



CLEAR PROJECT

Facilitated by Derry Healthy Cities
Supported by the Western Suicide Strategy Implementation Group

Mapping of Community and Voluntary Sector Organisations Currently Delivering Mental Health and Well-Being Services across the WHSSB Area

February 2009

MOORE STEPHENS
CHARTERED ACCOUNTANTS
BUSINESS ADVISORS

Table of Contents

Introduction	4
1 Mapping Exercise Overview.....	10
1.1 Introduction	10
1.2 Data Provided	10
1.3 Mapping Exercise Population / Return	10
1.4 Returning Organisation Type	12
1.5 Frequency of Contact with Individuals Experiencing Distress.....	13
2 Current Service Provision	15
2.1 Council Area Covered.....	15
2.2 Needs Addressed	16
2.3 Level of Support.....	17
2.4 Target Group	21
2.5 Type of Support	23
2.6 Gaps in Service Provision	26
3 Governance	29
3.1 Organisation Type.....	29
3.2 Organisation Constitution, Purpose and Management	29
3.3 Procedures	30
3.4 Policies and Procedures	31
3.5 Staff / Volunteer Background Checks.....	32
3.6 Data Protection	33
3.7 Monitoring and Evaluation.....	35
3.8 Quality Assurance.....	37
4 Staffing / Volunteers	40
4.1 Staff / Volunteer Qualifications	40
4.2 Accreditation	42
4.3 Types of Counselling Staff / Volunteers	44
4.4 Supervision for Counselling Staff / Volunteers	44
4.5 Training.....	45
4.6 Service User Involvement	46
5 Referrals	50
5.1 Referrals in to an Organisation.....	52
5.2 Referrals out of an Organisation	53
5.3 Action in the Case of Suicidal Behaviour or Self-Harm.....	56
6 Communication.....	58
6.1 Informing Stakeholders	58
6.2 Partnership Working	58
6.3 Networking.....	59
7 Resources	63
7.1 Current Funding.....	63
7.2 Meeting Need	63
7.3 Further Resources	64
8 Strengths, Weaknesses, Opportunities and Threats	67
8.1 Strengths and Challenges.....	67

8.2	Analysis of Strengths, Weaknesses, Opportunities and Threats	69
9	Areas for Development	70
10	Health and Social Care Service Perspectives on Mental Health and Well-being Provision across the Community and Voluntary Sector	72
10.1	Services Provided	72
10.2	Quality	73
10.3	Standards	73
10.4	Referrals	74
10.5	Collaboration and Communication	75
10.6	General Comments	76
10.7	Future Direction	77
11	Perspectives of those Bereaved by Suicide on Mental Health and Well-being Provision	80
11.1	Experience Following Bereavement	80
11.2	Support for Relative Prior to Death	80
11.3	Mental Health Awareness	81
11.4	Considerations for CLEAR	81
12	Overall Conclusions	83
12.1	Service Provision	83
12.2	Governance	84
12.3	Staffing / Volunteers	86
12.4	Referrals	87
12.5	Communication	88
12.6	Resources	88
12.7	Strengths, Weakness, Opportunities and Threats	89
12.8	Areas for Development	89
12.9	Health Service Perspectives	89
12.10	Perspectives of Those Bereaved by Suicide	91
13	Summary of Recommendations and Action Plan	92
13.1	Summary of Recommendations	92
13.2	Action Plan	96
14	Future Direction and Priorities	100
14.1	Service Provision	100
14.2	Governance	101
14.3	Referral Processes	101
14.4	Communication	102
14.5	Resources	103
	Appendix 1 – Pre-Meeting Questionnaire	105
	Appendix 2 – Questionnaire for Health Service Representatives	115
	Appendix 3 – Glossary	120

Introduction

Background to CLEAR Project

In 2006 the *Northern Ireland Suicide Prevention Strategy – Protect Life (A shared vision)* was launched by the Minister for Health, Social Services and Public Safety. The aim of the Strategy is to reduce the suicide rate in Northern Ireland by:

- raising awareness of mental health and well-being issues
- ensuring early recognition of mental ill health and providing appropriate follow-up action by support services
- developing co-ordinated, effective, accessible and timely response mechanisms for those seeking help
- providing appropriate training for people dealing with suicide and mental health issues
- enhancing the support role currently carried out by the voluntary/community sectors, bereaved families and individuals who have made previous suicide attempts
- supporting the media in the development and implementation of guidelines for a suitable response to suicide-related matters
- providing support for research and evaluation of relevant suicide and self-harm issues
- restricting access, where possible, to the means of carrying out suicide.

The Northern Ireland Assembly made funding available to implement the Strategy and the Department of Health, Social Services and Public Safety (DHSSPS) identified a number of regional initiatives. A separate fund was also set aside for Community Support Programmes which are to be developed and rolled out locally in each of the four Health and Social Services Board areas. The purpose of this funding is to support initiatives that either develop local community-based delivery or bring advice and assistance to communities.

Following the publication of the draft *Northern Ireland Suicide Prevention Strategy* in 2006, the Western Health and Social Services Board (WHSSB) established a board-wide group, the Western Suicide Strategy Implementation Group (WSSIG), to take forward implementation of the Strategy at a local level in the West. Membership of the Group is currently made up of the following statutory and non-statutory representatives and further representatives from community and voluntary organisations are in the process of being invited to join the group:

Statutory

Dorothy Hutchinson, Commissioning Lead, WHSSB (Co-Chair)
Brendan Bonner, Manager, Western Investing for Health
Cathy Mullan, Health Promotion Commissioner, WHSSB
Hilary Parke, Suicide Strategy Development Officer, WHSSB
Jim Simpson, Service Planner, WHSSB
Dr Denise O'Hagan, Public Health Medicine, WHSSB
Sally Kelly, Communications, WHSSB
Barry McGale, Suicide Liaison Officer, WHSCT
Dermot Lynch, Suicide Liaison Officer, WHSCT
Kieron Downey, Assistant Director of Children, Mental Health and Disability, WHSCT
Vincent Ryan, Assistant Director, Secondary Care, WHSCT
Debbie Hunter, Suicide Strategy Liaison Officer, WHSCT
Magella Magee, Assistant Health Promotion Manager, WHSCT
Gail Sheen, Communications Officer, WHSCT
Philomena McDermott, Assistant Senior Education Officer, Western Education and Library Board

Non-Statutory

Noella McConnalogue, Zest (Co-Chair)

Kieran Fegan, STEER

Judy Colhoun, Aware Defeat Depression

Alicea McDaid, Cruse

John Friel, Tara Centre

Caroline Ferguson, AMH Fermanagh New Horizons.

Anne McGarrigle, Foyle Bereaved Families Representative & Regional Families Voice

Sandra McDermott, Bereaved Families Representative

As part of the public consultation process undertaken by the WHSSB in 2006/2007 in relation to the Suicide Prevention Strategy, those who attended clearly identified the need for a more robust service re-design, both within the statutory sector and within the community and voluntary sector. Those consulted made it clear that there should be better communication between the various organisations and there should also be clear pathways for individuals to follow. As part of this process, the WHSCT has re-designed its services for those who have been bereaved as a result of suicide, re-designed its training and development intervention, looked at closer opportunities for integration of the various strategies that exist, has put new investment in addressing the issue of self-harm and following up those at risk and is committed to supporting the community and voluntary sector to re-design services that complement those within the statutory sector.

In January 2008 the WHSSB issued a tender inviting applications for the creation of an integrated community delivery programme that would encourage and enable community and voluntary sector organisations in the field of mental health improvement to network, collaborate and link services within the WHSSB area. This tender was awarded to a consortium led by Derry Healthy Cities – whose bid was subsequently branded as the CLEAR Project.

The CLEAR Project aims to forge strong and sustainable links between community and statutory sector service providers through the delivery of the following objectives:

- to promote networking and co-operation by service providers to ensure co-ordinated delivery of accessible and relevant services
- to conduct a SWOT analysis of current community and voluntary sector service provision, cooperation and networking
- to produce a service enhancement development plan
- to research and develop quality standards for best practice in service delivery
- to enable quicker access routes for individuals and families to crisis support in times of distress
- to establish clear and profiled access routes to support following self-harm and suicide
- to develop a communications plan for those engaged in promoting positive mental health.

Mapping Exercise Terms of Reference

As part of its bid, CLEAR included a proposal to undertake an analysis of the community and voluntary sector provision of mental health and emotional well-being services and prepare a strategic development plan aimed at enhancing services. Following a competitive tendering process, Moore Stephens was commissioned by CLEAR in October 2008 to conduct a mapping exercise under the following terms of reference:

to make available to the CLEAR Steering Group an analysis of the strengths of and challenges facing voluntary and community sector organisations currently delivering mental

health and well-being services across the WHSSB area including an assessment of areas of need.

Within this the following were highlighted:

- to map current provision of mental health and well-being services across the WHSSB area
- to identify gaps in provision
- to provide an analysis of the strengths and challenges facing the sector
- to identify areas of need or service development
- to identify areas for improvement in governance.

In defining the organisations to be included in the exercise, it was agreed by a specially-established sub-group that it would not be possible to map every organisation providing mental health and well-being services, given the broad nature of this term¹. The following groups of organisations were therefore selected for the exercise:

- Group 1 - Organisations providing counselling to those experiencing emotional distress
- Group 2 - Organisations providing support to those experiencing emotional distress
- Group 3 - Organisations providing advice or mental health and well-being services and who might be likely to come into contact with people experiencing emotional distress but who would refer these people to the other organisations in the groups above for intensive support/counselling. In particular we focused on organisations that were either already involved in the CLEAR Project or had received funding under the WHSSB Suicide Prevention Strategy.

Approach to Conducting the Mapping Exercise

The approach adopted for the mapping exercise is set out below:

Stage 1 - Project Initiation

A project initiation meeting was held with the sub-group established by the CLEAR Steering Group. The members of the sub-group are:

Eamon O’Kane, Derry Healthy Cities/Health NW (lead agency)
Shauna Houston, CLEAR Project Manager
Jeff Barr, Koram Centre
Gerard Harkin, Strabane & District Caring Services
Marie Dunne, Health Promotion, WHSCT
Brendan Bonner, WHSSB

Stage 2 - Developing and Piloting Mapping Framework

- Meetings with sub-group to agree framework.
- Defining organisations to include in mapping exercise.
- Piloting of framework with four community and voluntary organisations from the Steering Group.

¹ According to the Investing for Health Report *Promoting Mental Health Strategy and Action Plan 2003-2008*,

Mental health is the emotional and spiritual resilience that enables us to enjoy life and to survive pain, disappointment and sadness. It is a positive sense of well being and an underlying belief in our own and others’ dignity and worth... Mental and emotional health is a resource we need for everyday life, and which enables us to manage our lives successfully.

- Taking on board feedback from pilot organisations, a meeting was held with the sub-group to agree final changes and sign-off the questionnaire and list of organisations to be included.
- Meeting with CLEAR Steering Group to update on progress.

Stage 3 – Undertaking Mapping Exercise

- Telephone contact with 73 organisations and branches requesting permission to include in mapping exercise.
- Questionnaires sent to 56 organisations and branches.
- Questionnaires returned from 43 organisations.
- Follow-up interviews held with 31 organisations from Groups 1, 2 and 3 on their premises. Group 1 (counselling) and Group 2 (support) organisations were asked a more detailed series of questions than Group 3 (health and well-being) organisations including information on Quality Assurance, Standards and Resourcing.
- Feedback to sub-group and CLEAR Steering Group including attendance at Steering Group meetings.

Stage 4 - Collecting Additional Information

Additional information was collected through:

- consultation with staff from the WHSSB and WHSCT including:
Barry McGale, Suicide Liaison Officer, WHSCT
Dermot Lynch, Suicide Liaison Officer, WHSCT
Brendan Bonner, Manager, Western Investing for Health
Marie Dunne, Health Promotion Officer, WHSCT
Tommy Monteith, Assistant Programme Manager, Mental Health, Foyle Area, WHSCT
Hilary Parke, Suicide Strategy Development Officer, WHSSB
Jim Simpson, Mental Health Service Planner, WHSSB
Eugene Gallagher, Head of Primary Care and Family Practitioner Services, WHSSB
Debbie Hunter, Health Promotion Officer, WHSCT
- consultation with members of the North West Bereaved by Suicide Support Group.

Stage 5 - Reporting

- Draft report prepared and issued to sub-group for comment.
- Feedback on draft report taken into consideration and report edited.
- Final overall report produced for CLEAR Steering Group (individual organisations are not named within this report).
- Individual reports prepared for each participating organisation, highlighting any particular governance or development areas.

Report Layout

This report sets out the findings from the mapping exercise, provides an analysis of the strengths and challenges facing the community and voluntary sector organisations included in the exercise and identifies possible areas for service development and improvement.

The report is structured as follows:

Section 1 – Mapping Exercise Overview

This section provides an overview of the mapping exercise and the participating organisations.

Section 2 – Current Service Provision

This section outlines the services provided by the community and voluntary organisations participating in the mapping exercise.

Section 3 – Governance

This section reviews the governance arrangements within participating organisations, including an overview of monitoring and evaluation and quality assurance processes.

Section 4 – Staffing / Volunteers

This section reviews the staffing and training arrangements within participating organisations, including an overview of service user involvement.

Section 5 – Referrals

This section reviews the referrals processes adopted by participating organisations.

Section 6 – Communication

This section outlines the current communication methods adopted by participating organisations and reviews organisations' feedback on methods of increasing communication within the sector.

Section 7 – Resources

This section provides an overview of resourcing within participating organisations.

Section 8 – Analysis of Strengths, Weaknesses, Opportunities and Threats

This section sets out the strengths within the sector and challenges facing participating organisations.

Section 9 – Areas for Development

This section reviews the areas for service improvement investment/development as stated by participating organisations.

Section 10 – Health and Social Care Service Perspectives on Mental Health and Well-Being Provision across the Community and Voluntary Sector

This section reviews the perspectives of those working within the WHSSB and WHSCT who were interviewed as part of the mapping exercise on mental health and well-being provision across the community and voluntary sector.

Section 11 – Perspectives of those Bereaved by Suicide on Mental Health and Well-being Provision

This section reviews the feedback from members of the North West Bereaved by Suicide Support Group on mental health and well-being provision in the WHSSB area.

Section 12 – Overall Conclusions

This section sets out the overall conclusions from the research.

Section 13 – Summary of Recommendations and Action Plan

This section sets out a summary of recommendations together with a suggested action plan for CLEAR based on the recommendations.

Section 14 – Future Direction and Priorities

This section sets out a number of areas that CLEAR may wish to focus on and which we consider key to the future direction of mental health and well-being services.

Acknowledgements

We would like to thank all staff and management within the participating community and voluntary organisations for their time, input and openness in completing the questionnaires and participating in the follow-up interviews. We would also like to thank the representatives of the Western Health and Social Services Board and Western Health and Social Care Trust for taking the time to meet with us. We would particularly like to thank the representatives of the North West Bereaved by Suicide Support Group for the time they took to meet with us and their candour in talking about such personal experiences.

The willingness of organisations and individuals participating in this exercise has been notable and we wish to highlight the concern that many expressed to us of ensuring that the information presented within this report is used and acted upon to ensure that people receive the support and can access the services they need, when they need it and in a manner appropriate to them. We are mindful that when talking about mental health and emotional well-being, and in particular suicide and self-harm, we are talking about people and within strategies, reports and consultations we must ensure that people and the need to make a difference to their lives remains at the core. This is a challenge to everyone working in this field – including the CLEAR Project.

Moore Stephens
February 2009

1 Mapping Exercise Overview

1.1 Introduction

This section presents the results of the survey of community and voluntary sector providers of mental health and well-being services. The questionnaire used as part of the survey is attached in Appendix 1.

1.2 Data Provided

At the outset it is important to note that much of the data analysed in this report has been self-reported and, in keeping with our remit, we have not sought to audit or test all such data.

The data gathered from the returned questionnaires has been subjected to a validation process. This involved:

- Reviewing the data for gaps or unusual entries
- Clarifying queried entries with respondents, primarily during the follow-up interviews
- Where possible, cross-checking for consistency across the data.

There are limits to this process and the results outlined in this report are ultimately reliant on the accuracy of the data provided in the questionnaire returns and at interview. The diverse nature of the participating organisations also means that it is not always possible to compare like with like. The results of the mapping exercise and the conclusions drawn from it must therefore take these factors into account.

1.3 Mapping Exercise Population / Return

In determining the organisations to be included in the mapping exercise and in conjunction with the CLEAR sub-group we used the following sources to build our contact list:

- Mental Health West (www.mentalhealthwest.com)
- *Help at Hand* poster produced by the former Sperrin Lakeland Health and Social Care Trust
- *Towards Healing: A Self-Help Directory* produced by the Sperrin Lakeland Victims Programme within the former Sperrin Lakeland Health and Social Care Trust
- CLEAR Project Manager.

In order to focus the mapping exercise we targeted organisations within the following three groups:

- Group 1 - Organisations providing counselling to those experiencing emotional distress
- Group 2 - Organisations providing support to those experiencing emotional distress
- Group 3 - Organisations providing advice or mental health and well-being services and who might be likely to come into contact with people experiencing emotional distress but who would refer these people to the other organisations in the groups above for intensive support / counselling. In particular we focused on organisations that were either already involved in the CLEAR Project or had received funding under the WHSSB Suicide Prevention Strategy (Group 3).

A total of 73 organisations and branches providing services in the Western Health and Social Services Board (WHSSB) area were contacted to introduce the mapping exercise and request permission to forward a questionnaire. Of the 73 organisations and branches contacted:

- Three declined to participate
- One indicated that the exercise was not applicable to them as they were a statutory service
- Two organisations do not exist anymore
- Four numbers were unavailable or did not reply when we called
- Five indicated that they were the same across their branches so only one branch would need to be questioned.

A total of 56 questionnaires were therefore sent out, 43 of which were returned, giving a return rate of 76%. Aware of the limitations of questionnaires, we conducted a further 31 follow-up interviews with responding organisations.

Figure 1.1
Location of Returning Questionnaire Organisations

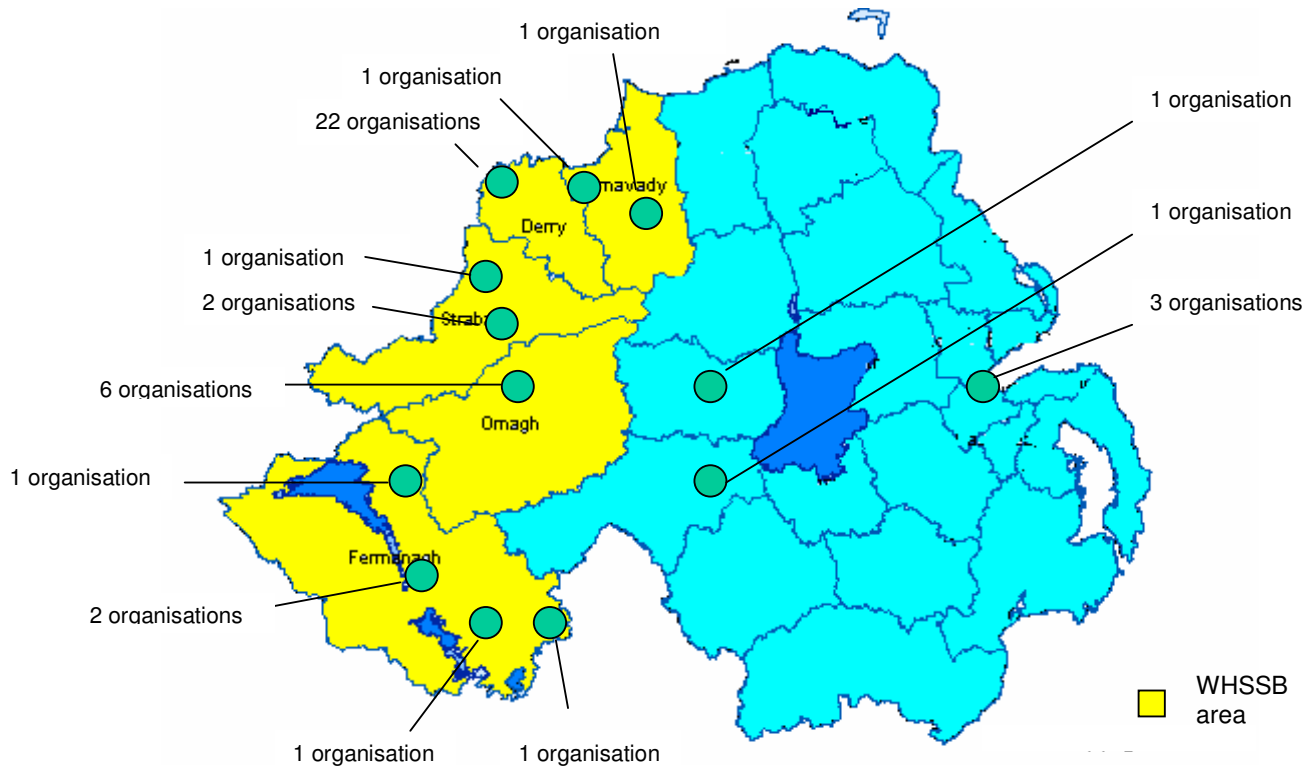


Table 1.1
Location of Returning Organisations

Organisation Group	Limavady Borough Council	Derry City Council	Strabane District Council	Omagh District Council	Fermanagh District Council	Other	Total
Population²	34,000	108,000	39,000	51,000	61,000		
Group 1 (counselling)	2	15	2	2	1	2	24
Group 2 (support)		5		3	3	3	14
Group 3 (health & well-being)		2	1	1	1		5
Total	2	22	3	6	5	5	43

Table 1.1 shows that the majority of returning organisations are based in the primary settlements within the WHSSB area (Derry, Strabane, Omagh, Enniskillen) with a small number located in other regional centres in Belfast, Dungannon or Cookstown. We have further reviewed the coverage provided by organisations in section 2.1 which demonstrates that, although the majority of organisations we covered are based within the Derry City Council area, organisations provide coverage across a number of areas (both within the WHSSB and on a wider regional basis) and services are provided in all council areas within the WHSSB.

It should be noted that whilst 43 organisations returned completed questionnaires, not all questions were completed within the survey by all organisations. Our analysis takes account of this.

1.4 Returning Organisation Type

Against the three categories of organisations targeted under the mapping exercise, responses were returned from the following:

- Twenty-four organisations providing counselling services (Group 1)
- Fourteen organisations providing intensive support to those experiencing emotional distress or mental ill-health (Group 2)
- Five organisations providing advice or mental health and well-being services and who might be likely to come into contact with people experiencing emotional distress but who would refer these people to the other organisations in the groups above for intensive support / counselling (Group 3).

With regard to the 31 organisations interviewed, these broke down as follows:

- Eighteen organisations providing counselling services (Group 1)

² Projected Population (2006 based), by Administrative Area, Registrar General Annual Report 2007

- Ten organisations providing intensive support to those experiencing emotional distress or mental ill-health (Group 2)
- Three organisations providing advice or mental health and well-being services and who might be likely to come into contact with people experiencing emotional distress but who would refer these people to the other organisations in the groups above for intensive support / counselling (Group 3).

We focused our work on obtaining a representative sample of Group 1 (counselling) and Group 2 (support) organisations. It should be noted however that the above does not present a representative sample for Group 3 organisations – this particular group is extremely wide and we limited our contact to those organisations that were either already involved in the CLEAR Project or had received funding or were flagged as types of organisations to be included (eg advice centres).

1.5 Frequency of Contact with Individuals Experiencing Distress

We asked all organisations to note how often they would work with a person experiencing emotional distress, mental ill-health and suicidal behaviour (looking at the number of people and not number of contacts). We categorised this as never, rarely (once a year or less), occasionally (two to four people per year), often (five to twelve people per year) and frequently (more than 12 people per year).

As we had expected from the nature and work of the organisations surveyed, a high percentage of organisations reported that they frequently deal with individuals presenting with emotional distress (91%) and mental ill-health (79%).

The more startling figure is that 67% of organisations surveyed reported that they frequently or often work with people presenting with suicidal behaviour. It should be noted that the figure could be even higher given that a person may not share thoughts of suicide with an organisation from the outset and a much longer period of gaining trust and working with someone may be required before a person feels able to share and discuss such issues.

Key Points

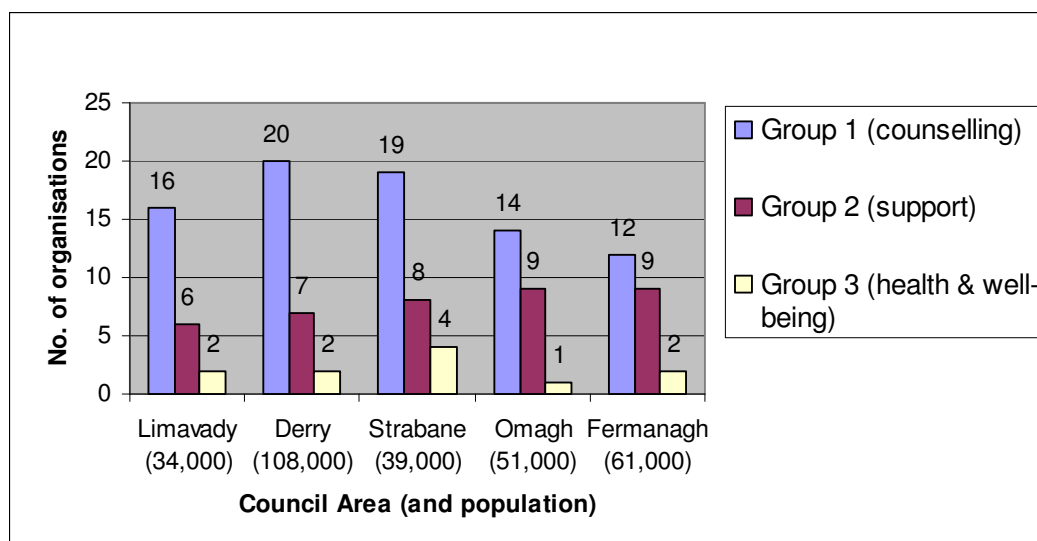
- Three groups of organisations were selected to participate in mapping exercise:
 - Group 1 – organisations providing counselling services
 - Group 2 – organisations providing intensive support to those experiencing emotional distress or mental ill-health
 - Group 3 – organisations providing advice or mental health and well-being services and who might be likely to come into contact with people experiencing emotional distress but who would refer these people to the other organisations in the groups above for intensive support/counselling.
- 43 organisations returned questionnaires.
- 31 organisations interviewed.
- 51% of organisations participating in the mapping exercise are based in the Derry City Council area, followed by 14% in the Omagh District Council area, 11.5% in the Fermanagh District Council area, 11.5% in areas outside of the WHSSB area, 7% in the Strabane District Council area and 5% in the Limavady Borough Council area.
- Organisations reported high frequency of contact with people suffering from emotional distress, mental ill-health and suicidal behaviour.

2 Current Service Provision

2.1 Council Area Covered

In addition to identifying where an organisation is based (Figure 1.1 and Table 1.1) we asked participating organisations to describe the areas covered by their services. The chart below illustrates the council areas within the WHSSB covered by organisations returning questionnaires (note: an organisation is counted in each council area that it covers).

Figure 2.1
Council Area Covered



From the above chart, it appears that there is a broad coverage of the WHSSB area by groups responding to the survey. The following should however be taken into account:

- Although an organisation may cover a particular council district, transport issues may prevent or restrict the ease of access to the service
- organisations operating in neighbouring districts such as Coleraine, Dungannon and the Republic of Ireland may also provide services, including outreach, to the five council areas within the WHSSB – we have only picked up on five such organisations within this mapping exercise but it is likely that more organisations outside the WHSSB area provide services to the WHSSB area
- some organisations based in the WHSSB area also provide services to areas outside the WHSSB.

From the above chart, it is clear that a large number of organisations provide services to the Strabane area (slightly more in total than the Derry area). Given the population size of such an area the need for collaboration may be important, particularly to avoid a situation where organisations are 'competing' for people to use their services.

2.2 Needs Addressed

Within the 43 organisations returning surveys, the following needs are addressed (note: most organisations indicated they addressed more than one need):

Table 2.1
Needs Addressed

Need	Group 1 (counselling - 24 organisations)		Group 2 (support - 14 organisations)		Group 3 (health & well-being - 5 organisations)		Total
	No. of organisations	% of Group 1 organisations	No. of organisations	% of Group 2 organisations	No. of organisations	% of Group 3 organisations	
Addictions	8	33%	4	29%	1	20%	13
Advice	7	29%	4	29%	2	40%	13
Bereavement	14	58%	4	29%			18
Depression	17	71%	7	50%	1	20%	25
Domestic Violence	12	50%	2	14%	1	20%	15
Drugs / Alcohol	7	29%	3	21%	3	60%	13
Family Support	14	58%	8	57%	2	40%	26
Health & Well- being	17	71%	5	36%	4	80%	26
Mental health	16	67%	9	64%	3	60%	28
Self-harm	18	75%	4	29%	1	20%	23
Suicide	13	54%	6	42%	3	60%	22
Trauma	10	41%	6	43%	3	60%	19

From the above table, the three generic areas of need:

- Mental health
- Health and well-being
- Family support

appear to be addressed by all groups of organisations.

The least common areas of need covered across all groups of organisations are the more specific areas:

- Advice
- Addictions
- Drugs / Alcohol.

This reflects particularly the specialist nature of providing addiction services.

It is interesting to note the diversity of needs addressed by the 23 Group 1 (counselling) organisations. The majority of these focus on self-harm, health and well-being and depression. However, this 'counselling sector' cannot therefore be thought of as a homogenous whole, but rather a diverse group of organisations, whose primary

focus may or may not be counselling and for whom the counselling provided will address a number of needs rather than one specialist need. Within this diversity however, the survey results show that some specialist areas, such as addictions, drugs and alcohol and trauma, are not widely covered by counselling organisations.

This diversity of needs addressed is also reflected within the 14 Group 2 (support) organisations, reflecting the holistic approach that many community and voluntary organisations adopt in working with people.

As expected, the largest need addressed by the five Group 3 (health and well-being) organisations is health and well-being.

With regard to the specific areas of suicide and self-harm it is interesting to note that self-harm is addressed by most Group 1 (counselling) organisations but is not addressed by as many Group 2 (support) and Group 3 (health and well-being) organisations. With regard to suicide, relatively speaking Group 3 (health and well-being) organisations surveyed are more involved in this area (predominantly through general awareness-raising).

Recommendation 1

The diversity of needs addressed by organisations, particularly by Group 1 (counselling) organisations, highlights the holistic approach adopted by many within the community and voluntary sector. A consideration for CLEAR in looking to future service development will be whether the holistic, 'one-stop-shop' model is extended or whether the focus is on more specialist-based services.

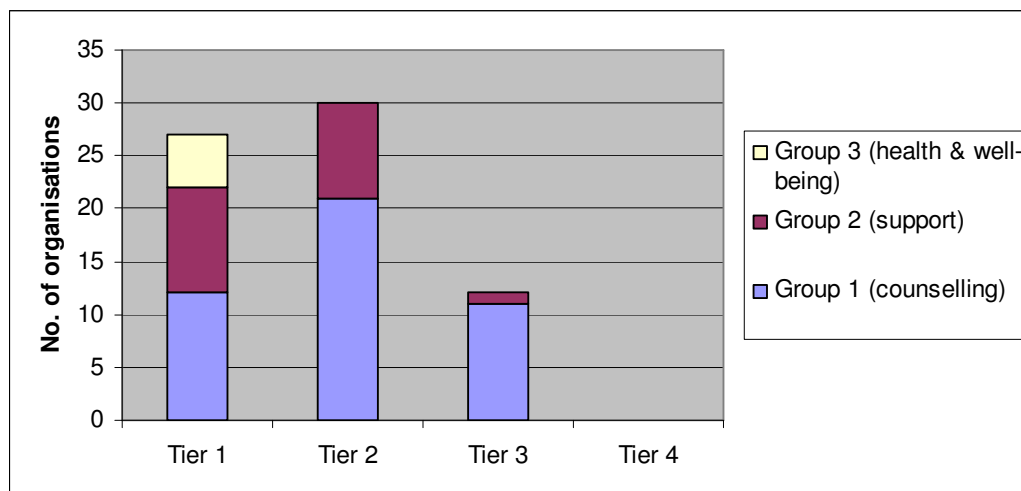
2.3 Level of Support

As part of the questionnaire, organisations were asked to indicate the level of support provided to individuals in relation to suicide/self-harm according to the following tiers:

- Tier 1 – universal services aimed at the general population
- Tier 2 – early intervention providing supportive environments for generally-targeted groups and those at risk
- Tier 3 – intensive intervention for more severe or complex issues providing specialist services
- Tier 4 – acute treatment providing very specialist treatment such as day units etc.

The results are set out in the chart below (note: an organisation may have identified that it provides support at more than one tier):

Figure 2.2
Level of Support



Note: Two organisations did not provide a response to the level of support provided

Organisations reported that the majority of work is provided at tier 2 level with some organisations providing more intensive services at tier 3.

We did not expect to find any community and voluntary organisations operating at tier 4, given that this specialist area of work is a primary concern of the statutory sector.

Tier 3 services are provided almost exclusively by Group 1 (counselling) organisations reflecting the specialist nature of intensive intervention. We did not expect any Group 2 (support) organisations to fall into tier 3 given the more specialised nature of work at this level; one Group 2 (support) organisation did however report that it operates at tier 3 (intensive intervention). At tier 3, it is likely that the statutory sector provides a number of services here through the Community Mental Health Teams for example.

At tier 2, services are provided by Group 1 (counselling) and Group 2 (support) organisations reflecting the relatively specialist nature of work provided by these organisations within early intervention.

At tier 1, services are provided by all three groups of organisations. As we would expect, Group 3 (health and wellbeing) organisations provide only tier 1 services in relation to suicide / self-harm. We would also expect to see Group 2 (support) organisations providing tier 1 services. It is interesting to note however that almost half of Group 1 (counselling) organisations also provide universal services at tier 1. The range of levels of support provided by Group 1 (counselling) organisations reflects the diversity of provision highlighted in section 2.2 on needs addressed. This may also reflect the path a person takes in obtaining support in that it is at the early intervention or universal services stage (tiers 2 and 1) that trust is built up allowing a person to move to intensive intervention at tier 3.

Recommendation 2

CLEAR may wish to consider further mapping the level of provision at each tier within the WHSSB area from both the community and voluntary and statutory sectors to determine the level of coverage across all tiers.

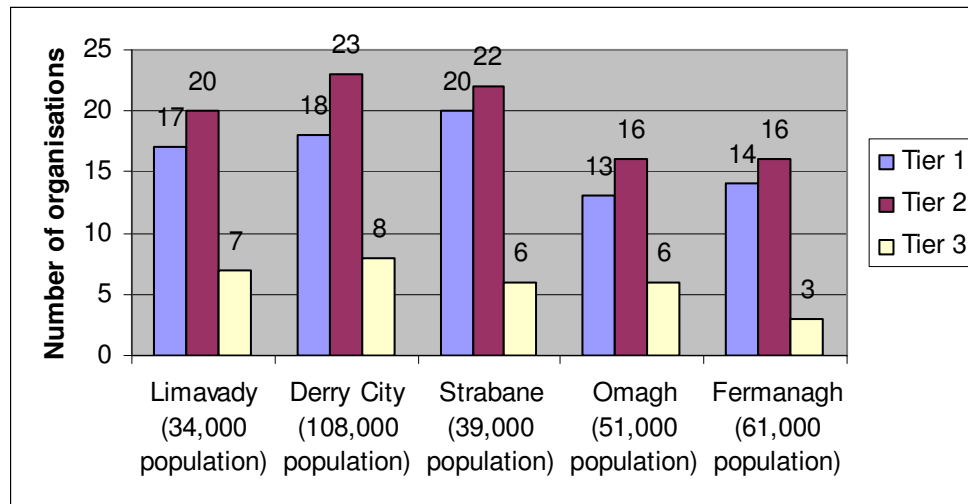
With regard to the level of services at each tier and according to District Council area, the results are set out in table 2.2 and figure 2.3 (note: an organisation may provide support across a number of tiers in a number of council areas):

Table 2.2
Level of Support by Council Area

Council	Number of organisations		
	Tier 1 Universal services	Tier 2 Early intervention	Tier 3 Intensive intervention
Limavady Borough Council (population 34,000)	17	20	7
Derry City Council (population 108,000)	18	23	8
Strabane District Council (population 39,000)	20	22	6
Omagh District Council (population 51,000)	13	16	6
Fermanagh District Council (population 61,000)	14	16	3

Note: Two organisations did not provide a response to the level of support provided

Figure 2.3
Level of Support by Council Area



It is notable that whilst the Derry council area has a significantly higher population than other council areas, in terms of early and intensive intervention the number of organisations providing services under this survey does not proportionally increase.

Recommendation 3

The CLEAR Project presents an opportunity for developing greater collaboration and improving communication amongst organisations providing services in individual council districts as well as throughout the WHSSB area as a whole. Where a large or low number of organisations per head of population are providing support services (particularly at tiers 2 and 3) CLEAR should research this further to ensure that all people have access to services and that a 'competition' amongst organisations is minimised.

2.4 Target Group

Table 2.3 sets out the target groups for whom organisations provide services (note: an organisation may have identified more than one target group):

Table 2.3
Target Group

Target Group	Number of Organisations Providing Services to Target Group			Total
	Group 1 (counselling – 24 orgs.)	Group 2 (support – 14 orgs.)	Group 3 (health & well-being – 5 orgs.)	
Children & young people	17	7	4	28
Women	19	12	4	35
Men	18	9	4	31
Older People	16	8	4	28
Ethnic minorities	7	6	3	16
Gay, Lesbian, Transgender	12	7	2	21
Rural dwellers	14	9	4	27
Urban dwellers	12	8	3	23
Other	6	3	1	10

Within the category of 'Other', groups listed here were:

- Victims and conflict-related
- Farming families
- Parents / carers
- No specific group
- Anyone in distress wanting to make change.

Of the groups surveyed, the majority of groups reported that they provide services to adult women (81%) and men (72%) with 65% provided to children and young people and older people respectively. The categories of people that the fewest numbers of organisations reported targeting are ethnic minorities and gay, lesbian, bisexual and transgender – this could be understandable given the often specialist focus of services provided to these groupings.

We had considered that ethnic minorities as a grouping would perhaps be either hard to reach or not served as widely by organisations across the three groups. We therefore asked the, 28 Group 1 (counselling) and Group 2 (support) organisations at interview whether dealing with ethnic minorities presented any challenges to their organisations. One organisation has developed a project specifically for the Polish community but many organisations responded that it can be hard engaging ethnic minority communities or that uptake of their services from ethnic minority groups is low. Individuals from ethnic minority groups are just as likely to suffer from mental ill-health

and emotional distress³. Possible reasons for low uptake of community and voluntary services within the organisations we questioned may be:

- Cultural stigma against mental ill-health and emotional well-being
- Individuals from ethnic minority backgrounds obtain support through general organisations focused specifically on ethnic minorities which were not covered within this exercise
- Language barriers
- Smaller ethnic minority population in WHSSB than in other areas.

All organisations questioned responded that when they did deal with ethnic minorities there were no major issues with language barriers and resourcing translators was the only real concern at times.

A further review of ethnic minority support organisations would have to be undertaken to determine the extent to which individuals present with mental health and emotional well-being issues and the actions taken by such organisations in providing support or referrals. It is however important that ethnic minority support organisations are included in any referral pathway or route map that CLEAR may develop and have a clear understanding of, for example, the counselling services available.

With regard to gay, lesbian, bisexual and transgender people, less than half of the organisations surveyed provide services targeted at this group. This is further reflected in section 2.6 with regard to gaps in provision. It should be noted however that evidence suggests that anxiety, depression, self-harm and suicidal feelings are more common among lesbian, gay and bisexual people than among heterosexual people – rates of drug and alcohol misuse are also higher among lesbian, gay and bisexual people⁴.

It was further noted by one organisation that, as a group under Section 75, men are often left out from services and not enough is done to provide male-specific services or services that encourage male uptake through their specific design and delivery. Whilst men appear relatively well targeted by the organisations surveyed there is perhaps therefore a distinction to be made between targeting men and designing and delivering services in such a way that encourages access by men.

Recommendation 4

The analysis of target groupings reported by organisations surveyed shows that ethnic minorities and lesbian, gay, bisexual and transgender people are not targeted as frequently as other groups. Further research is required to assess the need within these communities and to determine whether appropriate and accessible services are in place.

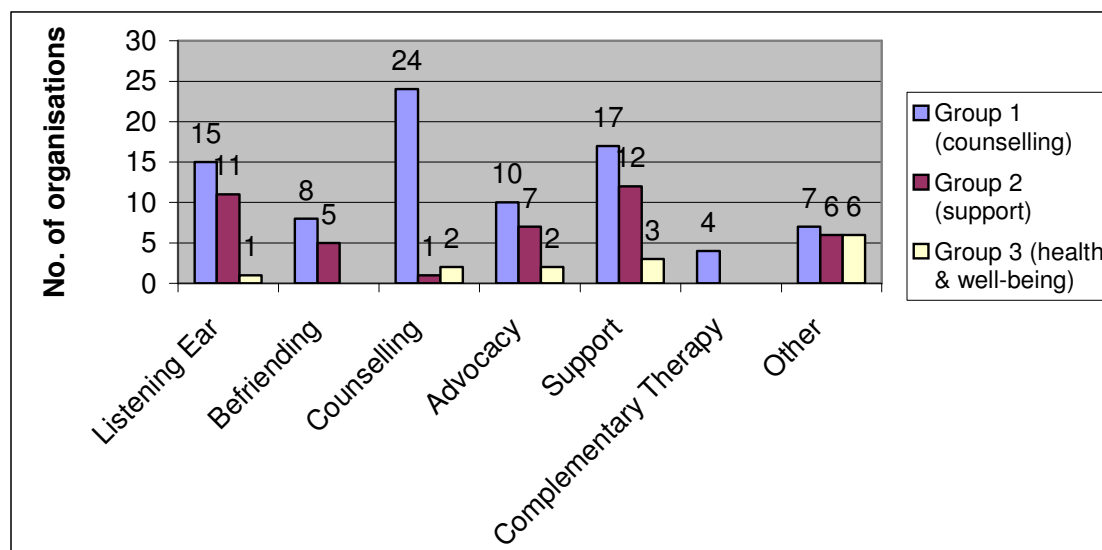
³ A report in the British Journal of Psychiatry (2003) noted *...reports of high rates of suicide and self-harm in Asian women... high rates of severe mental illness in people of African-Caribbean, African and Asian origin... and concerns about the acceptability of services to ethnic minority patients.* Hunt. I et al. Suicides in ethnic minorities within 12 months of contact with mental health services. The British Journal of Psychiatry (2003) 183: 155-160

⁴ www.mind.org.uk – information factsheet

2.5 Type of Support

Figure 2.4 shows the type of support provided by organisations within the mapping exercise (note: an organisation may provide more than one type of support).

Figure 2.4
Type of Support



It should be noted that where a Group 2 (support) or Group 3 (health and well-being) organisation has indicated that they provide counselling this is through the use of other counselling organisations, rather than their own directly-employed or sessional counsellors. Additionally, a further three organisations provide their offices as a base for other community and voluntary organisations to come in and deliver counselling for their members.

Activities within the 'Other' category include:

- Alternative therapy
- Mentoring
- Training
- Education
- Research
- Advice
- Accommodation.

The most common area of work (ie provided by all groups) is Support, followed by Listening Ear and Counselling with the least common area of work identified was Befriending. As has been highlighted earlier in this report, Group 1 (counselling) organisations remain diverse in the type of support provided. This reflects the holistic approach many organisations adopt where, for example, a person receiving counselling within an organisation may also avail of advocacy or befriending services. This does however present questions for consideration with regard to duplication and support pathways – how can organisations avoid the duplication of services whilst also ensuring that people do not have to visit a number of different organisations (each time repeating their story) to receive different types of support?

Recommendation 5

The issue of balancing the development of a holistic approach and reducing the need for people to see a number of different organisations with the avoidance of duplication of services, particularly in a time of restricted funding, is one that will require further consideration by CLEAR, particularly in the development of any referral pathway or route map.

We asked organisations to indicate the number of people supported in the last year within each category of support they provide. Table 2.4 presents the total number of people supported within each category by organisation group (note: these figures are self-reported and have not been audited).

Table 2.4
Number of People Supported

Type of Support	Total Number of People Supported (in the last year)			Total
	Group 1 (counselling – 24 orgs.)	Group 2 (support – 14 orgs.)	Group 3 (health & well-being – 5 orgs.)	
Listening Ear	1,227	3,025		4,252
Befriending	729	145		874
Counselling	2,640	5	2	2,647
Advocacy	288	386	3	677
Support	2,516	624	103	3,243
Complementary Therapy	112			112
Other	1,763	292	6,403	8,458

Note: These results are based on information from 20 organisations.

It should be noted that an individual may have received support across a number of areas such as counselling and complementary therapy and will therefore be counted twice.

Activities within the 'Other' category are as defined above. The highest figures within the 'other' category are reported by Group 3 (health and well-being) organisations in the following types of work:

- Conservation (2,000)
- Advice (4,000)
- Training and education (1,930).

With regard to activities within the 'other' category reported by Group 1 (counselling) organisations, the following types of work are included:

- Training and education (1,595)
- Mentoring (168).

In addition to the 20 organisations that provided the figures totalled in the table above, a further four organisations provided overall numbers of contacts (total of 42,103 contacts) in the year or numbers of individuals (total of 678 individuals) across all programmes.

2.5.1 Waiting List for Counselling Services

As part of the questionnaire, we asked the 23 organisations providing counselling services to provide details of their average waiting time to access services and the average number of people waiting. The results are presented in the table below.

Table 2.5
Average Wait for Counselling

2 weeks or less	3-4 weeks	1-3 months	4-6 months	6-9 months
9	6	3	0	1

Note: Three organisations did not give a response to this question and two indicated that the waiting time varies

Although four organisations have waiting lists of over one month, all organisations we spoke to indicated that if it was felt that an individual was in crisis and required an immediate appointment, such individuals would be accommodated immediately.

2.5.2 Waiting List for Other Services

All organisations completing questionnaires were asked whether they operated waiting lists for services other than counselling. We did not ask organisations to indicate an average waiting time for these other services. Table 2.6 sets out details of waiting lists for other services provided by organisations (such as listening ear and befriending).

Table 2.6
Waiting List for Other Services

	Yes	No	Don't Know
Group 1 (counselling – 24 organisations)	7	15	1
Group 2 (support - 14 organisations)	1	12	
Group 3 (health & well-being - 5 organisations)	2	3	

Note: Two organisations did not give a response to this question

Table 2.6 shows therefore that the majority of organisations surveyed do not have a waiting list for services. Of those who answered yes, waiting lists were for services such as:

- Complementary therapy
- Personal development workshops
- Grief resolution residential weekends
- Floating support
- Education programmes.

2.6 Gaps in Service Provision

All organisations interviewed were asked whether, from their experience, there are any gaps in provision across the local community / wider geography in terms of mental health and emotional well-being, and more particularly in terms of suicide/self-harm. The responses provided are set out below (note: these gaps in service provision are self-reported by those people interviewed – verification of these gaps in service provision would require a more detailed review and audit than has been conducted within the remit of the mapping exercise and we cannot therefore assure that these services are not currently being provided by other organisations or agencies):

Young People and Children

- Nothing for young people socially
- Young people - some organisations are dedicated to them but there is not enough focus on emotional health and well-being
- Very few supports for children with mental health problems or mothers with mental health problems
- Nothing for 16-18 year olds
- Would like to see more out there re provision of mental health and emotional well being for young people with special needs particularly around bereavement
- Nowhere for young gay people to meet (under 18 years old) and receive support
- Work with teenagers and fathers in domestic abuse settings

Men

- Young men aged 18-25 years
- Gap in suicide services for older men in the area
- Gap in counselling services for men in the Derry area
- Services are not specifically designed or targeted at men. The GP is the gatekeeper to services but men do not go to GP
- Need to do more prevention work with young men

Other Groups

- Lack of services for lesbian/bisexual women in the Western area
- Lack of services for transgender men or women
- Support for families of children who have come out as gay, bisexual or transgender
- Traveller community need something accessible
- Not much support in rural communities, although it should be acknowledged that often people like travelling outside of their community for support as they do not wish people within their community to know
- No support services for bereaved families locally - transport an issue
- Support for people in the poorest areas - giving encouragement and direction to people

- Involvement at school level eg social and personal education programmes in schools
- Rural outreach - extra volunteer time is required and lack of resources to access everyone
- Gap in terms of actively targeting ethnic minorities

Access

- Statutory organisations are moving out of the local area making it harder for people to access services given the rural geography
- GPs need to be encouraged to support or refer on to community and voluntary organisations
- Capacity-building in the community
- It can often take time to link people into services, but for someone in crisis this is an issue
- Waiting list for social services

Therapeutic Services

- More complementary therapy services are needed and less pharmacology
- Lack of applied psychotherapy service in northern sector of the WHSSB
- Mild cases not readily picked up – the focus is on chronic cases
- Statutory organisations fail to recognise that alcohol addiction is a mental health problem- nobody gets seen until they are sober and you are more likely to be seen for drug addiction than alcohol
- Anger management

Other

- Out-of-hours support
- My initial reaction is yes but I do not know what is out there so cannot be precise.

It should be noted that one person felt that services within the Omagh area were excellent and that there are no gaps in provision for that area.

Key Points

- From analysis of the surveys there is some disparity in services provided within council areas when assessed by population size. Where a large or low number of services are provided per head of population it is important that organisations across all sectors work together to avoid a situation where organisations are 'competing' for people to use their services.
- With regard to the specific areas of suicide and self-harm it is interesting to note that self-harm is addressed by most Group 1 (counselling) organisations but is not addressed by as many Group 2 (support) and Group 3 (health and well-being) organisations. With regard to suicide, relatively speaking Group 3 (health and well-being) organisations surveyed are more involved in this area (predominantly through general awareness-raising). The diversity of needs addressed by organisations, particularly by Group 1 (counselling) organisations, highlights the holistic approach adopted by many within the community and voluntary sector. A consideration for CLEAR in looking to future service development will be whether the holistic, 'one-stop-shop' model is extended or whether the focus is on more specialist-based services.
- There are a number of areas or groups of people that organisations reported as lacking in service provision. It is important that these are reviewed to ensure that everyone has access to the right kind of support, in a way that is meaningful to them and at a time when they need it to be met. In the event that a review of services shows that provision is already made in these areas, there is still a need for communicating what services are available and ensuring that people can access the services.

3 Governance

Organisations were questioned with regard to governance through questionnaires and interview. It should be noted that the information provided has been self-reported and that has not been audited as part of this exercise.

3.1 Organisation Type

All organisations returning questionnaires classified themselves as charities except two, one of which stated it is a Trust and the other which stated that it is a not-for-profit limited company.

Recommendation 6

The majority of organisations reported that they are charities or hold charitable status. With a new Charity Commission for Northern Ireland expected to be established by the end of March 2009 there may be some work for CLEAR in assisting organisations to prepare or ensuring that organisations prepare for and meet the relevant requirements imposed by the Commission on charities.

3.2 Organisation Constitution, Purpose and Management

From the 43 completed questionnaires, the key findings relating to organisation constitution and management are:

- all except one organisation (who responded 'don't know') reported that they are governed by a constitution
- all except one organisation (who responded 'don't know') reported that they have a defined purpose which they meet very well or well
- all except two organisations (one who responded 'don't know' and one with 'no') reported that they are led by a management board (in the case of the organisation that responded 'no', this is a deliberate decision given the nature of the group)
- 74% of organisations reported that they have developed Terms of Reference for the management board (Note that 12% of organisations did not know if Terms of Reference had been developed so the figure may in fact be higher).

3.3 Procedures

Organisations were asked to rate themselves against a number of statements – the results are set out in the table below.

Table 3.1
Organisation Procedures

Statement	Number of Organisations			
	Yes- we do this very well	Yes- this is sometimes/ partially true of us	We are thinking about doing this	We don't do/have this and are not thinking about it
The management board meets regularly and meetings are minuted and actions followed through	39	2		1
The relationship between staff and the management board is very good	37	3		1
The respective roles of the management board and staff are well established	37	3		1
There are clear roles and responsibilities for each staff member	37	4		1
The staff management team meets regularly	37	3	1	1
Staff and volunteers are consulted about the direction of the organisation	32	10		1
The organisation has a clear development plan / strategy	32	8	2	1
The organisation has well embedded monitoring systems (financial, output performance)	37	5		1
The organisation has all necessary policies eg child protection, health & safety, equal opportunities etc well established	38	4		1
The organisation has a clear, well-established complaints procedure	37	4	1	1
The organisation works well as a team	38	3		1
Key people delegate as much as they can	33	10		0

Given that this exercise was a self-assessment, it is not surprising that organisations would rate themselves well and further testing would be required to accurately measure each statement. In addition, a positive response that an organisation manages a

certain area well does not negate the need for further training and development to ensure that, for example, complaints procedures are well-established throughout an organisation or that policies are not only in place but are embedded within the practice of the organisation.

It should also be noted that all the responses “we do not have this” were provided by the same organisation and is due to the organisation not having the capacity or resources to address these areas.

The findings from the above show that the largest areas for development within organisations are in the setting of development plans/strategies, the consultation of staff and volunteers in the development of organisation strategy and delegation.

Recommendation 7

CLEAR may wish to consider how it can support organisations to set development plans and strategies and ensure that staff and volunteers are consulted in the development of organisation strategy. This support could be through activities such as training in strategic planning.

3.4 Policies and Procedures

As part of the questionnaire, we asked organisations to identify the key policies held (note: we did not evaluate the contents of the policies held or how widely their usage was embedded within an organisation). The table below sets out the policies and procedures held by organisations.

**Table 3.2
Policies and Procedures**

Policy / Procedure	Number of organisations			Total
	Group 1 (counselling - 24 orgs.)	Group 2 (support – 14 orgs.)	Group 3 (health & well-being – 5 orgs.)	
Child Protection	24	11	4	39
Vulnerable Adult Protection	21	10	3	34
Data Protection	22	10	5	37
Equal Opportunities	24	14	5	43
Financial Controls	23	12	5	40

The key findings relating to policies and procedures are:

- all organisations reported that they hold equal opportunities policies
- three organisations should develop a policy on financial controls
- six organisations should develop a data protection policy
- one organisation that indicated that it provides services to children and young people does not hold a child protection policy – we recommend that this is developed as soon as possible. The remaining three organisations that do not

hold a child protection policy have indicated that they do not provide services to children and young people; however, since organisations may come into contact with children and young people (eg a mother seeking support for postnatal depression may bring her child with her), the remaining three organisations should also develop child protection policies as a matter of good practice

- for the nine organisations that do not have a vulnerable adult protection policy in place, we recommend that they develop vulnerable adult protection policies as a matter of good practice, taking into consideration the definition of 'vulnerable adult' under the regional policy *Safeguarding Vulnerable Adults, Regional Adult Protection Policy and Procedural Guidance, September 2006* (see below).

Recommendation 8

The five policies and procedures in Section 3.4 could be considered the minimum required for best practice. A number of organisations should therefore develop child protection, vulnerable adult, data protection and financial controls policies. CLEAR should consider whether there is a role for it to play in supporting organisations in the development of policies and providing training or ensuring that training is provided on the implementation and updating of policies to all groups. CLEAR should also consider defining a mechanism for ensuring that policies are adopted, adhered to and reviewed.

3.5 Staff / Volunteer Background Checks

Of the organisations who returned questionnaires, 35 organisations conduct background checks on staff⁵ and seven organisations do not conduct checks (one organisation did not provide a response to this question).

Three of the organisations that do not conduct checks indicated that they provide services for children and young people – these organisations should proceed with POCVA checks as soon as possible, particularly for those staff who are delivering services for children and young people.

Under POCVA a vulnerable adult is defined as an adult in a nursing or residential home or where prescribed services are provided in a person's home by a health services body, a domiciliary care agency or a prescribed person. None of the seven organisations that do not conduct checks provide such services. However, the regional policy *Safeguarding Vulnerable Adults, Regional Adult Protection Policy and Procedural Guidance, September 2006* widens the definition of vulnerable adult to:

A person aged 18 years or over who is, or may be, in need of community care services or is resident in a continuing care facility by reason of mental or other disability, age or illness or who is, or may be, unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation.

This definition of adults who "may be eligible for community care services" ... include informal carers, family and friends who provide personal assistance and care to adults on an unpaid basis.

⁵ These checks are currently conducted by Access NI. Previously these checks would have been referred to as POC, POVA or POCVA checks and conducted through the PSNI and DHSSPS

It is therefore our opinion that in order to maintain best practice, the remaining four organisations that do not conduct POCVA checks on staff/volunteers should implement this procedure.

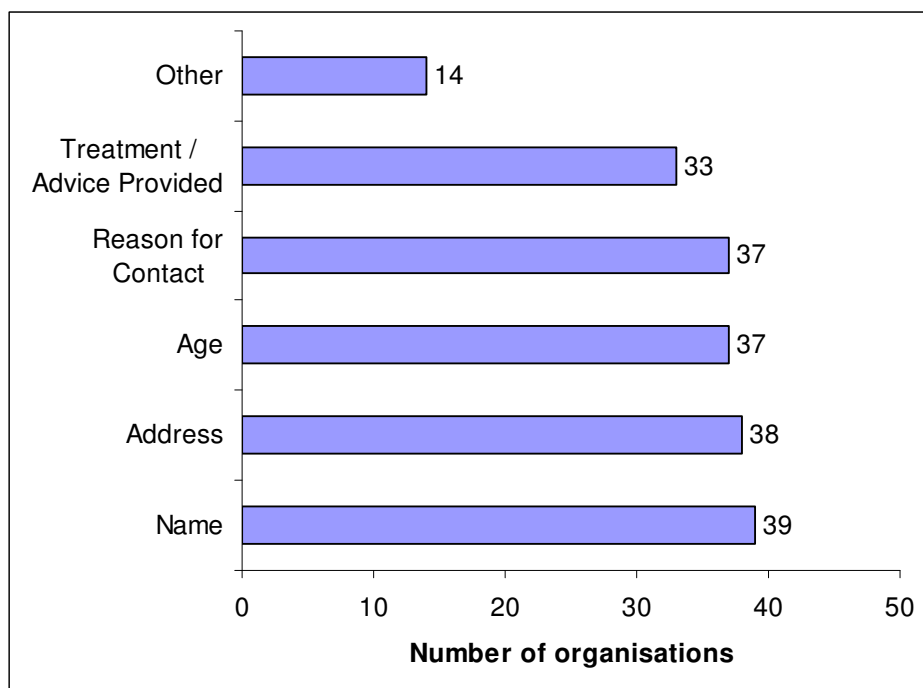
For the organisation that did not provide a response to this question, if staff/volunteers are not currently assessed through a POCVA check, the organisation should proceed to implement this.

3.6 Data Protection

3.6.1 Information Type

As expected, all organisations, except three hold client information. For the three organisations that do not hold client information this is a conscious policy decision – only the minimum information to complete monitoring returns (ie numbers of contacts) is held. The type of information held is summarised in the chart below.

Figure 3.1
Client Information Type



The types of information within the 'Other' category include:

- Medication
- GP details
- Client notes
- Counsellor case notes
- Assessment and support plans
- Ward
- Employment history.

Since the vast majority of organisations hold data on the people that they have contact with it is imperative that data protection arrangements are stringent and well-embedded. Confidentiality is paramount, particularly in areas where there is still stigma such as mental health or where the support or treatment is personal and sensitive. The onus is therefore on organisations to ensure data protection and confidentiality arrangements are in place and operational at all times.

3.6.2 Information Storage and Protection

The information that organisations report that they hold is kept, for the most part, on both computer and manual records.

Table 3.3
Policies and Procedures

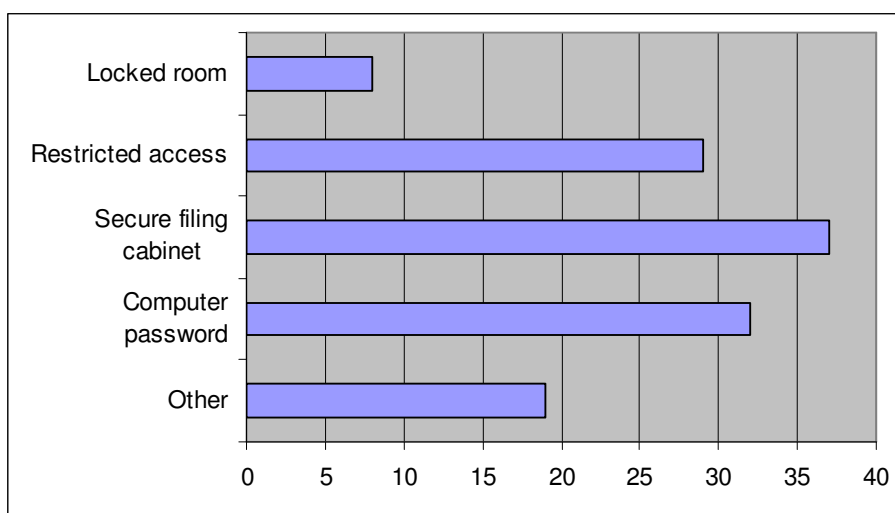
Storage Type	Group 1 (counselling – 24 orgs.)	Group 2 (support – 14 orgs.)	Group 3 (health & well-being – 5 orgs.)	Total
Manually	4	4		8
Computerised		1		1
Both	20	7	5	32

Note: Two organisations did not give a response to this question

We did not ask organisations how the computerised information was held but it is important that adequate data protection procedures are in place, particularly if laptops are used to store such information or when sending information (for instance by post or by email).

When asked how information held was protected, organisations returning questionnaires reported that they adequately protect client information through the following:

Figure 3.2
Data Protection Method



Methods of protecting information within the 'Other' category include:

- Case notes and client contact details kept separately from each other. Case notes only assigned a client reference and access to both sets of information restricted
- Minimum amount of information held
- Information shredded once it has been used for reporting
- Therapy days set to reduce clashes with non-treatment activities (therefore a person attending therapy is not likely to bump into someone attending a non-treatment activity and their confidentiality can be maintained).

Recommendation 9

Data protection and data storage best practice is continually updating, particularly in the light of recent 'loss of sensitive information' scandals in the media. The issue of data protection will also be extremely pertinent in determining what to do with client files and other data if an organisation closes due to funding constraints. Whilst organisations surveyed reported that they had data protection procedures in place, it is important that these data protection arrangements continue to be updated in light of new guidance and that they are well embedded throughout the organisation. If CLEAR proceeds to develop standards for mental health and well-being service provision, data protection and confidentiality will form an important part of these. There may therefore be a role for CLEAR in not only providing information on data protection, but providing training and assistance or ensuring that training and assistance are provided to enable organisations to ensure that they can meet any standards developed.

3.7 Monitoring and Evaluation

3.7.1 Strategic Planning

Of the 28 Group 1 (counselling) and Group 2 (support) organisations interviewed, 89% stated that they have or are currently developing a strategic

plan and would measure progress against it. Of the remainder 7% did not know if there was a strategic plan in place and 4% did not have a strategic plan. Many of the organisations that stated that they have or are currently developing a strategic plan also stated that they involve staff, volunteers and management as well as the management Board in developing the plans. A small number of organisations highlighted that strategic plans were developed as a response to funder requirements or as part of funding applications.

3.7.2 Evaluations

Of the 28 Group 1 (counselling) and Group 2 (support) organisations interviewed, 100% reported that they conduct evaluations of their services. Many organisations highlighted that this was as a part of funding requirements and a number concluded external evaluations as required by funders.

3.7.3 Future Planning

The 28 Group 1 (counselling) and Group 2 (support) organisations interviewed were asked whether they use monitoring and evaluation information to inform future planning – 89% indicated that they do use information to inform future planning. Many of the organisations responding ‘yes’ highlighted that they had developed or improved services based on monitoring and evaluation information and client feedback. The remainder of the responses were not clear in this respect although none of the organisations indicated that they do not use information to inform future planning.

3.7.4 Service User Feedback

Of the 28 Group 1 (counselling) and Group 2 (support) organisations interviewed, 89% stated that they have mechanisms for feedback from service users including:

- end of programme/course questionnaires
- survey
- focus groups
- informal feedback from service users and their families.

Only one organisation responded that it did not have any mechanism for feedback from service users due to the nature of the service.

Recommendation 10

We are mindful that, given the nature of the organisations and the services provided, obtaining service user feedback can be more difficult than for community and voluntary organisations providing other, more general, services. This point is also linked with the involvement of service users in the design and delivery of services (see section 4.6). There may therefore be an opportunity for CLEAR to support organisations to develop appropriate mechanisms for service user feedback and involvement.

3.8 Quality Assurance

3.8.1 Standards

The 28 Group 1 (counselling) and Group 2 (support) organisations interviewed were asked whether they operated to any defined standards – 54% of organisations responding answered positively with the standards being defined by:

- BACP
- In-house standards for regional or national organisations
- OCN Code of Practice for Advocacy
- Supporting People.

Of the organisations responding ‘no’ 11% noted that they adopted a common sense approach to maintaining standards through defined job roles and the ethos of the organisation. The table below provides a breakdown of the responses provided by group.

Table 3.3
Standards

Defined Standards	Group 1 (counselling – 18 orgs.)	Group 2 (support – 10 orgs.)	Total
Yes	12	3	15
No	6	7	13

It is worth noting here that during the meeting with health and social care staff (see section 10), all staff responded that they expected organisations, particularly counselling organisations, to operate to standards. Whilst it was acknowledged that standards are currently not mandatory, there was agreement that standards need to be set in partnership with all stakeholders.

Recommendation 11

The health and social care staff we met with stated that they expect standards to be in place, particularly for organisations providing counselling. CLEAR should therefore consider defining standards or working with other relevant bodies to define standards for mental health and well-being service provision, particularly counselling, with the engagement of all stakeholders. Standards must be defined in agreement with all stakeholders and should be relevant to and ‘fit’ the type of organisation and the nature of its work. Consideration should also be given to ensuring ‘fit’ with public sector standards and expectations.

3.8.2 Quality Assurance Mechanisms

The 28 Group 1 (counselling) and Group 2 (support) organisations interviewed were asked what quality assurance mechanisms they operated to. From the answers provided we have grouped responses under five areas set out in the following table.

Table 3.4
Quality Assurance

QA Mechanism	Group 1 (counselling – 18 orgs.)	Group 2 (support – 10 orgs.)	Total
Formal framework (such as PQASSO, ISO etc.)	1	4	5
Accredited training	13	2	21
Supervision	14	7	21
Line management	14	5	19
Continuous Professional Development	6	2	8

Recommendation 12

Good practice for quality assurance would seek a balance between internal procedures (such as accredited training, supervision, line management) and external procedures (such as PQASSO, ISO, peer review etc). In looking to define and establish standards, CLEAR may also wish to consider whether the development of a quality assurance framework would add value to the work of the community and voluntary sector providing mental health and well-being services.

Key Points

- Overall, organisations state that they are well governed.
- The largest areas for development within organisations are in the setting of strategic plans, the consultation of staff and volunteers in the development of organisation strategy and delegation
- Three organisations should develop policies on financial controls as a matter of good practice
- Six organisations should develop a data protection policy as a matter of good practice
- One organisation that indicated that it provides services to children and young people should develop a child protection policy as soon as possible
- Three further organisations should develop child protection policies as a matter of good practice, even where their services are not specifically targeted at children and young people
- Nine organisations should develop vulnerable adult protection policies as a matter of good practice
- Three organisations that indicated that they provide services to children and young people should proceed as soon as possible with POCVA checks for staff / volunteers delivering services to children and young people
- Four further organisations should implement POCVA checks for staff/volunteers as a matter of good practice
- One organisation that did not provide a response in terms of POCVA checks for staff/volunteers should implement this procedure as a matter of good practice if it is not already in place
- All organisations report appropriate data protection arrangements; however data protection advice and safeguards are continually being updated and it is important that organisations maintain up-to-date practice and procedures that are well-embedded within their work
- All 28 Group 1 (counselling) and Group 2 (support) organisations interviewed reported that they conduct some form of monitoring and evaluation
- 89% of Group 1 (counselling) and Group 2 (support) organisations interviewed stated that they have a mechanism for feedback from service users
- 54% of Group 1 (counselling) and Group 2 (support) organisations interviewed stated that they operate to defined standards such as those set by the BACP, defined internal standards and OCN Code of Practice for Advocacy.
- Most organisations use informal quality assurance mechanisms rather than formal frameworks

4 Staffing / Volunteers

Staffing data extracted from the questionnaires returned is presented in the tables below.

Table 4.1
Staff / Volunteer Numbers

Organisation Group	Number of organisations	Staff	Volunteers	Total
Group 1 (counselling – 24 organisations)	24	214	310	524
Group 2 (support – 14 organisations)	14	52	318	370
Group 3 (health & well-being – 5 organisations)	5	72	258	330

In reviewing the above data it should be noted that some organisations provided the total number of staff, whilst others provided only the number of staff working in the WHSSB area.

Some organisations indicated the roles held by staff and volunteers (although it was not always defined which were staff and which were volunteers). For volunteers the roles included:

- Management committee
- Administration
- Befrienders / listeners
- Student counsellors
- Mentoring
- Information delivery
- Bereavement support
- Peer educators and peer advocates
- Outreach.

From the above table it is clear therefore that there is a reliance on volunteers by many organisations, not only in terms of service delivery, but also to assist with the day-to-day running of an organisation, such as admin/IT and the management board.

4.1 Staff / Volunteer Qualifications

Table 4.2 describes the relevant **minimum** qualifications that Group 1 (counselling) organisations stated they require staff / volunteers to hold as part of their roles (note: an organisation may require staff/volunteers to hold more than one minimum type of qualification).

Table 4.2
Staff / Volunteer Qualifications

Qualification	Number of organisations Group 1 (counselling – 24 organisations)
Diploma in Counselling	16
Certificate in Counselling	4
Diploma in Complementary Therapy	3
ASIST Training	1
Child Protection Training	1
Other	16

Qualifications included in the 'Other' category are:

- Masters in Counselling
- Level 3 Certificate in Community Mental Health Work
- Qualified in Cognitive Behavioural Therapy
- Social Work, Nursing or Psychology qualification
- Third level qualification
- In-house training
- Degree or diploma in Trauma Studies
- Accreditation by bodies such as the BACP or working towards accreditation
- Registered practitioners of complementary therapies.

All Group 1 (counselling) organisations require staff/volunteers to hold some minimum qualification, although it can be seen from Table 4.2 that the minimum level of qualification for counselling staff varies across Group 1 organisations. With regard to the Certificate in Counselling, it was noted by 3 of the organisations that this was required for their listening ear / befriending staff and counsellors were required to hold the Diploma in Counselling.

In addition to qualifications many organisations also highlighted during interview the need for relevant experience as a minimum requirement for staff, particularly counselling staff.

Recommendation 13

Although the majority of Group 1 (counselling) organisations reported that they require counsellors to hold a Diploma in Counselling, a range of minimum qualifications for counsellors was reported through the mapping exercise. Given this, CLEAR should consider whether a definition of the minimum expected qualification(s) should be included in the development of any agreed standards for counselling provision.

4.2 Accreditation

The tables below set out the numbers of Group 1 (counselling) organisations who are themselves accredited and/or require their staff / volunteers to be accredited or working towards accreditation.

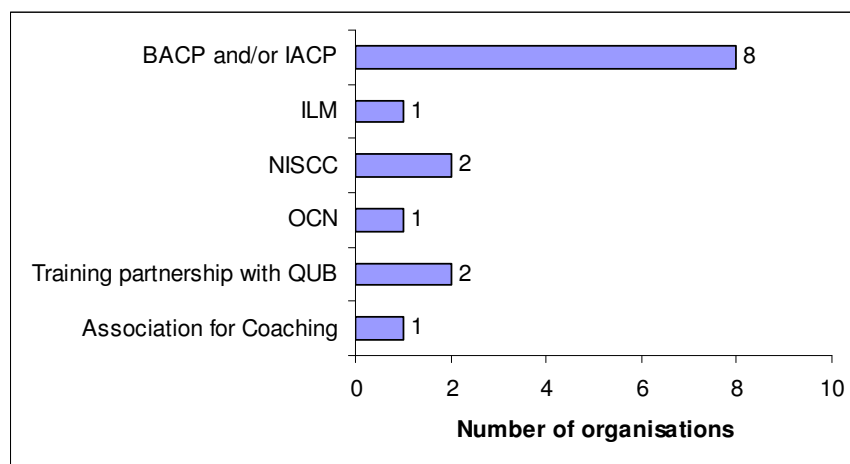
4.2.1 Organisation Accreditation

**Table 4.3
Organisation Accreditation**

Accreditation	Group 1 (counselling – 24 organisations)
Yes	15
No	8
Don't know	1

Of the 14 organisations that are accredited, their accreditation bodies are:

**Figure 4.1
Organisation Accrediting Body**



4.2.2 Staff / Volunteer Accreditation

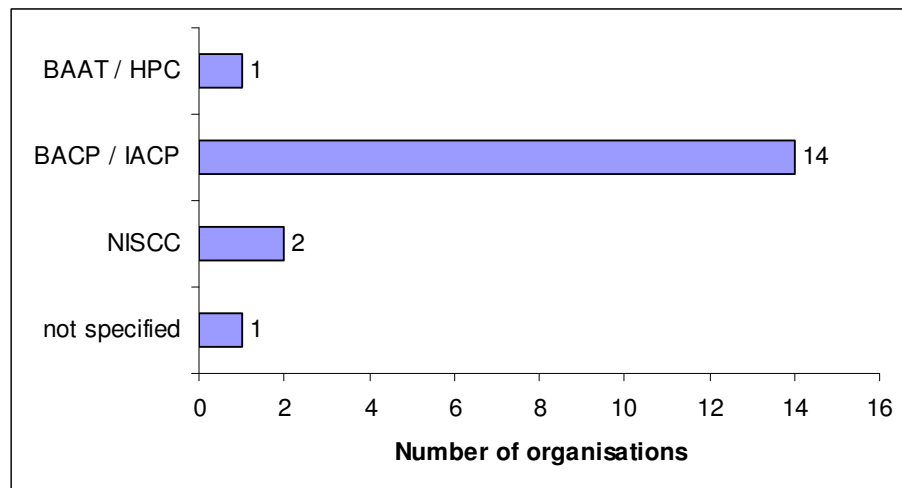
The table below sets out the number of Group 1 (counselling) organisations that require their counselling staff/volunteers to be accredited or working towards accreditation.

Table 4.4
Staff / Volunteer Accreditation

Accreditation	Group 1 (counselling – 24 organisations)
Yes	18
No	5
Don't know	1

From the above data therefore 75% of Group 1 (counselling) organisations require their staff / volunteers to be accredited or working towards accreditation. Of the 18 organisations that require their counselling staff/volunteers to be accredited, the bodies with which they must be accredited are:

Figure 4.2
Staff / Volunteer Accrediting Body



On the whole, Group 1 (counselling) organisations require their staff/volunteers to be accredited, with the majority accredited by the BACP or IACP. As with minimum qualifications however there is no set standard for accreditation of Group 1 (counselling) staff/volunteers.

Recommendation 14

In developing standards for counselling services, CLEAR should consider whether counselling staff/volunteer require accreditation and whether this should also be extended to accreditation of organisations.

4.3 Types of Counselling Staff / Volunteers

The table below sets out the number of organisations with either directly-employed or sessional counsellors or both.

Table 4.5
Types of Counselling Staff

Organisation Group	Number of Organisations			Total
	Directly-Employed Counsellors	Sessional, bought-in counsellors	Both	
Group 1 (counselling – 24 organisations)	6	8	9	23
Group 2 (support – 14 organisations)	1	1		2

Note: One Group 1 organisation did not provide a response to this question.

4.4 Supervision for Counselling Staff / Volunteers

Of the 18 Group 1 (counselling) organisations interviewed, 83% of the organisations' counsellors have external supervision and 17% have internal supervision arrangements only in place. It is not clear how these internal supervision arrangements differ from line management supervision but it is recommended that organisations providing counselling ensure that counselling supervision is differentiated from line management function⁶

Recommendation 15

The role of supervision for counsellors and therapeutic staff/volunteers is extremely important and is highlighted within the *BACP Ethical Framework for Good Practice in Counselling and Psychotherapy*. CLEAR may wish to consider whether supervision should form a part of the development of standards and how best organisations can be supported to ensure that they can maintain best practice in this area.

⁶ BACP Ethical Framework for Good Practice in Counselling & Psychotherapy

4.5 Training

4.5.1 Training for staff / volunteers

95% of organisations indicated that they provide training to staff / volunteers. Training is provided both internally and externally and includes:

- ASIST
- Mental Health First Aid
- Child Protection
- Drug and Alcohol
- Continuous Professional Development relevant to post.

With regard to the development of training plans for staff / volunteers, 76% of responding organisations reported that they provide training plans for staff / volunteers. 17% reported that they do not provide training plans for staff / volunteers and the remainder did not provide a response to this question.

4.5.2 Future training requirements

All organisations were asked during the interview meeting whether there was any training that they would like to access or see developed. 42% of responses indicated that organisations would like more access to existing training including:

- ASIST
- Suicide awareness such as Safe Talk
- Mental Health First Aid
- Risk Assessment training
- Relationships training
- Monitoring and evaluation
- Disability awareness.

It was noted by one organisation that not enough of the existing training offered includes sexual orientation and gender identity awareness, particularly how this impacts on mental and emotional well-being.

A further six organisations interviewed would like to see specific training developed in the following areas:

- Anger awareness (one organisation)
- Dealing with emotional distress (one organisation)
- How to signpost if you notice a problem but the individual has not asked for help (one organisation)
- Training for postvention work (one organisation)
- Mental health issues including how people perceive mental health issues and how people with mental health issues are perceived (two organisations).

A number of organisations commented that they would like to see training developed that was not as intense as ASIST and was more focused on suicide awareness – we understand that the Safe Talk programme delivered by the

WHSCT provides this level of awareness and would recommend that it is rolled out more widely within organisations and communities.

Other individual comments made in response to this question include:

- We don't know what training is required to work at each tier of support – if it is defined then we'll make sure we work to that standard
- Being based outside the WHSSB area we do not hear about training offered within the WHSSB area
- ASIST and Mental Health First Aid courses have been hard to get on and could be run more often
- We have developed some of our own training that we deliver but resources mean we cannot roll it out as widely as we would like
- Perhaps bringing together counsellors and social workers to share information and learning.

4.5.3 Access to Training

All organisations interviewed were asked what more could be done to help them access training:

- 26% noted that the times at which training is delivered could be more flexible (ie more evening and weekend courses), particularly to allow volunteers to attend
- 26% noted that the use of more local venues would assist them in accessing training (this is particularly the case for organisations based in rural areas or where the training tends to be delivered in only one location such as Belfast)
- 13% noted that more funding to allow staff / volunteers to attend training would help.

Other individual comments to this question include:

- Training does not come around as often as we would like
- Training is not offered early enough to allow for us to plan and budget for it
- The Trust used to provide training on how to prepare budgets and make funding applications – this was particularly useful and we would like to do this again
- More residentials
- We do not always hear about the training offered, particularly if a staff member is new and does not have the contacts.

Recommendation 16

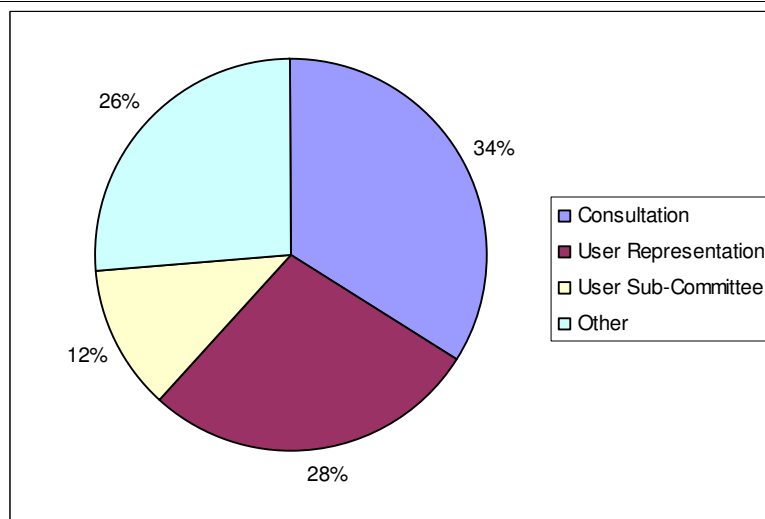
Organisations surveyed are keen to access appropriate training and a number specified possible new areas for training. CLEAR should provide a link between the training sub-group of the WSSIG and WHSCT Health Promotion Department to ensure that training can be accessed as widely as possible.

4.6 Service User Involvement

88% of organisations questioned involve service users in the design and delivery of their services. Of the remainder, 7% responded that they do not involve service users and a further 5% did not provide a response. The methods of involvement for service

users are represented in the Figure 4.3 (note: an organisation may have noted more than one method of service user involvement):

Figure 4.3
Service User Involvement



Within 'Other' the methods include:

- Focus groups
- Management board
- Evaluations
- Service-user led and run
- Volunteers
- Informal feedback
- Relevant courses.

From Figure 4.3 the majority of service user involvement is through consultation and user representation. A number of organisations also highlighted that many service users go on to become volunteers for the organisation.

Within the 7% of organisations that do not involve service users there is an even spread across all three groups: Group 1 (counselling), Group 2 (support) and Group 3 (health and well-being).

As noted in section 3.7.4, we are mindful that, due to the nature of the organisations involved in the mapping exercise, particularly Group 1 (counselling) organisations, it can be difficult to meaningfully involve service users in the design and delivery of services. Organisations are careful to ensure that involving service users is not at the detriment of the support and therapy they receive. It is important however that all organisations consider developing appropriate mechanisms for user engagement since:

Individuals feel better about themselves, and their care and treatment, when they have been listened to (DHSSPS, 2005)⁷

⁷ WHSSB Guide to Public Involvement and User Engagement, 2005

With regard to suicide and self-harm there may be opportunities for greater involvement of the Bereaved by Suicide Support Groups in informing the design and delivery of services, both within the statutory and community and voluntary sectors. It is important however that involvement of people in the design and delivery of services is meaningful and that both the organisation and the person contributing to the design or delivery feels that the process is one in which they can fully engage and will result in positive outcome.

Recommendation 17

Given the particular challenges for counselling organisations of involving service users in the design and delivery of services, CLEAR may wish to consider developing new and innovative ways of securing this engagement that meet the needs of both the organisation and the service users and do not hinder a person's therapy or progress.

Key Points

- The minimum level of qualification for counselling staff varies across Group 1 (counselling) organisations
- The majority of Group 1 (counselling) organisations require their staff / volunteers to be accredited or working towards accreditation and, although the majority require this accreditation to be with the BACP or IACP, there is some inconsistency in this area
- Most Group 1 (counselling) organisations use a mixture of directly-employed and sessional counsellors
- 17% of Group 1 (counselling) organisations have internal supervision arrangements only in place. It is not clear how these internal supervision arrangements differ from line management supervision but it is recommended that organisations providing counselling ensure that counselling supervision is differentiated from line management function
- 42% of responses indicated that organisations would like greater access to existing training including:
 - ASIST
 - Suicide awareness such as Safe Talk
 - Mental Health First Aid
 - Risk Assessment training
 - Relationships training
 - Monitoring and evaluation
 - Disability awareness
- A further six organisations interviewed would like to see specific training developed in the following areas:
 - Anger awareness (one organisation)
 - Dealing with emotional distress (one organisation)
 - How to signpost if you notice a problem but the individual has not asked for help (one organisation)
 - Training for postvention work (one organisation)
 - Mental health issues – including how people perceive mental health issues and how people with mental health issues are perceived (one organisation)
- A quarter of interviewees feel that more flexible training schedules and local venues would increase access to training
- 88% of organisations reported that they involve service users in the design and delivery of services predominantly through consultation and user representation.

5 Referrals

The table below outlines the number of organisations within each group that stated that they have a formal referrals process.

Table 5.1
Formal Referrals Process

Formal Referrals Process	Number of Organisations			Total
	Group 1 (counselling – 24 orgs.)	Group 2 (support – 14 orgs.)	Group 3 (health & well-being – 5 orgs.)	
Yes	19	7	2	28
No	5	6	2	13

Note: Two organisations did not give a response to this question

When asked to describe the referrals process during interview, most organisations indicated that referrals were mostly self-referrals and involved completion of an initial client details form. A number of organisations stated that they receive formal referrals from GPs and Community Mental Health Teams but where these referrals are received informally it was commented that referrals may be informal for a reason – if the referrals were formal the statutory services might have to provide funding along with the referral.

When discussing the potential development of a route map or referral pathway a small number of organisations made the point that if organisations receive additional referrals as a result of the pathway this will need to be funded since most organisations are just managing with their current workloads and resources.

Recommendation 18

In developing a referral pathway or route map, CLEAR should give consideration to those organisations that do not have formal referral systems and for whom this may be a conscious choice. It will also be important to consider the effect that any route map or referral pathway could have on the capacity of organisations to meet an increased demand for services.

We further asked organisations to indicate the numbers of referrals received and made over the last year (note: these numbers are self-reported to us via the questionnaire and have not been audited). Table 5.2 sets out the results from this question.

Table 5.2
Numbers of Referrals

Organisation Group	Number of referrals received from			Number of referrals made to		
	Statutory Services	C&V Organisations	Other	Statutory Services	C&V Organisations	Other
Group 1 (counselling)	1,467	338	1,104	763	177	63
Group 2 (support)	53	107	191	55	70	
Group 3 (health & well-being)	103	27		12	3	

Note: Five organisations did not provide a response to this question

Within the responses provided, four organisations provided overall figures across all referral agencies, nine organisations indicated that they do not keep this type of information, one organisation indicated that it did not have this information at present and two organisations indicated that this question was not applicable to them.

Recommendation 19

There is currently no uniform system for capturing referral data within the organisations surveyed. CLEAR may wish to consider whether the development of a standard system for capturing referral data would add value to the work within the sector, potentially supporting organisations to demonstrate the demands on their services or the effectiveness of any new route map or referral pathway. The value of such a system should also be reviewed with the health service as a funder/monitoring body.

Table 5.2 shows a high rate of referral particularly from statutory services to Group 1 (counselling) organisations. We note however that health and social care staff stated that many of their referrals would more correctly be considered signposting rather than formal written referrals – it is not clear therefore from the figures above how many of the referrals actively represent signposting.

Recommendation 20

It is clear that within the Group 1 (counselling) organisations surveyed people are being directed in to counselling and on to other services and support. The number of incoming and onward referrals within Group 2 (support) and Group 3 (health and well-being) is however lower – whilst there may be more signposting within these groups that is not captured in the reported referral figures, there are opportunities for CLEAR to consider how the referrals process within the statutory and community and voluntary sectors can be refined to encourage greater referral to support and health and well-being services.

5.1 Referrals in to an Organisation

The chart below sets out the referral mechanisms of individuals **in** to an organisation (note: an organisation may have indicated more than one referral mechanism and there is no weighting given to each mechanism).

Figure 5.1
Referral Mechanisms in to an Organisation

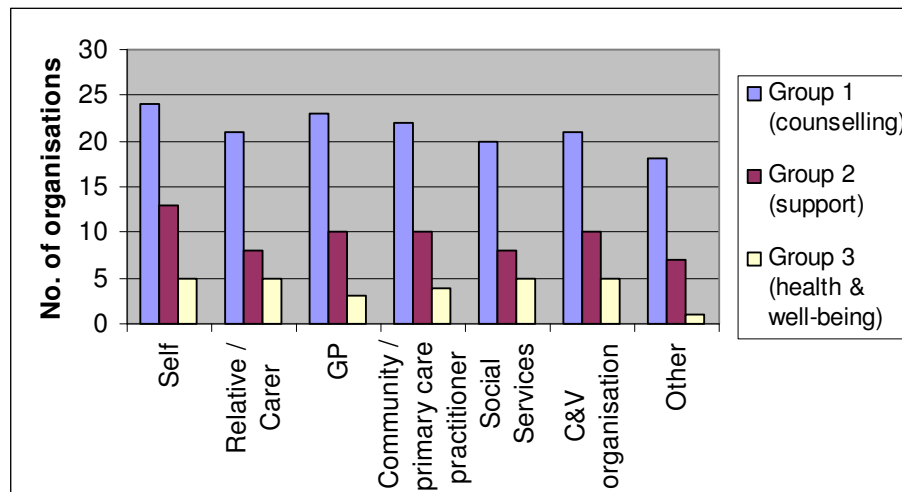


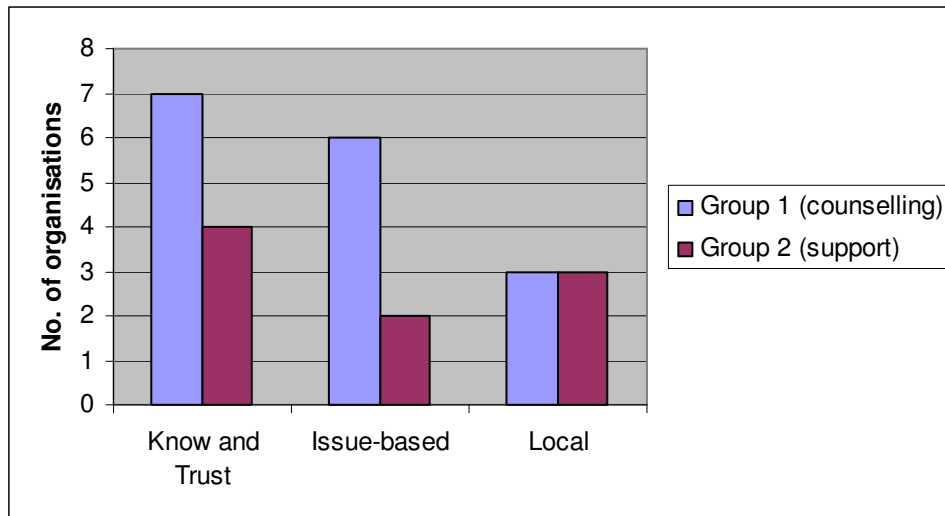
Figure 5.1 shows that a variety of referral mechanisms are used by people to access services, although most organisations when interviewed stated that self-referral was the most commonly-used mechanism and in some cases the preferred option as it indicated a commitment on behalf of the individual concerned to want to receive the service.

Recommendation 21

Given that self-referral is the most commonly-used mechanism by organisations surveyed, it will be important that any referral pathway/route map developed by CLEAR takes this into account and in particular addresses how individuals are enabled and empowered to make appropriate self-referrals.

During interviews, we asked the 28 Group 1 (counselling) and Group 2 (support) organisations what sort of community and voluntary groups would refer people to them. We have grouped the responses into three categories as represented in Figure 5.2 (note: an organisation may have indicated more than one category).

Figure 5.2
Types of C/V Organisations that would Refer in to an Organisation



The responses above show that the key type of community and voluntary group that would refer a client in to another community and voluntary organisation is a group that the organisation knows and trusts. The importance of developing relationships for many organisations is therefore vital if their services are to be promoted.

5.2 Referrals out of an Organisation

Figure 5.3 identifies to whom organisations refer individuals outside of their own services (note: an organisation may have indicated more than one type of agency and there is no weighting given to each mechanism).

Figure 5.3
Referrals out of an Organisation

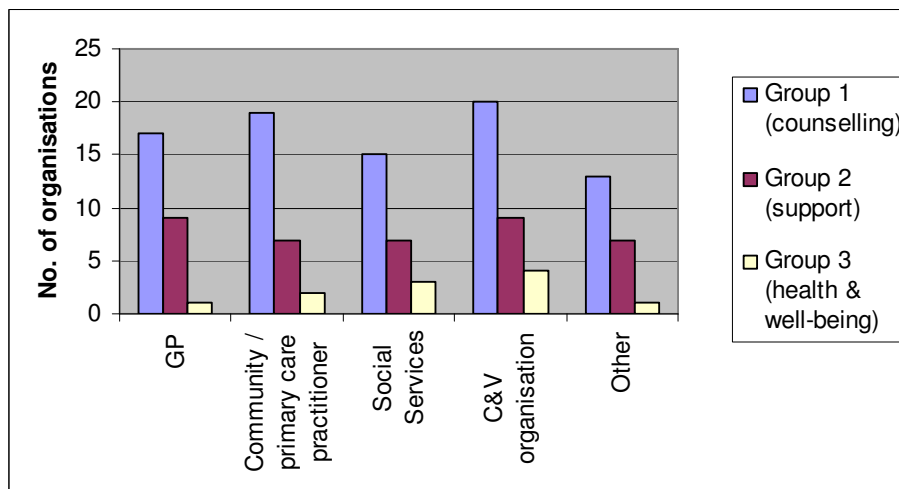
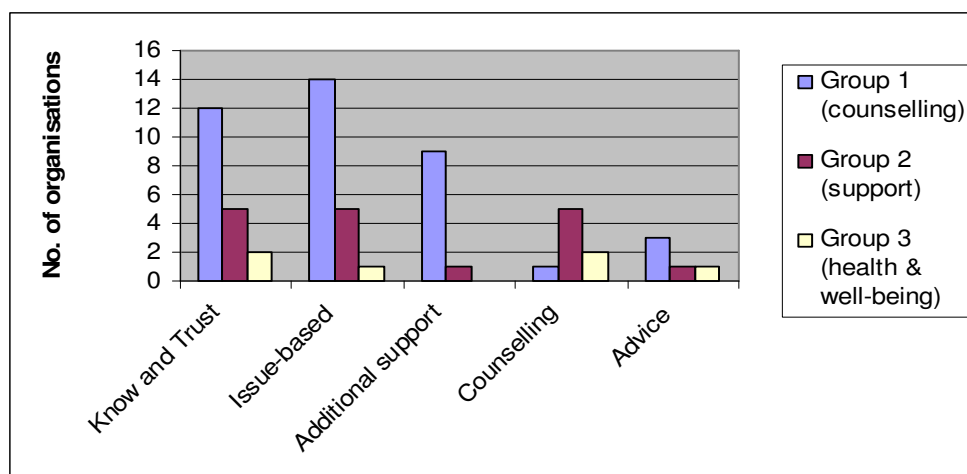


Figure 5.3 highlights that most community and voluntary organisations interviewed make outward referrals to other community and voluntary organisations. However, a wide range of agencies and organisations across many sectors are also points for referral.

During the interview, we asked all 31 organisations what sort of community and voluntary groups in particular they would refer on to. We have grouped the responses provided into five categories as presented in Figure 5.4 (note: an organisation may have indicated more than one category):

Figure 5.4
Types of c/v organisations to which outward referrals are made



The key findings from the above chart are:

- Organisations interviewed reported that they are willing to refer people to organisations that they feel can provide more specialist support such as specific issue-based organisations (eg dealing with domestic abuse, depression, sexual abuse)
- Organisations tend to refer on to organisations that they know and that they can trust – this generally means organisations with whom they have been able to develop a relationship or who would be well-known.

Additional comments to the question regarding the types of community and voluntary organisations individuals are referred to are:

- The GP is often the gatekeeper to support within other organisations
- Sometimes people do not want to be referred to local organisations in case they would know someone
- Many vulnerable individuals do not want to see their GP to access services as they are concerned because the GP also looks after another member of their family
- There is no appropriate system to inform therapists that people may be seeing other counsellors elsewhere and conflicting treatment advice might be given
- There is a lack of organisations and opportunities now to whom we can refer people who are unable to hold down a job but who previously we could have referred to assist charity organisations such as St Vincent de Paul or Barnardos.

Recommendation 22

A key issue reported by many organisations is knowing and trusting the community and voluntary organisation to which a person might be referred – if connections and relationships have not been sufficiently developed across the sector, there is a possibility that people are not referred on and that organisations choose to provide all services themselves, potentially leading to a duplication of services. CLEAR presents an excellent opportunity for organisations and individuals to make these connections and build these relationships across organisations and sectors.

5.2.1 Ease of Referral to Statutory Organisation

In looking at referrals out of an organisation, we asked all 31 organisations interviewed to describe how easy it was to make a referral to a statutory organisation. 39% of organisations interviewed stated that they found it easy and 6% stated that it was difficult. The remaining organisations made no specific assessment but commented as follows:

- It can sometimes take a long time to speak to someone when you have a person in crisis
- It's about knowing the right person within the statutory organisation
- Long waiting lists within statutory sector
- Personnel changes, particularly since RPA, can make it hard to know who is the right person within the organisation
- Confidentiality means people have to repeat their stories and sometimes statutory services do not fully explain what they are doing with people
- We do not know the political backgrounds of staff within the statutory organisations which can make referrals difficult
- In the Northern Health and Social Services Board a forum has been created amongst statutory and community/voluntary organisations for all tier 2 providers – this has made it much easier for us to refer because we have developed relationships with statutory providers and we are also aware of the variety of services offered by each organisation
- We encourage people to make the referral themselves.

5.2.2 Ease of Referral to a Community and Voluntary Organisation

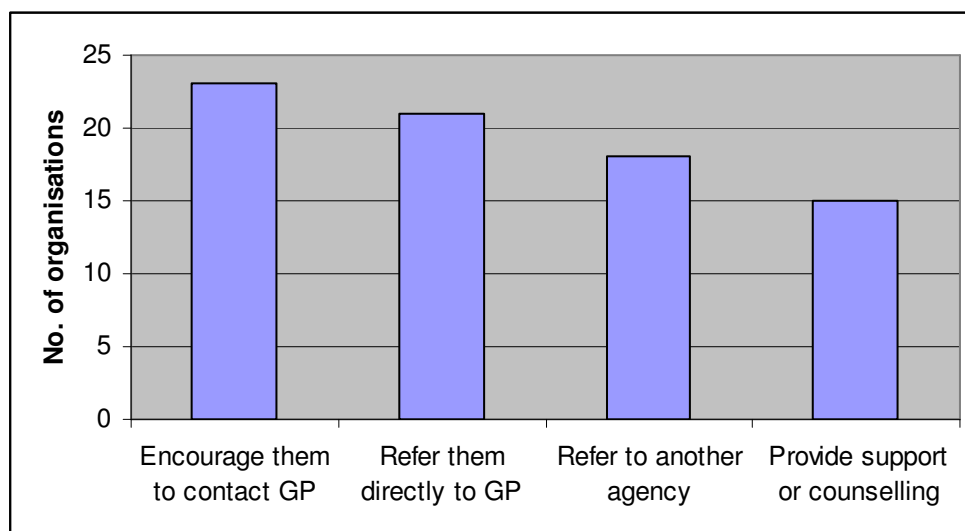
In looking at referrals out of an organisation, we also asked all 31 organisations interviewed to describe how easy it was to make a referral to a community/voluntary organisation. 35% of organisations reported that they found it easy and 3% stated it was difficult. The remaining organisations made no specific assessment but commented as follows:

- Referrals are informal – usually just lifting the phone
- We just make the introduction and let the individual make the contact themselves with the organisation
- Some counselling organisations have long waiting lists
- Wary of referring in case it turns out to be a bad idea.

5.3 Action in the Case of Suicidal Behaviour or Self-Harm

All 31 organisations interviewed were asked what course of action they would take if an individual presented with suicide or self-harm issues. Figure 5.5 highlights the actions that would be taken:

Figure 5.5
Action in the case of suicidal behaviour or self-harm



It is important to note that the above actions are not mutually exclusive and all organisations stated that the actions they would take would involve one or all of the above depending on the individual situation. In the first instance all organisations would encourage the person to contact their GP – particularly since access to services is often through GP referral. Only if a staff member felt that there was an immediate danger to the person would the staff member contact the GP or another agency themselves.

Within the comments made by organisation representatives interviewed, it was highlighted first and foremost that any course of action would depend on the situation and after making a risk assessment. In addition, it was highlighted that the above actions are not mutually exclusive and that an organisation may undertake one or all of the actions depending on the situation.

Of the 31 organisations interviewed:

- 35% specifically highlighted that they would follow ASIST protocol in deciding a course of action
- One organisation highlighted they would be wary of referring an individual for counselling as they could not be sure of the political background of counselling or other staff within an outside organisation
- One organisation highlighted that their ethos is to create a space for individuals to explore their options and that according to their policy of self-determination they would have to respect an individual's wish to take his/her life.

Recommendation 23

If GPs are considered the gatekeepers to many services, it is essential that mechanisms are developed to ensure that all GPs can be confident in making referrals to the community and voluntary sector and that they have knowledge of the services provided within the community and voluntary sector. CLEAR should consider the role of GPs within any referral pathway or route map. CLEAR could also be a link between the community and voluntary sector in developing relationships between GPs and community and voluntary organisations (see also recommendation 28).

Key Points

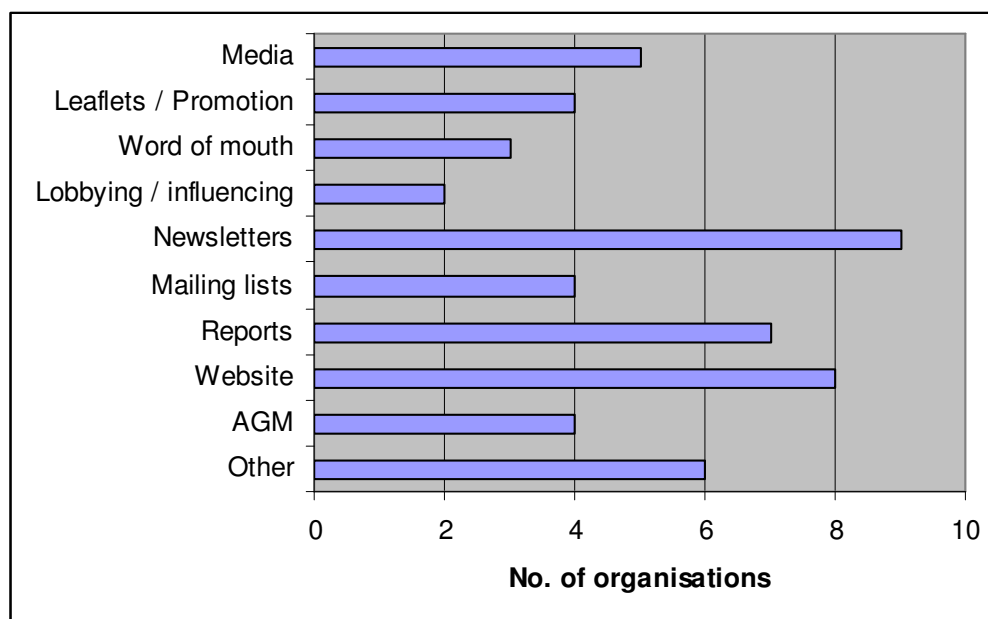
- The majority of organisations have formal procedures for dealing with referrals with the majority of referrals in to an organisation being self-referrals
- A number of organisations indicated that if groups receive additional referrals as a result of a new route map/referral pathway this will need to be funded since most organisations are just managing with their current workloads and resources
- Organisations are willing to refer people to organisations that they feel can provide more specialist support such as specific issue-based organisations
- Most referrals in to and out of organisations are made from/to organisations that are known and trusted – developing relationships is therefore key
- 39% of organisations interviewed found it easy making a referral to a statutory service, whilst 6% stated that it was difficult. The remainder made no specific comment
- 35% of organisations interviewed found it easy making a referral to community and voluntary organisations, whilst only 3% stated that it was difficult. The remainder made no specific comment
- 35% of organisations specifically highlighted that they would follow ASIST protocol to decide on a course of action if an individual presented with suicide or self-harm issues

6 Communication

6.1 Informing Stakeholders

During interview we asked the 28 Group 1 (counselling) and Group 2 (support) organisations to describe how they informed key stakeholders of their activities. We have grouped the responses under the following themes (note: an organisation may have provided more than one response):

Figure 6.1
Methods of Informing Stakeholders



A number of organisations highlighted that their level of promotion was measured against their ability to respond to demand and that they were extremely conscious of not creating a level of expectation within the community that they could not meet.

6.2 Partnership Working

Of the organisations returning questionnaires, 76% reported that they work in partnership with other community and voluntary organisations and 79% with statutory organisations. Note: Four organisations did not provide a response to this question.

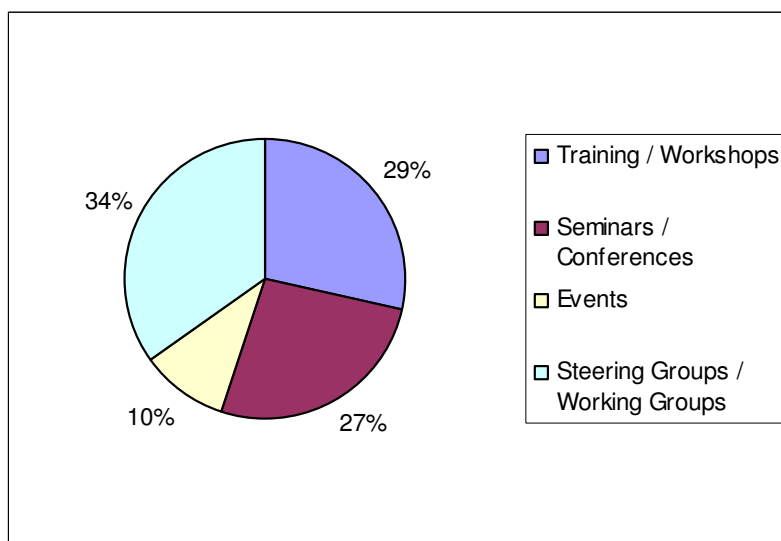
6.3 Networking

6.3.1 Current Networking Opportunities

Of the organisations returning questionnaires, 88% reported that they avail of networking opportunities with other community and voluntary organisations and 81% with statutory organisations. Note: Three organisations did not provide a response to this question.

We have grouped the responses into four categories as follows:

Figure 6.2
Current Networking Opportunities



From the above chart, the most common area for networking currently is via steering groups and working groups (both local and regional). Training/workshops and seminars/conferences are equally attended whilst information events etc are the least common method of networking according to the information received.

6.3.2 Future Networking Opportunities

Organisations were asked if they would like to avail of further networking opportunities – 88% of organisations responded positively that they would like to avail of further networking opportunities. 12% did not wish to avail of any further networking opportunities. It should be noted that during interview many organisations noted that networking should not just be ‘more talking shops’ but rather places of real development.

The types of networking opportunities organisations listed that they wish to avail of vary. They can be divided into general and specific comments as follows:

General

- information events
- email circulars

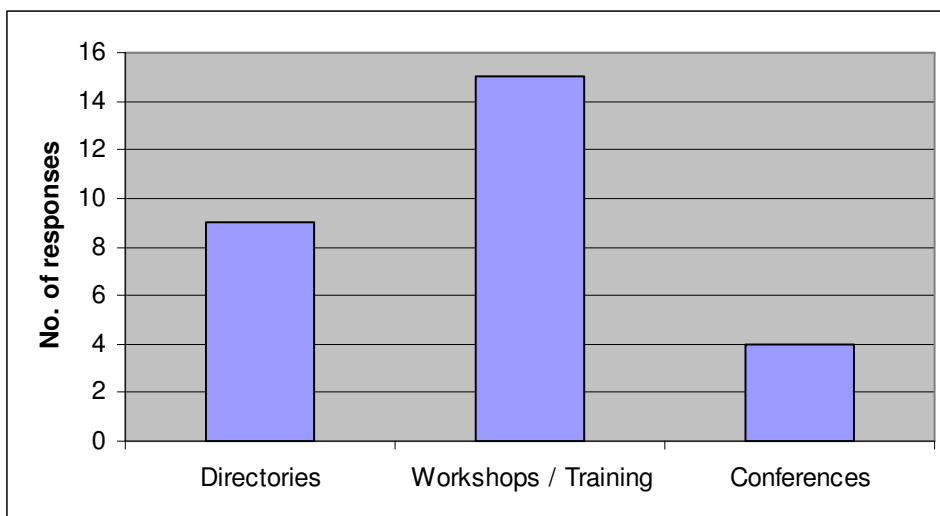
- training
- networking with others in similar work
- cross-border/statutory networks
- any opportunity which highlights, enlightens, shares or professionalises work or training around suicide prevention or self-harm
- other victims groups that are anti-terrorist in nature and disposition
- conferences and workshops, also working groups in relation to strategic developments within youth and children services and drugs/alcohol services
- as relevant and appropriate to our services
- similar ethos organisations throughout Europe and further afield to learn good practice models
- in principle but we restrict partnerships to specific initiatives;
- research
- more of what we currently do
- any opportunity to make people aware of our organisation and to find out more about other organisations/services in the area
- any that are relevant to suicide, self-harm, mental well-being, bereavement
- anywhere there is an interest to raise awareness of suicide/self-harm and mental ill-health and the development of methods/services which address these issues
- making personal contacts
- already-established networks and additional forums
- develop relationships with statutory and funding bodies

Specific

- good practice sharing events
- events relating to user participation
- independent providers' forum
- developing a critical care path or route map
- alcohol and drug forums
- events re family and relationship issues
- Board-led event where all organisations working specifically with young people could showcase their work and a directory compiled for referral processes

This was further expanded during interview where all organisations were asked what would help increase communication / networking. We have grouped the responses under three headings as follows (note: an organisation may have responded under more than one category):

Figure 6.3
Increasing Communication



Individual comments made in response to this question include:

- Directories are useful but can go out of date quickly. They need to be resourced to keep up-to-date. Perhaps an online directory⁸ Directories should include detail such as opening hours and referral procedures. They should be written in language that the public will understand
- People attending meetings need to disseminate the information within their organisations
- Broaden the invite base to mental health workshops/seminars – often only those working directly in the field are made aware of them
- Training is good but it is hard to get statutory sector staff to attend
- A forum for tier 2 organisations, such as the one in the Northern Health and Social Services Board, would be useful (see section 5.2.1)
- Not talking shops
- Utilise existing networks rather than create new networks
- Mail outs to organisations in plenty of time
- Southern Health and Social Care Trust have well-designed directory posters for each council area that are a good model
- Links need to be made across the statutory sector – it can be hard to get medical staff involved sometimes
- Regular updates about what is going on in the field would be useful
- A conference/ workshop where all organisations can have 10 minutes to present what they are about. Usually if we have a stall at conferences it has to be manned and you do not get a chance to find out about other organisations.

⁸ We note that an online directory is currently available at www.mentalhealthwest.com

Recommendation 24

Workshops and training present real opportunities, not only to increase the skills within organisations but to increase networking and communication. CLEAR should consider using the ASIST, Safe Talk and Mental Health First Aid training (highlighted by organisations as training they would wish to access) as best practice to promote networking and communication amongst community and voluntary organisations. There may also be opportunities to promote networking between sectors by including GPs/primary care staff and health and social care staff in this and any other training.

Key Points

- Organisations interviewed highlighted that their level of promotion was measured against their ability to respond to demand and that they were extremely conscious of not creating a level of expectation within the community that they could not meet
- 76% of organisations reported that they work in partnership with community and voluntary organisations and 79% with statutory organisations
- 88% of organisations reported that they avail of networking opportunities with other community and voluntary organisations and 81% with statutory organisations
- The most common area for networking is via steering groups and working groups (both local and regional). Training/workshops and seminars/conferences are equally attended whilst information events etc are the least common method of networking
- 88% of organisations responded that they would like to avail of further networking opportunities but not 'more talking shops'
- The majority of organisations interviewed felt that workshops and training could best help increase networking and communication

7 Resources

The 28 Group 1 (counselling) and Group 2 (support) organisations interviewed were asked about resources during interview.

7.1 Current Funding

The table below sets out the primary funders for the 28 Group 1 (counselling) and Group 2 (support) organisations interviewed.

Table 7.1
Primary Funders

Funding Body	Group 1 (counselling – 18 orgs.)	Group 2 (support – 10 orgs.)	Total
Health Service	10	6	16
Charitable Trust	3	1	4
Community Relations Council	4	1	5
Other Statutory Bodies	1	2	3

The 28 Group 1 (counselling) and Group 2 (support) organisations interviewed were further asked what category of funding would be their biggest source of income. The table below represents the category of funding by funder type.

Table 7.2
Funding Source Types

Funding Body	Grant	Service Contract	Total
Health Service	3	13	16
Charitable Trust	4		4
Community Relations Council	5		5
Other Statutory Bodies		3	3
Total	12	16	28

In terms of the duration of funding provided, 64% of organisations responded that funding is medium-term (2-3 years), with the remainder receiving short-term funding. No organisations interviewed indicated that funding was long-term.

7.2 Meeting Need

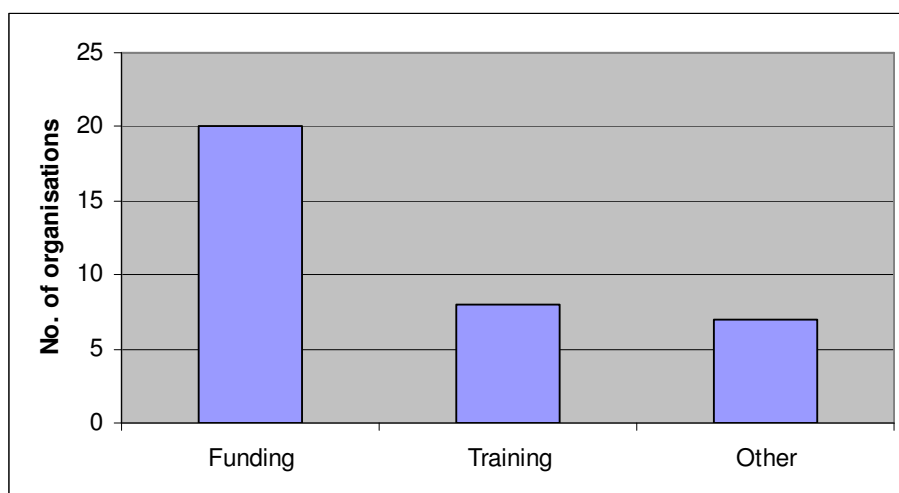
The 28 Group 1 (counselling) and Group 2 (support) organisations interviewed were asked whether they feel that they have the necessary resources to meet the assessed need. The key findings from this question are:

- All organisations stated that in their view they manage and do a good job with the funding they receive but the majority of organisations included that additional funding is required to meet the assessed need
- Organisations made the point that it can be difficult to make long-term plans with short-term, inconsistent funding – more long-term, core, un-restricted funding would therefore be important
- One organisation had managed for a number of years with volunteers, but has acknowledged that if it wishes to meet demand it will have to employ paid staff
- Organisations noted that they are constantly having to fund-raise or make funding applications – some felt that they should not have to keep looking for core funding
- Some organisations have programmes in place but are restricted in rolling them out due to lack of funds
- Some programme/service funding is due to finish soon – if new funding is not secured, these services will be lost.

7.3 Further Resources

As part of the questionnaire, organisations were asked whether, in terms of resources there was anything further that they would benefit from to enhance services. Figure 7.1 highlights the responses received from the 43 organisations returning questionnaires (we have grouped responses into three categories). Note: not all organisations provided a response to this question:

Figure 7.1
Further Resources



Within the categories identified, the comments returned include:

Funding

- Sustainable funding
- Devolution of parts of the mental health budgets to local commissioning groups / councils
- More support from the statutory sector and local council
- Funding for staff development
- Support on funding issues
- Greater financial support to provide counselling for people living in disadvantaged areas

- Core, unrestricted funding
- Longer-term funding
- Parity with statutory sector regarding funding
- Funding is the main issue. Without it services will be limited to short bursts rather than a sustained service

Training

- More risk assessment training
- More flexible training at evenings and weekends
- Training opportunities that contribute to the continuous professional development of staff
- Training for counsellors working with young people
- Customised training for victims of terrorist violence
- Sexual identify training
- Marriage / couples training
- Support and training in recognising emotional/mental well-being
- Training in mental health first aid, listening skills, referral procedures and legal implications

Other

- Support focusing models of good practice
- More staff
- Build relationships across sectors
- Recognition from social services of the work we do very well
- Referral pathways
- Advice on quality assurance certification.

Recommendation 25

Although CLEAR is not a funding body the issue of resourcing within the community and voluntary sector must be addressed if sustainable services are to be provided and particularly if a route map is to highlight certain organisations that may then see an increase in the uptake of their services. Representatives of CLEAR participating in WSSIG provide CLEAR with an opportunity for the question of resourcing to be raised at Board and Trust level and, as highlighted in Section 10, there may be opportunities for example under the GP Direct Enhanced Services framework for collaboration in resourcing particular services.

Key Points

- The Health Service is the primary funder for Group 1 (counselling) and Group 2 (support) organisations interviewed, mostly through medium-term (two to three years) service contracts
- All organisations stated that they manage and do a good job with the funding they receive but the majority of organisations included that more funding is required to meet the assessed need
- Organisations made the point that it can be difficult to make long-term plans with short-term, inconsistent funding – more long-term, core and unrestricted funding would therefore be important
- Some programme/service funding is due to finish soon – if new funding is not secured, these services will be lost
- The majority of Group 1 (counselling) and Group 2 (support) organisations interviewed stated that funding was the area they would most benefit from to enhance services

8 Strengths, Weaknesses, Opportunities and Threats

8.1 Strengths and Challenges

All organisations were asked at interview to describe their strengths, particularly with regard to mental health and well-being, and the challenges they face. The responses provided by the 31 organisations interviewed are set out below:

Strengths

- Client-centred
- Voluntary sector is both vocational and professional
- Reaching rural communities
- Potential to bring in volunteers to maximise programme capacity
- Empowering people
- Confidentiality
- Only charity solely on this issue
- Service-user / peer led – understand what people have been through
- Accessible
- Prepared to listen
- Knowing our competencies
- Professional
- Strong ethos within organisation
- Understand how to engage with our service users
- Trust and confidence
- Provide a safe environment
- Genuine in our care
- Respected
- Specialised knowledge of the issue
- Voluntary sector is seen as less threatening than statutory sector
- Service is very portable and easily-replicated
- Look at people in a holistic way
- Skilled management board and staff
- Tailored support
- Local nature of work
- Wealth of knowledge we can tap in to across our organisation
- Good track record
- Easy access to our services
- Experience and expertise
- Dedicated and committed staff / volunteers

Challenges

- Funding – particularly core funding
- Keeping the skills within the team if funding is lost
- Changes in the Health Trust have meant that relationships we built up have been lost
- Getting in to local communities
- Keeping our profile up as other organisations move in to this field
- Keeping up with emerging trends
- Delivering long-term goals on medium/short-term funding
- Lack of awareness of gender issues
- Lack of justice for victims
- Heterosexism in the statutory sector
- Changing political environment bringing new challenges, particularly for reconciliation
- Trying to dovetail with numerous strategies
- Retaining qualified staff
- Inter-agency working
- Responding to the demand
- Emotional effect on staff

8.2 Analysis of Strengths, Weaknesses, Opportunities and Threats

The following analysis of strengths, weaknesses, opportunities and threats to the community and voluntary sector providing mental health and well-being services in the WHSSB area has been prepared on the basis of information provided in the questionnaires and interviews.

<p>Strengths</p> <ul style="list-style-type: none"> - Organisations are client-centred - Peer/service-user led - Focus on empowering people - Choice for the individual – they may not wish to be seen within statutory sector - Professional attitudes - Skilled and dedicated staff and volunteers - Connecting with hard-to-reach communities - Provide a 'safe' environment - Take a holistic view of people 	<p>Weaknesses</p> <ul style="list-style-type: none"> - Lack of sustainable funding - No standards for counselling required to be adopted - Lack of integration across the community and voluntary and statutory sectors - Reliant on relationships - Stigma still exists in relation to mental health and suicide/self-harm - Lack of knowledge of other services
<p>Opportunities</p> <ul style="list-style-type: none"> - CLEAR Project presents opportunities to: <ul style="list-style-type: none"> o make real improvements to services o build relationships o develop connections between sectors - Government focus on suicide prevention - DHSSPS had started to review standards for counselling services 	<p>Threats</p> <ul style="list-style-type: none"> - Current economic climate could lead to more people experiencing mental health and well-being issues - Restriction of funding from all sources - 'Silo funding' (ie focused on one area or from one strategy) may lead organisations to branch into areas which are not their core business simply to secure resources - Loss of preventative work could lead to increased pressure on crisis services - Loss of key staff / services - Review of Public Administration may lead to loss of key contacts within statutory organisations

9 Areas for Development

All organisations interviewed were asked whether there are any development areas or key areas of need within their organisation. We have grouped the responses from the 31 organisations interviewed under five themes, listed below:

Training / Advice

- Training in how to identify or pick up on signals and what to do next
- Assistance in reviewing policies and procedures
- Training in networking
- Training in developing budgets and costing services
- Terms of reference for the management committee.
- A central resource across the community and voluntary sector that would have knowledge and information on developing policies, funding etc
- Knowledge of services and how to signpost
- More identified training for tier 1 and 2 work. Knowing exactly what is tier 1 and 2 work and being careful about the grey area above tier 2 and into tier 3
- Training that helps community and voluntary organisations to know how to access funding and completing funding applications
- Greater knowledge of what else is out there in terms of crisis response
- Our project workers have an interest in developing emotional and mental health of children and young people, particularly with regard to suicide and adolescence

Resources

- To have our own premises be able to offer complementary therapy (our current premises rule this out)
- We fear the loss of funding for an important area of our work
- Sustainability is an issue
- More space/premises and equipment
- Preparing for the new world of RPA and restricted funding sources
- Time and money required to look at the organisation's development needs
- To employ a counselling coordinator

Communication

- A mental-health trained person within the statutory sector who would have the role to liaise with our organisation so that we could refer people to them directly. Continuity of contact with one person is important for vulnerable people
- Communication is a big issue - working together in practice rather than in theory
- Building partnerships in a sustainable way.

Service Provision

- There is currently nothing positive for young people to join. Being in a rural area, leisure services and support services are far away
- Focus more on rural communities and families
- Supporting communities to support themselves
- Gaining more service users and getting more communities involved in our programmes

Other

- Generic standards would be helpful
- Better structure between senior management and staff on the ground
- Creation of a database to enable analysis of statistical trends amongst service users

One organisation interviewed noted that the Northern Ireland Council for Voluntary Action (NICVA) and North West Community Network are already involved in developing community and voluntary sector organisations.

Other comments that were made and which perhaps relate to wider development areas include the following:

- Belfast has a central, one-point access where people can contact and be referred or signposted across the community and voluntary and statutory sectors – something like this could be useful
- Too many bits and pieces are developed around suicide but there is no single, strategic, coordinated fit for them all
- In looking at the health of a community it is important that community leaders are involved.

Key Points

- Training and advice were the most common areas stated by organisations in terms of development
- Resources were also highlighted as a key area for development
- It is important that work developed is based around a single, coordinated fit.

10 Health and Social Care Service Perspectives on Mental Health and Well-being Provision across the Community and Voluntary Sector

As part of the mapping exercise we met with people working in the WHSCT and WHSSB to discuss community and voluntary sector and statutory sector provision of mental health and emotional well-being services. In addition to discussions we asked those we met with to complete a short questionnaire covering:

- Services provided
- Quality
- Standards
- Referrals
- Collaboration
- Communication
- General
- Future Direction.

The above themes also formed the basis for a group discussion. A summary of the principal areas covered through the discussions and questionnaires is provided below.

10.1 Services Provided

From the responses provided it was identified that gaps in service provision currently exist, particularly amongst Groups 1 and 2 (counselling and intensive support) services, within both the statutory and community and voluntary sectors. In addition to the role of the community and voluntary organisations within Group 3 (health and well-being) it was noted that the Trust has a dynamic Health Promotion department and health and well-being should also be the role of all health and social care staff although resource constraints can impact upon service provision across both sectors in Group 3.

In terms of community and voluntary sector provision, the comments relating to gaps in service provision were:

- Access in rural areas
- Out of hours services for counselling
- Awareness of services available
- Require additional listening ear provision to be developed
- May be some overlap and potential duplication – a map of existing provision would be useful
- Waiting lists for some counselling services can pose a problem
- Resource constraints.

In relation to statutory sector provision, the comments relating to gaps were:

- Resource constraints, particularly around specialist therapies
- Young people and older adults (for counselling services)
- Access in rural areas
- Out of hours service between 1am and 9am
- Services can be overwhelmed by in appropriate referrals – good signposting is key
- Some gaps in tier 4 provision for children and further investment required to develop specialist services/teams
- Counselling at primary care level
- Waiting lists for counselling services can post a problem

- Need to continue to build on what is available, especially in rural locations and in partnership with schools.

We asked those we met with what could be done to ensure that gaps in service provision are minimised. We have highlighted the responses below under three emerging themes:

Information

- directory and promotion of services
- greater awareness within GPs/hospital (A&E)
- good signposting

Processes

- better coordination
- review existing services - unmet need
- need to explore patient pathways as part of service developments
- consult re where and when services should be provided
- strategic approach to commissioning and providing consistent funding
- provision at GP level - front end work
- mainstreaming / funding community and voluntary sector
- more joined up working - development of learning circles (learn from each other)

Collaboration

- better linkages, cross referral and purchase of services in community and voluntary sector
- partnerships based on complementarity of roles.

10.2 Quality

In terms of quality, respondents noted that this was varied across the sector and was perhaps hard to measure without an agreed baseline and common assessment criteria for quality. It was further noted that this variation was potentially no different in the statutory sector and that statutory services are less subject to evaluation than the community and voluntary sector.

With regard to the differences in the level of quality across the community and voluntary sector it was acknowledged that inconsistency may occur as a result of:

- Lack of recurrent funding
- Organisations struggling to survive may be more reluctant to share their experience
- Lack of a corporate entity for the community and voluntary sector to report to.

It was highlighted however that where organisations have applied for funding through the Suicide Prevention Strategy a high level of service provision is standard and monitored according to the performance monitoring system in place with the funding.

10.3 Standards

We asked those we met with whether they expected community and voluntary organisations providing counselling and intensive support services to work to defined standards. All responded that they did expect standards to be in place, particularly for counselling. With regard to what standards should apply, the following was noted:

- BACP / IACP standards should apply
- Standardised minimum qualifications for counsellors
- Rigorous monitoring and evaluation of standards/quality
- Ensuring confidentiality
- The same standards that the public would expect and are entitled to from statutory services.

It was further highlighted that standards need to be set in agreement with all stakeholders and that standards should be tailored appropriately (ie what might apply for a counselling organisation may not necessarily apply to an organisation providing intensive support).

10.4 Referrals

The referrals processes from the WHSCT/GPs to the community and voluntary sector and vice versa were both described as weak. Although it was noted that ad hoc informal processes may be in place, without a formal referral pathway there can sometimes be a reluctance to formalise these without adequate knowledge of quality and governance issues.

Within Trust's mental health services it was noted this operates on a very closed referral system with referrals having to come through the GP. Whilst the Trust would like to have a more open referrals process into its services, resourcing this is an issue. In contrast, the community and voluntary sector, in its role of empowering people, often works through self-referral and it is perhaps more difficult therefore for the Trust in making outward referrals.

For the individuals caught up in the referrals process, long waiting lists and a difficult process can contribute to the overall well-being of the person deteriorating and was therefore an issue that required review (it should be noted that from April the target for seeing individuals within the statutory services will be lowered from thirteen to nine weeks). It was noted that it can be a challenge to know where the right place for someone to be supported is and often this is not discovered until someone has been assessed, although this means that an individual may be assessed by a number of organisations or people before they receive the support they require.

A model that was highlighted as having been particularly successful in increasing referrals from GPs to the community and voluntary sector was an initiative run previously in Limavady. The model was based around finding the most appropriate support for the individual in whichever sector was best placed to provide the service. Through the active involvement of both the Trust, GPs and Limavady Community Development Initiative, GPs and community and voluntary organisations were brought together to discuss services and respond to any queries that GPs may have had with regard to the community and voluntary sector provision. Following this information event the number of referrals by GPs to community and voluntary organisations increased. The Limavady model no longer runs but health service staff are keen to see it running again and extended to other areas – particularly since the statutory services for the Limavady area have seen an increase in pressures on their services since the Limavady model finished.

The role of the churches as referrers was also highlighted – it was noted that the Church of Ireland is currently developing a toolkit for dealing with drug and alcohol issues that includes a map-based directory of services.

Amongst the key actions that could be taken to facilitate and increase active referral by the WHSCT and GPs to community and voluntary organisations the following were noted:

- Better communication across sectors
- More information on what services are available and how to access them
- More focus on the client – what does the person need?
- Agreed referral protocols in place
- Working together where possible and the removal of duplication
- Assurance of standards and mutual confidence in the quality of services delivered
- Identified funding and resourcing of the community and voluntary sector.

It was further noted that a challenge to the statutory sector is to relinquish primacy to the community and voluntary sector where appropriate within a partnership framework.

10.5 Collaboration and Communication

We asked those we met with to identify what both the community and voluntary and statutory sectors could do to enable greater collaboration across the three groups. The responses are outlined below:

Group 1 (counselling)

- Establish clear pathways and referral processes
- Develop agreed standards
- Greater awareness of the step care model (who works at what level)
- WHSCT could be more inclusive in engaging non-statutory providers
- Promotion of contacts

Group 2 (support)

- Sharing best practice
- Opportunity for the statutory sector to work in the community and voluntary sector and vice versa
- Updates and better linkages
- Agreed protocols

Group 3 (health and well-being)

- Develop models to promote mental health (ie Mental Health Promotion Toolkit)
- Promotion of contacts.

A number of general comments were also noted with regard to increasing communication:

- Face to face sharing of information re services and how to access them
- Demonstrating the 'added value'
- Delivering results to agreed quality standards.

With regard to communication we asked those we met with what more could be done to help increase communication between the statutory and community and voluntary sectors. The responses are provided below:

- establish an interface group/process
- develop a link (new post) to streamline the process and coordinate network meetings, share models of good practice

- face to face sharing of information regarding the range of services available and how to access them
- respect for each other's role and professionalism
- better use of electronic communications
- clear points of contact for the community and voluntary sector (agreed representatives/fora for the community and voluntary sector) – this could be an important role for CLEAR in representing the community and voluntary sector
- common objectives / strategic plan
- shared funding to deliver agreed goals.

Engagement from all sectors is important and we note that currently all community and voluntary organisations receiving funding from the WHSSB under relevant mental health or well-being strategies are asked to sign-up to the principles of the CLEAR Project through the Service and Budget Agreement. This engagement could further be increased if the WHSCT adopts this model.

10.6 General Comments

When asked to rate their experience of working with the community and voluntary sector organisations providing mental health and emotional well-being services, health service representative noted generally excellent experiences, highlighting the commitment and enthusiasm of community and voluntary organisations. Although there may be some concerns with regard to governance and accountability it was noted that there was an expertise within the community and voluntary sector that could be better utilised.

The struggle for funding by the community and voluntary sector was highlighted as an area that can sometimes impede progress through the constant focus organisations must devote to sourcing and securing funding. With regard to funding we asked whether, in times of restricted funding, there can be equal emphasis on suicide/self-harm (crisis) services and general mental health and emotional well-being (prevention/promotion) services. There was a general consensus that it is not enough to separate the areas and view them individually but that they are both of equal importance. The responses were further defined below:

- Mental health and emotional well-being should be part of all service development and not a stand-alone issue
- Mental health impact assessment could be a good way forward
- There probably should be equal emphasis, however quite often the community expects a greater, faster response to those in crisis
- Crisis response and preventative work are two sides of the same coin - self-esteem, resilience etc are protective factors but a crisis response needs to be available
- Crisis and prevention have to be linked but there is a need to ensure there is effective investment on prevention and in areas beyond mental health, eg drugs and alcohol, sexual health, poverty, unemployment
- with limited funding it is important that the key issues are addressed under the Suicide Strategy – this is a challenging task
- No. Active issues need to be prioritised.

10.7 Future Direction

The CLEAR Project is keen to influence future direction of mental health and emotional well-being/suicide prevention service provision. We asked those we met with therefore what they see are the key issues that will impact on the future direction of mental health and emotional well-being services (both in the community and voluntary and statutory sectors). We have grouped the responses under three themes set out below:

Collaboration

- opportunities through future partnership working and community planning
- greater integration between statutory and community and voluntary sectors
- greater understanding/working together
- get GPs and extended primary care team to embrace issues

Services

- Direct Enhanced Services (DES)⁹ - depression/anxiety is a good way/framework for going forward
- the role of the Regional Agency for Public Health and Social Well-being
- waiting lists in the community and voluntary sector
- providing access to early help pre crisis
- providing accessible services to intercept isolation
- access targets for mental health services
- clear referral pathways
- greater awareness of services provided
- avoid duplication of effort/services

General

- funding
- acknowledgement that there shall always be choice
- listening to users / carers
- developing a joined-up vision
- discovering why young people see suicide as a viable option nowadays.

For WSSIG, the biggest role for CLEAR is in pulling together the relevant community and voluntary sector organisations to avoid duplication and ensure that appropriate pathways are developed for individuals in need of support. There is therefore an opportunity for CLEAR and the CLEAR Project Manager to become, with the backing of the community and voluntary sector they represent, the representative of the community and voluntary sector at a number of levels and in a number of related mental health or well-being strategies. Likewise the CLEAR Project provides an excellent opportunity to become a central point of contact for statutory agencies wishing to engage with the community and voluntary sector providers of mental health and well-being services. This central role for CLEAR will be especially important as the WHSSB is dissolved under the Review of Public Administration and a new Regional Public Health and Social Well-Being Agency becomes the new lead on suicide.

⁹ DES are special services or activities provided by GP practices that have been negotiated nationally. All practices can choose whether or not to provide these services.

Recommendation 26

There is a willingness and an openness from those health and social care staff we met to develop more joined-up working and shared resources that better meets the needs of people in local communities. CLEAR presents an excellent opportunity to develop a coordinated community and voluntary response mechanism for statutory services to engage with the relevant community and voluntary organisations.

Recommendation 27

The Limavady Model has been highlighted as a model of good practice in increasing GP referrals to the community and voluntary sector. The CLEAR project should consider with health and social care staff how this model could be revitalised and supported to promote the use of services within the community and voluntary sector.

Recommendation 28

The Direct Enhanced Services framework provides a good opportunity for not only linking GPs with community and voluntary services but finding ways to resource this. CLEAR should therefore consult with the relevant health and social care staff with a view to exploring this further.

Key Points

- Gaps in service provision across Groups 1 and 2 (counselling and support) within both the statutory and community and voluntary sectors in relation to:
 - Access in rural areas
 - Out of hours services
 - Long waiting lists
 - Awareness of services available
 - Resource constraints
 - Young people and older adults
 - Counselling at primary care level
- More information, more efficient processes and greater collaboration would help to address gaps in service provision
- Inconsistency in terms of quality of services, although it is hard to define without an agreed baseline and common assessment measure
- Standards should be in place, particularly for counselling services. Standards should be set in agreement with all stakeholders and 'tailored' appropriately
- Referrals processes between both sectors are weak. The Limavady model offers a good basis for improving referral processes but will require resources to implement
- The role of the churches as referrers should be considered in any referral pathway
- Collaboration and communication vital to developing improved services and processes
- A potential role for CLEAR in providing the community and voluntary sector representation in meetings/initiatives
- Excellent experiences of working with the community and voluntary sector
- Struggle for funding can hamper work and must be addressed in future strategic developments
- Collaboration, services and funding are the key issues that will impact on the future direction of mental health and emotional well-being services (both in the community and voluntary and statutory sectors).
- Role for CLEAR in coordinating community and voluntary sector response and providing point of contact through changing times in the statutory sector.

11 Perspectives of those Bereaved by Suicide on Mental Health and Well-being Provision

There are two support groups in the WHSSB area for those bereaved by suicide: the North West Bereaved by Suicide Support Group based in Derry and PATHS based in Omagh. Both groups are facilitated by the WHSCT Suicide Liaison Officers and meet on a monthly or bi-weekly basis.

As part of the mapping exercise we met with two members of the North West Bereaved by Suicide Group, who had each been bereaved by suicide, to examine their experience of support following their bereavement and their loved one's experience of support prior to their death. Naturally, the majority of the feedback from the people we met with is specifically related to their personal experience – there are however a number of areas for CLEAR to consider within this.

11.1 Experience Following Bereavement

Both members stated that their biggest support comes from the Bereaved by Suicide Group – one person describing it as a 'lifeline'. The support offered by the group was felt to be most appropriate because members understood and shared the same experiences and feelings.

In terms of community and voluntary organisations, both cited Foyle Search and Rescue for high praise, particularly in the way they conduct their services and the support they provide. For the statutory sector the WHSCT Suicide Liaison Officer was praised for the level of support provided, at any time of day. Dealings with other statutory agencies were not so easy however, and one representative explained that they had found the Police very detached in their dealings and not particularly communicative.

In terms of being able to access support, one member commented that they received no support following their first bereavement and did not know where to go to receive support. The member noted that now they had a list of where to go but at the time of death three and a half years ago the information was not provided.

Both members had attended counselling but did not feel they had connected with the counsellors and had not continued with the counselling nor sought to find a new counsellor. One member commented that they felt too tired and drained by the situation to maintain the search for a counsellor.

11.2 Support for Relative Prior to Death

11.2.1 WHSCT and Primary Care

Both members spoke of experiences with the WHSCT and Primary Care. In one case, one of the deceased had been engaged with the Community Mental Health Team prior to their death and had been admitted at various times to Gransha Hospital. The experience of Gransha was not a happy one and the member expressed strong concern that the facilities at Gransha were not suitable for young people, nor for a modern health service. The member also spoke of an experience when the GP referred their relative to Gransha Hospital, they and their relative therefore attended Gransha on the GP advice, but they were turned away as they did not have a referral letter from the GP.

In another case, their relative was keen to access support but was only prescribed medication, even when requesting admittance to Gransha Hospital. In this case, the GP did suggest some organisations that the individual could speak to but this was not followed up and did not seem to work for the individual concerned.

11.2.2 Additional Support

One member spoke of the difficulties they and their relative had in finding additional support for their particular issue. Support was found eventually but it took a long time – perhaps because until the support is needed, it is not a priority to find out about services. The member further noted that the waiting list for services from one community and voluntary organisation was long and their relative had passed away before they would have been seen.

It is also worth noting that support was not found for the members themselves in their situation of having a relative with mental health or other issues.

11.3 Mental Health Awareness

Both members expressed the view that mental health awareness is vital, does not receive enough attention and requires more funding. On occasions where thoughts of suicide were expressed by the relatives prior to death, the members found it hard to know what to do and at times felt that the expressions were not seriously intended. One member explained that they also found it difficult to understand what the various labels given to their relative meant (ie bi-polar etc) and it was not explained by medical staff.

One member also spoke of the need for suicide awareness to be taken into consideration in the design of the proposed new bridge over the River Foyle.

11.4 Considerations for CLEAR

It is of note that, although time was limited and we would have liked to explore some areas in more detail, the majority of feedback from the members of the Bereaved by Suicide Group was on health service provision, particularly GP and psychiatric services. This may be an issue that should be further explored by the Western Suicide Strategy Implementation Group.

For CLEAR the issues highlighted by the members of the Bereaved by Suicide Group we spoke to are that:

- It can be hard to know where to go for support
- There can be long waiting lists for some community and voluntary organisation services
- Better linkages with GPs and psychiatric services should be developed to ensure that individuals are provided with a holistic range of support (medical, psychiatric, counselling etc)
- Ensuring that support is provided to families of individuals with mental health, emotional well-being and addiction issues
- People within other community and voluntary organisations do not have the same level of understanding of what it is like to be bereaved by suicide – the Bereaved by Suicide Group provides the most supportive environment for those bereaved by suicide

- Counselling does not always work for every individual and very much depends on the relationship between the counsellor and the person seeking counselling.

We note that a community response plan following suicide for the Derry City Council area is currently in development by the Western Suicide Strategy Implementation Group. The view that the most appropriate support following a bereavement by suicide is provided by a Bereaved by Suicide Group should also be taken into consideration in the development of the community response.

Recommendation 29

There are a number of considerations for CLEAR arising from the feedback of those who have been bereaved by suicide including ensuring information on services is widely available, developing connections across the health service and community and voluntary sectors and providing support for families. The development of a community response plan in several council areas also presents opportunities for CLEAR to develop local, multi-agency and multi-sectoral linkages and increase collaboration at a local level.

Key Points

- The Bereaved by Suicide Support Group provides an invaluable space where members can obtain the support they need
- The Suicide Liaison Officer role in providing support to families following a bereavement is highly praised
- It can be difficult to know where to go to for support following a bereavement by suicide – when someone is dealing with grief it can be too exhausting physically and emotionally to seek information and support.
- It can equally be difficult to know where to go to find support for a loved one experiencing mental health or emotional well-being difficulties. However, it was noted that it is often the case that a person does not seek to find out what types of services are available within their community if they do not feel a need to avail of a particular service
- Access to services, both within the statutory and community and voluntary sectors, can be difficult, particularly if it requires GP referral
- Long waiting lists can mean that people slip through the net and do not receive support when they need it
- Counselling appears to very much depend on the connection between the counsellor and the person seeking counselling. If this connection is not made a person experiencing grief may not feel they have enough energy to continue to seek a counsellor with whom they do connect
- Mental health awareness right across society is vital, but requires funding.

12 Overall Conclusions

Our analysis within this report is based on self-reported information and we did not set out to 'audit' organisations. It is evident however that the community and voluntary organisations surveyed are both active and diverse. The willingness of the organisations participating in this mapping exercise and the desire to ensure that the focus of this work remains the goal of making a difference in people's lives has been particularly notable. The organisations interviewed as part of this process highlighted a deep commitment to providing quality services to vulnerable individuals across a range of age groups and communities.

12.1 Service Provision

It is no surprise that the majority of participating organisations are located in the primary settlements within the WHSSB area with coverage across all five council areas. It is clear that a large number of the organisations surveyed provide services to the Strabane area (slightly more than the Derry area) – given the population size of such an area it is important that organisations across all sectors work together to avoid a situation where, given the nature of funding, organisations are forced to 'compete' for people to use their services.

A high percentage of organisations frequently deal with individuals presenting with emotional distress (91%) and mental ill-health (79%) and 67% of organisations responding often or frequently deal with individuals presenting with suicidal behaviour.

The majority of organisations participating in the mapping exercise provide tier 2 services in relation to suicide/self-harm.

The most common area of work is Support, followed by Listening Ear and Counselling, with the average wait for counselling less than one month (we note however that one organisation has an average wait of nine months).

The majority of organisations surveyed adopt a holistic approach to working with people, addressing a variety of needs. Mental health is well covered by organisations as a need; however an area that is recognised to impact on suicide and self-harm, alcohol, is less common as a need addressed by organisations surveyed. A review of the more specific needs such as addiction, suicide and self-harm could be undertaken to ensure that they are addressed at all levels, from awareness-raising to support and counselling.

The gap that was most highlighted in terms of service provision was services for young people. Others included:

- Young men aged 18-25 years
- Lesbian/Bisexual women
- Transgender men and women
- Local access
- Applied psychotherapy
- Mild mental health issues
- Anger management.

Recommendation 1

The diversity of needs reported as addressed by organisations, particularly by Group 1 (counselling) organisations, highlights the holistic approach to working with people (ie looking at the whole person and the breadth of issues a person faces) adopted by many within the community and voluntary sector. A consideration for CLEAR in looking to future service development will be whether the holistic, 'one-stop-shop' model is extended or whether the focus is on more specialist-based services.

Recommendation 2

CLEAR may wish to consider further mapping the level of provision at each tier within the WHSSB area from both the community and voluntary and statutory sectors to determine the level of coverage across all tiers.

Recommendation 3

The CLEAR Project presents an opportunity for developing greater collaboration and improving communication amongst organisations providing services in individual council districts as well as throughout the WHSSB area as a whole. Where a large or low number of organisations per head of population are providing support services (particularly at tiers 2 and 3) CLEAR should research this further to ensure that all people have access to services and that a 'competition' amongst organisations is minimised.

Recommendation 4

The analysis of target groupings reported by organisations surveyed shows that ethnic minorities and lesbian, gay, bisexual and transgender people are not targeted as frequently as other groups. Further research is required to assess the need within these communities and to determine whether appropriate and accessible services are in place.

Recommendation 5

The issue of balancing the development of a holistic approach and reducing the need for people to see a number of different organisations with the avoidance of duplication of services, particularly in a time of restricted funding, is one that will require further consideration by CLEAR, particularly in the development of any referral pathway or route map.

12.2 Governance

Good governance not only provides reassurance for service users, but provides a safety net for organisations and funders. The largest areas for development within organisations are in the setting of strategic plans, the consultation of staff and volunteers in the development of organisation strategy and delegation.

Many participating organisations highlighted the importance of a strong management board with a broad skills mix. The majority of organisations have ensured the necessary policies and procedures are in place although we recommend that a small number of organisations consider developing data protection or child protection policies and/or policies on financial controls. We further recommend that a small number of organisations that indicated that they provide services to children and young people seek advice as to whether staff/volunteers require to be checked through Access NI.

All organisations report appropriate data protection arrangements and many of the organisations providing counselling services demonstrated good practice in allocating service users a reference, ensuring that personal details are not stored with case notes

(case notes are stored by reference) and ensuring that access to each set of information is restricted.

Recommendation 6

The majority of organisations reported that they are charities or hold charitable status. With a new Charity Commission for Northern Ireland expected to be established by the end of March 2009 there may be some work for CLEAR in assisting organisations to prepare or ensuring that organisations prepare for and meet the relevant requirements imposed by the Commission on charities.

Recommendation 7

CLEAR may wish to consider how it can support organisations to set development plans and strategies and ensure that staff and volunteers are consulted in the development of organisation strategy. This support could be through activities such as training in strategic planning.

Recommendation 8

The five policies and procedures in Section 3.4 could be considered the minimum required for best practice. A number of organisations should therefore develop child protection, vulnerable adult, data protection and financial controls policies. CLEAR should consider whether there is a role for it to play in supporting organisations in the development of policies and providing training or ensuring that training is provided on the implementation and updating of policies to all groups. CLEAR should also consider defining a mechanism for ensuring that policies are adopted, adhered to and reviewed.

Recommendation 9

Data protection and data storage best practice is continually updating, particularly in the light of recent 'loss of sensitive information' scandals in the media. The issue of data protection will also be extremely pertinent in determining what to do with client files and other data if an organisation closes due to funding constraints. Whilst organisations surveyed reported that they had data protection procedures in place, it is important that these data protection arrangements continue to be updated in light of new guidance and that they are well embedded throughout the organisation. If CLEAR proceeds to develop standards for mental health and well-being service provision, data protection and confidentiality will form an important part of these. There may therefore be a role for CLEAR in not only providing information on data protection, but providing training and assistance or ensuring that training and assistance are provided to enable organisations to ensure that they can meet any standards developed.

Recommendation 10

We are mindful that, given the nature of the organisations and the services provided by the organisations taking part in the mapping exercise, obtaining service user feedback can be more difficult than for community and voluntary organisations providing other, more general, services. This point is also linked with the involvement of service users in the design and delivery of services. There may therefore be an opportunity for CLEAR to support organisations to develop appropriate mechanisms for service user feedback and involvement.

Recommendation 11

The health and social care staff we met with stated that they expect standards to be in place, particularly for organisations providing counselling. CLEAR should therefore consider defining standards or working with other relevant bodies to define standards for mental health and well-being service provision, particularly counselling, with the engagement of all stakeholders. Standards must be defined in agreement with all stakeholders and should be relevant to and 'fit' the type of organisation and the nature of its work. Consideration should

also be given to ensuring 'fit' with public sector standards and expectations.

Recommendation 12

Good practice for quality assurance would seek a balance between internal procedures (such as accredited training, supervision, line management) and external procedures (such as PQASSO, ISO, peer review etc). In looking to define and establish standards, CLEAR may also wish to consider whether the development of a quality assurance framework would add value to the work of the community and voluntary sector providing mental health and well-being services.

12.3 Staffing / Volunteers

With limited resources, community and voluntary organisations are reliant on volunteers to provide support across a range of areas from service delivery to management board, fundraising and administration.

Community and voluntary organisations are committed to ensuring that their staff and volunteers are skilled and experienced with a focus on building capacity within the community.

The minimum level of qualification for counselling staff varies across Group 1 (counselling) organisations although the majority of Group 1 organisations require their counselling staff / volunteers to be accredited or working towards accreditation. Supervision arrangements for counselling staff are on the whole well-established with the majority of counselling staff externally supervised. We advise however that those organisations providing internal supervision only ensure that counselling supervision is differentiated from line management function.

Organisations are keen to access appropriate training with the majority satisfied with the current breadth of training programmes offered.

Recommendation 13

Although the majority of Group 1 (counselling) organisations reported that they require counsellors to hold a Diploma in Counselling, a range of minimum qualifications for counsellors was reported through the mapping exercise. Given this, CLEAR should consider whether a definition of the minimum expected qualification(s) should be included in the development of any agreed standards for counselling provision.

Recommendation 14

In developing standards for counselling services, CLEAR should consider whether counselling staff/volunteer require accreditation and whether this should also be extended to accreditation of organisations.

Recommendation 15

The role of supervision for counsellors and therapeutic staff/volunteers is extremely important and is highlighted within the *BACP Ethical Framework for Good Practice in Counselling and Psychotherapy*. CLEAR may wish to consider whether supervision should form a part of the development of standards and how best organisations can be supported to ensure that they can maintain best practice in this area.

Recommendation 16

Organisations surveyed are keen to access appropriate training and a number specified possible new areas for training. CLEAR should provide a link between the training sub-group of the WSSIG and WHSCT Health Promotion Department to ensure that training can be accessed as widely as possible.

Recommendation 17

Given the particular challenges for counselling organisations of involving service users in the design and delivery of services, CLEAR may wish to consider developing new and innovative ways of securing this engagement that meet the needs of both the organisation and the service users and do not hinder a person's therapy or progress.

12.4 Referrals

Through the mapping exercise organisations indicated a willingness to refer individuals to organisations that they feel can provide more specific support although, since organisations refer in the main to those other organisations that they know and trust, the importance of the development of relationships and connections within the sector is evident.

In terms of referrals across sectors a number of organisations indicated that if groups receive additional referrals as a result of a new route map/referral pathway this will require resourcing since most organisations are just managing with their current workloads and resources.

A further area for consideration is the issue of confidentiality in making referrals. The vast majority of community and voluntary organisations encourage individuals to self-refer so perhaps signpost and facilitate a contact rather than refer. Where referrals are made it was noted by a number of organisations that the issue of data protection and confidentiality can at times add an extra layer of difficulty for the individual concerned as they are required to repeat their story each time rather than the information being provided by the referrer.

Recommendation 18

In developing a referral pathway or route map, CLEAR should give consideration to those organisations that do not have formal referral systems and for whom this may be a conscious choice. It will also be important to consider the effect that any route map or referral pathway could have on the capacity of organisations to meet an increased demand for services.

Recommendation 19

There is currently no uniform system for capturing referral data within the organisations surveyed. CLEAR may wish to consider whether the development of a standard system for capturing referral data would add value to the work within the sector, potentially supporting organisations to demonstrate the demands on their services or the effectiveness of any new route map or referral pathway. The value of such a system should also be reviewed with the health service as a funder/monitoring body.

Recommendation 20

It is clear that within the Group 1 (counselling) organisations surveyed people are being directed in to counselling and on to other services and support. The number of incoming and onward referrals within Group 2 (support) and Group 3 (health and well-being) is however lower – whilst there may be more signposting within these groups that is not captured in the reported referral figures, there are opportunities for CLEAR to consider how the referrals

process within the statutory and community and voluntary sectors can be refined to encourage greater referral to support and health and well-being services.

Recommendation 21

Given that self-referral is the most commonly-used mechanism by organisations surveyed, it will be important that any referral pathway/route map developed by CLEAR takes this into account and in particular addresses how individuals are enabled and empowered to make appropriate self-referrals.

Recommendation 22

A key issue reported by many organisations is knowing and trusting the community and voluntary organisation to which a person might be referred – if connections and relationships have not been sufficiently developed across the sector, there is a possibility that people are not referred on and that organisations choose to provide all services themselves, potentially leading to a duplication of services. CLEAR presents an excellent opportunity for organisations and individuals to make these connections and build these relationships across organisations and sectors.

Recommendation 23

If GPs are considered the gatekeepers to many services, it is essential that mechanisms are developed to ensure that all GPs can be confident in making referrals to the community and voluntary sector and that they have knowledge of the services provided within the community and voluntary sector. CLEAR should consider the role of GPs within any referral pathway or route map. CLEAR could also be a link between the community and voluntary sector in developing relationships between GPs and community and voluntary organisations (see also recommendation 28).

12.5 Communication

Community and voluntary organisations are both passionate and dedicated in their aims of community development and health improvement with the individual at the heart of all they do. They are keen to build working relationships across all sectors and learn from others and participate in activities and events which promote networking and partnership.

The majority of organisations interviewed felt that workshops and training could best help increase networking and communication.

Recommendation 24

Workshops and training present real opportunities, not only to increase the skills within organisations but to increase networking and communication. CLEAR should consider using the ASIST, Safe Talk and Mental Health First Aid training (highlighted by organisations as training they would wish to access) as best practice to promote networking and communication amongst community and voluntary organisations. There may also be opportunities to promote networking between sectors by including GPs/primary care staff and health and social care staff in this and other training.

12.6 Resources

All organisations manage and endeavour to deliver quality services with the funding they receive but the majority of organisations noted that additional funding is required to meet the assessed need with the community. Organisations noted that it can be a

challenge to make long-term plans on short-term, inconsistent funding and highlighted the need for more core, unrestricted funding.

Both the community and voluntary and statutory sectors are going through major periods of change – the statutory sector with the Review of Public Administration and the requirement for efficiency savings and the community and voluntary sector with increased restriction of funding streams. Given these challenges, it is perhaps an opportune time to consider and ensure effective and efficient ways of working are delivered to minimise the effect on the individuals that organisations across the sectors serve.

Recommendation 25

Although CLEAR is not a funding body the issue of resourcing within the community and voluntary sector must be addressed if sustainable services are to be provided and particularly if a route map is to highlight certain organisations that may then see an increase in the uptake of their services. Representatives of CLEAR participating in WSSIG provide CLEAR with an opportunity for the question of resourcing to be raised at Board and Trust level and there may be opportunities for example under the GP Direct Enhanced Services framework for collaboration in resourcing particular services.

12.7 Strengths, Weakness, Opportunities and Threats

The main strengths of the community and voluntary sector delivering mental health and well-being services in the WHSSB area are its client focus, aimed at empowering individuals, matched by a skilled and dedicated staff and volunteer base. Its largest area of weakness is in its lack of sustainable funding, leaving many services, skilled staff and organisations vulnerable.

The largest threat is that any potential loss of focus on preventative services could lead to increased pressure on crisis services, particularly as the current economic crisis impacts on individuals and families and could lead to more people experiencing mental health and well-being issues. The CLEAR Project represents however an excellent opportunity to engage, through a spirit of cooperation and openness, in addressing the issues and ultimately leading to an increase in good mental health and emotional well-being for the WHSSB population.

12.8 Areas for Development

In terms of areas for development, the largest area highlighted by organisations was training and advice, with resources being the next largest area for development.

12.9 Health Service Perspectives

Gaps in service provision across both the statutory and community and voluntary sectors were once again highlighted. In order to successfully address these gaps and improve services and processes, more information and communication, more efficient processes and greater collaboration must be developed.

In terms of addressing quality and standards, it was acknowledged that a true assessment of these areas can only be undertaken if a common and agreed quality and standards framework is adopted. These are areas however that require a focus and will particularly enable an increase in referrals from GPs and Trust staff to the community and voluntary sector.

In looking at referral processes, the Limavady model was highlighted as having been particularly successful. The model brought together GPs, the WHSCT and community and voluntary organisations in an active engagement to promote an open dialogue and increase confidence in the ability to refer. As a result of the work undertaken through the model, referrals from GPs in the Limavady area to community and voluntary organisations increased and reduced the pressures on statutory services. It was acknowledged that this model is an active model, requiring active engagement from all involved and ongoing work to maintain the engagement.

In looking at the future direction of mental health and well-being services, the three key issues that will impact on the future direction are:

- Collaboration
- service provision
- funding.

In moving towards the future the CLEAR Project represents an important development in facilitating engagement with the community and voluntary sector. It is evident that the health service believes that a key role for CLEAR is in the provision of a coordinated community and voluntary sector response and representation in the development of collaborative work. In addition, as the health service and particularly the WHSSB move through the final changes of the Review of Public Administration an important role for CLEAR will be in providing a point of contact through the changing times and ensuring that momentum and relations are not lost.

Recommendation 26

There is a willingness and an openness from those health and social care staff we met with to develop more joined-up working and provision of shared resources that better meet the needs of people in local communities. CLEAR presents an excellent opportunity to develop a coordinated community and voluntary response mechanism for statutory services to engage with the relevant community and voluntary organisations.

Recommendation 27

The Limavady Model has been highlighted as a model of good practice in increasing GP referrals to the community and voluntary sector. The CLEAR project should consider with health and social care staff how this model could be revitalised and supported to promote the use of services within the community and voluntary sector.

Recommendation 28

The Direct Enhanced Services framework¹⁰ provides a good opportunity for not only linking GPs with community and voluntary services but finding ways to resource this. CLEAR should therefore consult with the relevant health and social care staff with a view to exploring this further.

¹⁰ Direct Enhanced Services are special services or activities provided by GP practices that have been negotiated nationally. All practices can choose whether or not to provide these services.

12.10 Perspectives of Those Bereaved by Suicide

The Bereaved by Suicide Support Group provides an invaluable space where members can obtain the support they need. The role of the Suicide Liaison Officer in providing support to families was also highly praised and noted.

It can be difficult for families to know where to go to for support following a bereavement by suicide – in the aftermath of such an event seeking information and support can be exhausting both physically and emotionally. It is often the case that a person does not seek to find out what types of services are available within their community until a need arises to for a particular service.

Access to services, both within the statutory and community and voluntary sectors, can be difficult, particularly if it requires GP referral and long waiting lists can mean that people slip through the net and do not receive support when they need it.

By its nature, the success of counselling depends very much on the connection between the counsellor and the person seeking counselling. If this connection is not made, an individual may find it hard to maintain the search for a counsellor with whom they do connect.

Recommendation 29

There are a number of considerations for CLEAR arising from the feedback of those who have been bereaved by suicide including ensuring information on services is widely available, developing connections across the health service and community and voluntary sectors and providing support for families. The development of a community response plan in several council areas also presents opportunities for CLEAR to develop local, multi-agency and multi-sectoral linkages and increase collaboration at a local level.

13 Summary of Recommendations and Action Plan

13.1 Summary of Recommendations

The following sets out a summary of the recommendations made within the report, noting the report section under which the recommendations have been made.

Recommendation
Service Provision
1. The diversity of needs reported as addressed by organisations, particularly by Group 1 (counselling) organisations, highlights the holistic approach to working with people (ie looking at the whole person and the breadth of issues a person faces) adopted by many within the community and voluntary sector. A consideration for CLEAR in looking to future service development will be whether the holistic, 'one-stop-shop' model is extended or whether the focus is on more specialist-based services.
2. CLEAR may wish to consider further mapping the level of provision at each tier within the WHSSB area from both the community and voluntary and statutory sectors to determine the level of coverage across all tiers.
3. The CLEAR Project presents an opportunity for developing greater collaboration and improving communication amongst organisations providing services in individual council districts as well as throughout the WHSSB area as a whole. Where a large or low number of organisations per head of population are providing support services (particularly at tiers 2 and 3) CLEAR should research this further to ensure that all people have access to services and that a 'competition' amongst organisations is minimised.
4. The analysis of target groupings reported by organisations surveyed shows that ethnic minorities and lesbian, gay, bisexual and transgender people are not targeted as frequently as other groups. Further research is required to assess the need within these communities and to determine whether appropriate and accessible services are in place.
5. The issue of balancing the development of a holistic approach and reducing the need for people to see a number of different organisations with the avoidance of duplication of services, particularly in a time of restricted funding, is one that will require further consideration by CLEAR, particularly in the development of any referral pathway or route map.
Governance
6. The majority of organisations reported that they are charities or hold charitable status. With a new Charity Commission for Northern Ireland expected to be established by the end of March 2009 there may be some work for CLEAR in assisting organisations to prepare or ensuring that organisations prepare for and meet the relevant requirements imposed by the Commission on charities.

Recommendation
7. CLEAR may wish to consider how it can support organisations to set development plans and strategies and ensure that staff and volunteers are consulted in the development of organisation strategy. This support could be through activities such as training in strategic planning.
8. The five policies and procedures in Section 3.4 could be considered the minimum required for best practice. A number of organisations should therefore develop child protection, vulnerable adult, data protection and financial controls policies. CLEAR should consider whether there is a role for it to play in supporting organisations in the development of policies and providing training or ensuring that training is provided on the implementation and updating of policies to all groups. CLEAR should also consider defining a mechanism for ensuring that policies are adopted, adhered to and reviewed.
9. Data protection and data storage best practice is continually updating, particularly in the light of recent 'loss of sensitive information' scandals in the media. The issue of data protection will also be extremely pertinent in determining what to do with client files and other data if an organisation closes due to funding constraints Whilst organisations surveyed reported that they had data protection procedures in place, it is important that these data protection arrangements continue to be updated in light of new guidance and that they are well embedded throughout the organisation. If CLEAR proceeds to develop standards for mental health and well-being service provision, data protection and confidentiality will form an important part of these. There may therefore be a role for CLEAR in not only providing information on data protection, but providing training and assistance or ensuring that training and assistance are provided to enable organisations to ensure that they can meet any standards developed.
10. We are mindful that, given the nature of the organisations and the services provided by the organisations taking part in the mapping exercise, obtaining service user feedback can be more difficult than for community and voluntary organisations providing other, more general, services. This point is also linked with the involvement of service users in the design and delivery of services. There may therefore be an opportunity for CLEAR to support organisations to develop appropriate mechanisms for service user feedback and involvement.
11. The health and social care staff we met with stated that they expect standards to be in place, particularly for organisations providing counselling. CLEAR should therefore consider defining standards or working with other relevant bodies to define standards for mental health and well-being service provision, particularly counselling, with the engagement of all stakeholders. Standards must be defined in agreement with all stakeholders and should be relevant to and 'fit' the type of organisation and the nature of its work. Consideration should also be given to ensuring 'fit' with public sector standards and expectations.
12. Good practice for quality assurance would seek a balance between internal procedures (such as accredited training, supervision, line management) and external procedures (such as PQASSO, ISO, peer review etc). In looking to define and establish standards, CLEAR may also wish to consider whether the development of a quality assurance framework would add value to the work of the community and voluntary sector providing mental health and well-being services.

Recommendation
Staffing and Volunteers
13. Although the majority of Group 1 (counselling) organisations reported that they require counsellors to hold a Diploma in Counselling, a range of minimum qualifications for counsellors was reported through the mapping exercise. Given this, CLEAR should consider whether a definition of the minimum expected qualification(s) should be included in the development of any agreed standards for counselling provision.
14. In developing standards for counselling services, CLEAR should consider whether counselling staff/volunteer require accreditation and whether this should also be extended to accreditation of organisations.
15. The role of supervision for counsellors and therapeutic staff/volunteers is extremely important and is highlighted within the <i>BACP Ethical Framework for Good Practice in Counselling and Psychotherapy</i> . CLEAR may wish to consider whether supervision should form a part of the development of standards and how best organisations can be supported to ensure that they can maintain best practice in this area.
16. Organisations surveyed are keen to access appropriate training and a number specified possible new areas for training. CLEAR should provide a link between the training sub-group of the WSSIG and WHSCT Health Promotion Department to ensure that training can be accessed as widely as possible.
17. Given the particular challenges for counselling organisations of involving service users in the design and delivery of services, CLEAR may wish to consider developing new and innovative ways of securing this engagement that meet the needs of both the organisation and the service users and do not hinder a person's therapy or progress.
Referrals
18. In developing a referral pathway or route map, CLEAR should give consideration to those organisations that do not have formal referral systems and for whom this may be a conscious choice. It will also be important to consider the effect that any route map or referral pathway could have on the capacity of organisations to meet an increased demand for services.
19. There is currently no uniform system for capturing referral data within the organisations surveyed. CLEAR may wish to consider whether the development of a standard system for capturing referral data would add value to the work within the sector, potentially supporting organisations to demonstrate the demands on their services or the effectiveness of any new route map or referral pathway. The value of such a system should also be reviewed with the health service as a funder/monitoring body.
20. It is clear that within the Group 1 (counselling) organisations surveyed people are being directed in to counselling and on to other services and support. The number of incoming and onward referrals within Group 2 (support) and Group 3 (health and well-being) is however lower – whilst there may be more signposting within these groups that is not captured in the reported referral figures, there are opportunities for CLEAR to consider how the referrals process within the statutory and community and voluntary sectors can be refined to encourage greater referral to support and health and well-being services.

Recommendation
21. Given that self-referral is the most commonly-used mechanism by organisations surveyed, it will be important that any referral pathway/route map developed by CLEAR takes this into account and in particular addresses how individuals are enabled and empowered to make appropriate self-referrals.
22. A key issue reported by many organisations is knowing and trusting the community and voluntary organisation to which a person might be referred – if connections and relationships have not been sufficiently developed across the sector, there is a possibility that people are not referred on and that organisations choose to provide all services themselves, potentially leading to a duplication of services. CLEAR presents an excellent opportunity for organisations and individuals to make these connections and build these relationships across organisations and sectors.
23. If GPs are considered the gatekeepers to many services, it is essential that mechanisms are developed to ensure that all GPs can be confident in making referrals to the community and voluntary sector and that they have knowledge of the services provided within the community and voluntary sector. CLEAR should consider the role of GPs within any referral pathway or route map. CLEAR could also be a link between the community and voluntary sector in developing relationships between GPs and community and voluntary organisations (see also recommendation 28).
Communication
24. Workshops and training present real opportunities, not only to increase the skills within organisations but to increase networking and communication. CLEAR should consider using the ASIST, Safe Talk and Mental Health First Aid training (highlighted by organisations as training they would wish to access) as best practice to promote networking and communication amongst community and voluntary organisations. There may also be opportunities to promote networking between sectors by including GPs/primary care staff and health and social care staff in this and other training.
Resources
25. Although CLEAR is not a funding body the issue of resourcing within the community and voluntary sector must be addressed if sustainable services are to be provided and particularly if a route map is to highlight certain organisations that may then see an increase in the uptake of their services. Representatives of CLEAR participating in WSSIG provide CLEAR with an opportunity for the question of resourcing to be raised at Board and Trust level and there may be opportunities for example under the GP Direct Enhanced Services framework for collaboration in resourcing particular services.
Health and Social Care Perspectives
26. There is a willingness and an openness from those health and social care staff we met with to develop more joined-up working and provision of shared resources that better meet the needs of people in local communities. CLEAR presents an excellent opportunity to develop a coordinated community and voluntary response mechanism for statutory services to engage with the relevant community and voluntary organisations.

Recommendation
27. The Limavady Model has been highlighted as a model of good practice in increasing GP referrals to the community and voluntary sector. The CLEAR project should consider with health and social care staff how this model could be revitalised and supported to promote the use of services within the community and voluntary sector.
28. The Direct Enhanced Services framework ¹¹ provides a good opportunity for not only linking GPs with community and voluntary services but finding ways to resource this. CLEAR should therefore consult with the relevant health and social care staff with a view to exploring this further.
Meeting with Bereaved by Suicide Group representatives
29. There are a number of considerations for CLEAR arising from the feedback of those who have been bereaved by suicide including ensuring information on services is widely available, developing connections across the health service and community and voluntary sectors and providing support for families. The development of a community response plan in several council areas also presents opportunities for CLEAR to develop local, multi-agency and multi-sectoral linkages and increase collaboration at a local level.

13.2 Action Plan

We have further developed the recommendations to produce a suggested action plan for CLEAR. The action plan summarises each recommendation, grouping them under the following headings:

- Standards
- Referrals pathway
- Support and training
- Mapping and review
- Communication and linking

and noting the priority level for each recommendation and associated action for CLEAR.

An important consideration for CLEAR in reviewing the suggested actions within the action plan will be whether CLEAR itself becomes a provider of some actions/initiatives, such as training in developing policies and procedures or further reviews of service provision, or whether CLEAR's role is to source or lobby for such initiatives to be developed by other groups or agencies.

¹¹ Direct Enhanced Services are special services or activities provided by GP practices that have been negotiated nationally. All practices can choose whether or not to provide these services.

Action Plan

Recommendation Summary	Priority	By when	Action
Standards			
<ul style="list-style-type: none"> Define standards, particularly for counselling services Build in data protection standards Consider developing quality assurance framework Consider minimum qualifications for counsellors Consider accreditation of staff Consider standards on supervision 	Immediate	This should be started in the next six months	CLEAR should consider setting up a working group to liaise with relevant stakeholders, review standards that have already been prepared by DHSSPS and South West Local Strategy Partnerships and take forward the development of standards, particularly for counselling services and potentially for listening ear and befriending services, taking into account the recommendations within this area
Referrals Pathway			
<ul style="list-style-type: none"> Consider how to encourage greater referral Balance holistic approach with avoidance of duplication of services Consider organisations who do not want a formal referrals process Consider impact of referrals process on organisations' capacity Build in pathways for self-referral Consider role of GPs 	Immediate	This should be started in the next six months	CLEAR should consider setting up a working group to take forward the development of a referral pathway/route map for: <ul style="list-style-type: none"> individuals and families to crisis support in times of distress individuals and families to support following self-harm and suicide taking into account the recommendations within this area
<ul style="list-style-type: none"> Consider system for capturing referrals data 	Longer-term	The end of the Project	CLEAR should consider whether a system to capture referrals data would add value to the development of a referral pathway. If appropriate, CLEAR should set up a small working group to take forward this action
Support and Training			
<ul style="list-style-type: none"> Utilise training to promote networking 	Immediate	This should be started in the next six months	CLEAR should liaise with the relevant training arms of the WHSCT and WSSIG t to promote networking through training

Recommendation Summary	Priority	By when	Action
<ul style="list-style-type: none"> Support organisations to develop policies Support organisations to develop appropriate data protection arrangements 	Immediate	This should be started in the next six months	CLEAR should liaise with the relevant training arms of the WHSCT and WSSIG, to review how best to support organisations in developing policies and procedures, ensuring that all required policies and procedures are well-embedded within an organisation
<ul style="list-style-type: none"> Support organisations to develop strategic plans 	Medium term	This should be started in the next 6-12 months	CLEAR should consider, with the relevant training arms of the WHSCT and WSSIG, how best to support organisations to develop strategic plans
<ul style="list-style-type: none"> Assist organisations to prepare for Charity Commission 	Longer-term	May 2009	The Charity Commission is due to be formalised in March 2009 and CLEAR may wish to consider, with groups such as the Community Networks, whether it has a role to play in assisting organisations to prepare for this
<ul style="list-style-type: none"> Support organisations to develop mechanisms for service user feedback and involvement 	Longer-term	The end of the Project	CLEAR may wish to review existing mechanisms for service user engagement with a view to enhancing user involvement
Mapping and Review			
<ul style="list-style-type: none"> Review service provision at each tier Review service provision by council area Review service provision for specific target groups 	Immediate	This should be started in the next six months	CLEAR should engage with WSSIG to consider and potentially undertake further reviews of service provision in the WHSSB area across both the statutory and community and voluntary sectors
<ul style="list-style-type: none"> Review service development – one stop shop model? 	Medium term	This should be started in the next 6-12 months	In considering future direction, CLEAR should review how best to promote service development (ie through a one stop shop model?)

Recommendation Summary	Priority	By when	Action
Communication and Linking			
<ul style="list-style-type: none"> Raise issue of resourcing with Trust/Board Consult with relevant staff re Direct Enhanced Services 	Immediate	This should be started in the next six months	Through its involvement in WSSIG, CLEAR should raise the issue of resourcing and possible use of the Direct Enhanced Services framework to resource community and voluntary sector services
<ul style="list-style-type: none"> Facilitate connections between organisations and sectors Provide mechanism for statutory sector to engage with community and voluntary sector Provide link between GPs and community and voluntary organisations providing mental health & well-being services 	Immediate	This should be started in the next six months	CLEAR should consider how best to facilitate connections between organisations and sectors, potentially providing representation of the community and voluntary sector organisations delivering mental health and well-being services to public bodies such as the WHSCT and new Regional Health and Social Care Board
<ul style="list-style-type: none"> Explore redeveloping Limavady model 	Immediate	This should be started in the next six months	Through its involvement in WSSIG, CLEAR should consider how the Limavady model of developing GP referral to community and voluntary organisations can be redeveloped and extended throughout the WHSSB area
<ul style="list-style-type: none"> Link with WSSIG training sub-group to promote training 	Medium term	This should be started in the next 6-12 months	This action links with the action highlighted above with regard to training but also extends to include promoting existing training such as ASIST, Mental Health First Aid etc
<ul style="list-style-type: none"> Facilitate linkages in community response plans 	Medium term	This should be started in the next 6-12 months	CLEAR should consider how best to support WSSIG in developing community response plans for all the council areas in the WHSSB
<ul style="list-style-type: none"> Develop innovative ways of involving service users in the design and delivery of services 	Longer-term	The end of the Project	This action links with the action highlighted above with regard to service user engagement

14 Future Direction and Priorities

Having concluded the mapping exercise and made the recommendations outlined above there are a number of priority areas that CLEAR may wish to focus on. These are:

- Service provision
- Governance
- Referral processes
- Communication
- Resources.

The priority areas have been based on the recommendations made within this report, taking those areas which we consider key to the future direction of mental health and well-being services.

An important consideration for CLEAR in looking to its future and assessing the recommendations and priority areas within this report will be whether CLEAR itself becomes a provider of some initiatives, such as training in developing policies and procedures or further reviews of service provision, or whether CLEAR's role is to source or lobby for such initiatives to be developed by other groups or agencies.

14.1 Service Provision

Within service provision there are three priority areas:

- Derry City council area has the highest rate of self-harm across both genders of the five council areas within the WHSSB area¹² and yet (according to the mapping exercise) the lowest number of providers of tier 1 and 2 services per head of population – the low number of providers per head of population does not in itself indicate a gap in service provision and further review would need to be conducted to assess whether enough tier 1 and 2 services are provided in the Derry City Council area
- a significant percentage of episodes of self-harm involve alcohol¹³ yet the number of organisations surveyed that reported that they address drugs and alcohol issues is low across the WHSSB area. Further review of the level of service provision in relation to drugs and alcohol would be required to determine whether there is adequate provision of services or if this requires further development
- mental health and emotional well-being services for young people were highlighted by those taking part in the mapping exercise as particularly lacking yet the highest rates of self-harm in the *WHSSB Registry of Self Harm January-December 2007 Summary Report* were among 20-24 year old males and females. Additional research by the Prince's Trust in January 2009 also found that one in ten young people aged 16-25 in the UK do not find life worth living¹⁴. This research also noted that:
 - One in five will experience a mental health problem

¹² WHSSB Registry of Self Harm January – December 2007 Summary Report

¹³ WHSSB Registry of Self Harm January – December 2007 Summary Report

¹⁴ Prince's Trust YouGov Youth Index

- More than one in ten feel that life is meaningless
- More than a quarter admitted they are “often” or “always” down or depressed
- More than one in four say they are less happy now than they were as a child
- One in five feels like crying “often” or “always”
- Almost half say they are regularly stressed.¹⁵

Further review of the level of provision of mental health and emotional well-being services for young people would be required to determine whether there is adequate provision of services or if this requires further development.

14.2 Governance

Through the mapping exercise two areas within governance have been highlighted as potential areas for development by CLEAR:

- Policies and procedures:
 - a number of organisations indicated that it would be helpful to have a central resource for policies and procedures to advise on what was required and how to develop policies appropriate to each organisation
 - Ensuring that organisations hold the relevant policies and conduct the necessary procedures such as POCVA checks for staff/volunteers and that training is provided to ensure that policies are not just ‘off the shelf’ but are relevant and well embedded within the practice of organisations
- Standards – in the area of counselling particularly there are no mandatory standards that must be followed or regulation of the profession. We are aware that the DHSSPS has undertaken some work to develop draft standards of good practice for counselling services in Northern Ireland¹⁶. In addition, a new project (Nechama Project) in the Fermanagh/Tyrone area is seeking to develop collaboration and standardisation of services for likeminded victims’ organisations. CLEAR representatives have also met with a representative from the Regulation and Quality Improvement Authority (RQIA) with regard to future developments in the regulation of organisations providing ‘personal care’ and, whilst RQIA has no specific plans to review counselling services, RQIA will be taking over the role of the Mental Health Commission in April 2009 and there is an opportunity to look at where CLEAR and RQIA could work together or where CLEAR could work ‘ahead of the game’ and seek to develop agreed, relevant standards.

It is our opinion that if CLEAR is to be successful in its future work, developing linkages with the above initiatives on standards is key, particularly since the work of CLEAR could have a wider importance than just the WHSSB area.

14.3 Referral Processes

Referral processes are already an area that CLEAR is planning to address through the development of a route map or referral pathway. The referral process across sectors is particularly important: in summarising the recommended next care for self-harm

¹⁵ British Youth Council, www.byc.org.uk

¹⁶ Based on *Guidance for best practice: the employment of counsellors and psychotherapists in the NHS* BACP 2004 and *Contributing to Wellbeing: Addressing the Human and Community Consequences of Civil Violence – Standards for Counselling, Listening Ear and Befriending Services* South West Local Strategy Partnerships’ Community Victims and Survivors Initiative 2006

presentations to hospitals in the WHSSB area, the *WHSSB Registry of Self Harm January – December 2007 Summary Report* makes no mention of referral to community and voluntary organisation support. With one in five (19%) self-harm presentations not admitted after emergency care¹⁷ there is an opportunity for GPs and Community Psychiatric Nurses to develop effective referral systems to the community and voluntary sector to provide a holistic support service to individuals. We understand that a pilot mentoring project has been developed in Altnagelvin Hospital – people attending the hospital after having self-harmed and having been assessed by a member of the Mental Health Team are offered the opportunity to participate in the mentoring project through Zest, based in Derry. The patients targeted through this project are those aged over 16, deemed fit for discharge and where no new follow-up statutory mental health services are required. The mentors within Zest are carefully selected and are trained volunteers who come from various backgrounds within the community. On the basis of an evaluation of the pilot CLEAR and WSSIG should consider rolling out such mentoring services through community and voluntary organisations to all hospitals and potentially GPs.

The Limavady model of developing GP referrals to the community and voluntary sector is also one that CLEAR could engage with, together with the WHSCT and WHSSB, to re-develop and promote within local practices.

As noted previously in this report, organisations taking part in the mapping exercise fear that they do not have the resources to deliver services if referrals increase significantly - consideration should therefore be given to resourcing referrals if this is likely to impact on an organisation's capacity to deliver. We note that the Direct Enhanced Services framework may provide opportunities for resourcing referrals and CLEAR may wish to explore this further with the relevant health and social care and primary care staff.

Where referrals are made it was noted by a number of organisations surveyed that the issues of data protection and confidentiality can at times add an extra layer of difficulty for the individual concerned as they are required to repeat their story several times rather than the information being provided by the referrer. In looking at this issue, a balance must be struck between ensuring that access to services is quick and easy with a minimum of distress, and the legal requirements for data protection and confidentiality are met. CLEAR should explore this issue further with Board and Trust staff through WSSIG to determine how data protection arrangements can best be developed to ensure confidentiality but promote ease of access to services.

14.4 Communication

Participating organisations stated that they are keen to build relationships across all sectors and learn from others. They highlighted that the best way of increasing communication and networking is through training and workshops. A number of organisations highlighted a wish to access training such as ASIST, Safe Talk and Mental Health First Aid and such activities may provide platforms for networking events initiated by CLEAR.

We note that a community response plan following suicide has been developed for the Strabane District Council area and that a community response plan for the Derry City Council area is currently in development by WSSIG. In addition, we understand that work will begin to develop community response plans with the remaining councils

¹⁷ WHSSB Registry of Self Harm January – December 2007 Summary Report

within the WHSSB area in February 2009. An effective response will hinge on clear, comprehensive communication and partnership across a number of agencies and sectors. As community response plans are to be developed for other council areas these should provide excellent opportunities to increase inter-sectoral, multi-agency communication and partnership working. CLEAR presents a good opportunity to provide the link between the community and voluntary and statutory agencies within the community response plans, ensuring greater communication and partnership working.

A further area for increasing communication is with the wider general public. As highlighted by the representatives of the Bereaved by Suicide Group many people do not seek or take note of information until services are needed. At that stage many individuals may not have the physical or emotional energy to seek out information. It is therefore important to ensure that information is available and accessible at times when it is needed and in a format which people find easy to take note of. The community and voluntary sector is known for its innovative ways in developing projects and practices and CLEAR should consider how information can be disseminated to ensure that the general public are aware of the range of services and supports available.

14.5 Resources

Whilst CLEAR itself will not be a funding body, the issue of resources should not be ignored. All organisations participating in the mapping exercise consider funding to be the biggest challenge they face with most relying on short-medium term funding. A number highlighted that there may be a loss of services if funding finishes. In addition, it was noted through the meetings with health and social care staff that funding is a key issue that will impact on the future direction of mental health and well-being services and must be addressed in future strategic developments.

One suggested framework that could provide opportunities for collaborative working and sharing resources is the Direct Enhanced Services (DES) element of the GP contract – DES presents an excellent opportunity for CLEAR to engage with health and social care staff to further assess the possibilities under this framework.

The answer to the issue of resources is not simple – both the statutory and community and voluntary sectors are facing an immediate future in which it is unlikely that funding will be increased - indeed it may well be reduced. Based on the general consensus that equal emphasis must be placed on both suicide and self-harm (crisis) services and general mental health and emotional well-being (prevention/promotion) services, consideration should therefore be given to ensuring that:

- funding is 'shared' and allocated appropriately across both sectors and to those organisations and agencies best placed to deliver the services
- effective and efficient ways of working are delivered to minimise the effect on the individuals that organisations across the sectors serve.

CLEAR, through its membership of WSSIG, should ensure that the issue of resources and delivering efficient and effective ways of working is therefore placed on the agenda of WSSIG and the new public bodies that will be created under the Review of Public Administration.

Appendix 1 – Pre-Meeting Questionnaire

Moore Stephens has been commissioned by Derry Healthy Cities on behalf of the CLEAR Project to conduct a mapping exercise of community and voluntary organisations providing mental health and well-being services across the WHSSB area.

Background to the CLEAR Project

The CLEAR Project is a consortium of community, voluntary and statutory sector organisations led by Derry Healthy Cities and established under funding provided by the Western Health and Social Services Board as part of its response to the NI Suicide Prevention Strategy. The CLEAR Project aims to forge strong and sustainable links between community and statutory sector service providers through the delivery of its objectives.

Mapping Exercise

As part of the CLEAR Project's remit from the Western Health and Social Services Board, a mapping exercise of community and voluntary organisations in the WHSSB area providing mental health and well-being services is being carried out to answer the following key questions:

- What services are being provided?
- What are the strengths and development areas of the sector?
- Where do gaps in provision for particular areas / communities exist?
- How are referrals/signposting to specialised support processed?
- To what extent is the sector operating to quality standards?

The information gathered during the mapping exercise should allow the CLEAR Project to:

- Identify models of best practice
- Highlight development needs to Western Suicide Strategy Implementation Group
- Implement training or other activities to meet development needs
- Influence the design of recognised protocols / standards.

Principles of the mapping exercise:

- Promote improvement within the sector
- Contribute to the CLEAR Project's work developing strong and sustainable links between community and statutory sector service providers
- Independent and open
- Gather first-hand evidence of an organisation's work.

The mapping exercise will seek to gather information on the following areas:

- Services provided
- Governance
- Staffing / Volunteers
- Referrals processes
- Communication
- Data collection
- Monitoring and evaluation processes
- Quality assurance processes.

In conducting the mapping exercise Moore Stephens and the CLEAR Project have agreed to focus on the following organisation groupings:

1. Organisations providing counselling to those experiencing emotional distress
2. Organisations providing support to those experiencing emotional distress
3. Organisations providing advice or mental health & well-being services but who would refer clients experiencing crisis to the other organisations in the groupings above for intensive support / counselling.

As part of the mapping exercise we will seek to meet with the community and voluntary organisations within the above groupings. Prior to this meeting, we wish to collate initial information through this pre-meeting questionnaire. Please note that information collected by Moore Stephens will be presented to the CLEAR Project in an **overall anonymised report so that no individual organisation is identified**. Each participating organisation will receive its own individual summary report at the end of the mapping exercise process in January 2009.

This questionnaire contains 39 questions and we anticipate that it should take you no longer than 25 minutes to complete.

We would be grateful if you would complete the questionnaire and return it to Camille McDermott, Consultant at Moore Stephens, 21/23 Clarendon Street, Derry, BT48 7EP. If you prefer to complete the questionnaire electronically, please contact Camille at cmcdermott@msca.co.uk and an electronic copy can be sent to you. Should you have any queries in relation to this questionnaire, please contact Camille on 028 7126 1020. Additionally, if you have any queries in relation to the CLEAR Project, please contact Shauna Houston, CLEAR Project Manager, on 028 8225 3953. **We would be grateful if you could please return your completed questionnaire by 4 December 2008. Many thanks.**

Thank you for taking the time to complete this questionnaire. Please note that information collected by Moore Stephens will be presented to the CLEAR Project in an **overall anonymised report so that no individual organisation is identified**. Each participating organisation will receive its own individual summary report at the end of the mapping exercise process in January 2009.

ORGANISATION DETAILS

Name of organisation _____

Organisation address _____

Tel: _____ Email: _____

Organisation _____ web _____ address: _____

Name of person completing questionnaire _____

Role of person completing questionnaire _____

SERVICES PROVIDED

1. Do you or your organisation deal with people who present with (please tick against each category):

	Never	Rarely (Once a year or less)	Occasionally (2-4 times per year)	Often (5-12 times per year)	Frequently (more than 12 per year)
Emotional distress					
Mental ill-health					
Suicidal behaviour					

2. Please tick the needs your organisation principally addresses (tick all that apply):

- Addictions Family Support
- Advice Health & Well-being
- Bereavement Mental Health
- Depression Self-harm
- Domestic Violence Suicide
- Drugs / Alcohol Trauma
- Other (please specify) _____

3. Please indicate the target group(s) that your organisation provides services for (tick all that apply). Please put a 1 next to your organisation's principal client group:

- | | | | |
|--|--------------------------|------------------------------|--------------------------|
| Children and young people | <input type="checkbox"/> | Gay, Lesbian and Transgender | <input type="checkbox"/> |
| Women | <input type="checkbox"/> | Rural dwellers | <input type="checkbox"/> |
| Men | <input type="checkbox"/> | Urban dwellers | <input type="checkbox"/> |
| Older people | <input type="checkbox"/> | | |
| Ethnic minorities (please specify) _____ | | | <input type="checkbox"/> |
| Other (please specify) _____ | | | <input type="checkbox"/> |

4. Please indicate the type of support provided to service users / beneficiaries (tick all that apply), noting the percentage of your organisation's time that these activities take and the number of people your organisation has worked with within these categories over the last year:

	Tick	% of time	No. of people in the last year
Listening ear			
Befriending			
Counselling			
Advocacy			
Support			
Other (please specify) _____			

5. Please indicate the level of support your organisation provides to service users / beneficiaries **in relation to suicide / self-harm**. Please tick all that apply:

- | | |
|---|--------------------------|
| Tier 1 – universal services aimed at the general population | <input type="checkbox"/> |
| Tier 2 – early intervention providing supportive environments for generally-targeted groups and those at risk | <input type="checkbox"/> |
| Tier 3 – intensive intervention for more severe or complex issues providing specialist services | <input type="checkbox"/> |
| Tier 4 – acute treatment providing very specialist treatment such as day units etc | <input type="checkbox"/> |

6. Please outline the council area covered by your organisation (tick all that apply):

- | | | | |
|------------------------------|--------------------------|-----------|--------------------------|
| Limavady | <input type="checkbox"/> | Omagh | <input type="checkbox"/> |
| Derry City | <input type="checkbox"/> | Fermanagh | <input type="checkbox"/> |
| Strabane | <input type="checkbox"/> | | |
| Other (please specify) _____ | | | <input type="checkbox"/> |

7. If you provide counselling, please state the average waiting time for counselling services and the average number of people waiting to access your organisation's counselling services:

Average waiting time	Average number of people waiting

8. Is there a waiting list for your organisation's other services (ie befriending, listening ear)?

YES / NO / DON'T KNOW

If yes, please state which: _____

GOVERNANCE

9. What is your organisation's legal status?

10. Does your organisation have a constitution?

YES / NO / DON'T KNOW

11. Does your organisation have a defined purpose / mission / aim? YES / NO / DON'T KNOW

If yes, please state your organisation's purpose below:

12. Please rate how well you consider your organisation meets its defined purpose:

Not at all	Not much	Some	Well	Very well

13. Does your organisation have a management board?

YES / NO / DON'T KNOW

14. If you answered yes to the above question, does your organisation have terms of reference for the management board? YES / NO / DON'T KNOW

15. For each statement below, select the rating which applies to your organisation:

	Yes- we do this very well	Yes- this is sometimes/ partially true of us	We are thinking about doing this	We don't do/have this and are not thinking about it
The management board meets regularly and meetings are minuted and actions followed through				
The relationship between staff and the management board is very good				
The respective roles of the management board and staff are well established				
There are clear roles and responsibilities for each staff member				
The staff management team meets regularly				
Staff and volunteers are consulted about the direction of the organisation				
The organisation has a clear development plan / strategy				
The organisation has well embedded monitoring systems (financial, output performance)				
The organisation has all necessary policies eg child protection, health & safety, equal opportunities etc well established				
The organisation has a clear, well-established complaints procedure				
The organisation works well as a team				
Key people delegate as much as they can				

16. Please tick which of the following policies and procedures your organisation holds and operates to:

- Child Protection
 Equal Opportunities
 Vulnerable Adult Protection
 Financial Controls
 Data Protection

17. Do you require staff / volunteers to be checked through POCVA / AccessNI? YES / NO

18. Do you hold client information? YES / NO / DON'T KNOW

19. If you answered yes, please tick which types of information you hold about your clients:

- Name
 Reason for Contact
 Address
 Treatment/ Advice Provided

Age

Other (please specify) _____

20. How is client information held?

Computerised

Manually

Both

21. Please indicate how client information held is protected (eg computer password protected, secure filing cabinets, restricted access etc)

STAFFING / VOLUNTEERS

22. Please summarise the numbers and roles of staff / volunteers within your organisation. If you have one, please attach an organisation chart to this questionnaire return.

Number of staff:

Number of volunteers:

23. Please indicate the relevant minimum qualifications that you require your staff / volunteers to hold as part of their roles (this refers particularly to areas such as counselling etc)

24. Please state whether your organisation is a member of an accredited body.

YES / NO / DON'T KNOW

Accredited

body

25. Do you require any of your staff to be accredited?

YES / NO / DON'T KNOW

If yes, please describe: _____

26. If you provide counselling, please state whether the counselling is provided through directly employed counsellors or through sessional, bought-in counsellors:

- Directly employed counsellors
- Sessional, bought-in counsellors
- Both

27. Do you provide training to staff / volunteers? YES / NO / DON'T KNOW

If yes, is this training: please provide details:

In-house _____

External _____

Both _____

28. Do you develop training plans for staff / volunteers? YES / NO / DON'T KNOW

29. Do you involve service users / beneficiaries / experts by experience in your work?

YES / NO / DON'T KNOW

If yes, how do you involve service users / beneficiaries / experts by experience:

Consultation

User Representative(s)

User sub-committee

Other (please specify)

REFERRALS

30. Do you have a formal process dealing with referrals in and/or out of your organisation? YES / NO / DON'T KNOW

31. Please identify the referral mechanisms of service users **in to** your organisation

- Self
- Relative / Carer
- GP
- Other community or primary care practitioner
- Community or voluntary organisation
- Social Services
- Other (eg faith-based, ex-prisoner network, education services)

32. Please identify to whom you refer service users **outside** your organisation

- GP
- Other community or primary care practitioner
- Community or voluntary organisation
- Social Services

Other (eg faith-based, ex-prisoner network, education services)

33. Please state the number of referrals received / made over the last year

	Referrals received from	Referrals made to
Statutory services		
Community / voluntary organisations		
Other		

COMMUNICATION

34. Please tick all that apply. Does your organisation work in partnership (ie working together on a defined project) with:

Community / voluntary organisations
 Statutory organisations

35. Please tick all that apply. Does your organisation avail of networking opportunities (ie sector conferences, workshops, training etc) with:

Community / voluntary organisations
 Statutory organisations

36. If you have ticked any boxes in question 35, please identify what type of networking opportunities you avail of:

37. Would you like to avail of further networking opportunities? YES / NO

38. If yes, what sort of networking opportunities would you like to participate in?

39. In terms of resources, is there anything further your organisation would benefit from to enhance your services? (eg support, training)

FURTHER COMMENTS

Any further comments you feel may be relevant:

Thank you for taking the time to complete this questionnaire. Please note that information collected by Moore Stephens will be presented to the CLEAR Project in an **overall anonymised report so that no individual organisation is identified**. Each participating organisation will receive its own individual summary report at the end of the mapping exercise process in January 2009.

We would be grateful if you would complete the attached and return it to Camille McDermott, Consultant at Moore Stephens, 21/23 Clarendon Street, Derry, BT48 7EP. If you prefer to complete the questionnaire electronically, please contact Camille at cmcdermott@msca.co.uk and an electronic copy can be sent to you. Should you have any queries in relation to this pre-meeting questionnaire, please contact Camille on 028 7126 1020. We would be grateful if you could please return your completed questionnaire by 4 December 2008. Many thanks.

Appendix 2 – Questionnaire for Health Service Representatives

Moore Stephens has been commissioned by Derry Healthy Cities on behalf of the CLEAR Project to conduct a mapping exercise/analysis of community and voluntary organisations providing mental health and well-being services across the WHSSB area. The exercise is reviewing three types of organisation:

- Those providing counselling and therapeutic services
- Those providing Intensive support to those experiencing emotional distress (organisations such as Samaritans, Aware Defeat Depression, etc)
- Those providing General health and emotional well-being services (such as healthy living centres, youth projects)

In order to maximise the feedback during the meeting on 21 January 2009 and gain an understanding from a variety of perspectives (commissioning, delivery, health improvement, primary care) we would be grateful if you would take 15 minutes to answer the following 13 questions. If any questions are not relevant to your area of work, please note 'n/a' and move on to the next question. Thank you for taking the time to complete this questionnaire.

Name	Job Title
Organisation	

SERVICE PROVISION

40. From your experience, are there gaps in **community and voluntary** sector service provision for communities (both geographical or of interest):

Please tick

	Yes	No	Don't know	Comment
For counselling and therapeutic services				
Intensive support to those experiencing emotional distress				
General health and well-being				

41. From your experience, are there gaps in **statutory sector** provision for communities (both geographical or of interest):

Please tick

	Yes	No	Don't know	Comment
For counselling and therapeutic services				
Intensive support to those experiencing emotional distress				
General health and well-being				

42. Briefly describe what could be done to ensure that gaps in service provision are minimised and individuals can access the services they need, when they need them and in a manner that is appropriate to them.

QUALITY

43. In general, how would you rate the quality of service provision by community and voluntary (c/v) organisations in the fields providing:

Please tick

	Unsatisfactory	Weak	Adequate	Good	Excellent
Counselling and therapeutic services					
Intensive support to those experiencing emotional distress					
General health and well-being					

Comment

44. In relation to question 4, to what extent do you feel the level of quality is consistent across the community and voluntary sector?

Comment

STANDARDS

45. Do you expect community and voluntary organisations providing counselling and intensive support services to work to defined standards?

YES / NO / DON'T KNOW

If yes, what standards?

REFERRALS

46. How would you rate the referrals process for counselling, intensive support and general mental health and well-being services:

Please tick

	Unsatisfactory	Weak	Adequate	Good	Excellent
From the WHSCT/GPs to the c/v sector					
From the c/v sector to the WHSCT/GPs					

Comment

47. What key actions could be taken to facilitate and increase active WHSCT/GP referral of patients to community and voluntary sector services?

Comment

COLLABORATION

48. What could the community and voluntary and statutory sectors do to enable greater collaboration (particularly with medical services) within:

Counselling and	
-----------------	--

therapeutic services	
Intensive support to those experiencing emotional distress	
General health and emotional well-being services	

COMMUNICATION

49. What more could be done to help increase communication between the statutory and community and voluntary sectors?

Comment

GENERAL

50. How would you rate your experience of working with community and voluntary sector organisations providing mental health and emotional well-being services?

Comment

51. In times of restricted funding, can there be equal emphasis on suicide/self-harm (crisis) services and general mental health and emotional well-being (prevention/promotion) services?

Comment

FUTURE DIRECTION

52. The CLEAR Project is keen to influence future direction; what do you see as the key issues that will impact on the future direction of mental health and emotional well-being services (both in the community and voluntary and statutory sectors)?

Comment

Thank you for taking the time to complete this questionnaire.

Appendix 3 – Glossary

Acronyms

ASIST	Applied Suicide Intervention Training
BAAT	British Association of Art Therapists
BABCP	British Association for Behavioural and Cognitive Psychotherapies
BACP	The British Association for Counselling and Psychotherapy
HPC	Health Professions Council
IACP	Irish Association for Counselling and Psychotherapy
ILM	Institute of Leadership and Management
ISO	International Organisation for Standardization
NISCC	Northern Ireland Social Care Council
OCN	Open College Network
PQASSO	Practical Quality Assurance System for Small Organisations
QUB	Queen’s University Belfast
WHST	Western Health and Social Care Trust
WHSSB	Western Health and Social Services Board
WSSIG	Western Suicide Strategy Implementation Group
Postvention	A postvention is an intervention conducted after a suicide, largely taking the form of support for the bereaved (family, friends, professionals and peers). The aim is to support and debrief those affected and reduce the possibility of further suicides.