LIFELINE CRISIS RESPONSE SERVICE

Consultation Report

A summary of the feedback to the Public Health Agency's public consultation process on the Lifeline Crisis Response Service

August 2014

Contents

1.0 Background

Lifeline is a free-to-call Northern Ireland regional confidential telephone helpline for people who are experiencing emotional crisis and who are at risk of suicide. The service is commissioned as part of the Northern Ireland Suicide Prevention Strategy – Protect Life.

In 2007 the then Health Minister, announced the establishment of a pilot 24/7 Crisis Response Telephone Helpline. The helpline was initially piloted in one area of Belfast for the under 25s. In 2008 a decision was then taken to expand the service to include access across all of Northern Ireland, for all age groups and was to be strengthened by the provision of additional face-to-face support services for people in crisis.

The overall aim of the helpline is to provide additional support to all people in crisis across Northern Ireland, thereby helping to reduce the levels of suicide and self-harm. The Northern Ireland crisis response helpline is promoted as LIFELINE.

During the first regional contract period 2008 to 2012 the range of support services were increased to include services such as complementary therapies, befriending, mentoring alongside face to face counselling. This service became known as 'wraparound services'. The wraparound services were provided directly by the contract service provider who also sub-contracted wraparound support from a variety of other community & voluntary organisations across Northern Ireland.

At the time of mainstreaming the service in 2008, there had been no evaluation of the initial pilot service. When the Public Health Agency (PHA) took over the contract in 2010, one of the first priorities in respect of the contract was an assessment of the effectiveness of the service, in order to inform the project and performance management as well as future commissioning. The PHA undertook a pilot of the process to evaluate outcomes for

Lifeline clients and found that when comparing talking therapies with complementary therapies; talking therapy proved more effective.

As a result of these findings, and in order to focus the resources on those at greatest risk, the service specification was changed to a telephone helpline service with referral into talking therapies only. The contract was re-tendered in 2011/12 through public procurement and the existing provider (Contact) was successful in securing the contract.

The contract specification was based on best evidence available at that time, gathered from raw data for the 2008-12 contract and focused on service demand and level of engagement required with callers. The latter was noted as “Active Calls”, defined as those interactions on the telephone that required a qualified counsellor to directly engage with a caller in crisis, or a third party ringing on behalf of another individual.

Whereas the crisis service was based on a short term intervention approach, there was provision for the telephone helpline to refer appropriately assessed individuals into talking therapies. The volume of referrals into counselling was based on previous data from those assessed as active calls.

The contract was initially awarded for the three year period 2012-15 with the provision of an 18 months extension dependant on finance, performance and outcomes evaluations. The total value of the contract was for £3.48M pa

The contract specification invited bidders to consider their contract costings based on three levels of both telephone demand and access to talking therapies. These activity levels were based on the information that was available to the PHA in 2011.

The activity levels were:

Telephone calls levels:

- 1 – 999 Active Telephone Calls per Week
- 1000 – 1499 Active Telephone Calls Per Week
- 1500+ Active Telephone Calls Per Week

Counselling sessions per levels:

- 1 – 399 Counselling Sessions Per Week
- 400 – 499 Counselling Sessions Per Week
- 500+ Counselling Sessions Per Week

Bidders were asked to provide costings across the above ranges. It was also highlighted (based on past performance) that the upper limit was 1500 calls per week and 500 counselling sessions – these could be surpassed as long as the contract value did not exceed £3.5M p.a.

In 2013/14 the PHA began the review process to determine if the current contract and service model should be rolled forward in line with the contract provision of up to 18 months and if so for what period of time. The PHA was also keen to examine how the service could be developed in the future in order to ensure that the service provided was the most appropriate service for those at risk of self-harm and/or suicide and that it was clinically safe.

To support this process a number of actions were undertaken, namely:

- A performance review in terms of KPIs, budgets and contractual arrangements;
- An independent clinical review;

- A public consultation process on the current contract and future options.

This report is a summary of the feedback from the public consultation process.

2.0 Public Consultation Process

The framework for the consultation was set within the current remit for the service and the budget of £3.5M per annum. The consultation process also acknowledged and built on the wider engagement process which was been undertaken by the Department of Health, Social Services and Public Safety (DHSSPS) at that time in terms of the future of the wider suicide prevention strategy – Protect Life.

The consultation process was approved by the PHA Management Team and ran for a period 12 weeks from 1 April 2014 to 24 June 2014.

The methodology was to develop a context paper which outlined the history of the contract and reported on the actual performance based on available data as at 31 January 2014 (see Appendix I). The context paper was accompanied by structured questionnaire which sought to focus respondents' views on some key aspects of the contract, as well as providing an opportunity for respondents to outline the potential development or enhancement of the service, (see Appendix II).

An Equality Screening and human rights screening template was completed for the consultation process which identified key stakeholder groups, (see Appendix III). The context paper, questionnaire and equality screening and human rights papers were uploaded onto the PHA website on the 31 March 2014.

The PHA then circulated notice of the consultation process to over 150 key stakeholder groups and organisations on its databases and made staff available to attend a series of workshops to discuss the current service design, performance and future options.

Throughout the consultation process, the PHA presented at 14 workshops (see Appendix IV) in various locations across Northern Ireland. A standard presentation (see Appendix V) was given at each event which covered the following key points:

- Focus of the consultation i.e. the Lifeline service rather than service provider;
- The current contract duration, scheduled to end 31 March 2015 and the fact that PHA was keen to engage with relevant

stakeholders to ensure that the future service specification is appropriately informed in order to secure future services that are fit for purpose;

- The consultation process sought feedback from key stakeholders to inform the decision making process on the future of the Lifeline Crisis Response Service;
- The history/background to the contract design and commissioning;
- The contract terms and conditions, specifically that the contract was initially awarded for a three year period 2012-15 with the provision of an 18 months extension, dependant on finance, performance and outcome evaluation. The total value of the contract is £10.48 million for the three year term;
- A summary of the call demand and trends in referrals into counselling as part of the Lifeline Service;
- A summary of performance of the current contract against the Key Performance Indicators;
- An outline of the communications and PR commitments;
- An overview of the contract management arrangements; and
- Key challenges and considerations that respondents needed to consider about any future service.

The PHA was particularly keen to ensure that there was feedback from individuals and/or organisations that had received support from or directly worked with the Lifeline service.

A request to extend the contract consultation period until October 2014 had been proposed by the current provider to the Suicide Strategy Implementation Board (SSIB), however, it was agreed that the 12 week period was reasonable and given that a decision on contract roll forward would be required no later than December 2014, to extend beyond the planned period would delay any future decision making and potential

procurement processes. However, a commitment was given to include any submissions that came shortly after the closing date.

Respondents were invited to complete a structured questionnaire (see Appendix II) which sought to ascertain:

- their previous experience of the Lifeline service;
- views on the current model;
- views on what an ideal service would include;
- prioritisation of service model given budget constraints;
- how the service should/could work with other service providers in the sector.

As part of the presentation, it was made clear that the feedback from the consultation process would be one of a number of factors that would influence the decision making process on the contract roll forward and any future redesign. Other factors that had to be taken into consideration included:

- Performance review;
- Contract management experience and accountability;
- Findings of the independent clinical review;
- Outcomes evaluation from clients;
- Budget availability and value for money;
- Best practice elsewhere.

The Department of Justice sought a separate meeting on the issue of a crisis helpline, rather than completing the standard questionnaire. It was DOJ's view that given the fact that their services targeted a very specific population group (the prison population) in Northern Ireland the questionnaire did not provide sufficient opportunity to focus on this group's particular needs.

The PHA then assimilated the responses into key themes and incorporated into a summary format providing an overview of the findings.

3.0 Feedback from Consultation

There were a variety of responses to the questionnaire (see Appendix II) and this section of the report provides a summary of those inputs. It is important to note that this report does not drawn on any conclusions as its primary purpose is to report on the commentary and the feedback. This information will be used to inform and support the wider decision making process on the future contract extension and/or any future business case and/or procurement process.

3.1 Introduction

A total of 154 responses were received by the (PHA) during the consultation period. It is worth noting that eight of the responses were received from respondents outside of Northern Ireland. These responses will be reported on separately, since they are distinct from those individuals and organisations from within Northern Ireland that mostly will have direct experience of the service. Single quotation marks and italics have been used to identify when direct quotes from respondents have been used.

A small number of respondents (n=3) changed the question in column two, question six, (see Appendix II) from 48 hours to 'within one week' resulting in their responses for this question being excluded in figure 8. It was also noted that a small number of respondents (n=3) submitted completed questionnaires with exactly the same comments. The responses appear to have been 'cut and paste' from a master copy. In the analysis of the questionnaires, individual responses have been included, while in the text commentary (n=3) are referred to as 'respondents with exactly the same response'.

A separate section will report back on the issue of the Lifeline service in the prisons, given that this is a specifically vulnerable population and was referred to by a number of respondents.

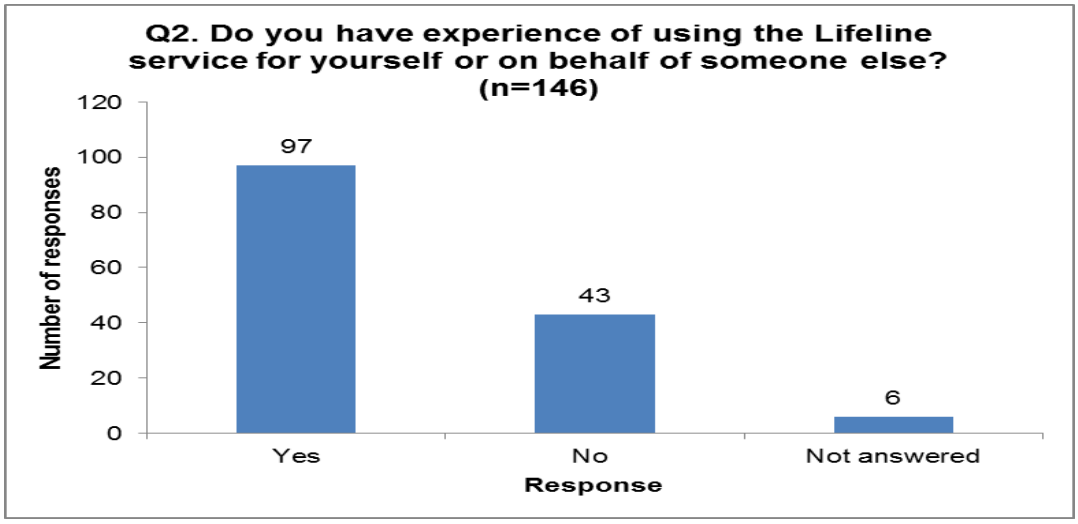
3.2 Summary of Respondents

The initial questions sought to gather background information about the respondent in terms of their organisations' constituted structure and experience of the Lifeline service.

As stated earlier, there were a total of 146 responses from within Northern Ireland: 57 responses from individuals; 66 responses from representatives of community and voluntary organisations; 13 responses from Health & Social Care organisations; 6 responses from other statutory bodies, and four 'other'. Of the four 'other' responses; two were received from the education sector; one from the sports sector; and one anonymous response.

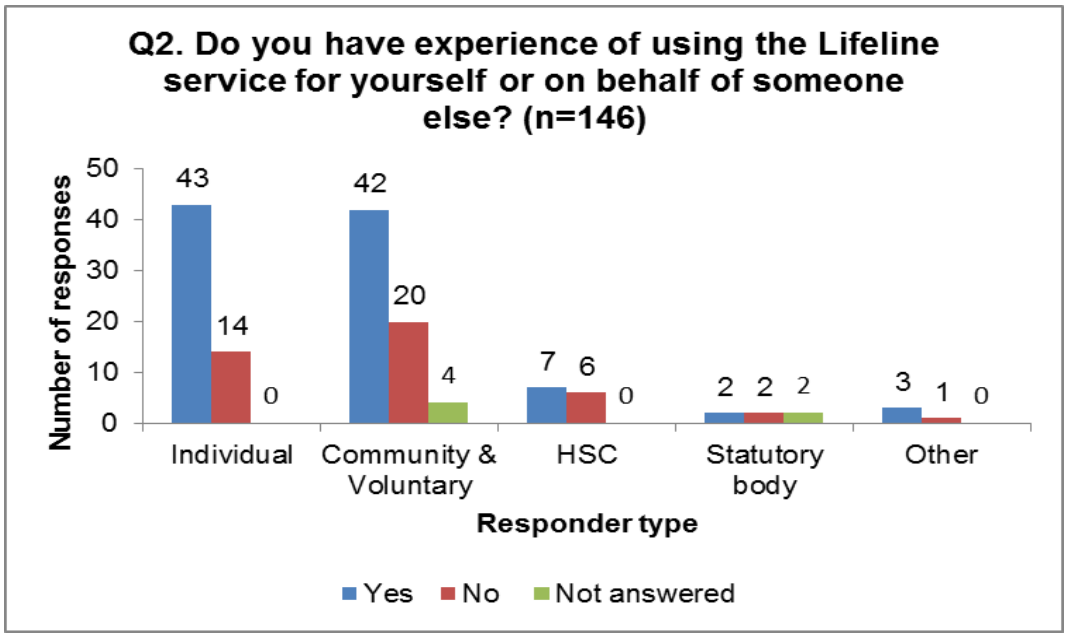
Almost two thirds of those who responded to the questionnaire indicated that they had direct experience of the Lifeline Service, while 31% (n=43) had no experience, see Figure 1 below.

Figure 1: Summary of experience of using the Lifeline service



Three quarters of individuals who responded were either service users or carers of someone who used the service. Almost two thirds (n=42) of community and voluntary groups who responded also indicated that they had direct experience of using the Lifeline service, see Figure 2 below.

Figure 2: Summary of experience of using the Lifeline service by organisation status.

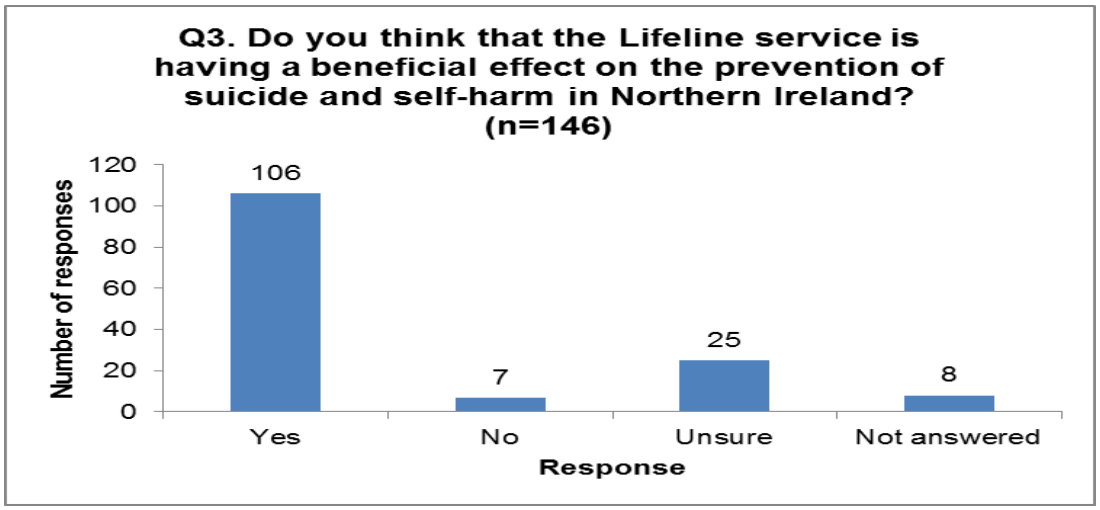


3.3 Summary of Responses on the Impact on Suicide and Self Harm

As the Lifeline Crisis Response service was funded under the Northern Ireland Suicide Prevention Strategy – Protect Life, the PHA were keen to ascertain the views of respondents on its effectiveness in addressing the issues of self-harm and suicide.

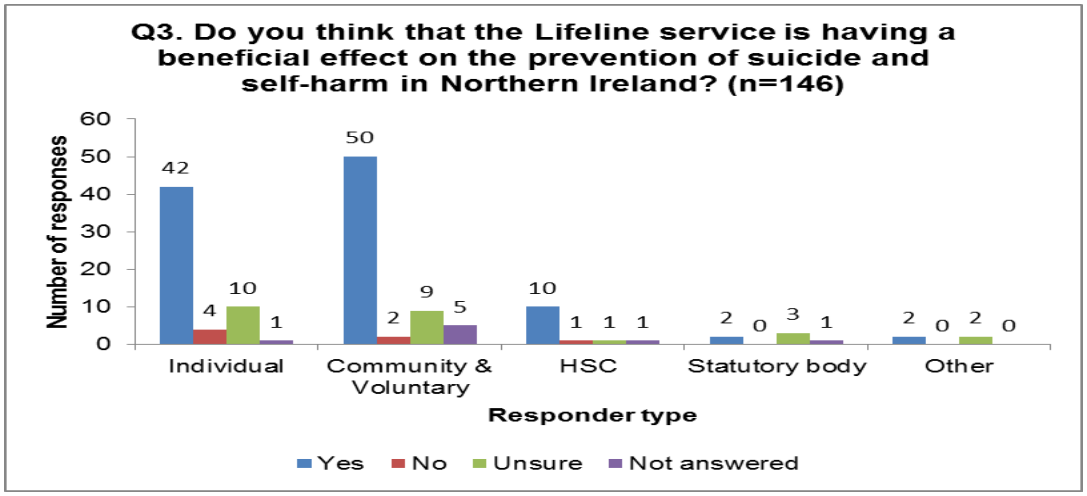
The majority of respondents felt that the service did have a positive impact on suicide and self-harm prevalence. Almost three quarters (73%) of respondents felt that the service was having a beneficial effect, 5% of respondents indicated that they did not think it was having a beneficial effect, 17% were unsure and further 5% did not answer the question, see Figure 3 below.

Figure 3: Summary of views in terms of beneficial effect on the prevention of suicide and self-harm.



In terms of the background of respondents, some 74% of individual respondents felt that the service had a beneficial effect on prevalence rates of self-harm and suicide, as did 76% of community & voluntary sector respondents, 77% of health & social care respondents, 33% of other statutory bodies and 50% of other respondents, see Figure 4 below.

Figure 4: Summary of views on beneficial effect on the prevention of suicide and self-harm in Northern Ireland by constituted status.



Some 88% of respondents (n=128) recorded narrative comments in response to the question about the impact of the Lifeline service on rates of self-harm and suicide. It was noted that a small number of respondents (n=3) submitted exactly the same response.

Whereas there was generally widespread support for the view that the service was beneficial, some respondents commented that they were unsure if the service is actually having a beneficial impact as they felt there was '***no clear evidence base'***. One respondent noted that they were unable to access any independent evaluation of the service on which to make an assessment. However it was also acknowledged that while statistics indicate no significant reduction in the number of suicides in Northern Ireland, it would be difficult to measure the benefits of Lifeline in isolation to the range of Protect Life initiatives as the '***prevention of suicide and self harm is a very complex issue due to the diverse bio psycho social factors involved'***.

The respondents, who had submitted exactly the same response (n=3), reported that, '***independently verified Lifeline clinical outcome measures have clearly indicated consistent significant benefit from Lifeline'***.

Other respondents raised concern that there was '***insufficient data'*** and ambiguity about performance definitions such as 'active' call and 'level of risk' which made it difficult to determine the appropriateness and benefit of usage. Some respondents recommended that methods for clients to evaluate the impact of interventions on their behaviour would be a useful mechanism for measuring the benefit given the level of investment in the Lifeline service.

The benefits of the Lifeline service that were identified by respondents can be described as:

- an accessible & responsive crisis service;
- free/no charge;
- the confidentially element;
- additional signposting to supportive services;
- the check-in service, and
- the provision of 'long term empathic support'.

One respondent noted that; '***talking helps, and talking about suicide helps to prevent people from acting on their thoughts of suicide'***.

A number of respondents described the benefit of being able to signpost to a Lifeline service where clients felt that they did not have to, '***contain their crisis 9-5 Monday to Friday'***. It was reported that particular groups, such as young people, find the anonymity of the helpline service beneficial while others noted the benefit of immediate access. One comment referred to the view that many of the community & voluntary and statutory counselling providers have long waiting lists and the Lifeline service often provides the immediate support needed for vulnerable people.

There was general agreement that the experience and knowledge of the Lifeline call handlers was an important element of the service, that they are able to, '***talk people down from a position of contemplation to pre-contemplation***'.

Many respondents recorded a positive experience of Lifeline counsellors, describing them as, '***compassionate and caring'***, with a '***professional diligent approach towards clients***' and with effective relationships both with emergency services and mental health services. One respondent raised concern that Lifeline was using, '***unqualified staff'*** noting that all services should be delivered by, '***appropriately qualified staff with a baseline standard for all practitioners of a diploma and working towards accreditation***'.

Respondents were divided in their personal experience of the Lifeline service. There were a number of positive comments; ***'Lifeline has kept me alive on many occasions. It has also helped me to reduce my self-harm and at times to delay it completely. They have empowered me to find better, healthier ways to cope when my feelings overwhelm me***'.

Another respondent noted, '***Lifeline provides an essential service, particularly to those in crisis who do not have a diagnosable and treatable mental health condition'.***

One of the organisations who responded noted that Lifeline had helped many of their service users get to a place of safety when they have been in crisis.

Other respondents described a negative experience of engaging with the Lifeline service. There were a number of concerns raised about the difficulty in getting through on telephone; one respondent reported that more than 10 of their clients told them that they couldn't get through when they phoned the service.

There was also concern that Lifeline had developed into a, ***'call centre rather than a crisis helpline***'. A number of respondents noted that previously Lifeline had signposted/referred to local organisations and that this did not happen anymore, as Lifeline had '***expanded internally'*** and become what they considered to as a '***one stop service***'.

It was noted, by a few respondents, that Lifeline counselling had been the only service offered and that they felt pressurised into accepting Lifeline counselling, ***'I was subjected to a full assessment and offer of counselling despite telling the counsellor I was already in counselling'***.

In this context one respondent quoted the BACP Ethical Framework, '***the right of the person to make his/her own choices and decisions without undue influence or pressure, the commitment to do only what is good and right for the person and the resolve not to hurt the person in any way***'.

Some respondents complained about the of lack of face to face counselling provision in their rural localities while others respondents raised concern that Lifeline was replicating counselling in areas already adequately resourced. There was concern regarding how the Lifeline service provider is managing demand and performance. One respondent described their experience as phone calls which were not always answered and that more phone lines and/or staff were needed. There was a view expressed that a central contact point was needed

where feedback relating to the experience of the Lifeline service could be directed.

A carer described a negative experience that related to the clinical practices of the service. They reported that during a counselling session their family member was reportedly taken back to a traumatic event in their childhood. The impact had very detrimental consequences to the person's mental and emotional state. The carer felt the service user was left with '***no tools'*** to deal with what they had experienced in the counselling session.

Another carer reported that the service appeared to be overwhelmed and described having to wait 20 minutes before getting through to a counsellor, their family member who was in crisis was then told that they would have to wait another 24hrs for an assessment. While the respondent was complimentary about the counsellor, they were concerned that when assessed, the client was advised that Lifeline counselling services (only six sessions) would not be offered to him as he needed longer term help.

A number of respondents noted that the widespread publicity about the Lifeline service has helped to raise general awareness. The logo and telephone number are easily recognised and '***the national press and TV campaigns are strong and by their very presence offer individuals not currently engaged with services the opportunity to seek help from a confidential support service'***. The Lifeline public information messages were described as '***well presented'***, '***sensitive and professional not seen to be sensational but clear messages aimed not to escalate crisis or traumatic matters***'.

One respondent suggested raising awareness to highlight the 24/7 nature of the Lifeline service and free at the point of delivery and another suggested, '***more emphasis on the fact that the Lifeline service operates out of hours as one of the most unique and valued features of the service***'.

It was noted by other respondents that some groups such as young people continue to say that they would be reluctant to contact Lifeline if they were at risk of self-harm or suicide. It was felt by some, that the

loss of confidential client information in July 2012 may have, '***damaged trust and confidence'*** in the Lifeline service.

It was noted that Lifeline was originally intended to focus on individuals '***at risk of suicide***' but that the service was now presented and advertised as dealing with '***distress and despair'*** which involves a much wider target group and not necessarily those who are suicidal. Those respondents, with exactly the same response (n=3), suggested that '***Lifeline needs to adapt it's public profile to reflect renewed focus upon crisis-line intervention at acute crisis point, providing 24/7 support, providing assessment, access to urgent crisis counselling and referrals***'.

There were a number of comments identifying a need for a renewed focus upon crisis-line intervention at acute crisis point, and stated there should only be one tier level, high risk. Respondents (n=3), with exactly the same response, indicated that '***the provider has responded by applying a re-profiling strategy to continuously address all issues of concern, maturing the regional Lifeline service while maintaining public confidence***'. A number of respondents raised concern about the equality of provision across the locality, particularly in rural areas, groups identified as high risk and groups that are socially isolated such as the transgender community and the older population.

It was recognised that there is a need to refocus on meeting key performance indicators, particularly relating to answered call rate and response time into counselling. Clinical Outcome in Routine Evaluation (CORE) was suggested as a method of evaluating effectiveness.

Some respondents noted the benefit of Lifeline, providing creative and family therapy such as with children with special needs, while a number of other respondents wondered how these services fit with the crisis response Lifeline remit. Some respondents felt that there should be alternative support offered, '***as counselling is not appropriate for everyone***'. One respondent suggested that interventions, '***proven and recommended by NICE***' should be delivered by Lifeline. A number of respondents stated that Lifeline needed a renewed focus on a collaborative multi-agency approach and that this would resolve a lot of

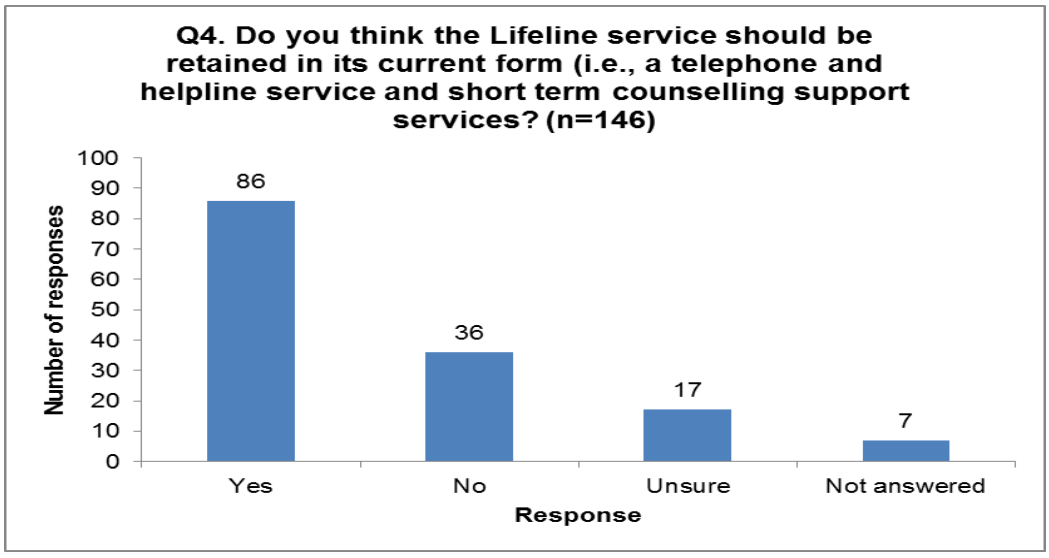
the current issues of concern such as expansion and duplication existing services.

The idea of an all Ireland and United Kingdom Lifeline service was also suggested by some respondents.

3.4 Responses on Service Design

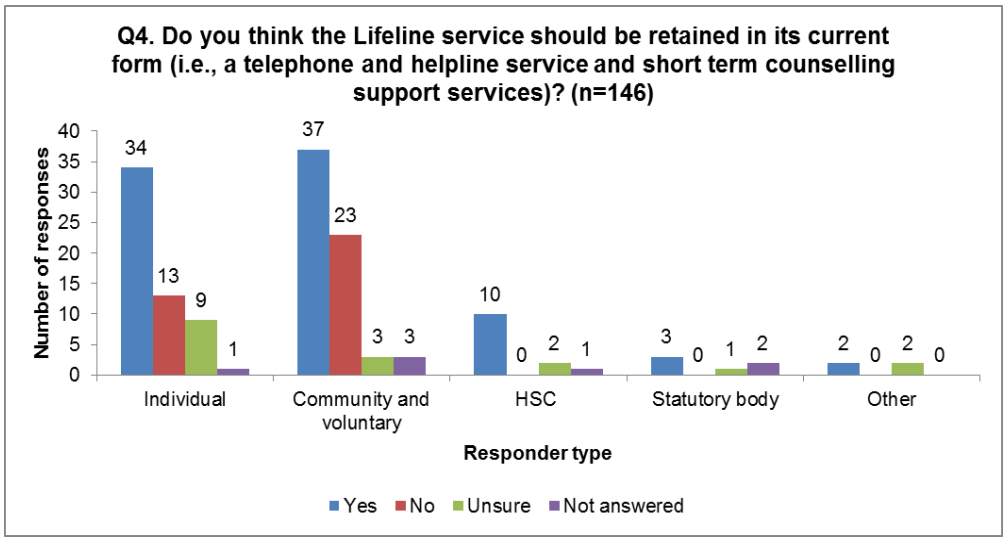
Just over half of respondents felt that the Lifeline service should be retained in its current form. Almost one quarter indicated that Lifeline should not be retained in its current form, 12% were unsure and 5% did not respond, see Figure 5 below.

Figure 5: Summary of response to the need for the Lifeline service to change.



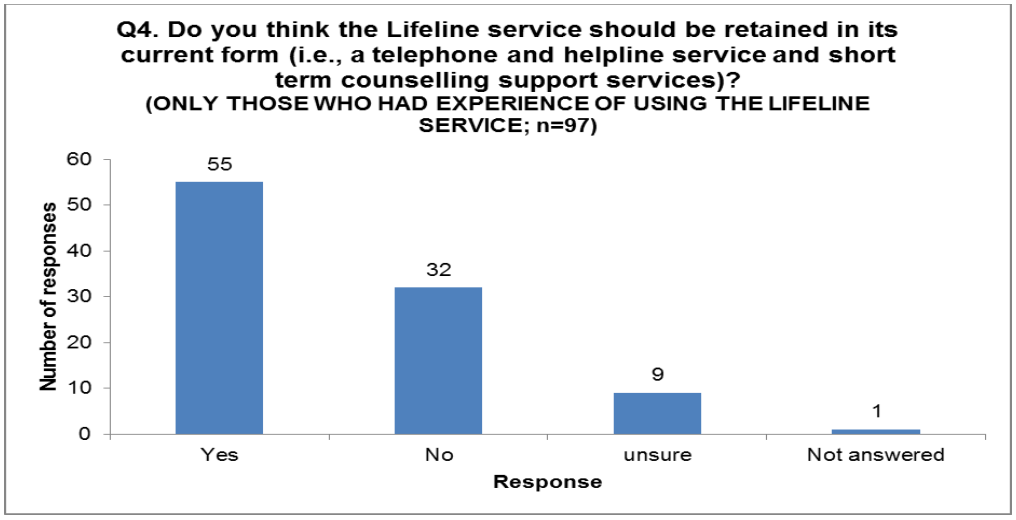
Individuals were keener than community and voluntary groups that Lifeline should be retained in the current form, while over three quarters of Health & Social Care respondents also favoured no change to the current model, see Figure 6 below.

Figure 6: Summary of responses on the need for the Lifeline service to change by constituted status.



In terms of those who had experienced the service just over half (n= 96) indicate that they thought the Lifeline service should be retained in its current form, a third indicated that they thought the service should be changed, while 9% were unsure, see Figure 7.

Figure 7: Summary of responses on the need for the Lifeline service to change by previous service experience.



Just under half of respondents (n=65) provided a commentary to explain their view. Many respondents who indicated that the service should change stated that it would help make the service more efficient and responsive to the needs of clients. There was general agreement that

change is an on-going process of continuous improvement and that limited resources should be focused on '***priority areas***' and ***'targeted to those in greatest need'***. Some respondents suggested that there should be lobbying for additional funding to expand the service, while other respondents focused on the need for services to receive longer term funding.

Respondents suggested different options for the strategic direction of Lifeline. Some respondents felt that Lifeline had changed '***without consultation with stakeholders'*** and should ***'revert back to the service it was originally set up to be under the Suicide Strategy',*** a ***'public facing', 'signposting only' 'crisis response'*** service, while others suggested formal '***referral***' with a '***check-in***' facility to follow-up callers at risk.

One respondent commented that '***clients being assessed should get what they need not offered every service on offer***'. It was noted that clients ***'are not consumers so you don't sell them everything you have***'. There was general agreement that the anonymous 24/7 helpline facility should be retained with the development of online facilities.

A number of respondents stated that the helpline should be '***standalone***' and separate from the counselling element and that an alternative model should be explored. The reasons expressed for separating the helpline from Lifeline counselling were to:

- improve the governance arrangements;
- locality based providers can '***link in with other local service provision'***;
- enable counselling to be extended into rural areas and equality of access; and
- provide continuity.

Some respondents reported how clients had told them that they were left feeling '***abandoned after using the Lifeline service because it is short term***'. There was concern expressed about the risk of duplication and how to meet the needs of service users with '***multiple issues'*** and/or those who may require more than six counselling sessions and

who ran the risk of increased likelihood of receiving an inappropriate crisis response for their main presenting issue.

Some respondents suggested that there should be '***quick and professional intervention***' developed as an alternative to taking high risk clients to emergency departments. Those respondents, with exactly the same response, felt that the Lifeline service should be expanded to include a number of interventions such as:

- two additional helplines '***dedicated***' to support the NI prison population;
- development of a call-centre with real time switchboard to transfer calls;
- mobile crisis response assertive outreach pilot teams;
- walk-in safer places for '***one stop'*** flagship community centred crisis containment.

One respondent questioned the assumption that the Lifeline service will continue in some form and that the Department will continue to promote a crisis intervention model as its mainstay approach and recommended a more balanced approach to suicide prevention.

Some respondents indicated that it was difficult to comment with, in their view, '***insufficient information'*** and they raised concern about an apparent lack of openness and transparency and what they described as a breakdown in '***partnerships***'.

Concern was expressed about the information provided as part of the consultation process which was overly reliant on activity instead of measures which were outcome and quality focused. It was suggested that, '***clinical outcomes were measured to provide evidence of impact***'.

Some respondents stated that the level of incoming calls not answered with this crisis response service was '***unacceptable***', another suggested that staffing levels should be increased in the helpline to improve the answered call rate. One respondent felt that the key performance indicator for answered call rate was '***unrealistic***' and should be revised

while another respondent noted that '***about 80% of its [Lifeline] callers do not require a high level of therapeutic intervention'*** and questioned if '***Lifeline is appropriate first point of contact for the vast majority of its callers***'. There was a general agreement that interventions should be '***based on evidence'*** relating to suicide prevention and research.

A number of respondents felt that in line with '***other helpline models, it would be sufficient for call handlers staff to be appropriately trained and managed to answer calls***'. Some suggested '***peer service user facility to respond to low risk / frequent service users***'. There was agreement that Lifeline call handers needed to be trained and skilled in suicide/self harm interventions as well as a broad range of mental health issues.

The role of Lifeline in educating the public and raising levels of awareness was raised in discussions. There was general agreement expressed that the advertising needed to inform both the public and relevant professionals about what Lifeline does and this would help manage expectations. Clear messages were needed about who the service is for and how it sits with other services without "***putting off***" potential clients as ***'they don't think that they are in crisis enough to call'***.

In terms of the nature of the services that should be part of a Lifeline Crisis Response service, there was general consensus (>90%) of the primary elements, those being de-escalation and client assessment. The level of consensus was less clear regarding other elements with the only other strong agreement expressed about the use of check-in services, supported by approximately two-thirds of respondents, see Figure 8.

It should be noted that a number (n=3) of respondents either changed the question (see Appendix II) and subsequently their responses have not been included in this analysis.

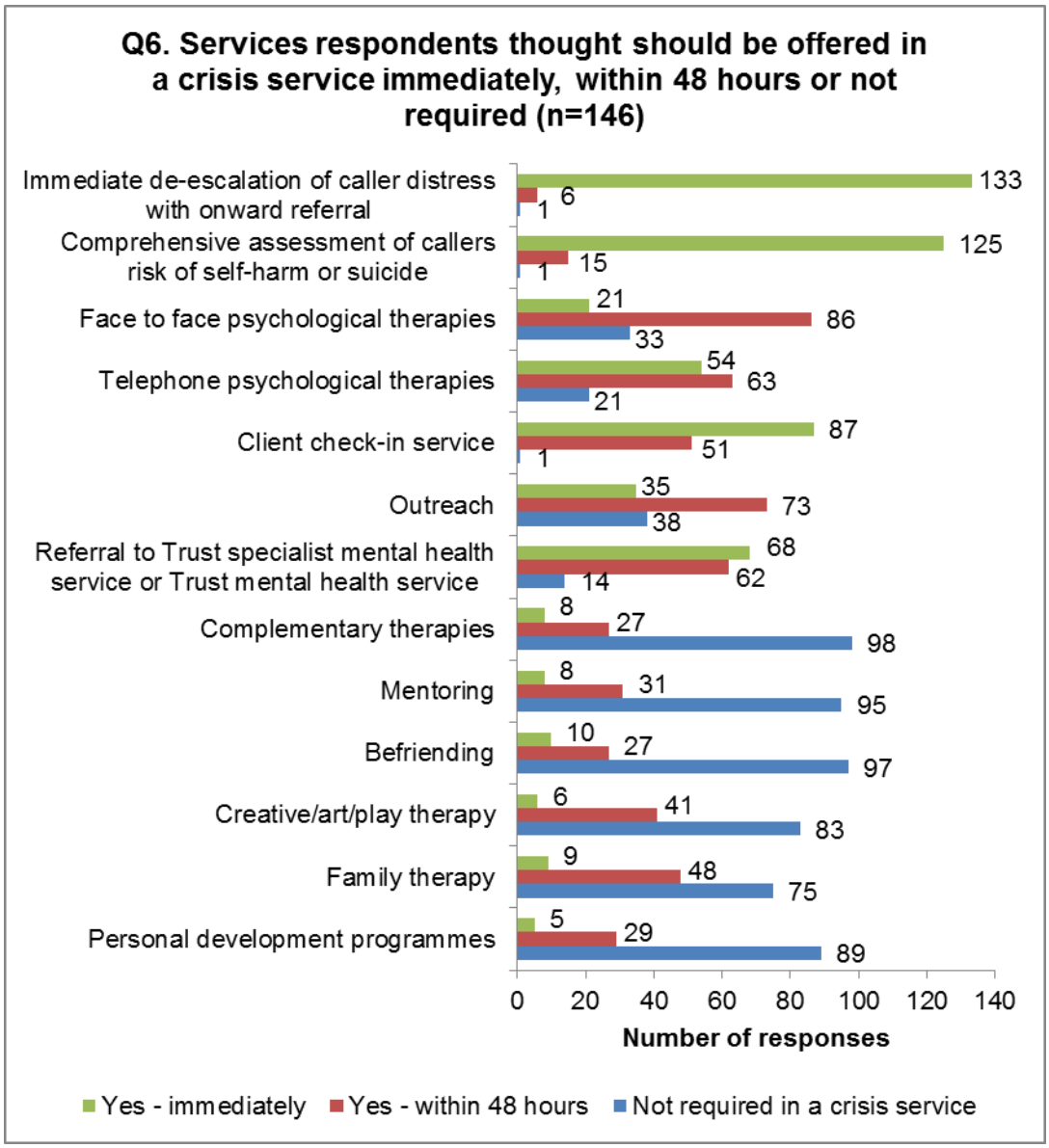
Some respondents who completed the narrative in terms of service designs suggested that Lifeline could also provide: a listening ear; family assessment; and interventions which are not necessarily counselling or

therapy, such as explaining the care pathway process and bereavement support.

Further specialist services were suggested, such as Dialectical Behavioural Therapy and Mindfulness. These suggestions were proposed by respondents with exactly the same response, while initiatives such as safe places/crisis drop-in centres and community response were also raised by other respondents.

The importance of effective liaison / signposting to the appropriate statutory or voluntary and community service was noted by a number of respondents to ensure that '***no-one slips through the net'***. Non clinical interventions and support were welcomed as an alternative to the '***medical model'***. There was some caution expressed in terms of the use of a 'check-in' service, it was felt that it had the potential to remove '***the focus of control from the individual and has the potential to compromise self-management'***.

Figure 8: Summary of service elements which should be part of a Crisis Service.



In terms of the rationale for the inclusion or exclusion of various elements within the service design, the narrative responses varied, depending on the services being suggested. It was also noted that some of the responses provided feedback which was more relevant to the wider suicide strategy consultation process rather than specifically a crisis response service.

Nonetheless, whereas there were a variety of responses about what support should be available immediately as part of a crisis response service, what would be available within 48 hours and what was relevant, there was general consensus on a number of key issues detailed below.

It was clear that respondents valued a single contact number which could be dialled when an individual was in crisis. It was suggested that a single point of contact would ensure consistency and accessibility. It was generally felt that a single regional service ensured capacity, quality standards, and co-ordination of service.

Whereas some respondents stated that the service should only operate when core services were not operating, the majority supported the idea of a 24/7 free to telephone service that would provide immediate de-escalation and onward referral as appropriate. It was noted that the service may not be free to callers from the border areas and this should be clearly communicated. Many expressed the view that the availability of such a crisis service ensures that issues such as experience of the troubles, alcohol and drug misuse, stigmatisation of mental health services did not act as a barrier to those seeking help.

There was a general acknowledgement of the complexity of the issues that an individual in crisis had to face and that '***in an ideal world a single access point with a holistic service was what was required***'. However, it was also acknowledged that funding was limited and therefore there was a need to prioritise the focus of the service and there was general consensus on the importance of access to a telephone crisis service, assessment of risk and de-escalation.

In terms of the follow on support there were a variety of opinions, some noted that having a service based on the current model was the ideal solution, while others noted that the current model diluted the, '***crisis***' element and caused confusion about the purpose of the Lifeline crisis service. There was a particular challenge about the interface with other statutory services, especially mental health services and CAMHs and how they linked with the wider service provision, how service users felt '***passed around***' with little compassion for their situation.

Some respondents based their commentary on their own experience about how they noted that the access threshold for other services was too high compared to Lifeline and felt that there was less stigma attached to Lifeline than some other services. Others referred to how Lifeline helped them to reconnect, alleviate stress and develop hope. Others referred to inappropriate access to support which lead to

defragmentation for high risk clients, or service users concerned about the family support being offered and the distress that this could cause other family members.

There was strong support for the use of safety plans for people at risk, the de-escalation, followed by support helping to ensure the safety of the person at risk. There was also frequent reference to the critical interface with police and ambulance services in this respect. This was also linked to the interface with other voluntary organisations such as the Samaritans.

The nature of intervention also varied widely from those who stated it should be face to face psychological therapies to those who suggested there should be a range of alternative interventions. The issue of referral and signposting was noted several times and the need to ensure that this was timely and appropriate.

It was also noted that the service was more likely to be used by higher risk groups such as men and those who would not normally avail of statutory services. Respondents also noted the waiting list for therapies in other services and the risk of misuse of the crisis service to get quicker access and therefore those in real crisis not receiving the support when they needed it. There were a number of references to enhancing the nature of intervention with therapies such as dialectical behavioural therapy (DBT) and mindfulness being part of any crisis support package.

There was strong support for the concept that the service needs to focus on the person in immediate distress and crisis. The service should be for short term intervention and that longer term therapeutic needs should be addressed through other services. In particular, some respondents felt that the use of mentoring, befriending, complementary therapies would be useful to develop coping mechanisms once the immediate crisis is overcome, but that this would not necessarily be part of a crisis response service. The service needed to focus on immediate de-escalation, advice, support and onward referral, providing the client with support to become more '***self-reliant'***.

A number of respondents referred to those individuals who used the Lifeline service on a regular basis and how there needed to be a

different support mechanism for this group of service users. The issues identified were the risk of creating a dependency on the service and the impact on call demand and capacity.

There was consensus that the first 48 hours following contact with the service was critical in terms of helping vulnerable individuals, and that where a referral was appropriate, the support needed to be provided within that time frame. Concern was expressed about equity of access to support between urban and rural dwellers, with the former often feeling excluded as services cannot be provided in their locality or the risk of a '***postcode lottery'*** in terms of access.

One area which lacked consensus was the use of technology, email, text messaging, online chat etc and the value of telephone counselling. Many noted that these are developing areas and that any new service needs to be flexible to address emerging technologies that could be used to reduce risk of harm or loss of life.

When it came to commenting on why specific listed services should not be part of a crisis service there was a general agreement that the services ticked by respondents in column three, question six of the questionnaire (see Appendix II), were already being provided by existing voluntary and community providers and that this should continue.

It was suggested that Lifeline should improve their links, and work more closely with existing providers, to ensure clients get access to longer term support if they need it, and that the PHA should ensure that these organisations have funding to provide services.

The services ticked in column three, question six of the questionnaire (see Appendix II), were seen as not appropriate for Lifeline who need to focus on, '***immediate crisis response'***. It was suggested that Lifeline should avoid duplicating existing services such as outreach, which is currently being provided by statutory home treatments teams.

One respondent's comments are illustrative of many others, '***we do not regard these as crisis support services, rather they are follow-on services for those who have recently been, but are no longer in, crisis'***.

A few respondents were unsure about two categories creative art, play therapy and family therapy, stating that while they understand that they can be used as a vehicle for delivering crisis support for children, young people and vulnerable adults, they did not feel that not enough details had been provided within the consultation document, about how and in what crisis response situations such services would be employed in the short term.

There was agreement that the primary role of the Lifeline service was one of crisis response, '***the service needs to be very clear that it is for people in crisis, people are confused when they listen to others' experience of using the service'***. Some respondents suggested that Lifeline should be realigned with the development of the primary care talking therapy hubs with suicide prevention remaining a multi-agency approach with associated partners and stakeholders all working together for the well-being and safety of communities.

Others commented on the evidence base for the use of complementary therapies not being robust, however acknowledged that such services are highly acceptable to individuals. It was suggested that funding should be in accordance with National Institute for Health & Care Excellence (NICE) guidance. Services such as; befriending, mentoring, outreach services and personal development programmes were noted to be of benefit. These services generally require a longer term approach to work with an individual than would be provided by a crisis service.

3.5 Responses on Service Priorities

There was general acknowledgement that budgets were limited and services need to be prioritised. A number of respondents indicated that the categories they had ticked in column one (should be seen immediately) and two (should be available within 48 hours) should be prioritised, (see Appendix II). A few respondents (n=3) amended the question in column two, question six from 48 hours to one week.

Many respondents focused on Lifeline as a protect life service with immediate accessibility, crisis response, immediate assessment, de-escalation and appropriate intervention as the core requirements of the service. This was to be achieved from a free, regional, confidential, 24/7

telephone helpline service available to all age groups of the population which was adequately staffed by trained personnel. Follow-up 'check-in' service and rapid response counselling (not limited to six sessions) were also identified as important.

There was a preference for face to face counselling over telephone counselling, '***more face to face services, more premises in other areas'***, face to face counselling '***within clients own location of choice within 48 hours'*** which provides access in rural communities and targeting at risk groups.

There was a preference to see a service that provided a helpline service with no delays and no automated response, '***the Lifeline helpline needs to be staffed to a level whereby every call for help and support is answered'***.

Some respondents suggested that there should be more telephone lines/counsellors available while another respondent suggested increasing capacity to more than six call handlers.

The importance of call handlers having effective professional development programmes in place which includes mental health training was noted. The possible use of volunteers as call handlers was suggested with support provided by trained supervisors either on shift or contactable via the telephone. A triage system was suggested where service users can be trained to respond to low risk, frequent service users and be part of the decision making processes. One respondent suggested that there should be a system introduced to ensure that calls coming through are crisis calls.

The ability of the helpline caller handler to refer or signpost high risk callers to both emergency and/or statutory services and knowledge of the range of community services available was noted as an important element of crisis response. It was suggested that, '***working protocols'*** are required between agencies.

There was reference to the Lifeline service developing a, '***drop-in'***, a peer-led crisis house to stabilise crisis situations or alternatively a safe place model open 24/7. Other responses talked about, '***assertive outreach or mobile crisis response'***, the need for evaluation of the

effectiveness of interventions, development of specialist counselling teams, brief solution focussed DBT, informed crisis counselling, addition services and '***family support'***. Other respondents suggested that family therapy, personal development programmes, mentoring and be-friending were important priorities, although not as part of the Lifeline Service. The provision of counselling options for more than six sessions for clients with trauma was identified as a priority area, although not necessarily as part of the Lifeline Service.

Exploration of other modes of communication was suggested such as: text; twitter; chat room; SMS follow-up; and email to link in with younger people and socially isolated. One respondent suggested that, in their experience, these methods have been effective in engaging with '***hard to reach'*** groups.

Respondents noted the importance of Lifeline providing both potential clients and professionals with clear information on the Lifeline service which should include a programme of public awareness raising, marketing as a '***crisis response service' 'stressing the risk of suicide/extreme distress'*** and not set up as a generic Mental Health service provider nor a '***one stop shop across Northern Ireland'***. Education about what lifeline does 'promoting success stories', including literature in different languages, to the younger age range, working class males, farmers and rural communities were also noted as important, as well as the importance of early intervention enabling people to seek help before it escalates into a crisis.

3.6 Responses on the Interface with other services

It was acknowledged that research suggests that multiple complementary interventions are more effective in reducing suicidality than any one intervention delivered on a stand-alone basis. It was suggested that the mapping of services and a directory of existing services should be available for information sharing. Other issues, such as the risk of service duplication, reduced risk of '***postcode lottery'*** experience and enhanced stability in 3rd sector were also noted as critical, while ensuring that all areas of Northern Ireland are 'covered with face to face' counselling'.

Some respondents suggested that partnerships could be developed to lobby for lasting and effective change to support agencies, especially those with a charitable and community ethos which are, '***totally underfunded'***. It was also suggested that there should be lobbying for a Lifeline service to be developed in Republic of Ireland and the United Kingdom, as well as lobbying for young people's mental health issues and equality of service provision in each locality.

Respondents noted that there was a need for joined-up thinking and planning at a strategic level hence ***'joined-up'*** services; inter / cross-departmental funding and shared service provision which would avoid duplication of services. Whereas this issue was directed at the wider suicide prevention strategy, it would also have implications for the delivery of a crisis response service.

Respondents stated that there was a need for Lifeline to have a clear and explicit contract outlining the requirements of the Lifeline service that will allow those interfacing with the service to avoid duplication, particularly with commissioned trust services already in place. It was suggested this could be done by ensuring that the service provision provides a telephone crisis helpline and de-escalation service only. Robust assessment at crisis stage with clear recommendation for either signposting or referral into existing organisations (statutory, voluntary, community) that provide counselling in locality areas.

Respondents stated that there was an increased need for counselling in the community, along with an increase in tensions within some communities particularly Protestant Unionist Loyalist (PUL areas) related to socio-economic issues. Responses suggested, '***looking at the bigger picture'***, meet the needs of local communities by broadening the number of organisations included in the services that specialise in self harm and suicide, and develop a better understanding between the organisations about how best to collaborate and support people in distress.

It was suggested by some respondents that in line with the step care model, the voluntary and community sector could deal with a broad range of identified mental health needs. Community support interventions suggested included; peer support, groups to build

resilience, family therapy, complementary therapies, supporting carers, personal development, befriending and mentoring in the community services should be considered. A number of respondents noted the importance of developing volunteering opportunities and civic participation opportunities to enhance a sense of belonging.

Most of the community and voluntary organisations identify Lifeline as the crisis support service and rely heavily on it for out of hours support. It was suggested that Lifeline should work more closely with established community organisations that are experienced and have facilities to provide counselling services. There was reference made to waiting lists for community counselling organisations that lead to referrals into Lifeline to '***bypass the waiting lists'***. Co-ordination between providers of short and long term services could be improved through existing forums and networks, the development of hubs and a community database which would provide opportunities for pathways to be developed.

It was suggested that time should be spent finding out how to link organisations and develop '***proper'*** relationships, such as sharing accommodation and joint funding bids, '***Together For You'*** was cited as an example of organisations working together. Many respondents noted the importance of developing relationships through involvement in networks / forums such as; Neighbourhood Partnerships, Rural Support Networks, linking services into area Action Plans and raising the profile in communities where there is a lower level of Lifeline presence. It was suggested that the PHA should support collaborative initiatives such as the Helplines Network NI and consider the development of processes such as where a caller can be transferred on without having to call another number in order to '***have a seamless service***'.

There were some general comments noting the importance of professionals being clear about roles and responsibilities. It was suggested that the Lifeline service provider could be involved in joint training initiatives and or provide placement opportunities for professionals. One respondent suggested that there should be engagement regarding how to deal with '***emotional trauma / conditioning – not recognised as mental health issue***' while other respondents, with exactly the same response (n=3), expressed an

interest in developing a prison specific crisis-line, which would be '***a strand of the Lifeline crisis – line'***.

A number of statutory respondents reported a positive experience when interfacing with Lifeline. Examples were provided of working collaboratively, such as client case meetings, responding in times of community crisis and attending local community promotional events. There was general agreement that a '***joined up'*** approach is necessary among all service providers in each locality to include invitations and attendance at multi-disciplinary and serious adverse incident meetings, regular interface meetings between team managers and to agree client plans. It was acknowledged that it was difficult for Lifeline to develop links with each Trust as they all have different policies and procedures.

An issue for one statutory respondent was the appropriateness of a number of Lifeline referrals to Emergency Departments where clients present to Lifeline in crisis, particularly when intoxicated, and it was suggested that a clear pathway could potentially address some of the issues involved. A number of respondents noted the importance of developing robust data sharing agreements or Memoranda of Understanding between Lifeline and the statutory sector including Northern Ireland Ambulance service, PSNI and prison service to allow direct referrals between parties. While other respondents noted that statutory service referrals should continue to be received through GPs, and not directly through Lifeline.

One respondent reported that Lifeline should be more transparent about their '***work product'*** and ensure that the budget is used in crisis intervention. It was stated that it would be useful if Lifeline could disseminate case studies and information on data trends, regularly to key stakeholders such as the number of calls not answered and clarity on issues such as time frames.

There was some criticism that the current services offered by Lifeline were not in the original remit and the service has evolved without consultation with stakeholders. One respondent suggested that the Lifeline service provider should have a steering committee made up of representatives from community, voluntary, statutory organisations and service users. It was stated that Lifeline needs to examine their

infrastructure and focus their needs solely on crisis response with some community and voluntary organisations noting that, whilst they refer into the Lifeline Service, they do not receive referrals from Lifeline. Another respondent noted that there was not enough communication and counselling services signposted to specific organisations and, '***there is an assumption that counselling is free'***.

A number of respondents praised the crisis response service provided and follow-up check-in, particularly the availability outside of office hours. One respondent who had previously used Lifeline felt that it would have been more appropriate if they had been referred out to a specialist community provider, while another stated that they had complained twice about the service they had received but '***got no reply'***. Another respondent reported that while previously Lifeline was accepting referrals, that this situation had changed and they are only accepting '***crisis***' referrals.

One respondent noted that the Lifeline contract requirements need to be clear and be explicit in order to ensure that those interfacing with the service avoid duplication, particularly with commissioned trust services already in place. It was suggested that any new Lifeline contract should provide a telephone crisis helpline and de-escalation service only, with robust assessment at crisis stage and with clear recommendation for either signposting or referral into existing organisations (statutory, voluntary and community) that provide counselling in locality areas.

A number of respondents (n=3), with exactly the same response, suggested promoting Lifeline at international conferences and join other providers to promote and deliver presentations on Lifeline in the local community with social networking used to advertise events. Others suggested promotional activities included: pre-installed Lifeline number on all mobile phones; use of mobile phone APP; facebook; twitter; and awareness raising with older population, particularly men. It was suggested that stories of hope and success were published, however there was also concern raised from one respondent that a continued focus on raising awareness of Lifeline may distract from other early intervention initiatives.

The knowledge of Lifeline call handlers was noted as important to signpost a caller to relevant community and voluntary services. It was also noted that the call handler should have effective communication skills to identify existing support services that the caller has in place this would reduce the risk of Lifeline duplicating existing service provision and encourage client empowerment. Information sharing (with service users' permission) was noted as important, however the July 2012 data breach had an impact on '***client trust in Lifeline providing a confidential service'***. It was stated that Lifeline should be clear regarding its anonymity and limitations of confidentiality and should adhere to similar governance and professional standards as social care trusts and standards as set out by the PHA.

3.7 Lifeline Crisis Response Service and Prison Settings

There were a number of responses which directly related to access to the service a crisis service for prisoners.

One view proposed the establishment of a separate standalone crisis service with telephone and wraparound services being developed to compliment the core Lifeline service. This service would be more reflective of the unique needs of prisoners and in particular the vulnerability they experience while in prison or on parole. The suggestion was that '***additional funding should come from other sources to support this development and it could be enhanced to support prisoners families'***. The emphasis behind this position was focused on a specialist support service beyond what the current Lifeline service could provide.

The alternative vision put forward presented prisoners as equal citizens, in terms of access to crisis care. It was suggested that prisoners should have the same access to a telephone crisis service as the wider population, and if the prisoner is assessed as needing follow up interventions, then that should be directly provided within the context of the current contractual arrangements with health and social care providers. This model focused on ensuring a process from committal to release, where a seamless service of support infrastructure was in place to assist prisoners who would be in crisis, either in prison or on release. It was suggested that it was critical that the service is seen as part of the

total care package. This suggestion focused on making better use of existing resource and equity of access.

3.8 Consultation Responses from Outside Northern Ireland

Although the Lifeline Crisis Response Service is for the population of Northern Ireland and the consultation process focused on that target audience there were eight responses (5.2%) that originated from outside of the service area. Six of these responses came from individuals and organisations that work in the field of suicide prevention and are summarised in table 1. It is worth nothing that a number of the responses make reference to the consultation response submitted by the current service provider in their submissions.

In the interest of balance the responses from outside of Northern Ireland are reported on separately, given that those contributing would not be as familiar with the health and social care structure in Northern Ireland and less likely to be service users or referrers into the service.

Two of the responses came from community and voluntary based organisations, two from private business, one from a health & social care organisation, one from a professional body and two from individuals. Three stated that they had experience of using the lifeline service either for themselves or someone else, while five indicated that they had no experience. Seven of the respondents stated that the service was having a beneficial effect on the prevention of self harm and suicide in Northern Ireland, and the one respondent who indicated that they were unsure, stated that the service in their country was invaluable. Of those respondents who stated that the service was having a positive impact, one referenced specific data about the Northern Ireland service, while others referenced research on other services or made general observations based on their personal experience.

Table 1: Summary Responses from Outside Northern Ireland

Country of Origin	Number	Experience of Lifeline
New Zealand	2	1
USA	2	1
England	3	
Republic of Ireland	1	1

Half of the eight respondents (n=4) stated that the current service needed to be changed from a telephone helpline service and short term counselling support service, three respondents stated that it should be unchanged and one was unsure. For those who indicated that the service needed to change, the key issues emerging can be summarised as:

- Creation of a single point of access to crisis and recovery services;
- Better use of new technology, social media, texting and emails to support people in crisis;
- Easier access to “safe places” be they virtual or physical;
- Greater multi-sectoral collaboration.

There were other suggestions, relating more to the strategic direction of suicide prevention on issues such as an attitudinal change, to a zero tolerance approach, suicide is preventable, and the creation of a forum to address the issue of suicide prevention. These suggestions have a wider impact on the strategic drivers, rather than simply the Lifeline Crisis Response Service.

In terms of the nature of services that should be part of a crisis response service, the feedback from consultantees from outside Northern Ireland is summarised in Table 2, see below. It should be noted that some respondents ticked both column 1 and 2 for three of the questions.

<u>Table 2:</u> Summary of Services that should be Available on a Crisis Response Service

Service	Column 1 Immediately available	Column 2 Available within 48 hours	Column 3 Not required in a crisis response service
Immediate de-escalation with onward referral as appropriate	7	0	0
Comprehensive assessment of risk of suicide or self-harm	7	0	0
Face to Face Psychological Therapies	1	6	0
Telephone Psychological Therapies	1	6	0
Check-In Service	7	2	0
Outreach Service	5	4	0
Referral to Trust Specialist	5	3	0
Complementary Therapies	0	1	6
Mentoring	0	2	5
Be-Friending	1	1	5
Creative Art/Play Therapy	0	5	2
Family Therapy	0	7	0
Personal Development Programmes	0	6	1

In addition to the services listed, two respondents also suggested the dialectical behavioural therapy (DBT) and mindfulness should also be available as part of the service. This response was echoed in a number of responses from respondents in Northern Ireland who submitted exactly the same response (n=3).

In terms of the areas highlighted as critical service, the timing of the treatment and care afforded to those considering suicide, attempt survivors and self-harming clients is paramount. It is important that convenient and user friendly options such as online such as text and

chat facilities are available for service users so that emergency situations can be de-escalated as soon as possible. Investment in technology could also help improve capacity and response times as well as supporting those, '***hard-to-reach'*** groups.

It was suggested that in keeping with NICE guidelines and internationally validated evidence, the use of DBT and mindfulness represent the best practice standards for self harm and suicide prevention treatments for adolescents and adults. It was recommended that all Lifeline crisis counsellors receive advanced training in; mindfulness, DBT, informed brief solution focused crisis counselling, relevant upgrades to clinical supervision, clinical governance and treatment planning, as a condition of service.

In respect of frequent callers it was suggested that they could benefit from '***personal development***' as a crisis management and crisis reduction option when excessive Lifeline usage and crisis service dependency issues are identified for noteworthy callers. This approach would feature as a key ingredient to mindfulness and DBT programme provision.

It was highlighted that responding comprehensively to crisis with a range of services provides the best opportunity to intervene at multiple levels to reduce or mitigate risk of suicide in a wide range of clients. The supports indicated in columns one and two, question six of the questionnaire, (see Appendix II) are regarded in many countries as those which can be appropriately provided by well-trained, adequately resourced, crisis services located external to clinical and hospital care but with step-up links into such care as necessary and step-down links from clinical care to crisis service follow up when necessary. Crisis services are now seen as providing the essential linkages between and among services with an extension of clinical services necessary to provide seamless care and services considered to best minimise suicide risk.

It was also suggested that the use of family support, creative therapy and individual brief solution focussed therapy would appear to be

effective and that the current Lifeline family support and creative therapy requires immediate evaluation.

In terms of those services highlighted as not essential in a crisis service, respondents stated that although they represented valuable supports for individuals experiencing anxiety and stress they were not critical to de-escalation or crisis response. If it is a crisis service, then the focus should be on immediate intervention and support. The other options listed could act as a gateway to other services in the longer term.

When asked to prioritise the services that could be provided with a limited budget, where a response was given, the general consensus was:

- The main lifeline helpline service - 24/7 free-phone crisis helpline, de-escalation of immediate crisis and suicide risk;
- Comprehensive assessment of callers risk of self-harm or suicide;
- Referral to specialist mental health services;
- Face to face Psychological Therapies i.e. counselling;
- Client check-in service via; telephone, text and/ or online;
- Telephone Psychological Therapies such as counselling via telephone and mobile crisis response.

Finally, in response to the question on how the Lifeline service provider could work with other stakeholders to ensure a more joined-up service, the lack of understanding of the Northern Ireland health and social care system was somewhat evident, with most respondents either commenting on general suicide prevention structures or deferring the question.

Where a suggestion was given the practical solutions suggested were:

- Joint training opportunities;
- The use of social networking can help;
- Ensure local health and social care plans take account of these needs and the range of providers;
- Consult clients and their families.

4.0 Acknowledgements

The PHA would like to acknowledge the contribution of everyone who responded to the consultation process.

In particular the PHA would like to note the input from those with previous experience of the Lifeline service, their families and carers whose contribution to the process has been invaluable.

Particular thanks to all those groups who facilitated the various workshops and distribution of the context paper and questionnaire. In particular to the individuals and groups who attended the workshops and participated in the frank and open discussions which took place and in many instances took the time to submit a response.

PHA would acknowledge the role of the Communications/PR and Health Intelligence team for the promotion of the process and assistance in analysing the responses.

The responses provided as part of this process will inform the commissioning decisions in terms of the current contract and the future development of a crisis response service for Northern Ireland

5.0 Appendices

5.1 Appendix I - Context paper for the consultation process

Introduction

The Public Health Agency (PHA) is currently reviewing the 'Lifeline Crisis Response Service', seeking to develop the most appropriate and effective service to ensure the best outcomes for the public within the resources available.

The current contract is due to end 31 March 2015 and the Public Health Agency is keen to engage with relevant stakeholders to ensure that the future service specification is appropriately informed and that future services are fit for purpose. This consultation process seeks feedback from key stakeholders to inform the decision making process on the future of the Lifeline Crisis Response Service.

Background

Lifeline is a free-to-call regional confidential telephone helpline for people who are experiencing emotional crisis and who are at risk of suicide.

The Health Minister, announced the establishment of a pilot 24/7 Crisis Response Telephone Helpline in 2007 as part of a range of measures to tackle suicide under the new suicide prevention strategy *Protect life*.

The helpline was initially piloted in one area of Belfast for the under 25s, and a decision was then taken to expand the service to include access across all of Northern Ireland, for all age groups and was to be strengthened by the provision of additional face-to-face support services for people in crisis.

The overall aim of the helpline is to provide crisis support to all people in crisis across Northern Ireland, thereby helping to reduce the levels of

suicide and self-harm incidents. The Northern Ireland Crisis Response Helpline is promoted as LIFELINE.

The regional Lifeline service commenced in 2008 and was awarded through public tendering to Contact NI, given the transitional arrangement under the Review of Public Administration (RPA) the Southern Health & Social Care Trust (SHSCT) agreed to undertake the contract management/commissioning in support of Department of Health (DHSSPS) until agreement on the new commissioner arrangements were put in place. In April 2010 the contract was passed to the Public Health Agency (PHA) to manage.

During the first contract period for the regional service the range of support services were increased to include complimentary therapies, befriending, mentoring etc, these along with the face to face counselling were known as wraparound services. The wraparound services were provided directly by Contact NI and they also sub-contracted wraparound support from a variety of other community & voluntary organisations across Northern Ireland.

There had been no evaluation of the initial pilot service in 2007 therefore in order to assess the effectiveness of the service one of the first actions of the PHA was to undertake a review to inform performance management as well as future commissioning. The PHA undertook an evaluation of the range of services and the findings indicated that for people in crisis talking therapies/ counselling was more effective than other forms of wraparound services provided.

In order to focus the resources on those most at risk the service specification was changed to include only a telephone helpline with subsequent referral into appropriate counselling services. The contract was re-tendered in 2011/12 through public procurement and the existing provider was successful in securing the contract.

Contract Management from 2012- Present

The contract is overseen by a regional steering group which includes the PHA, Health & Social Care Board, DHSSPS and the six Trusts. The service providers are also invited to attend part of the meeting to input on key issues that emerge. The project also has a Clinical & Social Care Governance sub-group, Performance and Evaluation sub-group and Communications/PR sub-group. The sub-group membership includes representation from a range of stakeholders include PHA, HSCB, DHSSPS, Contact NI, Trusts and service users.

The contract specification was based on the evidence that was available from contract performance data in terms of determining service demand and level of engagement required with callers. The latter was noted as "Active Calls" and defined as those interactions on the telephone that required the qualified counsellor to directly engage with a caller who was in crisis or a third party ringing on behalf of another individual.

Whereas the crisis service was based on a short term intervention approach there was provision for the telephone helpline to refer appropriately assessed individuals into talking therapies. Again the volume of referrals into counselling was based on previous data from those assessed as active calls.

The contract was initially awarded for the three year period 2012-15 with the provision of an 18 months extension dependant on finance, performance and outcomes evaluations. The total value of the contract is £10.48 million for the three year term.

The contract specification invited bidders to consider their contract costings based on three levels of both telephone demand and access to talking therapies. These activity levels were based on the information that was available to the PHA in 2011.
The activity levels were:

Telephone calls levels:

- 1 – 999 Active Telephone Calls per Week
- 1000 – 1499 Active Telephone Calls Per Week
- 1500+ Active Telephone Calls Per Week

Counselling sessions per levels:

- 1 – 399 Counselling Sessions Per Week
- 400 – 499 Counselling Sessions Per Week
- 500+ Counselling Sessions Per Week

Service Demand

Call demand from 2010/11 to date is shown in table 1 below.

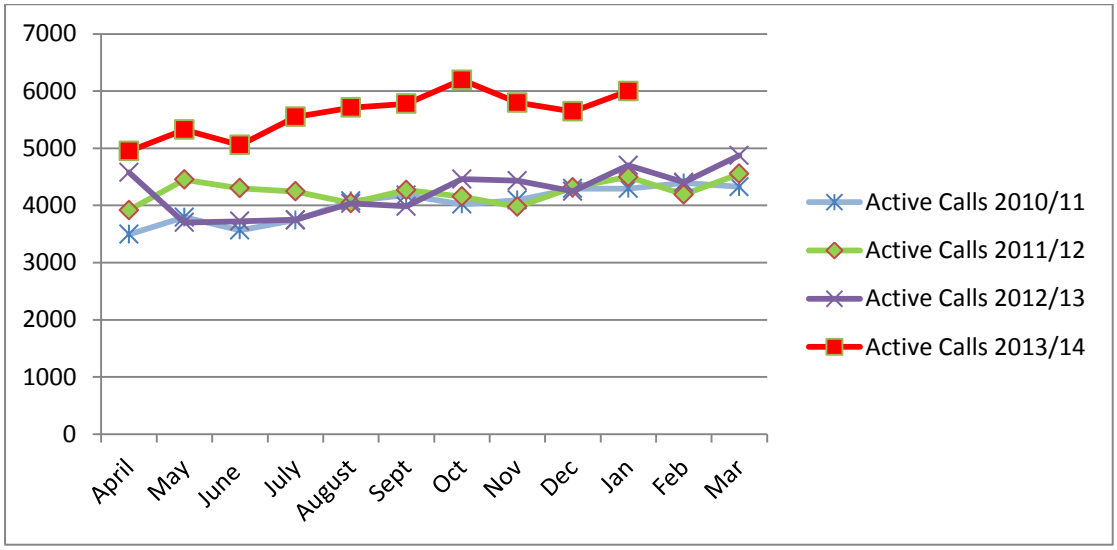
The most notable change in the demand trends are those calls which the service provider has classified as an active call, that is those requiring a direct intervention from a counsellor/call handler and which are subject to a contract charge. These calls have increased since the second half of 2012/13 and are currently 31% higher than in the previous contract arrangements. It should be noted however that definitions have differed slightly between the current contract (2012/13 to date), and the previous contract period.

Table 1 Summary of Service Demand for Crisis Telephone Service April 2010 / January 2014

Total calls Answered	Apr	May	Jun	Q1	Jul	Aug	Sept	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	Total
Calls answered by Counsellor 2010/11	5803	7130	7088	20021	6492	6197	7621	20310	7971	7033	6266	21270	7507	7509	6592	21608	**83209**
Calls Answered by Councillor 2011/12	6017	7674	7602	21293	7926	7131	6868	21925	8059	7071	7601	22731	8686	7150	8385	24221	**90170**
Calls Answered by Councillor 2012/13	7638	6403	6874	20915	6350	6946	6298	19594	6843	6776	6250	19869	7183	6711	7282	21176	**81554**
Calls Answered by Councillor 2013/14	7328	7921	7064	22313	7530	7482	7744	22756	8241	7687	7977	23905	7936				
Calls Classified as Active	**Apr**	**May**	**Jun**	**Q1**	**Jul**	**Aug**	**Sept**	**Q2**	**Oct**	**Nov**	**Dec**	**Q3**	**Jan**	**Feb**	**Mar**	**Q4**	**Total**
Active Calls 2010/11	3495	3793	3567	10855	3744	4075	4179	11998	4019	4093	4296	12408	4294	4393	4324	13011	**48272**
Active Calls 2011/12	3918	4452	4301	12671	4243	4040	4270	12553	4155	3976	4314	12445	4499	4190	4553	13242	**50911**
Active Calls 2012/13	4577	3700	3723	12000	3750	4034	3985	11769	4460	4433	4246	13139	4701	4405	4875	13981	**50889**
Active Calls 2013/14	4951	5325	5056	15332	5549	5712	5778	17039	6194	5798	5644	17636	5999				

This is further illustrated in figure 1 which demonstrates the dramatic change in active call classification.

Figure 1: Summary of Active Call Demand April 2010 / January 2014



The number of clients subsequently referred into talking therapies/counselling is shown in table 2 below. This demonstrates the increased number of clients being referred into counselling and the consequent increase in counselling sessions.

Table 2: Summary of Referrals Into Counselling Support April 2010 / January 2014

	Apr	May	Jun	1st Qtr	Jul	Aug	Sep	2nd Qtr	Oct	Nov	Dec	3rd Qtr	Jan	Feb	Mar	4th Qtr	YTD
Support Clients Referred 2010/11	277	347	377	1001	368	349	431	1148	544	515	463	1522	421	427	489	1337	**5008**
Support Clients Referred 2011/12	367	454	441	1262	363	379	274	1016	273	264	269	806	363	308	311	982	**4066**
Support Clients Referred 2012/13	206	408	347	961	288	457	379	1124	422	484	390	1296	488	479	515	1482	**4863**
Support Clients Referred 2013/14	542	580	469	1591	540	603	596	1739	734	647	521	1902	724				

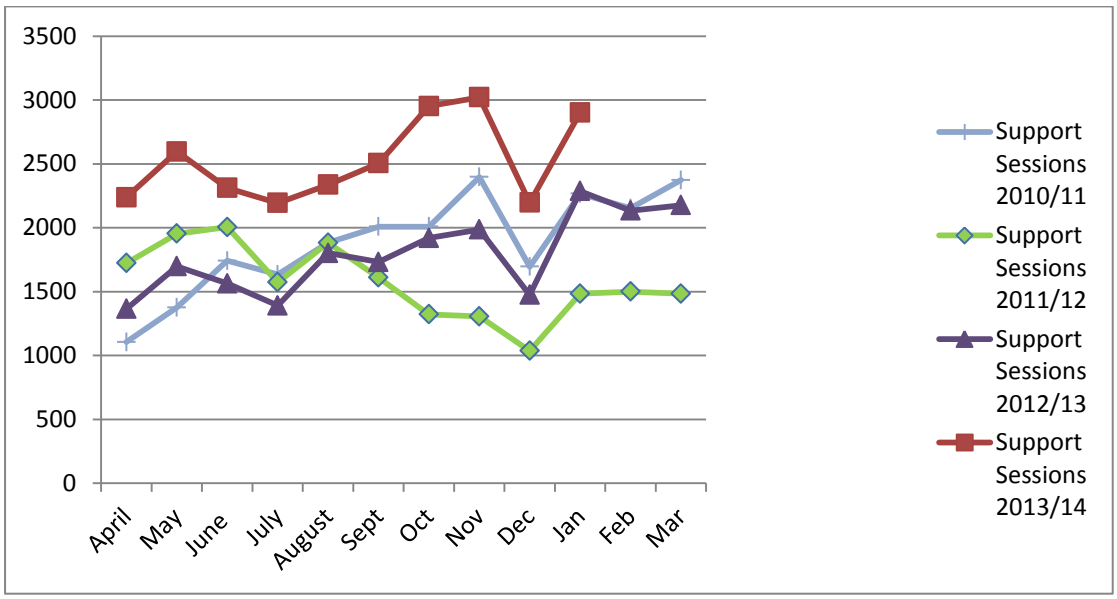
Total Support Clients 2010/11	634	732	923	2289	990	1022	1049	3061	1193	1216	1118	3527	1240	1203	1258	3701	**12578**
Total Support Clients 2011/12	1102	1100	1083	3285	1058	1039	981	3078	754	677	659	2090	836	854	837	2527	**10980**
Total Support Clients 2012/13	743	857	827	2427	790	915	973	2678	1001	1,039	981	3021	1,183	1,158	1215	3556	**11682**
Total Support Clients 2013/14	1280	1347	1226	3853	1276	1363	1417	4056	1550	1589	1401	4540	1647			1647	**14096**

Support Sessions 2010/11	1105	1375	1741	4221	1633	1883	2008	5524	2008	2397	1695	6100	2266	2152	2373	6791	**22635**
Support Sessions 2011/12	1723	1953	2005	5681	1572	1882	1610	5064	1322	1305	1036	3663	1483	1499	1483	4465	**18873**
Support Sessions 2012/13	1364	1697	1564	4625	1391	1802	1731	4924	1919	1986	1474	5379	2287	2133	2176	6596	**21524**
Support Sessions 2013/14	2238	2596	2312	7146	2194	2337	2505	7036	2952	3021	2196	8169	2902				**22351**

The average number of clients being referred into counselling services has increased from an average of 417 per month between 2010/11 to 595 in 2013/14 an increase of 43%. The number of sessions

undertaken has increased over the same period from 1886 per month in 2010/11 to 2525 (+34%). This increase is reflected in figure 2.

Figure 2: Summary of Counselling Support Services April 2010 / January 2014



Key Performance Indicators

A number of key Performance Indicators (KPIs) were agreed to assist with the contract monitoring process. The PHA regularly monitors the performance against the KPIs as reported by the service provider.

The primary KPIs in the Lifeline contract are set out in table 3, along with a summary of performance between April 2012 and January 2014. The KPIs reflect the fact that the Lifeline service is a crisis response service and that counselling staff should appropriately qualified.

Table 3 Summary of Primary KPIs Performance for the Lifeline Contract April 2012 – January 2014

Key Performance Indicator (KPI)	Target	Performance Summary from Lifeline Provider KPI returns April 2012 – January 2014
% of staff, excluding administration, who are accredited or have a time framed action plan in place to work towards accreditation with BACP/IACP or equivalent	100 %	The Lifeline service is currently provided by counsellors directly employed by the provider, locums and a small number of subcontracted counselling providers. Directly employed counsellors work on the helpline as well as delivering the counselling element of the service. • 100% of Lifeline qualified counselling staff are either accredited or have a time framed action plan in place to work towards accreditation. • 100% of the Lifeline counsellors have completed enhanced AccessNI checks.
% of staff who have completed Access NI enhanced checks	100 %	
% Comprehensive assessments accepted and completed during first call where it is appropriate to offer	100 %	A caller may decline the offer or a helpline counsellor may decide that it is not appropriate to offer

		a caller a comprehensive assessment during first call to the helpline. This may be because it is an emergency/ third party call or the counsellor assesses that it would be more appropriate to delay the assessment due to substance levels or communication difficulties. Where it was appropriate to offer and complete a comprehensive assessment during first call 53% were completed between April'12 – March'13 and 63% complete between April'13 – January'14.
% of Tier 1 clients provided session appointment within 10 days	100 %	From April 2012 – March 2013, 92% of Tier 1 clients were provided with an appointment within 10 days of decision to offer an appointment and 85% between April 2013 – January 2014.
% of Tier 2 clients provided session appointment within 7 days	100 %	From April 2012 – March 2013, 93% of Tier 2 clients were provided with an appointment within 7 days of decision to offer an appointment and 89% between from April 2013 – January 2014.

% of Tier 3 clients provided session appointment within 5 days	100 %	From April 2012 – March 2013 91% of Tier 3 clients were provided with an appointment within 5 days of decision to offer and appointment and 84% between April 2013 - January 2014.
% Clients exceeding 6 attending sessions (package limit)	<5%	13% of clients exceeded 6 sessions from April 2012 – March 2013 and 11% between April 2013 - January 2014.
% Attendance rate	90%	82% of counselling sessions were attended from April 2012 – March 2013 and 81% from April 2013 - January 2014.
Incoming calls answered as a % of missed and answered incoming calls	100 %	86% of incoming (missed and answered) calls were answered from April 2012 – March 2013 and 78% from April 2103 and January 2014 (excludes calls ended before 5 seconds)
Answered calls within 10 seconds	90%	79% of answered calls were answered within 10 seconds from April 2012 – March 2013 and 66% from April 2103 and January 2014.
Answered calls with 30 seconds	100 %	90% of answered calls were answered within 30 seconds from April 2012 – March 2013 and 81% from April 2103 and January 2014.

Summary of Lifeline Communication / PR Activity and Performance

The Assistant Director of Communications, PHA monitors the PR activity of the provider through both the Communication subgroup and individual meetings. The provider receives £150,000 each year for the three years of the contract to deliver on the Lifeline communication strategic plan. In 2012/13 this was boosted by an additional £50,000 slippage for media advertising between January 2013 and March 2013.

The PHA continues to support the provider to deliver the service required within the budget allocated while adhering to the branding protocols which outline how the Lifeline brand must be treated. The provider has been involved in a number of initiatives to promote the Lifeline service since April 2012 such as presentations at GP practice learning events and is also working with Trust media representatives.

The provider established a service user advocacy group in November 2013 who will become involved in promotional activities.

A survey of public awareness commissioned by PHA in March 2013 reported 29% of the public surveyed were aware of the service which is an increase from 23% awareness in 2010/11 and in line with DHSSPS target of 30%. As a result the provider's communication plan for 2013/14 targeted: men, over 65 years, southern and western Trust areas, groups with specific communication requirements such as people with sensory impairment and / or English is their second language.

Performance Management and Clinical Governance

The PHA as commissioner has regular meetings with the service provider. These meetings include colleagues from the HSCB and Trusts. Performance meetings include the review of contract performance, sharing best practice and discussion regarding corrective action as appropriate.

The provider follows the regional Serious Adverse Incidents (SAIs) process in respect of individual deaths through to major services issues.

PHA take account of the learning from SAIs as well as compliments and complaints in planning, commissioning and monitoring services

The Provider records data on clients and service provision via an electronic system. PHA receives regular anonymised data downloads.

The PHA ensures that the service provider is managing demand within the constraints of the service budget. Where there is an under demand for the service the PHA will ensure that the funding is re-allocated within the context of the Protect Life strategy. Where there is an over demand the contractor is required to bring performance back into budgetary line.

The PHA has recently commissioned a clinical audit of the Lifeline service. The review sought to identify best practice in the delivery of Lifeline and highlight any areas for development or further review. As well as informing the management of the existing service, the findings of the audit will inform the development of future services

Challenges

In the delivery and management of the Lifeline contract there are a number of key principles that must underpin the service delivery as follows:

- The telephone service must be available 24 hours 365 days a year for people in crisis and at risk of self-harm or suicide
- Free of charge
- Staffed by appropriate qualified professionals
- Confidential service
- Non-judgemental
- Non-discriminatory
- Ability to refer/signpost, as appropriate, dependant on the level of crisis

The service must also demonstrate value for money and operate within the budget available within the overall Protect Life budget. The PHA must ensure that expenditure is used for the intended purpose and

properly accounted for. This requires that the PHA must ensure there is a competitive procurement process to ensure transparency and competition for the service in future commissioning

The service must operate with the highest level of quality and safety ensuring that there are processes in place to protect and support clients who use the Lifeline service. It also requires that reporting back to the commissioner on performance and outcomes is accurate and dependable and subject to review and scrutiny. The service must be supported and valued by all statutory bodies, other service providers and the general public.

The purpose of the service must be clear ensuring that it is a Crisis Response service for those who are at risk of self-harm and/or suicide and should not be used as a general counselling or support service.

Procedures should be in place to ensure there is no duplication of service, overlap or dual referral ensuring that all clinical guidelines are adhered to and preventing the spend of public funds on duplicate services.

Consultation Considerations

This consultation is an intricate part of the decision making process along with exploring what else can assist decision making in terms of the future of the Lifeline contract in Northern Ireland within the context of limited funding. The responses to this process should take account of the information contained within the context paper and an acknowledgement that there is a limited amount of funding available to the service and therefore it is critical that it is targeted at those most in need.

The decision making process will take account of the feedback from this process as well as information collected by the PHA during the contract management and evaluation processes and best practice models internationally.

Any decision on the future roll-forward of the contract, service design or implications will take account of the wider strategic context in terms of the next suicide prevention strategy, new public health framework and proposed developments in the wider mental health and suicide prevention sphere.

5.2 Appendix II – Consultation questionnaire

The Public Health Agency (PHA) is currently reviewing the 'Lifeline Crisis Response Service', seeking to develop the most appropriate and effective service to ensure the best outcomes for the public within the resources available.

Lifeline is a free-to-call regional confidential telephone helpline with provision of additional counselling support services for people of all age groups who are experiencing emotional crisis and who are at risk of suicide. Counselling can be defined as a service provided by any counsellor/psychotherapist who is or is well on the way to obtaining a counselling or psychotherapy qualification.

Current Lifeline Service Objectives:

- De-escalate clients at risk of self harm or taking their own life
- Provide an immediate response proportionate to client's assessed risk
- Deliver rapid response, short term community based counselling
- Refer / signpost clients for on-going support, as appropriate

Current Lifeline Service Description:

- Immediate free 24 hour telephone based response for people in crisis
- Risk assessment for suicide and/or self-harming, carried out by counsellors
- Immediate referral to emergency services if the individual is at high risk
- Up to six sessions of counselling intervention, as appropriate
- Rapid response counselling available throughout the geographical spread of Northern Ireland to all age groups

- Referral / signpost to existing statutory and voluntary / community support services who provide longer term interventions.

For further information on the Lifeline service please see attached '**Consultation Context Paper To Inform Future Procurement of the Lifeline Crisis Response Service'**.

The current Lifeline contract is due to end on 31 March 2015 and the Public Health Agency is keen to engage with relevant stakeholders to ensure that the future service specification is appropriately informed and that future services are fit for purpose. This questionnaire seeks feedback from key stakeholders to inform the decision making process on the future of the Lifeline Crisis Response Service.

Your response will only be used for the purpose intended, informing the future specification of the Lifeline contract.

You can get involved in the following ways:

- Attending PHA consultation presentations
- Download the consultation paper and response questionnaire via the PHA website **http://www.publichealth.hscni.net/current-consultations**
- Send your completed consultation questionnaire response by email to: **liz.mcgrath@hscni.net** or post to: **Elizabeth McGrath,** PHA office, Towerhill, Armagh, BT61 9DR**.**

Following the consultation period, which runs to 24 June 2014, the PHA will undertake an analysis of the responses and comments on the future configuration of the Lifeline service. This analysis will inform the development of the future model of provision for the Lifeline service from spring 2015. Equality screening and, if appropriate, an equality impact assessment will also be undertaken as part of this process.

We would appreciate if you would complete the following questionnaire and return it to: **Elizabeth McGrath** at **liz.mcgrath@hscni.net** or post to: **Elizabeth McGrath,** PHA office, Towerhill, Armagh, BT61 9DR**.**

1. 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_____

2. Do you have experience of using the Lifeline service on behalf of another person or for yourself? Tick one option below.

Yes experience of Lifeline for self or other ☐

No previous direct experience of Lifeline ☐

3. Do you think that the Lifeline service is having a beneficial effect on the prevention of suicide and self-harm in Northern Ireland?

Yes ☐ No ☐ Unsure ☐

Comment please:

4. Do you think the Lifeline service should be retained in its current form, i.e a telephone helpline service and short term counselling support services?

Yes ☐ No ☐ Unsure ☐

5. If you answered No to question 4 and you think that the current Lifeline service needs to change, please state what changes you would like to see made.

Comment please:

6. Please tick which of the following, if any, you think should be available:

- **Column 1**: <u>immediately</u> to people in crisis and suffering from severe emotional distress
- **Column 2**: <u>within 48 hours</u> to people in crisis and suffering from severe emotional distress.
- **Column 3**: <u>not required in a crisis service</u> / can be provided elsewhere

	Column 1 Yes, should be Immediately available	Column 2 Should be available within 48 hrs.	Column 3 Not required in a crisis service /can be provided elsewhere
Immediate de-escalation of caller distress with onward referral, as appropriate	☐	☐	☐
Comprehensive assessment of callers risk of self-harm or suicide	☐	☐	☐
Face to face Psychological Therapies i.e. counselling	☐	☐	☐
Telephone Psychological Therapies i.e. counselling via telephone	☐	☐	☐
Client check-in service via; telephone, text and/ or online	☐	☐	☐
Outreach (counsellor attends client in community)	☐	☐	☐
Referral to Trust specialist mental health service or Trust mental health services.	☐	☐	☐
Complementary Therapies	☐	☐	☐
Mentoring	☐	☐	☐
Be-friending	☐	☐	☐
Creative/Art/Play Therapy	☐	☐	☐
Family Therapy	☐	☐	☐
Personal Development Programmes	☐	☐	☐
Other (please specify): ……..			

7. Please explain why you think it is important that the support you ticked in column 1 and 2 (immediately or within 48 hours) question 6, should be provided from a regional crisis helpline service?

Comments please:

8. Please explain why you think it is important that the support you ticked in column 3 (not required in a crisis service, within 48 hours) can be provided elsewhere?

Comments:

9. With a limited budget for the Lifeline service, what do you / your organisation think are the most important elements of the Lifeline service that should be given priority for funding?

Please list:

10. Please tell us how the Lifeline service provider could work with other Community & Voluntary Sector providers and Health and Social Care Trusts and others to ensure a “joined-up” service?

Comment please:

11. If you wish to do so, please provide your name and contact details. *(please read privacy statement below)*

Name:_____

Name of organisation:_____

Address:_____

Post code _____/_____ Email:_____

Privacy statement

Freedom of Information Act (2000) – Confidentiality of Consultations

The Public Health Agency will publish a summary of responses following completion of the consultation process on their 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 PHA 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 PHA should not agree to hold information received from third parties "in confidence" which is not confidential in nature
- acceptance by the PHA 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/**

With our sincere thanks for your time in completing this questionnaire, we value your input. If you have any questions about this questionnaire or the consultation process please contact:

Elizabeth McGrath
Health Improvement Officer
Public Health Agency
Towerhill
Armagh
Co Armagh
Tele: (028) 37 414460
Email: liz.mcgrath@hscni.net

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 to meet the needs of those not fluent in English) please contact: Elizabeth McGrath, Health Improvement Officer (Contact details as above)

Questionnaires must be returned to **Elizabeth McGrath**, Health Improvement Officer, PHA (Contact details above) by either post or email by **5pm, 24 June 2014**. Late returns will not be accepted.

5.3 Appendix III – The context paper and questionnaire were circulated to the following groupings identified in the Equality and Human Rights Screening Template available on the PHA website:

- Bamford working group for suicide prevention and emotional wellbeing
- Black minority ethnic leads and services
- CONTACT - Lifeline provider and service user advocacy group
- Education sector
- Emergency services
- Equality unit database
- Family Voices Forum
- Health & Social Care Board (HSCB) children and adult mental health services
- Helplines Network Northern Ireland
- LGB&T leads and services
- Older people and disability leads and services
- Patient Client Council
- PHA mental health / suicide prevention locality commissioning leads
- Prison and probation service leads
- Protect Life Implementation groups
- Self-harm working group
- Suicide Strategy Implementation Body
- Training co-ordinator mental health and emotional wellbeing
- Trust – health and social care mental health service user groups

5.4 Appendix IV - The following groups received a formal power point presentation during the consultation process from a PHA representative:

- Council for the homeless - Service User Network
- Clear project forum, West
- Contact's staff group
- Contact's service user advocacy group
- East Belfast Network Centre
- Family Voices Forum
- Nexus client forum meeting
- North and West Belfast Protect Life Implementation Group
- Northern area joint Promoting Mental Health and Suicide Prevention Steering group.
- South Eastern area Protect Life Implementation Group
- Southern area Protect Life Implementation Group
- Southern Trust Mental Health service user group
- Suicide Strategy Implementation Board
- Western area Emotional Wellbeing Suicide Prevention Strategic Implementation Group

The following groups received an informal presentation during the consultation process from a PHA representative:

- Bamford working group
- Childline, NSPCC
- Department of Justice
- Helplines Network NI
- Northern Ireland Ambulance Service

5.5 Appendix V – The public consultation power point presentation

HSC Public Health Agency

Review Consultation Process

Lifeline Crisis Response Service

HSC Public Health Agency

Content

- Background
- Context for this Consultation
- Outline the Process
- Present Some Factual Information
- Explain the Feedback Process

HSC Public Health Agency

Background

- Suicide Prevention Strategy - Protect Life
- Initial Pilot Initiative
- 2008 Roll-out
- Service Content & Review
- Priority to Target Resources from

HSC Public Health Agency

Contract Basis

- 2012-15 £10.48m
- Potential 18 month extension
- Activity Levels based on past experience
- "Active Calls" & Counselling Service

HSC Public Health Agency

Call Demand

Total calls Answered	Apr	May	Jun	Q1	Jul	Aug	Sept	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	Total
Calls answered by Counsellor 2010/11	5383	7130	7088	20601	6482	6197	7621	20310	7971	7833	6266	21070	7587	7589	6592	21688	[illegible]
Calls Answered by Counsellor 2011/12	6917	7674	7682	21853	7526	7131	6863	21525	8859	7871	7601	22731	8636	7158	8385	24221	[illegible]
Calls Answered by Counsellor 2012/13	7632	6463	6874	20816	6380	6946	6258	19594	6843	6776	6230	19869	7103	6711	7282	21176	81684
Calls Answered by Counsellor 2013/14	7328	7521	7664	22513	7530	7482	7744	22756	8241	7607	7577	23605	7536				
Calls Classified as Active	Apr	May	Jun	Q1	Jul	Aug	Sept	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	Total
Active Calls 2010/11	3455	3753	3567	10855	3744	4075	4179	11598	4015	4053	4256	12408	4254	4353	4324	13011	48372
Active Calls 2011/12	3918	4452	4301	12671	4240	4040	4270	12553	4155	3576	4314	12445	4489	4156	4553	13242	50911
Active Calls 2012/13	4577	3788	3723	12088	3758	4034	3505	11769	4460	4403	4246	13109	4701	4465	4875	13681	50038
Active Calls 2013/14	4591	5325	5656	16332	5546	5702	5778	17035	6194	5758	5644	17626	5959				

HSC Public Health Agency

Referrals into Counselling

	Apr	May	Jun	1st Qtr	Jul	Aug	Sep	2nd Qtr	Oct	Nov	Dec	3rd Qtr	Jan	Feb	Mar	4th Qtr	YTD
Support Clients Referred 2010/11	277	347	377	1001	398	348	401	1148	544	515	463	1522	421	427	483	1332	5008
Support Clients Referred 2011/12	367	454	441	1262	363	379	274	1016	273	294	269	836	363	308	311	982	4066
Support Clients Referred 2012/13	396	488	347	981	398	457	379	1124	422	484	390	1296	488	478	516	1482	4883
Support Clients Referred 2013/14	542	581	458	1581	540	600	596	1736	734	647	521	1902	724				
Support Sessions 2010/11	1105	1375	1741	4221	1633	1883	2008	5524	2000	2257	1855	6100	2266	2132	2373	6781	[illegible]
Support Sessions 2011/12	1723	1953	2085	5861	1572	1882	1810	5264	1322	1385	1136	3863	1403	1485	1403	4465	[illegible]
Support Sessions 2012/13	1364	1687	1564	4625	1391	1882	1731	4824	1919	1986	1474	5379	2237	2133	2176	6556	[illegible]
Support Sessions 2013/14	2238	2396	2312	7146	2194	2337	2585	7036	2352	3021	2156	8169	2382				[illegible]

Public Health Agency

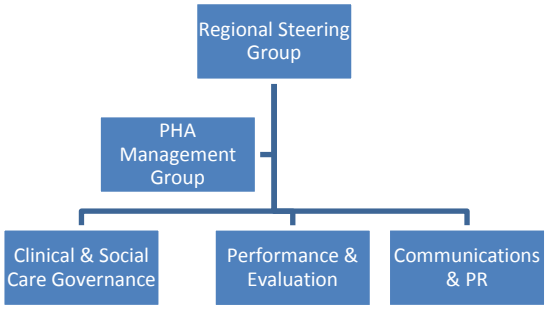
Key Performance Indicators (KPIs)

% of staff, excluding administration who are accredited, or have a time framed action plan in place to work towards accreditation with BACP/IACP or equivalent	100%
% of staff who have completed Access NI enhanced checks	100%
% Comprehensive assessments accepted and completed during first call where it is appropriate to offer	100%
% of Tier 1 clients provided session appointment within 10 days	100%
% of Tier 2 clients provided session appointment within 7 days	100%
% of Tier 3 clients provided session appointment within 5 days	100%
% Clients exceeding 6 attending sessions (package limit)	<5%
% Attendance rate	90%
Incoming calls answered as a % of missed and answered incoming calls	100%
Answered calls within 10 seconds	90%
Answered calls with 30 seconds	100%

Public Health Agency

Communication / PR Activity

Public Health Agency



Performance Management and Clinical Governance

Public Health Agency

Challenges

- The telephone service must be available 24 hours 365 days a year for people in crisis and at risk of self-harm or suicide
- Free of charge
- Staffed by appropriate qualified professionals
- Confidential service
- Non-judgemental
- Non-discriminatory
- Ability to refer/signpost, as appropriate, dependant on the level of crisis

Public Health Agency

Consultation Considerations

- Consultation is Part of the Process
- Performance
- Evidence of Best Practice
- Client Outcomes
- Accountability
- Strategic Fit

Public Health Agency

Contact Details

- Download context paper and questionnaire

www.publichealth.hscni.net/consultation-lifeline-crisis-response-service

- Send completed questionnaire to Elizabeth McGrath, Health Improvement Officer, PHA. Tele: (028) 37 414640 or email **liz.mcgrath@hscni.net**
- All responses must be received by **5pm on Tuesday 24 June 2014.** Late questionnaires will not be processes.