Connecting For Life Dublin North City and County Consultation Report

February 2018

INTRODUCTION

Connecting for Life (CfL) 2015-2020 is Ireland’s National Strategy to reduce suicide. In line with the National Strategy, a CfL Steering Group has been convened with responsibility for developing a Suicide Prevention Action Plan for Community Healthcare Organisation Dublin North City and County (CHO DNCC). To support the work of the Steering Group, a Consultation Working Group (CWG) was formed to guide a consultation process for the local Suicide Prevention Action Plan. This document reports on the outputs of that consultation. Membership of the CWG is included in Appendix 1.

STRUCTURE OF THIS DOCUMENT

This document outlines the consultation purpose and methodology. Under Consultation Results it reports in on the outputs of the four surveys, the focus groups and the interviews, aligned to the seven goals of the national Connecting for Life Strategy. Next steps are also presented. Graphs displaying the quantitative analysis of a selection of the survey questions are included in Appendix 2.

CONSULTATION PURPOSE

Effective consultation improves the quality of policy and engages stakeholders in the process. In order to ensure consultation is not just a bureaucratic exercise, careful consideration needs to be given to planning, coordinating and analysing the outputs of the consultation.

The Department of Public Health and Reform commits to ensuring the consultations undertaken by public bodies emphasise real, meaningful and targeted engagement. The Connecting for Life DNCC consultation process proactively sought to capture the knowledge and experience of community stakeholders to inform the Suicide Prevention Action Plan in DNCC. The Action Plan will use this information, alongside the available national and international evidence, to build on and improve existing services and activity in the area.

1 Prepared by Sara Maxwell, Resource Officer for Suicide Prevention, with support from AboutFace Consulting and the Connecting for Life Dublin North City and County Consultation Working Group. 2018.

CONSULTATION METHODOLOGY AND PROCESS

Surveys
Four online surveys were developed with the input of the Consultation Working Group. These were aimed at the general public, service providers, GPs and psychiatrists. An information webpage was set up at www.connectingforlifedncc.ie. The surveys were live from 25th of October until the 30th of November 2017. They were promoted and disseminated via local media, partner organisation contacts, social media, Public Participation Networks, Activelink, internally within the HSE and via word of mouth.

Focus Groups
Fourteen focus groups have been held with front line staff and community groups. Focus groups were facilitated by AboutFace Consulting and partner organisations who are already working with relevant priority populations, some of whom were members of the Consultation Working Group.

Interviews
Telephone interviews were held with some key stakeholders who could not attend focus groups.

Analysis
The consultation outputs were collated and analysed using qualitative and quantitative methodology. All open ended responses to the surveys were coded, with many responses receiving a number of codes. For example, if a respondent suggested a stigma reduction initiative in workplaces, then that response was coded as both ‘stigma reduction’ and ‘workplaces’. In total there were nearly 3000 items of coded data across the four surveys. Codes were further grouped into themes where appropriate.

Focus groups and interviews were transcribed into brief reports. These were collated and analysed according to qualitative themes.
CONSULTATION RESULTS

Profile of consultation participants

1. Public survey

One hundred and eighty five members of the general public responded to the public survey. The majority of respondents were female (76%) and white (97%). Age range was relatively evenly distributed.

![Public Survey Gender](image1)

![Public Survey Ethnicity](image2)

2. Service Providers’ survey

One hundred and forty four people responded to the service providers’ survey from the following organisations[^3].

[^3]: Abbreviations and Acronyms are listed in Appendix 3
3. GPs’ Survey

28 GPs responded to the survey from across the CHO.

4. Psychiatrists’ Survey

Seven consultant psychiatrists responded to the Psychiatry survey and a further 4 responded to the service providers’ survey. They were all based in adult services, from both acute and community settings across the CHO.

5. Focus Groups

Three groups were held with users of addiction services, two with youth groups, one with LGBTI+ youth, two with the Traveller Community and one with migrants. The front line staff participants were from a local Emergency Department, 2 Primary Care Centres, a Community Mental Health Team and the education sector.
Consultation Themes
The following section outlines a summary of consultation result themes aligned to the seven strategic goals of Connecting for Life.

To improve the nation’s understanding of, and attitudes to suicidal behavior, mental health and wellbeing.

Public awareness campaigns were requested across the consultation. Focus group participants suggested campaigns should be year-round and not just centred on mental health week. The stigma of mental health was recognised as a barrier to help seeking across the board although GPs reported that they were experiencing increased mental health presentations, which they attributed to greater public awareness. Schools were the sites for much of the mental health promotion recommended, with workplaces, youth groups, sports clubs and colleges also suggested. The need to provide more information was emphasised by many respondents; information about signs and symptoms of mental health problems and suicidality and also information on how to access services. Targeted, culturally appropriate information was requested by Travellers.

To support local communities capacity to prevent and respond to suicidal behaviour.

The value of providing support in local communities was highlighted by many consultation respondents, and statutory services often referred to local community services as key stakeholders. Alongside recognition for the significant contribution of local community support, there were calls for more capacity building, oversight, guidance and support for local community and voluntary services to ensure governance and quality for those in need. Some respondents questioned the sustainability of relying on local community services to provide mental health support in the absence of an adequate statutory response.

“Mental Health needs to be incorporated into all aspects of life such as school, sports, work and social life”. Public Survey Respondent No. 179

“Increase awareness among general public about what services there are for people suffering from mental health problems, what stages (and how) they can access them, and what each one will offer. The average person, for example, does not know the difference between a psychologist, a physiotherapist and a psychiatrist, and which one they should contact if they are in distress”. Public Survey Respondent No. 140
Increasing awareness and training within the general community was recommended. Much of the community training and support suggested was for the promotion of self care and resilience, and peer to peer support. There was repeated reference to the need to provide and promote activities that can enhance individuals’ mental wellbeing, such as exercise, social activities and volunteering. Access to employment and housing was also a major issue for some cohorts. Social prescribing models were suggested and supported at Primary Care level, requiring investment in staff to adequately establish and key-work the model. Respondents to the psychiatry survey emphasised the need to focus preventative efforts on community based services and risk factors to avoid the need for people to access crisis and secondary care.

Service providers were asked specifically for their recommendations for how community, voluntary and statutory organisations can work together better to improve mental health services. There was strong support for interagency working, specifically recommendations that services work together to strengthen referral pathways and undertake shared case management. This was strongly reflected by the education sector who reported tangible benefit of interagency working. To achieve interagency collaboration, greater information sharing, joint events and aligning organisational agendas were suggested. Conversely some of the gaps in service provision were identified as being exacerbated by the lack of cooperation and communication from overburdened services.

![Figure 4 Service Providers' Survey Working Together](image-url)
To target approaches to reduce suicidal behaviour and improve mental health among priority groups.

References to priority groups were made throughout the survey responses. In a positive sense organisations highlighted their own strengths in reaching and working with specific priority groups, including youth, LGBTI+, people using addiction services and Travellers. Providing a ‘safe space’ and one-to-one support were valued, and were seen as unique to each service and priority group relationship in comparison to general statutory services. Others discussed the higher level of risk amongst priority groups and the need to resource prevention efforts in this area. The increased risk of suicide for those with drug and alcohol problems was repeatedly raised and it was evident that the public and service providers saw dual diagnosis as an area needing increased services and more seamless care pathways. Similarly, the risk of suicide within the Traveller community, brought about in part by substance misuse, was causing concern. Many respondents recognised the need to focus efforts on environmental risks to mental wellbeing such as poverty and homelessness.

Respondents made many suggestions for where to target efforts for priority groups; schools were an overwhelming feature of responses. As well as mental wellbeing and awareness programmes in schools, there were suggestions that teachers needed to be trained to better understand the needs of minority students. Workplaces, colleges and community services were also referenced as sites for targeted mental health activity. A particular emphasis was put on the need to equip and support parents to prevent and respond to the mental distress of their children, including increasing their comfort in talking to their children about mental health. Innovative ways to reach and engage busy parents are needed.

“Ensure that interventions in relation to suicide are accessible to all and are tailored to fit the needs of marginalised groups”. Service Provider Respondent No. 32
To enhance accessibility, consistency and care pathways of services for people vulnerable to suicidal behaviour.

Consistent and timely access to mental health supports for people in need was repeatedly described as an area in need of improvement. This included mental health support at primary care level, with properly resourced and staffed services. Where they are posted, Clinical Nurse Specialists in Mental Health in Primary Care Teams were strongly supported for the expertise and capacity that they add to the team. Primary Care Psychology was valued, but long waiting lists were a cause for concern.

Similarly, timely access to specialist mental health services including child and adolescent services was seen as a priority. It was highlighted that due to waiting lists, severe cases of mental illness often have to be prioritised, which means those with moderate needs get little support until they get worse. Community and voluntary services try to fill this gap, but the sustainability and consistency of this model was questioned. Many local community and non-statutory services were praised, including but not limited to, Pieta House, Jigsaw and the Samaritans.

The Suicide Crisis Assessment Nurse (SCAN) service was strongly supported, especially by GPs, with calls for it to be extended. There were many specific references to challenges with referral pathways and waiting lists, coupled with support for greater interagency working to overcome these challenges. Access to counselling was a strong positive for respondents, as well as an area for further development. Counselling in Primary Care was seen as a very positive addition, although waiting lists were an issue. Many specific interventions were recommended. Access in crisis situations was repeatedly discussed, with many respondents highlighting how Emergency Departments were not adequate for this purpose, particularly outside the hours of the Clinical Nurse Specialists for Self Harm. Access to a range of mental health supports outside normal working hours was requested, including drop in services.

Specialist suicide bereavement support services was an area in need of development, acknowledging the strong work of existing providers but recognising the limits to their capacity and the gap regarding immediate practical support for bereaved families and friends. Furthermore, the consistency of support for staff members following the suicide death of a patient was questioned.
To ensure safe and high quality services for people vulnerable to suicide.

The quality and compassion of staff is a key strength of the existing response to suicide according to the survey respondents. Service providers, including GPs and psychiatrists highlighted how their service was delivering high quality patient-focused care in demanding circumstances. Adequate resourcing to meet the demands placed on services was discussed as a challenge, and staff wellbeing was raised as a concern. Generally respondents agreed that access to services (as discussed above) was where the need lies, rather than with service quality. The appropriateness of EDs for crisis care was an exception. Similarly the lack of services for people with dual diagnosis was repeatedly stated. Supporting and involving families and carers in treatment was strongly recommended.

Many specific interventions and treatment approaches were discussed in survey and focus group responses. In particular there were calls for the further roll out of the Suicide Crisis Assessment Nurse (SCAN) service and extension of the hour of operation of the Clinical Care Programme for Self Harm in Emergency Departments. Cognitive Behavioural Therapy (CBT) and Dialectical Behavioural Therapy (DBT) were supported, as were other evidence based treatments. As mentioned previously, greater capacity for mental health response within primary care settings was requested. Psychoeducation was also promoted. Follow-up care after discharge and local support groups were discussed.

Staff training was the action most considered by organisations when asked what they could do to improve suicide and self harm prevention. SafeTALK, ASIST, STORM and Collaborative Assessment and Management of Suicidality (CAMS) trainings were regularly mentioned. The lack of consistent suicide prevention and mental health training in undergraduate and postgraduate training for health professions was repeatedly raised as a concern. While training such as ASIST and STORM can bridge some of the gap, releasing staff for training remains a challenge.

“Listen to family members who care for individuals with mental health issues.... Individuals can overcome mental health issues with professional help, and support from families and community organizations.” Public Survey Respondent No. 156
To reduce and restrict access to means of suicidal behaviour.

A number of survey respondents advocated for specific measures to restrict access to means of lethal overdose and others recommended general consideration for restricting access to means.

To improve surveillance, evaluation and high quality research relating to suicidal behaviour.

Adherence to the evidence base and ensuring services are delivering on best practice was promoted throughout the survey responses, particularly by service providers.

NEXT STEPS

Further analysis of the consultation outputs will be undertaken and will feed directly into the process for developing and committing to actions under the Suicide Prevention Action Plan Dublin North City and County. This process will continue into Quarter 1 2018 and it is intended that the Plan will be launched in Quarter 2 2018.
APPENDIX 1

Membership of the Connecting for Life Dublin North City and County Consultation Working Group

AWARE
Ballymun Regional Youth Resource
BelongTo
Blanchardstown Local Drugs and Alcohol Task Force
Cairde
Dublin City University
Dublin Institute of Technology
Dublin North East Drugs and Alcohol Task Force
Dublin Simon Community (Representing the Homeless Mental Health Action Group)
Exchange House
Finglas Cabra Local Drugs and Alcohol Task Force
Fingal County Council
HSE Communications
HSE Mental Health
HSE Primary Care
Jigsaw
Mountjoy Prison
National Youth Council of Ireland
Shine
Union of Students Ireland

Membership of the Connecting for Life Steering Group

HSE Chief Officer CHO DNCC (Chair)
An Garda Siochana
City of Dublin Education and Training Board
Fingal County Council
HSE Area Directors of Nursing Mental Health CHO DNCC
HSE Children’s Hospital Group
HSE Communications CHO DNCC
HSE Executive Clinical Directors Mental Health CHO DNCC
HSE Health and Wellbeing CHO DNCC
HSE Ireland East Hospital Group
HSE Mental Health CHO DNCC
HSE Mental Health Engagement CHO DNCC
HSE National Counselling Service Dublin North East
HSE Primary Care CHO DNCC
HSE Psychology CHO DNCC
HSE RCSI Hospital Group
HSE Social Care CHO DNCC
Irish Prison Service
Pieta House
Samaritans
TUSLA
APPENDIX 2

Graphs displaying coded responses to survey questions

1. Public Survey

Table 1 Public Survey

Table 2 Public Survey

Many more responses and suggestions were received and will feed directly into the Connecting for Life DNCC Actions, only the issues that were raised by several respondents are presented here.
2. Service Providers’ survey

Challenges to providing your supports and services?

<table>
<thead>
<tr>
<th>Issue</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting lists</td>
<td>20%</td>
</tr>
<tr>
<td>Staffing levels</td>
<td>15%</td>
</tr>
<tr>
<td>Staff skills</td>
<td>10%</td>
</tr>
<tr>
<td>Referral pathways</td>
<td>15%</td>
</tr>
<tr>
<td>Priority groups</td>
<td>10%</td>
</tr>
<tr>
<td>Meeting demand</td>
<td>15%</td>
</tr>
<tr>
<td>Funding</td>
<td>20%</td>
</tr>
<tr>
<td>Engaging clients</td>
<td>15%</td>
</tr>
<tr>
<td>Dual diagnosis</td>
<td>10%</td>
</tr>
<tr>
<td>Access to counselling</td>
<td>10%</td>
</tr>
<tr>
<td>Access to CMHT</td>
<td>10%</td>
</tr>
<tr>
<td>Access to CAMHS</td>
<td>15%</td>
</tr>
<tr>
<td>Access in crisis</td>
<td>20%</td>
</tr>
<tr>
<td>24/7 access</td>
<td>5%</td>
</tr>
</tbody>
</table>

Table 3 Service Providers’ Survey

What actions can your organisation take?

<table>
<thead>
<tr>
<th>Action</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff training</td>
<td>30%</td>
</tr>
<tr>
<td>Services information</td>
<td>15%</td>
</tr>
<tr>
<td>Referral pathways</td>
<td>10%</td>
</tr>
<tr>
<td>Mental Health Promotion</td>
<td>15%</td>
</tr>
<tr>
<td>Interagency working</td>
<td>10%</td>
</tr>
<tr>
<td>General information provision</td>
<td>10%</td>
</tr>
<tr>
<td>Community training</td>
<td>5%</td>
</tr>
</tbody>
</table>

Table 4 Service Providers’ Survey
What needs to be done to reduce suicide and self harm?

Table 5 Service Providers Survey
APPENDIX 3

Abbreviations and Acronyms

ABI – Acquired Brain Injury
AMHS – Adult Mental Health Services
C & V - Community and Voluntary
CAMHS – Child and Adolescent Mental Health Services
CBT – Cognitive Behavioural Therapy
CHO – Community Healthcare Organisation
CIPC – Counselling in Primary Care
CMHT – Community Mental Health Team
CNS – Clinical Nurse Specialist
D&ATF – Drug and Alcohol Task Force
DBT – Dialectical Behavioural Therapy
DNCC – Dublin North City and County
ED – Emergency Department
ETB – Education and Training Board
GP – General Practitioner
HSE – Health Service Executive
LGBTI+ - Lesbian, Gay, Bisexual, Transgender, Intersex and others
SCAN – Suicide Crisis Assessment Nurse