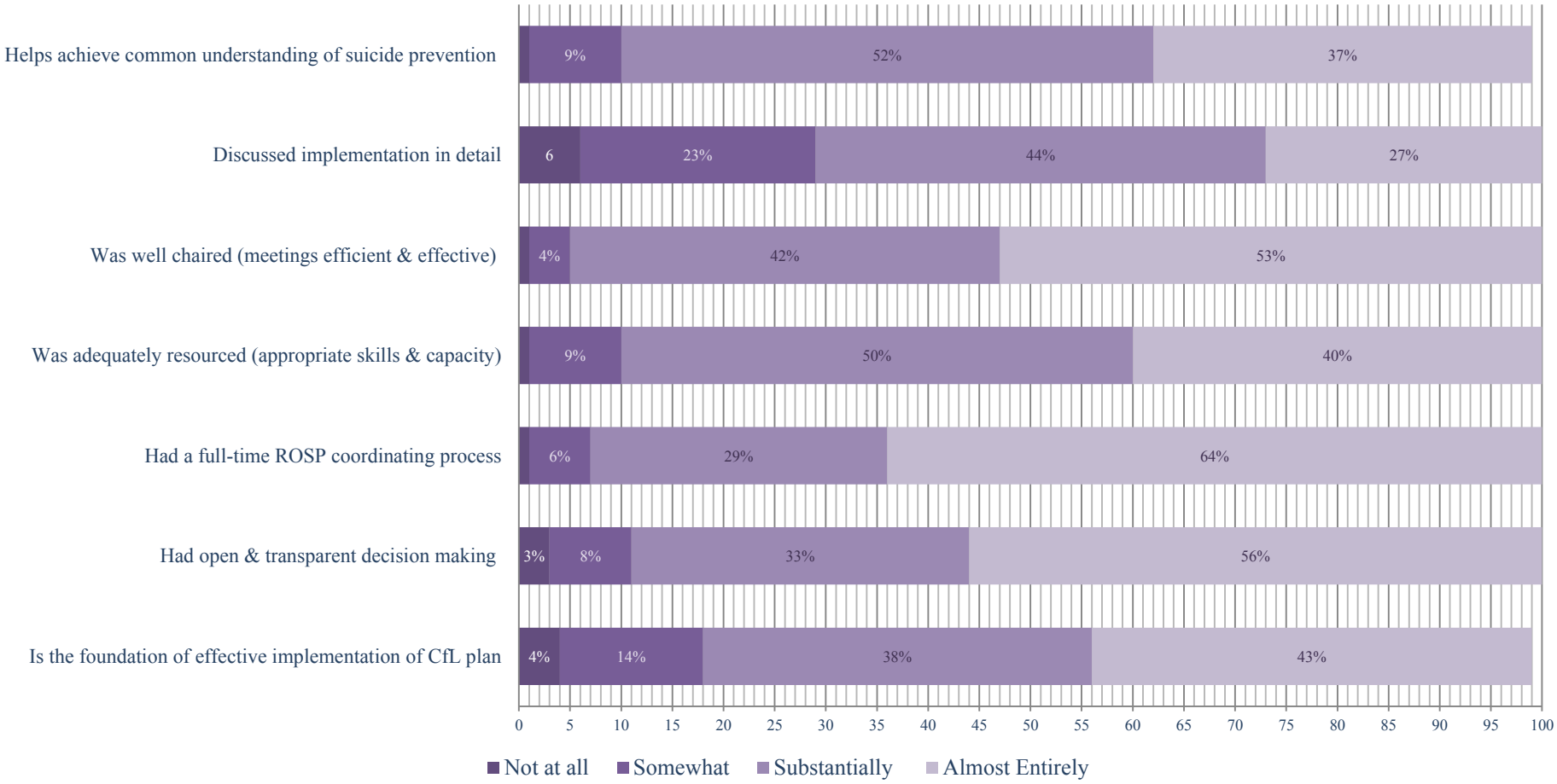
These Figures 1 - 7 relate to the "**Area Level Implementation of Connecting for Life, Survey Findings, December 2017**"
Available on www.connectingforlifeireland.ie

Figure 1. Survey respondents perspectives on the local CfL multi-agency PLANNING GROUP (n=145)



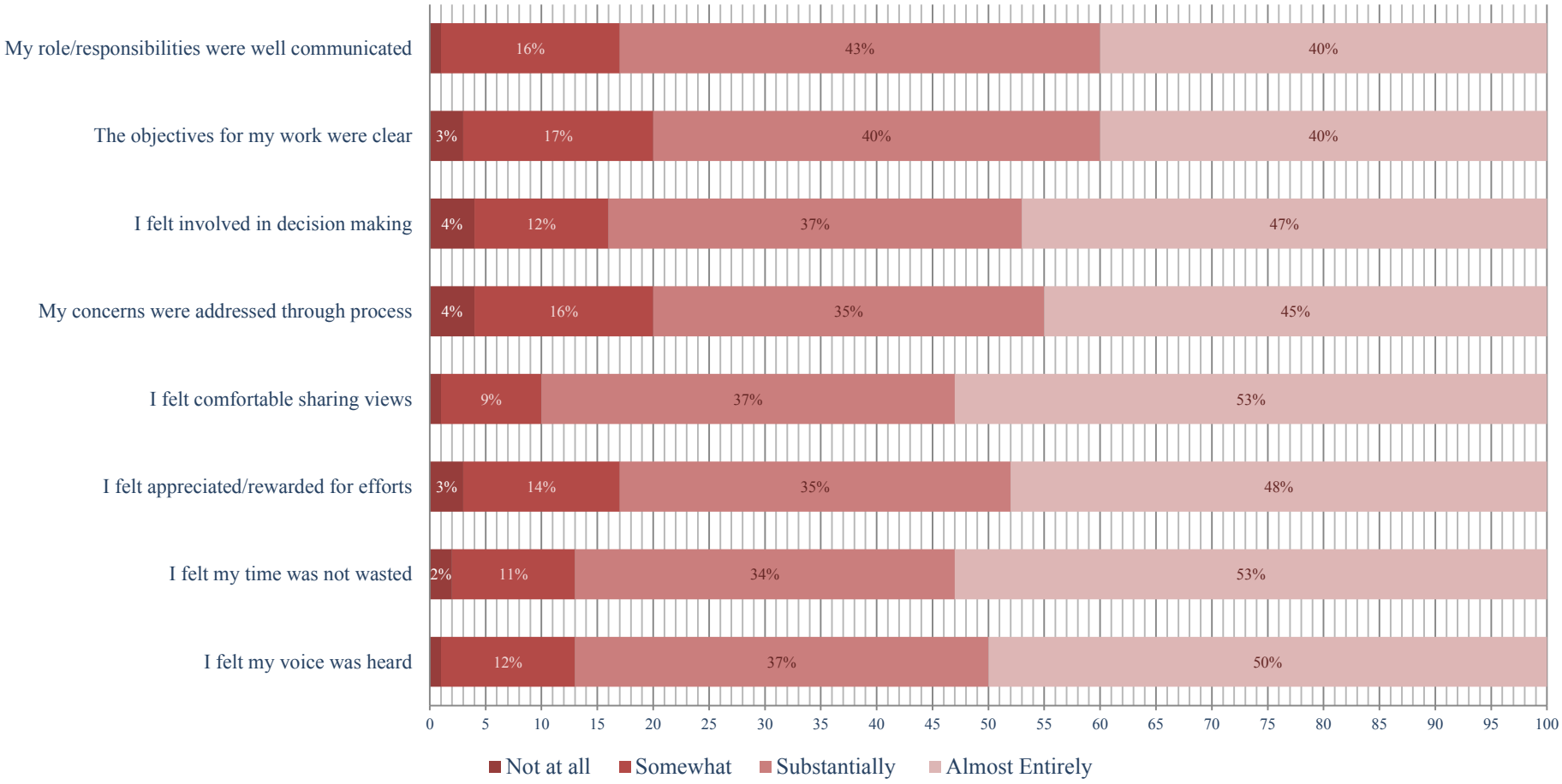
The results above are representative of planning group members from 17 groups

Figure 2. Survey respondents perspectives on the local CfL multi-agency PLANNING PROCESS (n=142)



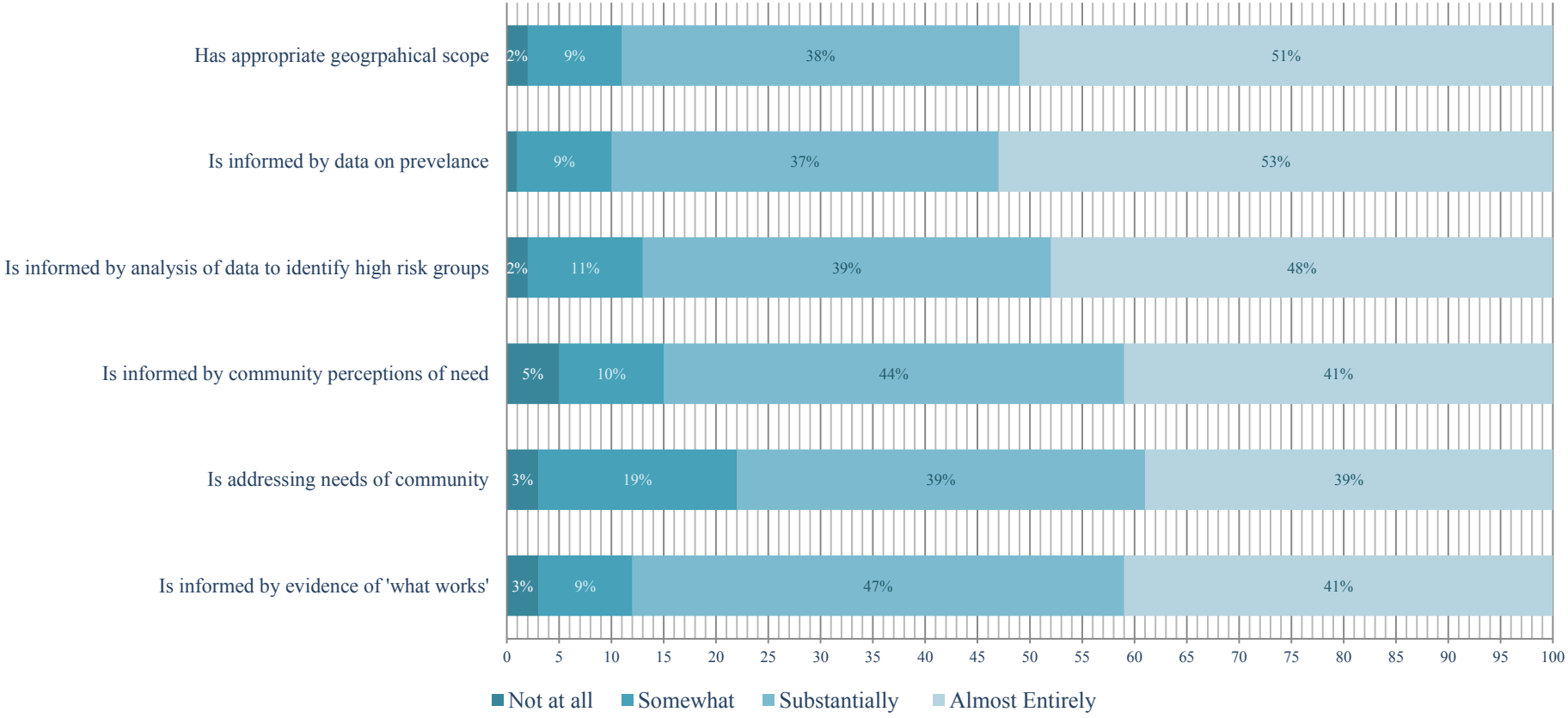
The results above are representative of planning group members from 17 groups

Figure 3. Survey respondents perspectives on THEIR INVOVLEMENTS in the local CfLaction planning (n=140)



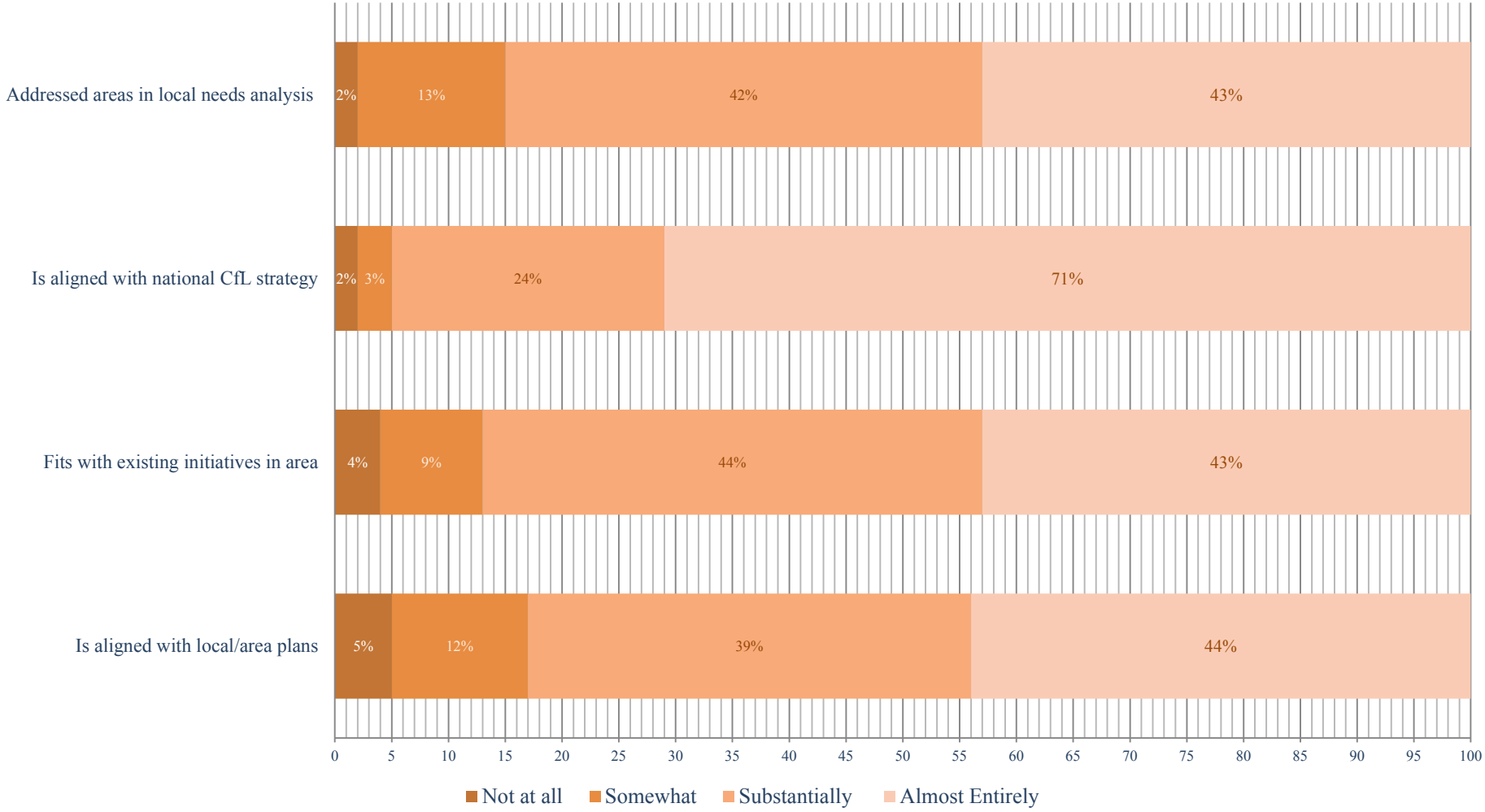
The results above are representative of planning group members from 17 groups

Figure 4. Survey respondents perspectives on the extent to which the local CfL plan was INFORMED BY LOCAL NEED (n=142)



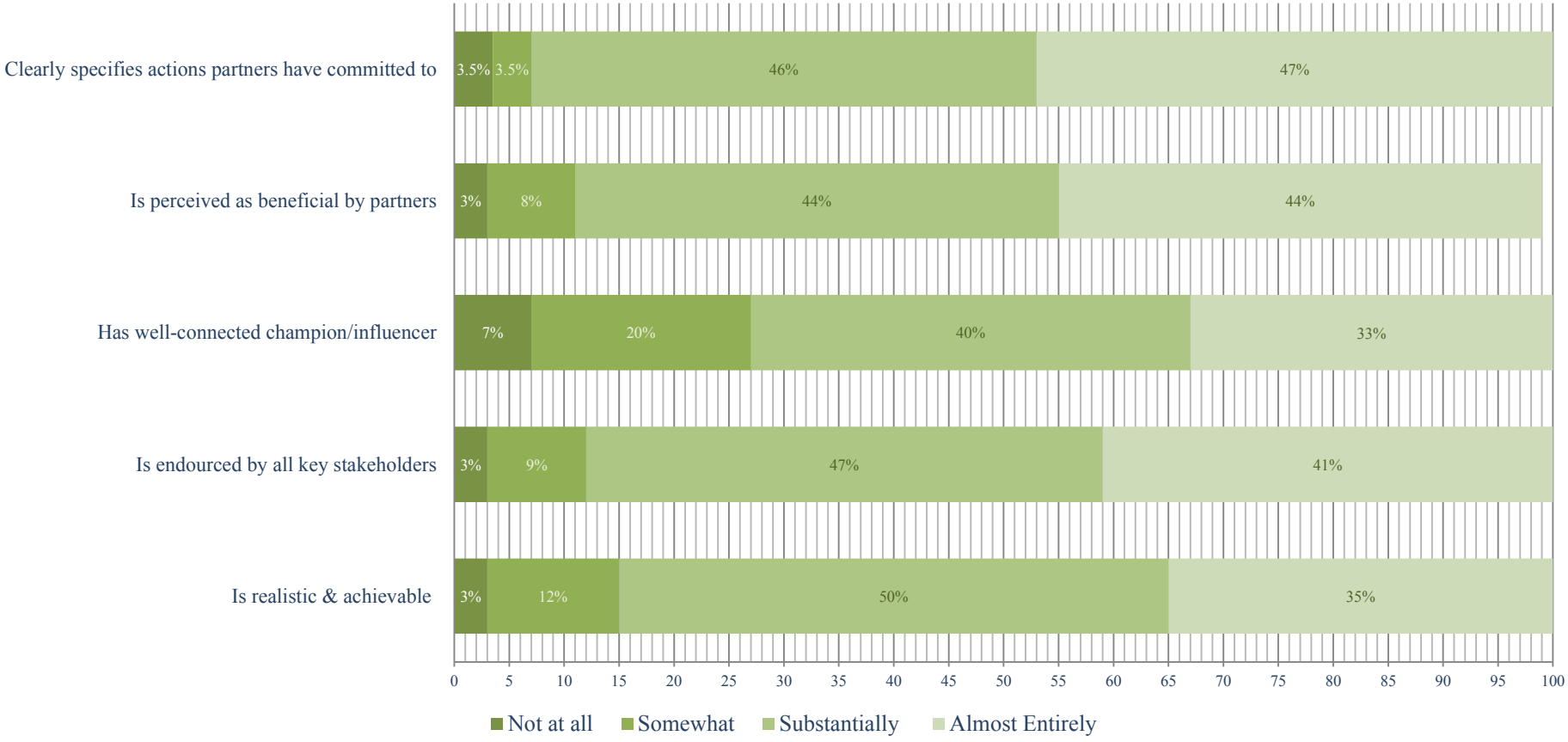
The results above are representative of planning group members from 17 groups

Figure 5. Survey respondents perspectives on the extent to which the local CfL plan fits local context (n=89)



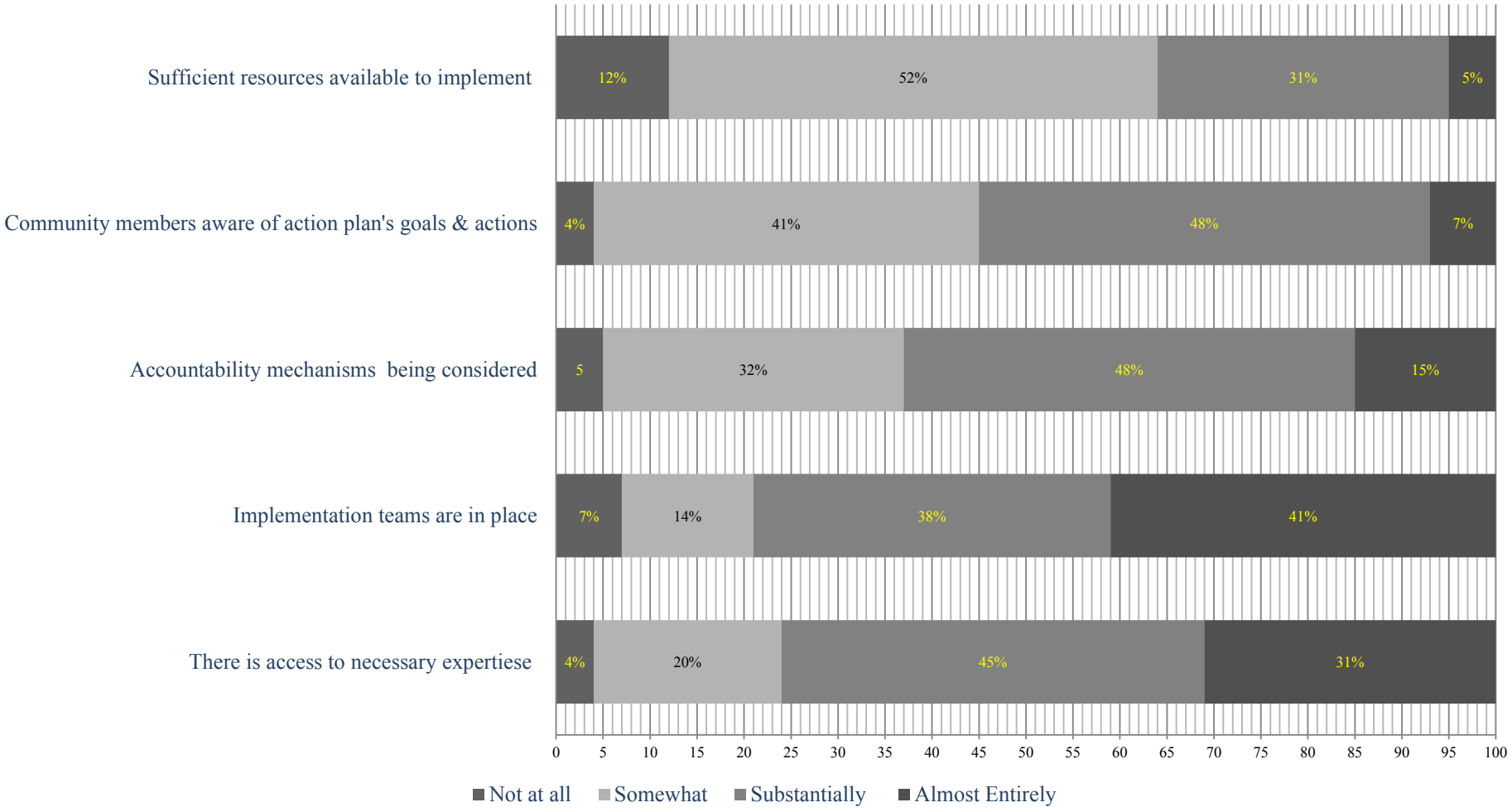
The results above are representative of planning group members from 11 groups

Figure 6. Survey respondents perspectives on the extent to which the local CfL plan has buy-in & support
(n=89)



The results above are representative of planning group members from 11 groups

Figure 7. Survey respondents perspectives on implementing the local CfL action plan (n=86)



The results above are representative of planning group members from 11 groups