

LIFELINE CRISIS INTERVENTION SERVICE PUBLIC CONSULTATION QUESTIONNAIRE

Opens: 1pm, 27 August 2015

Closes: 1pm, 19 November 2015

FOREWORD

The *Protect Life* Suicide Prevention Strategy was published in 2006 and refreshed in 2012, with Executive endorsement, to add impetus to cross-sectoral work to tackle increasing rates of suicide and self-harm.

The Lifeline Crisis Intervention Service is an integral part of *Protect Life*. Established in 2012 with a three-year budget of £10.5m, Lifeline is a free-to-call, 24/7, regional confidential telephone helpline for people who are experiencing emotional crisis and who are at risk of self-harm and/or suicide.

The Public Health Agency (PHA) conducted a review to help to inform the procurement of Lifeline and associated suicide and self-harm prevention services beyond 2015. A Strategic Outline Business Case, prepared on the basis of this review, has been approved by the PHA Board. While the outline Business Case proposes retention of many of the key elements of the current service, it includes the following significant changes:

- **Separation of the telephone crisis helpline from the follow-up support crisis intervention services;**
- **Re-focusing of the services on de-escalation, enablement and empowerment;**
- **Commissioning the telephone crisis helpline directly from the Northern Ireland Ambulance Service;**
- **Procuring follow-up services through separate contracts serving the five Local Commissioning Group/Trust geographies;**
- **Enhancing follow-up services to expand capacity for psychological therapies, and introducing complementary therapies and face-to-face de-escalation.**

This document sets out the proposed future model for these vital services. We want to hear your views on these proposals before we move to the preparation of a final Business Case. The Strategic Outline Business Case and accompanying Equality Impact Assessment are available on the PHA website www.publichealth.hscni.net and I recommend that these are read carefully in preparing your response.

The closing date for responses is **1pm, 19 November 2015**, by email to lifelineconsultation@hscni.net or by post to Elizabeth McGrath, PHA Office, Towerhill, Armagh, BT61 9DR. Late responses will not be considered.

During this consultation period, the PHA will also host a series of workshops to ensure that all stakeholders have the opportunity to input fully. Further details of these events are available at www.publichealth.hscni.net and other meetings will be considered on request.

Andrew Dougal
Chair

CONTEXT

When introducing the refreshed *Protect Life* strategy to the Northern Ireland Assembly in 2012, the Minister for Health acknowledged the range of measures that had been implemented to prevent suicide and self-harm, but recognised that *“Despite these programmes and a very high level of commitment across statutory and community sectors, the Northern Ireland suicide rate remains stubbornly high”*.

This remains the case today. While prevention measures are undoubtedly making a difference, factors such as alcohol and economic pressures mean that suicide and self-harm remain significant public health challenges.

The World Health Organization has recognised that as part of a package of services, a helpline can contribute to preventing suicide. Our experience here would support that finding. Based on information from service users in particular, it is reasonable to conclude that the current service has contributed to saving lives and improving the health and wellbeing of people in emotional crisis.

REVIEW OF EXISTING SERVICE PROVISION

In preparing the Strategic Outline Business Case for the future Lifeline service, the PHA consulted with people and organisations in Northern Ireland, analysed information from the current service here, and examined statutory and voluntary helplines and associated support services from elsewhere.

In relation to helplines from elsewhere, a variety of approaches are used, but we have been impressed in particular by elements of the Breathing Space service which is part of NHS24 Scotland. This is a “listening ear” service, provided by trained operators, which signposts callers to relevant services rather than make referrals. It is based on an empowerment and enabling model.

In consulting with people here, over 200 people attended 14 workshops; these included service users, staff involved in the delivery of Lifeline, and other key stakeholders. There were also 154 written responses. The findings from the Lifeline pre-consultation report are accessible at

www.publichealth.hscni.net/publications/lifeline-consultation-report

Based on the feedback from the pre-consultation exercise, it was clear that respondents felt that the Lifeline service is an important source of support for people of all ages across Northern Ireland who are experiencing emotional crisis and who are at risk of suicide or self-harm.

There are a number of strengths of the current Lifeline service and support to retain these as the foundation for any future service model, including:

- The level of empathy, compassion and support that call operators provide;
- Signposting of callers to appropriate care and provision of support to individuals at risk of self-harm and/or suicide;
- The implementation of a distinct Lifeline Communication Strategy which has increased awareness of this public-facing service across Northern Ireland.

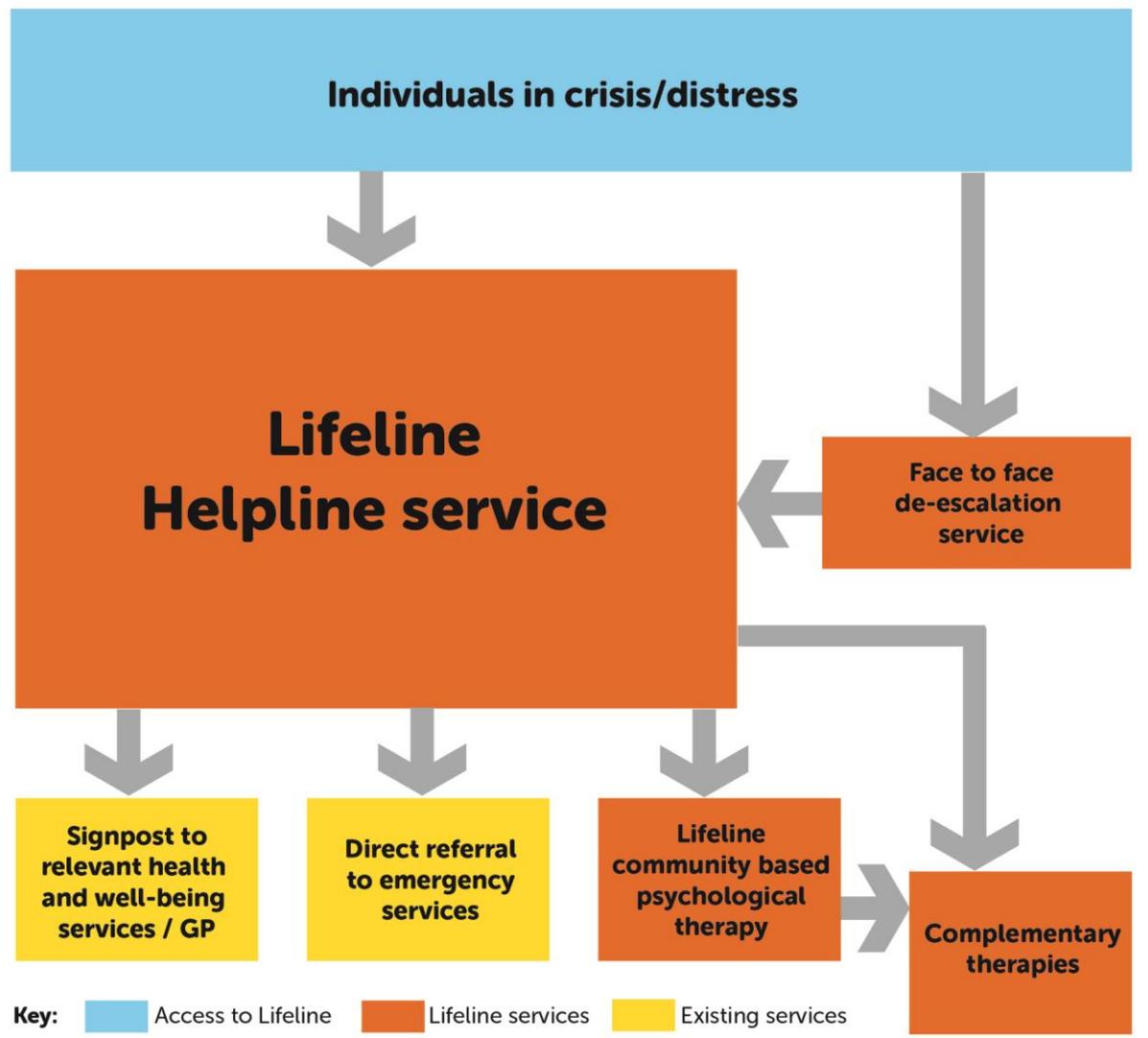
However, the feedback also identified that there are a number of limitations with the current service which need to be addressed. For example:

- There are concerns that the service has moved away from its core purpose as a crisis response service specifically for people at immediate risk of self-harm and/or suicide, to become one which was providing on-going support for most people who call the helpline. There is therefore a desire to see greater empowerment and enablement of people who call Lifeline;
- There are concerns that the service is not as integrated with other statutory, community and voluntary sector mental health and related services, and there is therefore a desire to see greater integration in the future;
- The Lifeline service has been perceived by some as 'Belfast centred' and 'the further away an individual lives from Belfast, the less likely they are to engage with the Lifeline service';
- The current service delivery model, which is built around one provider providing all aspects of the service, has a limited range of back-up options and carries a high risk in the event of service failure and business continuity.

This feedback, analysis of the current service, and learning from crisis response helplines elsewhere was considered carefully to inform the future proposed service model.

PROPOSED NEW LIFELINE CRISIS INTERVENTION SERVICE MODEL

The proposed service model, presented in the Strategic Outline Business Case, aims to build on the experiences gained during the past three years of the current Lifeline service and to enhance the strengths of the existing provision while addressing its limitations.



The overarching aim of the Lifeline Crisis Intervention Service is to help reduce the number of deaths as a result of suicide and the number of incidents of self-harm in Northern Ireland, by enabling access to appropriate services for those at immediate risk of suicide and self-harm.

It is proposed that the future Lifeline service will include the following core elements:

- It will continue to be a free-to-call, 24/7, 365 days/year telephone helpline accessible to people in Northern Ireland who are in crisis and at risk of suicide or self-harm;
- It will provide a 'virtual safe place' for those at immediate risk of suicide and self-harm Northern Ireland;
- It will assess individual callers, de-escalate their immediate crisis, determine their further risk of suicide or self-harm, and arrange appropriate follow-on care. Follow-on care may involve referral to emergency services, or advice and signposting to appropriate statutory or non-statutory follow-on support services. For callers with additional needs, for example a communication difficulty which may make it difficult for them to contact the follow-on support, Lifeline will help these callers to access the appropriate service. This process will be followed for each caller in crisis, including any callers under 18 years of age;
- It will encourage empowerment and enablement of people who call, where appropriate;
- Local support services will enable face-to-face de-escalation of a person in crisis who seeks their help, or is identified as at high risk by the local community. The local service will provide immediate de-escalation and arrange follow-on support as appropriate;
- It will provide an effective marketing and communication programme, which is responsive to suicide and self-harm trends in Northern Ireland, and which continues to raise awareness of the Lifeline services year on year;
- It will be fully integrated with relevant health and social care (HSC) organisations (including primary care), and other relevant statutory, community and voluntary sector organisations, and will work in partnership with them to make continuous improvements in services;
- It will ensure that effective corporate, clinical and social care governance arrangements are in place and maintained, including robust processes for clinical audit and quality improvement;

- It will explore the development of new and emerging communication technologies;
- It will demonstrate value for money and operate within its budget ;
- There will be a timely introduction of the new services, ensuring a smooth transition;
- To support the core elements of the service, an additional investment of £230,000 per year will be made available.

YOUR VIEWS

The following consultation questions focus on key changes to the structure, content and delivery of the future Lifeline service as proposed in the Lifeline Strategic Outline Business Case. The options for service models and delivery mechanisms considered in preparing this are set out in Appendices 1 and 2, although it is recommended that you refer to the full document on www.publichealthagency.hscni.net

A final question invites views on the wider aims and objectives of the proposed future Lifeline model. The responses to this consultation will inform the final future Lifeline model. The PHA is very open to feedback received through the consultation and to alternative approaches that meet the core elements.

1. Proposed Telephone Crisis Helpline Service

The proposed changes to the telephone element of the Lifeline service include:

- **Separation of the provider of the Helpline from the providers of follow-on crisis support services.** This was one of the key messages from stakeholders on the current service. Separating provision of the two elements of the service ensures that the focus of the telephone helpline will be on providing immediate crisis intervention. It also reduces the risk to the overall service in the event of failure of one or other elements.
- In line with the evidence supporting a recovery approach, **the Lifeline service ethos will focus on enablement and empowerment.** Callers will be empowered to take the next steps in their care, with less emphasis on automatic referral to support services. This is consistent with good practice based on enabling people to develop their skills in self-management and personal resilience.

The key elements are:

- Lifeline continuing as a free to call, 24/7, 365 days a year telephone helpline;
- The helpline will be a person centred, active listening service, offering immediate clinical assessment, de-escalation and clinical judgment to determine appropriate follow-on care;
- Call operators will have substantial clinical experience and qualifications in the disciplines relevant to crisis intervention for suicide or self-harm;
- Callers will be referred on to emergency services as appropriate;
- 'Enhanced signposting' will be available to assist callers who require additional support to access relevant services, with robust handover arrangements between the helpline and the follow-on service;
- The helpline will take calls from people of all ages, including children and young people. Helpline staff will assess each caller and their further needs, and refer or signpost each to the appropriate service. Children and young people who are assessed as being at minimal risk will be signposted to other services; those at low risk will be offered enhanced signposting to other services; those at high risk will be referred to existing gateway services; those at immediate risk will be referred to emergency services.

Question 1 (a) Do you agree with the proposed Telephone Crisis Helpline service element of the new model as outlined above. *Please delete as appropriate

***YES / **NO** / NOT SURE**

Question 1 (b) Please explain your answer (no more than 200 words)

In response to this question we are answering that we do not agree with the proposed telephone crisis helpline for the following reasons:

- It is proposed that the telephone helpline will be separated into two components however SBPB feel that there is little strategic context or justified evidence to demonstrate the need for the separation of the service. Members of the South Belfast Community Response are concerned this could be a financial decision rather than acknowledging the effectiveness of the crisis helpline, assessment and automatic referral process in place.
- Choice of Wording such as empowerment and enablement - We are concerned that separating the telephone line will form risk for clients who are in crisis and at risk of self harm/suicide therefore we feel the outlined service that states it will *'empower individuals to take next steps in their care with less emphasis on automatic referral to support services'* is not appropriate to support client who are in immediate crisis.
- The lifeline helpline is available for people of all ages; queries have been raised in South Belfast about how the calls to lifeline sit with Child line and Samaritans help lines that also receive calls re individuals at risk of self harm and suicidal thoughts.
- How will the helpline be joined up to form a seamless service if the helpline will be based in one place i.e. the proposed ambulance service and the follow up service to be based in another location. Consider these are people in crisis and referrals from one service to another could take considerably time particularly if service providers are not 24/7 services.

2. Proposed Follow-on Support Services: Psychological Therapy

Lifeline psychological therapy will be available in each of the five Local Commissioning Group/Trust areas. The only gateway into Lifeline psychological therapy will be through the helpline risk assessment process. This element of the service will normally be for adults aged 18 years and over, although some who are under 18 years may be assessed as suitable for the service. Lifeline psychological therapy providers will offer services that are based on the best current evidence from research and practice.

The primary elements of the proposed service are that:

- The services will only be available to callers who have been signposted from the Lifeline helpline following initial risk assessment, see **Appendices 3 and 4**;
- The service providers will undertake a full clinical assessment of each person to determine the support they need;
- Services will be reserved for those at immediate risk of suicide and self-harm, and who, following assessment, are deemed likely to benefit from psychological therapy in terms of reducing their likelihood to complete suicide, self-harm or suicide;
- If appropriate, clients will be offered an average of five sessions as part of this service;
- The clinical assessment criteria will be in accordance with standards agreed by the Public Health Agency and Health and Social Care Board;
- Clients considered not appropriate for psychological therapy will be signposted on to other more appropriate service(s);
- The services must be flexible and adapt to any emerging new commissioning priorities, for example primary care talking therapy hubs;
- Clinical Outcomes in Routine Evaluation (CORE) will be used to assess outcomes for service clients and this must be reported back to the commissioner in a set format;
- The services will be specific to the needs of the Lifeline client group and will not duplicate any other service commissioned through Health and Social Care in Northern Ireland;
- The services will not be offered to clients currently in receipt of psychological therapy from any other statutory or voluntary, community agencies or on a waiting list for such services;
- The services will enable and empower service users and avoid fostering dependency;
- Psychological therapy services will be commissioned with the face to face de-escalation support service and complementary therapies.

Question 2 (a) Do you agree with the proposed Lifeline Psychological Therapy service as outlined above? *Please delete as appropriate

***YES / **NO** / NOT SURE**

Question 2 (b) please explain your answer (no more than 200 words)

In response to this question we are answering that we do not agree with the proposed Lifeline Psychological Therapy service for the following reasons:

- We are concerned about the proposal to separate what is currently a regional coordinated service into a service managed by the ambulance service regionally but within this element of the service having multiple service providers within each trust area delivering this part of the contract. This has potential to cause different levels and qualities of experience of the psychological therapy service between organisations providing the service.
- How will communication, sharing of information and inter trust referrals between several trust service providers be managed? We are concerned and believe more information is required re response times and communication plans before we can make an informed decision.
- The proposed element of this service does not provide confidence for us as service providers with confidence that clients will be appropriately supported by the new model proposed – as quality of service may differ across trusts based on service provider experience
- Methods of delivery to clients through this element of the model is unclearly presented for us to make an informed decision
- There does not appear to be any service user PPI evidenced in the consultation proposed model

3. Proposed Follow-on Support Services: Complementary Therapy

The term 'complementary therapy' is used for a diverse group of therapies which support and complement other treatment and support services. It is important to note that the definition in this context includes reflexology, aromatherapy and body massage. It does not include other therapies which would be considered more invasive, such as acupuncture, herbal remedies, homeopathy and so forth. Whilst the Royal College of Psychiatrists highlight the lack of robust evidence on the effectiveness of complementary therapies, it does acknowledge that many patients report that they find them helpful in managing anxiety and depression. Local experience has also pointed to the benefit in helping individuals reach a stage where they are able to engage in other services. In these circumstances, it is proposed that the psychological therapy provider will also be able to offer up to a maximum of two sessions of complementary therapies to support the individual deal with their current state of distress and anxiety and enable them to commence psychological therapy.

The primary elements of the proposed complementary therapy service are that:

- The provision of complementary therapies will be accessed via the psychological therapy provider;
- The complementary therapies will be commissioned with the psychological therapy services in each Local Commissioning Group/Trust area;
- Complementary therapies must meet the required quality standards.

Question 3 (a) Do you agree with the proposed Complementary Therapy element as outlined above? *Please delete as appropriate

***YES / **NO** / NOT SURE**

Question 3 (b) Please explain your answer (no more than 200 words)

In response to this question we are answering that we do not agree with the proposed Lifeline Complementary Therapy service for the following reasons:

- South Belfast welcomes complementary therapies being added into the proposed Lifeline service. Studies and direct experience from crisis response units in Glasgow; Turning Point Scotland has found that complementary therapies in had with psychological treatment enable clients to relax, sleep and take time out from the daily pressures affecting their lives.
We do however query if this element is crisis response or be more suitable at the next stage of support following de-escalation.
- We believe complementary therapies should be broader than those three listed as it does not consider individuals who perhaps have back issues or conditions prohibiting them from hands on therapies such as massage or reflexology
- Are two sessions appropriate? Is there evidence to demonstrate that a maximum of two sessions is appropriate as this service may not be appropriate for all? Some clients may not wish to avail? Other clients may find this more effective to begin psychological therapy.
- Again five different contracted service providers may provide different type of complementary therapies and experience. We recommend a core set of therapies are not agreed from the onset to be provider by services across the region.
- The financial budget set aside for these therapies minimal and may not meet demand. Therefore if referral into these therapies choose to be selective how will this decision be made
- There does not appear to be any service user PPI evidenced in the consultation proposed model

4. Proposed Follow-on Support Services: Face-to-Face de-escalation support services

The findings from the *Providing Meaningful Care* report have indicated that some vulnerable people will not access services such as primary care or mental health services, and some will not use crisis support lines. Some of those who have survived a suicide attempt have referred to the impromptu nature of their acts and how walking into a support service was the critical factor in saving their lives. This has also been the feedback from service providers who have referred to vulnerable individuals arriving in their premises in need of immediate assistance.

It is proposed that a Lifeline-contracted community support service will provide a face-to-face de-escalation service for those occasions where those at immediate risk of suicide or self-harm are not able to call the helpline. This element of the service would only be appropriate for a small number of service users. In these circumstances, appointed providers will:

- Provide immediate de-escalation and support the individual who is in crisis;
- If the individual is at immediate risk, the provider can make direct contact with the Northern Ireland Ambulance Service or the local Trust-based crisis response team;
- If it is considered that the individual requires support from the Lifeline Psychological Therapy services, then they will be signposted to the telephone helpline for an appropriate assessment. The provider can also ring the Lifeline service on behalf of the individual if necessary;

Question 4 (a) Do you agree with the proposed local face-to-face de-escalation service element of the new model? *Please delete as appropriate

***YES / NO / NOT SURE**

Question 4 (b) Please explain your answer (no more than 200 words)

In response to this question we are answering that we do not agree with the proposed Lifeline face to face de-escalation service for the following reasons:

- We feel there is not enough detailed information and evidence on the effectiveness that the proposed service could have for clients
- There is concern about accessibility to the service for clients:
 1. Location of the venue if provide in one or multiple communities of Belfast for example
 2. Transport – some clients may not be able to drive to access the service
 3. Client Choice – should be considered – If one service provider is contracted for element of the model – choice is not being supports
- We acknowledge service provider feedback – in south Belfast individuals have arrived in a range of premises such as churches, community centres, counselling organisations Samaritans etc.
- We have concerns about the provision of a community based walk in service – there is an increasing percentage of self harm presentations and suicidal ideation in Belfast Trust hospitals and other services – there is potential risk that individuals may see this community space as the de-escalation treatment space – could this unit meet the potential demand?
- We have concerns about how this service could be implemented safely across all Trust areas given the budgeted allocated to this element.
- This could potentially be an element of the service that could implement innovation – Contact has recommended a mobile crisis response unit to deescalate situations locally at the place the individual is

Proposed option for delivery of Lifeline Crisis Intervention Service

The full list of options considered is set out in Appendices 1 and 2. The Lifeline Strategic Outline Business Case identified **Option 10B** as the preferred option and it is therefore the proposed option for delivery of the future Lifeline Crisis Intervention Service:

- Option 10: “**A helpline, referral to emergency services and signposting to Lifeline evidence based/informed support services and provision for locality based face-to-face de-escalation in exceptional circumstances. One contract for helpline and five separate contracts for Lifeline evidence based/informed support services in line with Trusts areas.**”
- Option B: “**Directly commissioning of the Lifeline crisis helpline to be housed under the management of the Northern Ireland Ambulance Service.**”

5. Proposed model for Delivery of the Helpline Service: Direct commissioning from the Northern Ireland Ambulance Service

In the proposed approach, the Lifeline helpline service would be within the Northern Ireland Ambulance Service (NIAS) but staffed, operated and branded as Lifeline. NIAS would be commissioned directly to provide the Lifeline helpline service and would therefore be the organisation responsible for the safe and effective running of the helpline.

This option scored highly as Lifeline would then be fully integrated with other emergency and statutory services. It would therefore enable more seamless and immediate handover of callers who need emergency support from statutory services, including mental health crisis response teams, emergency departments and primary care. In addition, as a statutory organisation, NIAS has robust and established clinical, information and corporate governance arrangements. These give reassurance on the quality of care that would be provided and oversight of that care.

Having the helpline service based under the management of NIAS will provide:

- Integrated governance and clinical structures in place for immediate and appropriate response for people at risk;
- Systems for immediate handover to emergency services for those clients who are actively suicidal;
- Expertise in telephony interventions and support for people in crisis;
- Contingency backup as part of United Kingdom National Health Service;
- Existing working protocols with the Police Service Northern Ireland and HSC Trusts;
- A consistent region-wide resource.

Question 5(a) Do you agree with the proposed delivery model of commissioning the telephone helpline element of the service from the Northern Ireland Ambulance Service? *Please delete as appropriate.

***YES / **NO** / NOT SURE**

Question 5 (b) Please explain your answer (no more than 200 words)

- There is concern about the rigid system within statutory care and we believe that a provider such as a community / voluntary enables innovation and coordination between the crisis response service and onward follow up support and referrals to existing services contracted in local communities.
- We are unsure about how the decision to commission the service via the ambulance service fits with the core role of the ambulance team in providing emergency physical care to get individuals from point A to hospital emergency departments. Does NIAS have experienced in suicidal crisis support for the individual and family – can NIAS meet the potential demand of self harm support that requires an ambulance, de-escalation processes and appropriate care for individuals with ideation of suicide.
- There are concerns about the immediate response rate as the telephone service will separate immediate crisis support and follow up services between organisations rather than it remaining as a whole service for the client

6. Proposed model for Delivery of Follow-on Support Services: Procurement from non-HSC organisations based on five Local Commissioning Group boundaries

The proposed model is that follow-on support services would be provided by non-statutory providers procured through a tendering process. Services would be available in local communities across Northern Ireland.

Through this option, it is intended to develop sustainable, community-based, Lifeline support services through five separate local contracts which will promote choice, competition and build capacity. The contracts would be based on the five Local Commissioning Group/Trust boundaries.

This option would ensure that the regional helpline would be supported by services that would relate closely to the needs of local geographical areas across Northern Ireland. This would help to maximise local access, facilitate flexibility and promote sensitive and responsive services relevant to local client and community needs.

Question 6 (a) Do you agree with the proposed procurement of the Lifeline support services through competition from non-HSC organisations based on the five Local Commissioning Group/Trust boundaries? *Please delete as appropriate.

***YES / NO / NOT SURE**

Question 6 (b) Please explain your answer (*no more than 200 words*)

No – we believe that this service would be better placed with one regional service providing across all Trust areas to ensure consistency and coordination of the service for clients.

Splitting the service across many service providers will not meet local user need and would demonstrate a lack of standardisation and experience in the service will differ as service providers have differing methods. Quality and effectiveness of service may differ .

7. Anticipated Benefits of the Proposed Future Lifeline Model

The sections above have set out the proposed changes to the Lifeline service. The proposed changes aim to build on the strengths of the existing Lifeline service, but with a renewed emphasis on its core purpose as a 24/7 telephony service available for anyone in crisis, and follow-up through enablement and empowerment to recovery.

The telephone crisis helpline will also be enhanced by further investment in a range of locally based follow-on support services. The current Lifeline support service model had an average capacity for approximately 22,500 counselling sessions per year over the three years of the contract. An additional investment of £230,000 per year will expand capacity in psychological therapies, and introduce the new face to face de-escalation service, and complementary therapy services.

The proposed new model will therefore have capacity for:

- Up to 32,400 psychological therapy sessions – a 44% increase on current capacity;
- Approximately 6,500 complementary therapy sessions – as a new service;
- Approximately 5,400 face-to-face de-escalation session – as a new service.

Question 7 (a) Do you have any comments on the anticipated benefits?
***Please delete as appropriate**

***YES / NO / NOT SURE**

Question 7 (b) Please explain your answer *(no more than 200 words)*

- We are concerned about the small financial budget set aside for complimentary therapies across Northern Ireland. 6500 complementary therapy sessions have been allocated above – this means that this service will not be available for all clients across the region – consistency in service for all clients is important – how will this be share between trust – will be based on current demand in the service, population size etc?
- We cannot clearly see any benefits of the face to face de-escalation service based in the community – will this service cope with potential demand, will it be accessibility for all
- In 2013 according to NINAS statistics there were 8453 self harm presentations to Trust hospitals across Northern Ireland and in Belfast there were 2506 presentations of self harm for the same year – the de-escalation service only provides 5400 sessions – we have concerns about how the number of sessions were calculated and if this could meet demand within Trust areas?
- The telephone helpline is meant to be a crisis support service –at this stage of contact with an individual we in South Belfast feel it is not timely or appropriate at this stage of contact to empower individuals to take the next steps in their care – we feel this may further the risk to clients have taken a lot of courage to access the helpline at the early stage of requiring support.

8. Proposed Lifeline Marketing/Promotion and Evaluation

As the Lifeline branding currently applies to the full service, it is proposed that it should continue to apply to all elements of the proposed new service. The key elements will include:

- A distinct element of public communication/ awareness-raising and evaluation;
- The providers working closely with the Public Health Agency communications team to ensure consistency and appropriateness of messaging;
- The providers will be required to ensure that the Lifeline brand is used within strict adherence to the branding guidelines.

It is important that the Lifeline service is evaluated robustly to assess the impact, effectiveness, efficiency and value for money of the service. This will be undertaken through regular performance monitoring, and through specific service evaluations.

Question 8 (a) Do you agree with the proposed marketing/promotion and evaluation element of the Lifeline service model? *Please delete as appropriate

***YES / NO / NOT SURE**

Question 8 (b) Please explain your answer *(no more than 200 words)*

- We propose the evaluation should be completed by an external and independent evaluator with the extensive allocated budget set aside for this.- Perhaps RQIA could assist with this

9. Equality Impact Assessment

A full equality impact assessment has been carried out by the PHA on the proposed new Lifeline service and delivery mechanism as part of the consultation process. A copy of the assessment is available on the PHA website www.publichealth.hscni.net.

Question 9 (a) Can you identify any further equality, disability or Human Rights issues and, if so, any relevant supporting evidence? (no more than 200 words)

No

Question 9 (b) Do you think that the actions we are proposing to address the equality, disability or Human Rights issues will be sufficient? (no more than 200 words)

No

Question 9 (c) Do you have any suggestions for further actions to address any of these issues? (no more than 200 words)

No

10. Additional Comments

Question 10 (a) In addition to your responses to questions 1-9, we would welcome any other comments that you may wish to make about the proposed new Lifeline service.

(no more than 200 words)

No

11. Are you responding as (please tick one of the following options)?

An individual

Representative of a community or voluntary organisation

Representative of a Health & Social Care organisation

Representative of another Statutory Body

Representative of another type of organisation, please specify type:_____

If responding on behalf of any organisation, please specify the name of the organisation:

South Belfast Partnership Board and South Belfast Community Response Plan to Suicide Group

11. Timescales

The timescales are:

- Consultation period 1pm, 27 August 2015, to 1pm, 19 November 2015
- Review findings of the consultation and report to the PHA Board by 17 December 2015
- Publish a report on the findings of the consultation by 31 December 2015
- Estimated procurement process commences 1 February 2016
- Estimated formally appointment of providers by June 2016
- Estimated new service operational 1 October 2016.

12. Consultation Process and Privacy Statement

Freedom of Information Act (2000) – Confidentiality of Consultations

The PHA will publish a summary of responses following completion of the consultation process on the corporate website. Your response, and all other responses to the consultation, may be disclosed on request. The PHA can only refuse to disclose information in exceptional circumstances. **Before** you submit your response, please read the paragraphs below on the confidentiality of consultations and they will give you guidance on the legal position about any information given by you in response to this consultation.

The Freedom of Information Act gives the public a right of access to any information held by a public authority, namely, the PHA in this case. This right of access to information includes information provided in response to a consultation. The PHA cannot automatically consider as confidential information supplied to it in response to a consultation. However, it does have the responsibility to decide whether any information provided by you in response to this consultation, including information about your identity should be made public or be treated as confidential.

This means that information provided by you in response to the consultation is unlikely to be treated as confidential, except in very particular circumstances. The Lord Chancellor's Code of Practice on the Freedom of Information Act provides that:

- The Public Health Agency should only accept information from third parties in confidence if it is necessary to obtain that information in connection with the exercise of any of the PHA's functions and it would not otherwise be provided;
- The Public Health Agency should not agree to hold information received from third parties "in confidence" which is not confidential in nature;
- Acceptance by the Public Health Agency of confidentiality provisions must be for good reasons, capable of being justified to the Information Commissioner.

For further information about confidentiality of responses please contact the Information Commissioner's Office or see web site at:
<http://www.informationcommissioner.gov.uk>

Thank you for taking the time to complete and return this questionnaire. We very much value your input.

If you have any questions about this questionnaire, or the consultation process, or if you require this document in an alternative format (such as large print, Braille, disk, audio file, audio cassette, Easy Read or in minority languages) please contact:

**Elizabeth McGrath, Health Improvement Officer, Public Health Agency,
Towerhill, Armagh BT61 9DR.**

Telephone: (028) 9536 3454 or email: liz.mcgrath@hscni.net.

Appendix: 1

Detailed Summary of Each Service Model

Option	Title	Description
1.	Status Quo (Do nothing)	Under this option the existing service model, ie the provision of the telephone helpline and support counselling services through one regional contract with a single provider, would be continued and retendered.
2.	Do minimum (Cease Lifeline helpline and wraparound services completely)	Under this option the existing Lifeline service (telephone helpline and wraparound services) would be terminated at the end of the current Lifeline contract. There would therefore be no dedicated Lifeline helpline for those at immediate risk of suicide or self-harm in Northern Ireland, nor any associated support services. The existing 'Lifeline' budget would be reallocated across a range of other existing PHA priorities within the suicide prevention strategy.
3.	Single regional Lifeline helpline with signposting only to other existing services	Under this option a regional Lifeline helpline service would continue to be commissioned, however the helpline would be 'stand-alone'. Call-operators would 'de-escalate' callers. They would not refer callers into any other relevant services (ie no referrals on to emergency services). The helpline service would only signpost callers to other appropriate existing services. Once the helpline service has been costed, the balance of the existing 'Lifeline' budget would be reallocated across a range of other existing PHA priorities within the suicide prevention strategy.
4.	Single regional Lifeline helpline with NO referrals or signposting	Under this option a regional Lifeline helpline service would continue to be commissioned, however the helpline would be 'stand-alone'. Call-operators would listen and 'de-escalate' callers. Callers would neither be referred to any services (including no referrals to emergency services) nor would they be signposted to other appropriate services. Once the helpline service has been costed, the balance of the existing 'Lifeline' budget would be reallocated across a range of other existing PHA priorities within the suicide prevention strategy.
5.	Single regional Lifeline helpline with agreed referral pathways to	Under this option a regional Lifeline helpline service would continue to be commissioned, however the helpline would be 'stand-alone'.

	emergency services and signposting to other existing services	Call-operators would listen and 'de-escalate' callers. Callers could be referred to emergency services, or signposted to other appropriate existing services. Once the helpline service has been costed, the balance of the existing 'Lifeline' budget would be reallocated across a range of other existing PHA priorities within the suicide prevention strategy.
6.	Single regional Lifeline helpline with referral to an associated regional evidence based/informed service, as separate but integrated services, through two distinct regional contracts	This option would provide a regional Lifeline helpline as a single service under a distinct contract. However, alongside it a separate single regional contract would be put in place for Lifeline evidence based/informed services. The helpline would triage, assess and de-escalate callers as above. Callers at immediate risk of suicide or self-harm would be referred to emergency services. Clients, not at immediate risk, but meeting the agreed criteria would be referred to the Lifeline evidence based/informed service provider or to other statutory or voluntary/community services (in line with agreed pathways and protocols). As above, callers not meeting the criteria for referral would be signposted to other relevant services.
7.	Single regional Lifeline helpline with referral to associated local evidence based/informed services, as separate but integrated services, through at least six distinct contracts	This option would be the same as option 6 above, however while there would be one single regional helpline, rather than having one single regional Lifeline evidence based/informed services provider, the provision of these services would be separated into at least five lots, according to the five Trust areas.
8.	Single regional Lifeline helpline and a range of associated services, including a physical safe place and assertive outreach	This option would provide for a single regional helpline (as a separate contract), with associated, but separate distinct contracts for a physical safe place, assertive outreach and counselling under 'Lifeline'. Callers would be triaged, assessed through the helpline, where possible they would be de-escalated through the helpline, or where appropriate referred for immediate access to the Lifeline 'safe place' or to Lifeline assertive outreach or to emergency services, if appropriate. Callers not meeting the criteria for these would be signposted to appropriate services.
9.	Single regional Lifeline helpline, referral to emergency services	This option would provide for a single regional helpline (as a separate contract), with an associated, but separate distinct single regional

	<p>and signposting to associated evidence based/informed services (regional contract) with provision for locality based incidental de-escalation in exceptional circumstances.</p>	<p>contract for relevant evidence based and/or informed interventions. Callers to the helpline would be triaged, assessed and where appropriate de-escalated and if appropriate referred to emergency services. Callers at immediate risk of suicide or self-harm but not meeting the criteria for emergency services would be signposted to the appropriate evidence based/informed interventions, (to the services funded through the Lifeline budget, or to other existing services as appropriate). The helpline would also, by exception, be able to connect a specified group of clients with appropriate services. Provision would be available, by exception, for incidental de-escalation (for those unable to directly access the service through the helpline), on a locality basis across each Trust area.</p>
10.	<p>Single regional Lifeline helpline, referral to emergency services and signposting to associated evidence based/informed services (at least 5 contracts in line with Local Commissioning Group/Trust areas) and provision for locality based incidental de-escalation in exceptional circumstances.</p>	<p>This option would be the same as option 10 above, however rather than one single regional contract for 'evidence based/informed services', the provision of these services would be separated into at least 5 lots covering the 5 Local Commissioning Group/Trust areas. The helpline would also, by exception, be able to connect a specified group of clients with appropriate services. Provision would be available, by exception, for incidental de-escalation (for those unable to directly access the service through the helpline), on a locality basis across each Trust area.</p>

Appendix: 2

Detailed Summary of Delivery Mechanisms

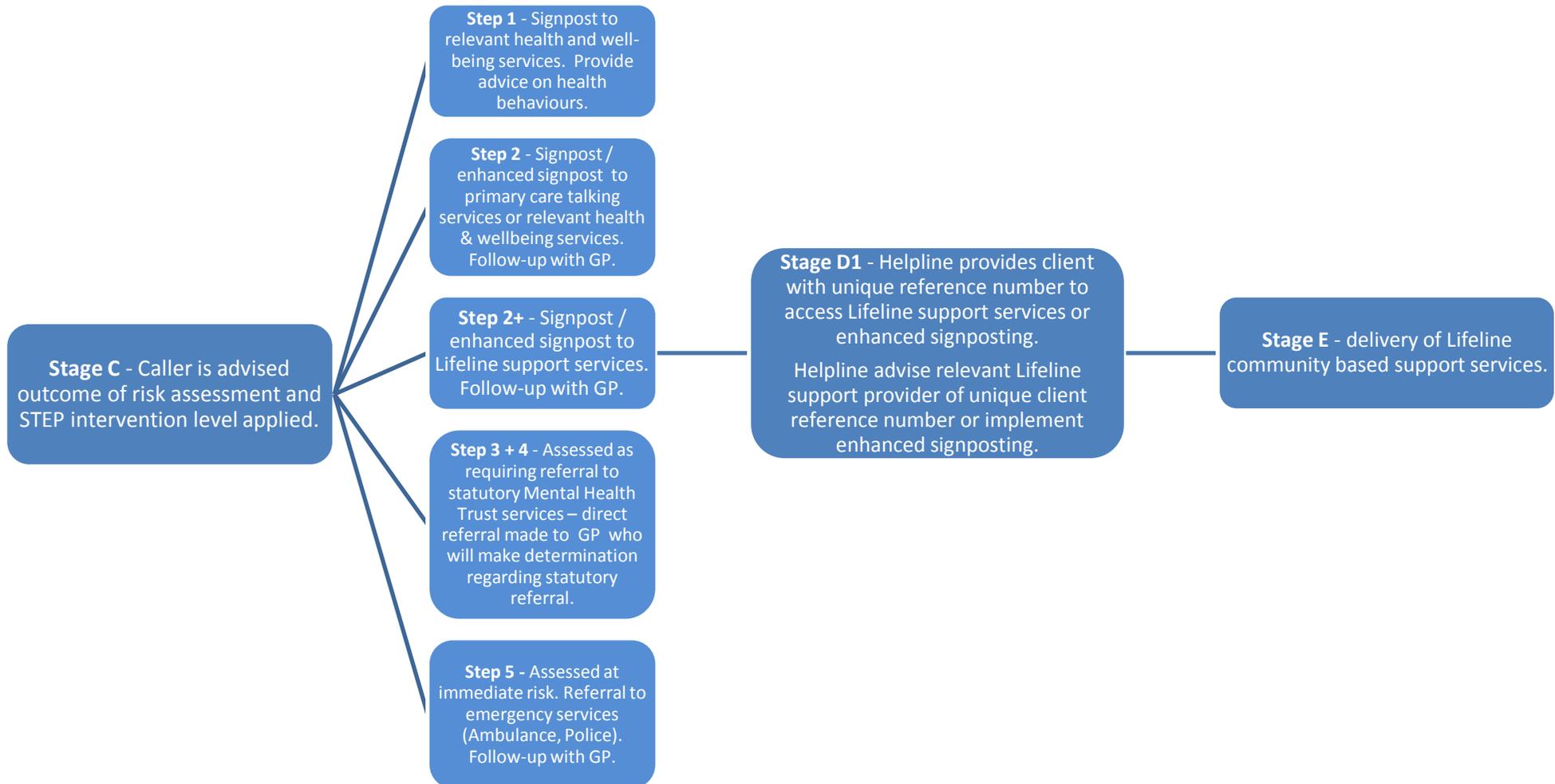
Option	Title	Description
A	Procurement of the Lifeline helpline service	Under this option the regional Lifeline helpline service would be taken forward through a procurement process, seeking tenders from non HSC organisations with adjudication and the award of contract in line with procurement regulations.
B	Commissioning of the Lifeline helpline from an existing HSC Trust	Under this option the regional Lifeline helpline would be directly commissioned from one HSC Trust, to facilitate referral and immediate 'hand over' in those instances where a caller is actively suicidal and where immediate intervention is required to prevent death or serious physical harm. The NI Ambulance Service (NIAS) is the only Trust to be considered as it is a regional Trust and has existing crisis telephony infrastructure and expertise.
C	Procurement of support services	Under this option the evidence based/informed services would be taken forward through a procurement process, seeking tenders from non HSC organisations, with adjudication and the award of contract in line with procurement regulations.
D	Commission support services directly from HSC Trusts	Under this option the support services would be directly commissioned from HSC Trusts.

Appendix: 3

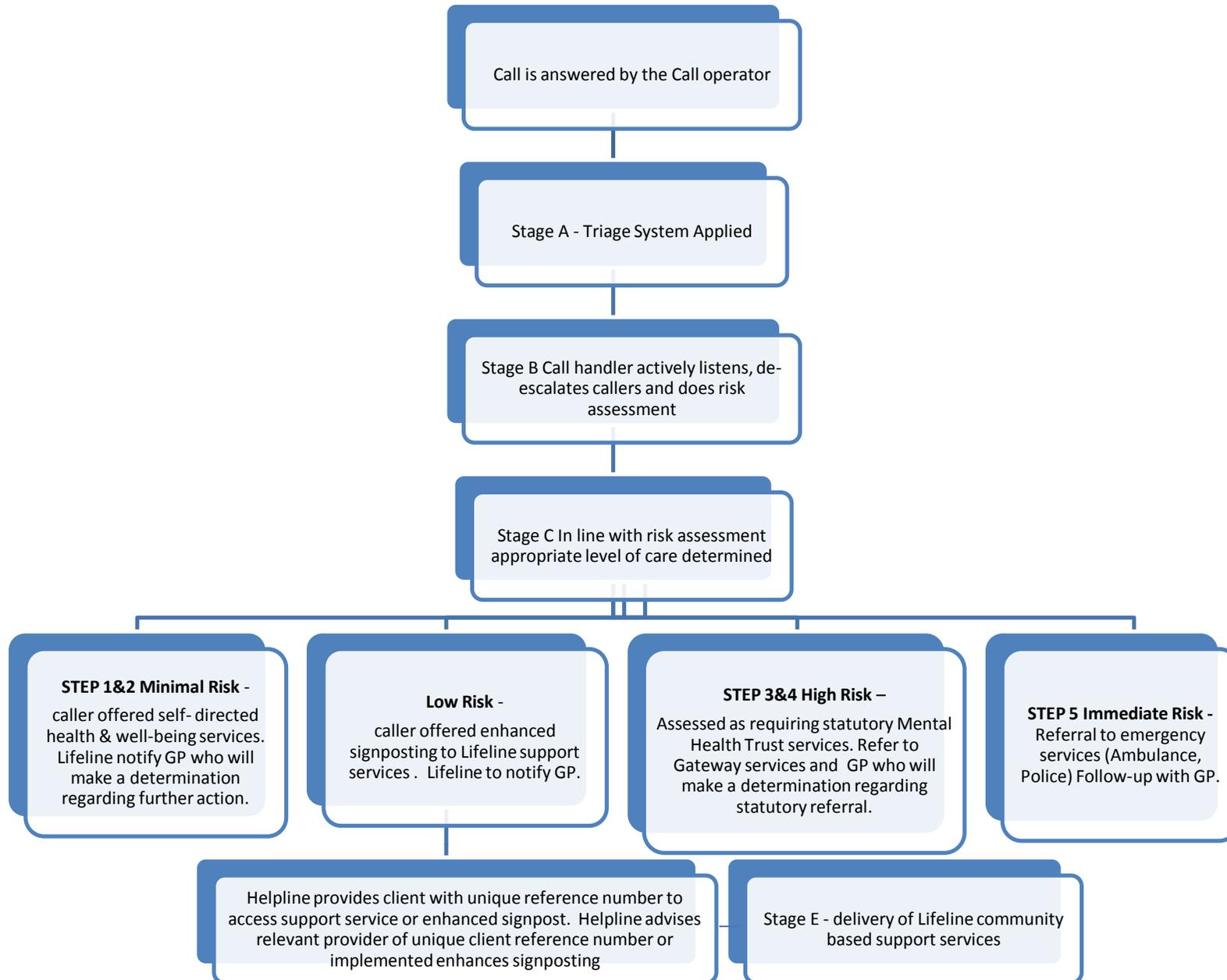
Care Pathway for Adult Caller

The telephone helpline will remain the primary access point for the Lifeline service. Appendix 3 outlines the care pathway for adult callers to the helpline and is consistent with PHA/HSCB Regional Psychological Therapies Mental Health Services Threshold Criteria, 2014; National Institute for Health & Care Excellence (NICE) clinical guidelines and the NI Regional Protection Children and Vulnerable Adult Policies and Procedures. Appendix 4 outlines the care pathway for a child and young person (C&YP) caller to the Lifeline helpline.

Appendix: 3 The care pathway for adult caller to the helpline.



Appendix: 4 Care pathway for a child and young person (C&YP) caller to the Lifeline helpline.



Glossary of Terms

Care pathway – a route to help a person to move through the different services they may need.

Commissioning – the term used for the process of planning and buying services from a health and social care Trust, rather than going to public procurement through a tendering process.

Community Based Psychological Therapies (CBPT) – also known as talking therapies. These are recognised psychological methods used to help a person develop skills in how to change their thoughts, feelings and emotions. They have been shown to help people with conditions like anxiety, depression, and phobias.

Complementary therapies – these are services that are complementary to treatment services to help people engage in treatment. These include reflexology, aromatherapy and body massage. ‘Alternative therapies’ including acupuncture, herbal remedies, homeopathy etc are not included.

De-escalation – the process of talking to a person to calm them and reduce their acute distress.

Enablement and empowerment – enablement is an assertive approach to help a person take more control of their own feelings and actions. It reduces the sense of lack of control and helplessness, and dependency on services that users have developed after long-term interactions with the mental health system. Empowerment includes the ability to act as an independent agent, a willingness to step outside safe routines, and a willingness to take responsibility for a person’s own actions.

Evidence-based practice – these are interventions that have been shown through research to improve outcomes for patients/clients.

Primary care talking therapy hubs – this is a new model being commissioned by the Health and Social Care Board in Northern Ireland for the treatment of people with common mental health problems that do not meet the threshold for a referral to a Trust mental health service. The hub helps to coordinate care for a person.

Procurement – describes the process of planning and buying services through the process of public procurement from the wider market, in line with the Department of Finance and Personnel's Public Procurement Guidelines.

Recovery – the phase of a person recovering from their mental health crisis.

Referral – request by the helpline operator for immediate assistance/intervention for a caller if they are assessed as being at high risk of suicide.

Risk-assessment – the process used by a trained clinical practitioner to assess a person's risk of suicide, self-harm, or other mental health crisis. It involves talking to the person to understand their personal and social history, thoughts, feelings, actions, medications, and other relevant details. It requires significant clinical skills and experience, and the outcome of the risk assessment determines the next stage of care.

Self-harm – a person harms themselves but not fatally.

Stepped care – is the description of the model used by health and social care to organise services to provide care that is tailored to an individual's needs and in line with self-help and recovery approaches.

Signposting – information is provided to a caller to enable them to contact a service for further support. It places responsibility for contacting the further support service with the caller as this empowers them to take control of their own health. For a small number of callers who have communication difficulties, or who may need assistance for other reasons, the helpline staff would provide enhanced signposting where they would be more involved in assisting the person to access the support service.

Triage – the process of determining the degree of urgency of care needed and/or risk, for example, urgent or routine. It is used to ensure that people at highest risk to health are prioritised and receive care promptly.

Virtual safe place – is used to describe how a crisis helpline can be used as a 'place of safety' as it provides telephone-based de-escalation and support for a person in crisis, but which is not an actual physical building.