BUILDING HOPE:

WORKING TOGETHER TO PREVENT SUICIDE

FUTURE SEARCH CONFERENCE

21 - 23 September 2016

Titanic Museum, Belfast

Full report

delegate draft

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Contact for attending delegates to feedback on draft report

This report is the first draft for attending delegates. If you were a participant of this workshop and anything in this report is not how you remember phrasing or writing it, or if there is any other mistake, please get in contact with the planning team. Their contact details can be found in Annex 1. Please submit your comments and suggestions before Friday the 21st of October. After this date, a final version of this report will be available for sharing.

EXECUTIVE SUMMARY

From September 21 to 23 2016, a group of 80 stakeholders in suicide and suicide prevention in Belfast came together for a three-day Future Search workshop. Together they represent key stakes within the issue of suicide prevention in Belfast.

Future Search is a whole system meeting method that enables large groups to discover common ground and transform their capacity for action in 2.5 days. The meeting took five months to plan with a planning group. It brought participants through a journey from the past, the present, the future, discovering common ground, and action planning.

After two and a half days of dialogue, the participants all agreed that the following eleven priorities represent the best opportunity for preventing deaths by suicide in Belfast. The detail of the dialogue, the tasks, the reports, discussions, agreements and action plans that underpin these themes are to be found in the report and its annexes.

The Agreed Priorities for Preventing Suicide in Belfast

1. **Political Leadership** – Ensuring that politicians and policy makers are able to make meaningful decisions that support a reduction in suicide. This may include policy proofing and joining up mechanisms.

2. **Culture of Care** – Taking care of staff, families, friends and carers to ensure they are supported in the crucial but very difficult work they do to keep people safe.

3. **Early Intervention for Children and Families** – Ensuring that this agenda recognises the importance and effectiveness of creating the best conditions at the start of life.

4. **Data Sharing and Collection** – Improving data, evidence and knowledge sharing to support better results.

5. **Funding and Procurement** – Changing the focus of funding to become long-term and outcome-focussed using the principles of a social value act (economic, social, health, environmental benefits). Exploring the full range of investment that contributes to suicide prevention across other funding streams.

6. **Wrap-around services** – Creating a way of ensuring that anyone in need receives the appropriate support, no matter the need. This will require a better comprehensive assessment system to help individuals access the right services at the right time through person-centred approach plans.

7. **Technology** - Maximising the effectiveness of the available technology to improve safety and information sharing and to enhance accessibility and flexibility of support.

8. **Emotionally Resilient Communities** – Creating an environment that promotes open and positive discussion on mental health and wellbeing to a reduce stigma and build hope.

9. **Link to Drugs & Alcohol** – Ensuring that policy and practice agendas that are interlinked can join up to jointly address these issues in a way that adds value.

10. **Community Development** – Ensuring that a community-development-approach is the preferred method for working with communities.

11. **Health Inequalities** – Committing to make better use of existing resources to reduce health inequalities through addressing social determinants within communities.

INTRODUCTION

On the 21st of September, about eighty stakeholders involved in suicide prevention in Belfast came together in the Titanic Museum for a Future Search workshop. The workshop was called '*Building Hope: Working Together to Prevent Suicide'*.

The purpose of this workshop was to bring together the whole system to help tackle the issue of suicide in our city and in our communities. During this three-day workshop, participants discovered common ground and built future action plans.

A planning team, made up of people from all of these sectors and areas, organised the workshop. The full programme of the workshop is noted in Annex 2. The workshop was facilitated by Michael Donnelly and Tara Haughian. The contact details of the planning team and facilitators are listed on page 2.

Stakeholders came from across the whole sector - they are each related to the complex causes and factors linked to suicide and suicide prevention in Belfast. Among the stakeholders were advocates for those with personal experience, crisis and bereavement support providers, funders and commissioners, policy-makers, political representatives, and representatives from the Health Trust Services, information and coordination of SD1 and community response, rights and advocacy organisations and organisations working in education, training and employment. A complete list of the participants can be found in Annex 1.

The explorations, discussions and results of this workshop are discussed in this report. It includes the highlights of the workshop, the common ground agenda and the suggested actions plans to realise the desired future.

ABOUT FUTURE SEARCH

The methodology used for the workshop is **Future Search.**

Future Search is an innovative planning conference used worldwide by hundreds of communities and organisations. It meets two goals at the same time, (1) helping large diverse groups discover values, purposes, and projects they hold in common; and (2) enabling people to create a desired future together and start implementing right away.

Future Search is especially helpful in uncertain, fast-changing situations. Participants need no prior training or expertise. Conferences focus on a wide range of purposes in schools, hospitals, churches, communities, government agencies, voluntary networks, foundations, business firms, and non-profits in every sector. Because Future Search is largely culture free, it has been adopted with success by people from all walks of life in North and South America, Africa, Australia, Europe and South Asia.

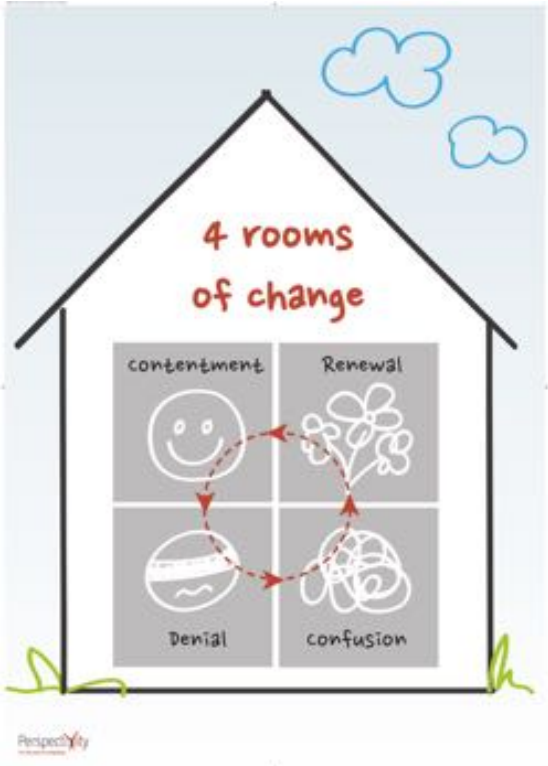
A Future Search usually involves 60 to 70 people - large enough to include many perspectives and small enough that the full group can be in dialogue at each step in the process. This makes possible a shared picture of the 'whole elephant'. (For larger groups, conferences may be run in parallel or in sequence.) The optimal length is about 2.5 days. When people stay engaged in a task for that long, they are more likely to make a notable shift in their trust of each other and in their capability for action. The task for us is always: *Building Hope: Working Together to Prevent Suicide.*

HOW FUTURE SEARCH WORKS

The conference is designed to principles that enable people to work together without having to defend or sell a particular agenda. This opens the door to creative new opportunities. The first principle involves getting the 'whole system in the room'. That means inviting people with a stake in the purpose who don't usually meet, thus enlarging everybody's potential for learning and action. The second involves putting the focal issue in global perspective, helping each person to see the same larger picture in which they have a part. The third means treating problems and conflicts as information rather than action items, while searching for common ground and desirable futures. The fourth invites people to manage their own small groups in talking about and acting on what they learn.

THE FUTURE SEARCH AGENDA

There are five tasks. The first establishes a common history, the second, a map of world trends affecting the whole group. The third step calls for an assessment by stakeholders of what they are doing now that they are proud of and sorry about, an important step toward mutual understanding. Next, people devise ideal future scenarios, living their dreams as if they have already happened. Then all groups identify common ground themes--key features that appear in every scenario. The whole group confirms their common future, acknowledges differences and makes choices about how to use their energy. In the final segment, they sign up to work together on desired plans and actions.



The Four Rooms of Change model

LETTING GO OF STEREOTYPES

Staging a Future Search means changing our assumptions about large, diverse groups. In these meetings we learn that most people can bridge lines of culture, class, gender, ethnicity, power, status and hierarchy if they will work as peers on tasks of mutual concern. They can do this despite stereotypes, prejudices, and "isms" that lie deep in all of us. They can do this despite scepticism and sometimes-gloomy predictions of what will or won't happen. Freed from the impulse to put pressure on each other to solve intractable problems, people often find common ground none of them knew existed.

CHANGING OUR ASSUMPTIONS

For decades it was assumed that the best way to bring a large group together was in the presence of an expert speaker or panellists who would answer peoples' questions. The belief that someone else has the knowledge we need is deep in us. So is the belief that if others tell us what to do we can do it. Future Search turns those assumptions upside down. Instead of speeches, we have working sessions among a wide range of parties who have information, authority to act, and a stake in the outcome, regardless of their status, skills, or attitudes. In addition, we assume that complex planning issues require value choices more than expertise and 'data'. We believe that people make different choices when they are in dialogue than they would make working alone or only with familiar faces.

RESOURCES

Future Search was created by Sandra Janoff and Marvin Weisbord. Sandra and Marvin each received a Lifetime Achievement Award for their work. You can discover more at: www.futuresearch.net.

For more information on Future Search in Ireland contact:

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WORKSHOP PROCEEDINGS

OPENING

Eddie Rooney, CEO of the Public Health Agency, and Minister of Health Michelle O'Neill opened the workshop.

Mr Rooney welcomed the participants to the Future Search. He paid testimony to the experience and commitment of the people in the room. He explained his wishes to genuinely create something collectively, not something that is imposed, but something that comes into being through cooperation. For this reason, he invited everyone to talk about what they are passionate about and to make sure they share what they want to share - this is the place to do it. Mr Rooney finished by noting how important working collectively together will be after the event. He urged everyone to help make it work for the individuals and their families living in communities across Belfast - the people who need outcomes from this process.

Ms O'Neill talked about her personal commitment to the issue. She is personally engaged with families and with people working on suicide prevention in Belfast and is dedicated to ensuring that policy reflects reality. She encouraged participants to express their views so that together we can help those individuals, and their families, who need mental health support.

CEO of Public Health Agency, Eddie Rooney, Health Minister Michelle O'Neill and Chief Medical Officer Dr Michael McBride

FOCUS ON THE PAST

The first task of the workshop is to create a shared picture of the past experienced by everyone in the room. The purpose is to understand what has happened, what experiences have shaped our community, and what we can learn from those stories that will help us create a shared picture of future success. Participants carry out this task in mixed groups with one voice of every stakeholder in every small group. Participants are asked to create timelines that note key events and milestones that happened during the period between 1980 (and before) and 2017 (now). They do so at three levels:

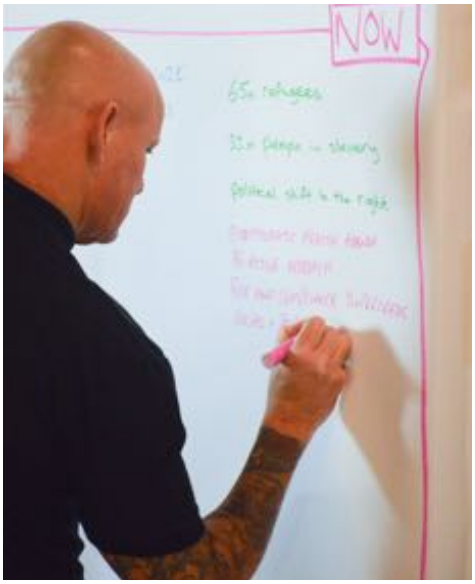
- At the personal level
- At the global level
- At the level of our work on suicide prevention

Next, the participants share the main themes and storylines in these histories. They also discuss what they see as the key implications of the past, for the future.

Reflections on the personal level:

- Many life experiences are shared. They are about death, marriage, education, employment, health and relationships. Both positive and negative life events are shared with great honesty.
- The majority of life events shared are about relationships: making, breaking or losing relationships.
- There are many references to suicide and mental health issues throughout the timeline, especially as it progresses. Everybody in the room seems to have been affected by it. These experiences show us where we are vulnerable.
- If we look at our own personal timelines, we see a reflection of those who we work with.
- What is missing or less visible on this timeline? We see little experiences of LGBT, minority, spirituality, custody and disability. Are these silent voices that aren't heard? What implications do these silent voices have for our work? How do we include them?
- There is little mention of caring for loved ones. We stress the importance of self-care for carers. What is the implication for us if it is not mentioned aloud?
- There are many experiences of coming to or leaving the North.
- There are virtually no material possessions mentioned.
- The issues that people face have not changed much over the years, but the context has changed, like conflict and technology.

Reflections on the global level:



- All global events allow us to think about where we were when the event happened and what it meant to us personally.
- There is a lot on the timeline about conflict and war, on the global, local as well as on the interpersonal level. There are periods of conflict, followed by periods of peace, followed by periods of conflict. History repeats itself and this history is the continually changing backdrop to suicide and suicide prevention.
- Most of the events mentioned are political. Political activism is mentioned throughout the timeline. Some events are about finance.
- There is a focus on the United States, in the form of the crash, wars and conflicts, and presidents.
- Innovations in technology and (social) media are mentioned frequently. These developments have an impact on our conversations, which are the basis of our work. They depersonalise, bring peer pressure and present images of the world that influence our thoughts.
- Overall, there is a focus on negative news. We seem to tend to forget the good news. We should challenge ourselves about this default disposition of negativity. The positive side of key events seems to be missing. An example is that the spread of HIV is mentioned, a definite negative example, but that the advances in medicine that have helped cure or prevent many other diseases are not highlighted.
- We are also missing key cultural events.

Reflections on our work on suicide preventions timeline:

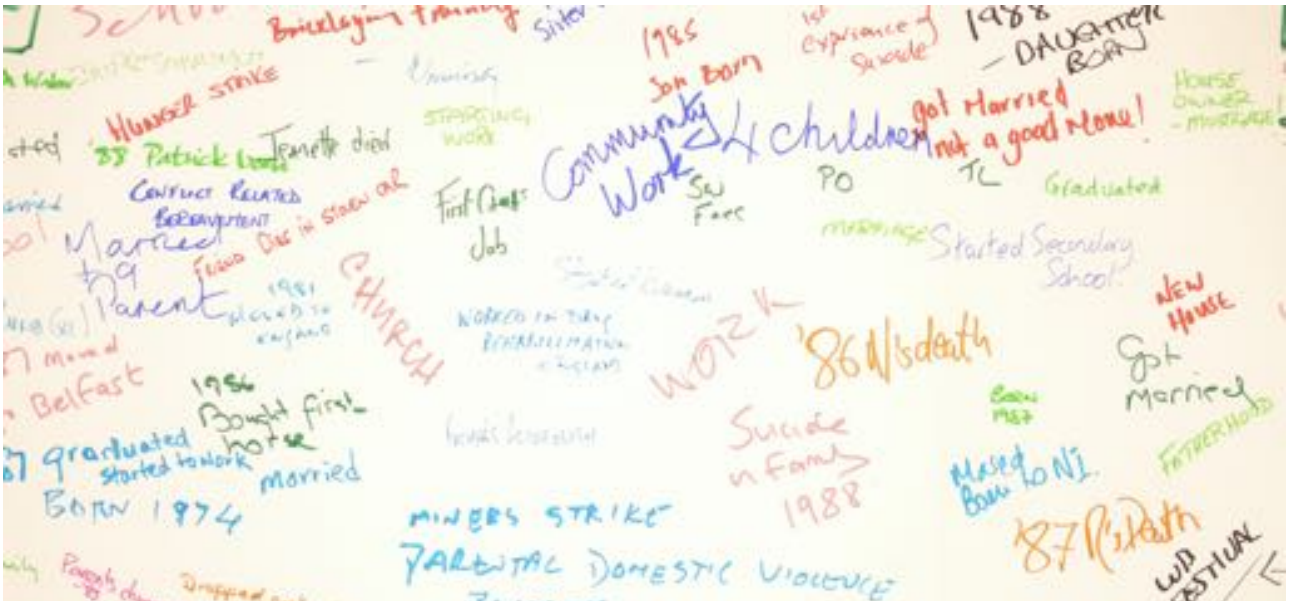
- Overall, we feel that, since the 1980's, we have made some progress, but still have some way to go.
- In the 70's to 80's, suicide was a taboo issue that was underground and not talked about. The church and government were 'hiding' the matter and minimal research was being done. This issue was perhaps overshadowed by the Troubles.
- In the 90's, there was the emergence of involvement in a variety of social issues. There was no statutory response but there were interventions coming from the communities, mainly because of more pressure from families. This created political cohesiveness. The ceasefire opened up conversations. Mental health became a subject.
- This further developed in the 2000s. Mental health strategies started and specialist units were set up, an example of which was the Protect Life Strategy. There was the development of knowledge and experts.
- In 2010s, the responses further diversified. There were options available such as therapy, counselling, consultation and the SHIP initiative. The development of these services was initially especially strong in North and West Belfast.

Reflections that combine the three timelines:

- There is a large collection of individual stories and perspectives. Global events affect personal events.
- Violence occurs in all timelines, in domestic and political forms.
- There are times of conflict and peace and their implications, such as of the Troubles, have to be taken into account in the work we do. An example of these implications can be the graphic exposure to violence.
- Apart from a back and forth movement between conflict and peace, there is a criminalisation and decriminalisation of suicide and their influence on others, such as on those in prison.
- Finance is frequently mentioned as well: in the personal sense of poverty and welfare, and in the political sense of reform, financial inequalities and Brexit.
- Music was mentioned as a coping mechanism, and as a vehicle for driving gay rights and equalities.

Reflections on the timelines:

- *"There is an absence of childhood factors in the trends."*
- *"Why are we talking about being too negative or too positive? Why can't we just observe what is there, rather than being right or wrong?"*
- *"One of the things that is surprising and even hurtful to me personally, is that no-one really knew what was happening before 2003 concerning the suicide prevention strategy. For the future and whatever we decide here, the community has to know what we are talking about and get the information."*
- *"If we talk about silent voices, we should also talk about males. They are silent voices and face issues that need to be addressed."*
- *"There are a lot of things that happen to us, like the financial crash, that have a huge impact. These things influence whether our services work or not."*
- *"Was the media invited to this Future Search? Their role is important in the perception of suicide."*
- *"What struck me is that the volume of services has increased and that the levels of suicide has also increased. What do we need to ask ourselves here?"*
- *"There are more resources, but more is actually done on voluntary basis than on a funded one. It is sometimes shocking to see what is not resourced."*
- *"There is competition for resources among us. To give an example, Finland brought down the suicide rates significantly recently. They did so by doubling their funding."*
- *"If we only focus on resources, we are wasting our time. All the stakeholders are here, we can use this opportunity to widen our connections."*
- *"Relationships are the context of suicide prevention. Do we spend value these enough in our work?"*
- *"It is difficult to ask a loved one 'Have you ever thought about suicide?' Can we find ways to open our hearts and speak about it directly, also to our loved ones?"*
- *"We don't talk about what doesn't work. We find it uncomfortable."*



FOCUS ON THE PRESENT

After having explored the story of our past, participants are invited to take time to unpack what is happening right now in their work. This is done in two stages. The first is a collective picture of all the external trends (political, social, technical, economic, etc.) that are impacting the issue of suicide in Belfast.

Having identified these trends and highlighted which ones seem most significant, participants move into their stakeholder groups where they spend time with people with whom they have a common cause. In this format they explore what they are and aren't doing to respond to the trends they see in their work and also what they are proud to stand over and also what they are able to own up to as "sorries".

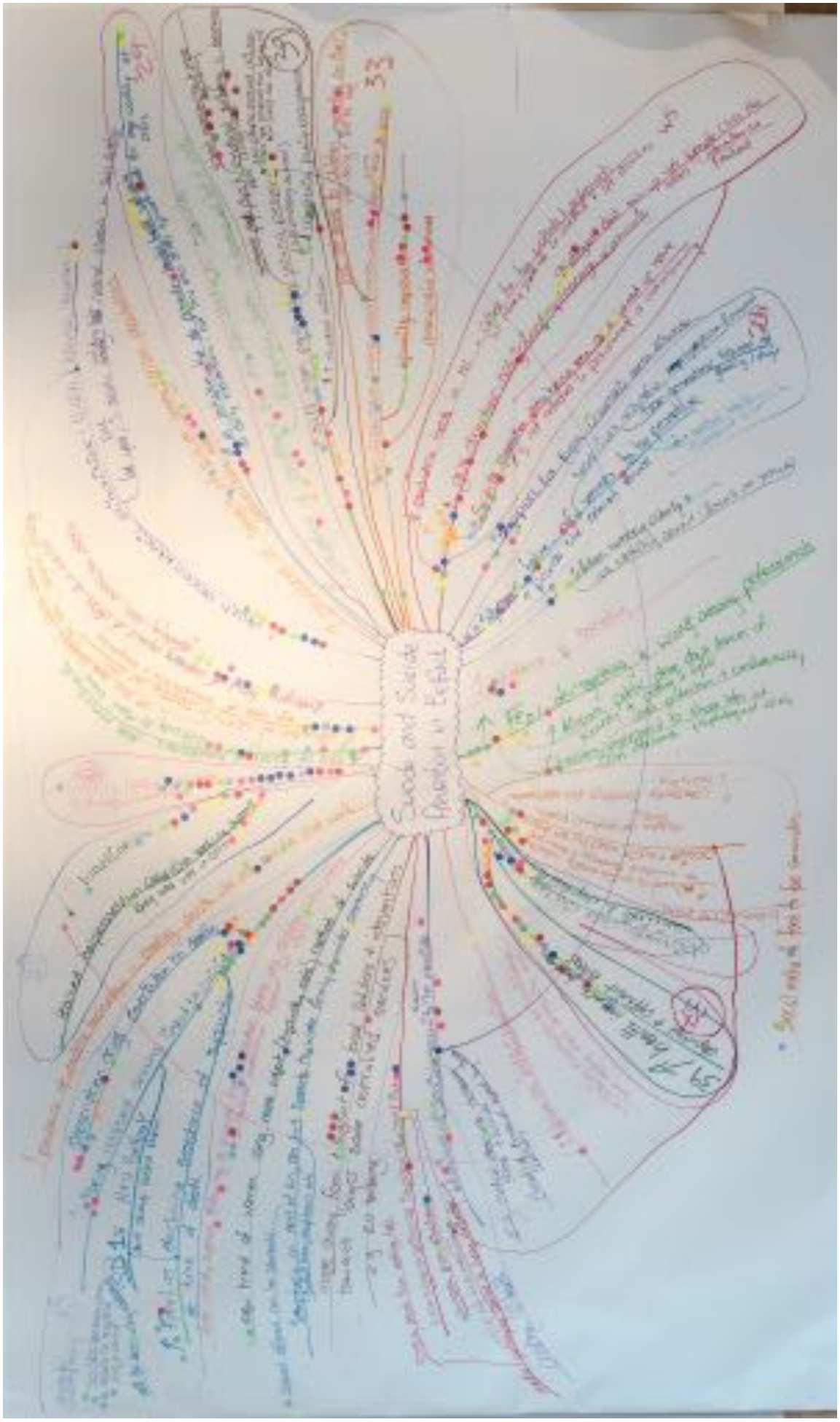
This mind map can be seen on the next page. Below, you can see the trends that the participants attached the most importance to (the number in parentheses):

Top trends

1. Increase in drug-related deaths (57)
2. Decrease in government structures joining up (45)
3. More frequent self-harm amongst young people (39)
4. Increase in health inequalities and the link to suicide (37)
5. Increase in suicide amongst males (33)
6. Greater failure of services to be proactive instead of reactive (28)
7. Higher prevalence of suicide amongst (former) prisoners (27)
8. Poverty more likely to be a factor in suicide (22)
9. Increase in loneliness and learnt helplessness (21)

Other key trends mentioned:

- Increasing failure of the social security system
- Greater fear of getting it wrong amongst care professionals
- Increase in use of social media and its negative influence
- Debt an increasing factor in suicide
- Increase in related health conditions leading to suicide
- Higher prevalence of ethnic minorities taking their own lives
- Trans-generational effects of the conflict
- Increasing violence in society
- Emphasis on next of kin limits support to wider pool of people affected
- Moving away from local provision to more centralised, longer-term services
- LGBT affirmation increasing but with more extreme levels of homophobia
- Increasing lack of support for the range of people/causes of PTSD
- Women taking more violent approaches to ending their lives
- More mobile technology advances in treatment



WHAT ARE WE ALREADY DOING AND NOT DOING

The trends that are identified are of importance to everybody. To get more insight into how this works out for every stakeholder group, participants are asked how these trends affect their specific group and what they are already doing and not doing regarding this trend. The stakeholder groups answer the following questions:

- What are important trends for us?
- What are we doing now?
- What are we not doing now?

These are the findings per stakeholder groups:

Information & Coordination of SD1 / Community Response Process

Trends:

- Increase in drug-related deaths
- Drugs and alcohol the 'go to' when in crisis
- Increase in female suicides
- Gambling debts, financial issues, social isolation, BME, LGBT, trauma and conflict increasingly more common reasons for suicide

What we are doing:

- De-escalating people in a crisis
- Identifying trends through CRP
- Putting information out to the BME community through the East Plan
- Coroner's office focusing more on drug related deaths

What we are not doing:

- Not always acting upon initiatives and new trends
- Not keeping consistency in recorded data at time of death and after
- Improving the SD1 process
- Training PSNI
- Developing information sharing protocol with Coroner's office regarding deaths in hospital
- Setting up an innovation fund
- Providing more debriefing and ongoing support for working people working on the ground
- Providing some reflective practice but having limited resources to support workers

Education, training and employment group

Trends:

- Low educational attainment
- Focus on results rather than individual achievement
- Devalue of community education
- Growth of students with stress, mental health concerns, lack of resources to support them, non-attendance, lack of self-worth
- Also increase in adults presented with complex issues

What we are doing:

- School curriculum providing space for emotional health and wellbeing
- Support Services available to schools e.g. schools counselling services
- Community services moving into schools
- Ensuring collective impact

What we are not doing:

- Stimulating more joined up working
- Increasing services to reduce waiting lists
- Providing community services with more access to schools to support young people
- Having more strategic conversations at community/operational level
- Capacity building within communities
- Being involved in shaping the Programme for Government
- Focusing on lifelong learning and looking ahead to future skills
- Providing collective impact across whole communities

Crisis and Bereavement Support Providers

Trends:

- Poverty is a form of violence
- Welfare reform encroachment
- Trans-generational issues
- Comprehensive assessment and rapid delivery response versus fragmentation
- Absence of support for rigorous inquests in the aftermath of a suicide

What we are not doing:

- Providing continuity of care and a safety net for people
- Acknowledging of life contexts, joint approaches and uniformity of approach

Advocating for those with personal experience

Trends:

- Lack of information and support for families
- Criteria for entering support is affecting people's ability to get it
- ED is not suitable for someone in distress or a crisis
- Mental Health Crisis is typically responded to by PSNI
- Parents not involved in assessment of a child in crisis
- Funding for tendering/contracts is the same as 12 years ago

What we are doing:

- Suicide prevention, intervention, postvention

What we are not doing:

- More honesty and communication
- More consortium work needed
- Campaigning: more visual, radio
- Reducing of the stigma and ensuring people know that distress and despair does not have to mean suicide

Funders and commissioners

Trends:

- Suicide is considered as a mental health issue but it more complex and broader and therefore needs more collective impact
- Need to do joint commissioning better and co-production is essential
- There is a strong focus on a deficit model

What we are doing:

- A lot is working
- We are open to learning and affecting change
- Turning asset versus deficit model around

What we are not doing:

- More joined up working
- BSP is a very fruitful platform to be explored
- Building relationships with everyone in this room
- The creation of an innovation fund
- The Programme for Government e.g. outcomes versus outputs

Policy

Trends:

- Budget constraints and government retreating leading to reductions in spending
- Labour market, i.e. those in work are the new face of poverty
- There is a new will to tackle the issue

What are we not doing:

- Building evidence to make good decisions
- Engaging people
- Engaging more in early intervention

Health Trust Services

Trends:

- Increase use of drugs
- Decrease in available beds on psych wards
- Increase in self-harm amongst young people
- Increase in presentations to acute services with alcohol on board i.e. leads to inability to become assessed

What we are doing:

- Having substance misuse services in place
- Providing more therapies e.g. CBT services and training
- Providing DSH Teams and focus on self care
- Teams (Home treatment and emergency) are working closely together

What we are not doing:

- Increasing health promotion
- Increasing training for nurses to get skills around mental health
- Improving response times for people to see mental health patients
- Increasing ASCERT outreach workers (at moment there are two workers)
- Providing training and support for third sectors
- Ensuring a holistic approach to complex patients

Political Representatives

Trends:

- No joined-up approach
- Poverty is related to drugs, loneliness and violence

What we are doing:

- Government has taken an outcome-based approach
- All Party Group is now in place
- Health Minister made mental health a priority

What we are not doing:

- A renewed emphasis on tackling these issues
- Putting in place a resilience strategy
- Basing our approach to funding on the trends/ needs and involve the community
- More sustainable funding and greater overall investment in mental health

Rights and Advocacy

Trends:

- The austerity agenda
- Needing to look at individual more
- Loneliness
- Working in silos

What we are doing:

- Positively influencing the lobby
- Providing crisis services to those who need them
- Understanding government strategies better

What we are not doing:

- More joined up approaches and we need to work closer together
- More holding to account
- More evidenced-based strategies

Shared (whole group) reflections on what the stakeholders were willing to work on:

- There are several common themes, such as a lack of working together and forming partnerships.
- *"There is a gap between politicians, commissioners and service users - how can we work together and find a better way?"*
- *"Is this about how you affect change? We do need to support politicians and not just throw this at them, we need the leadership too and people who make informed decisions."*
- *"We all need each other and it is positive that we are not blaming each other. What is not working? People have identified the need for change, but we do not know what it looks like?"*
- *"There is a pessimism around and we need to recognise this. We need to allow people to speak their mind without fear, i.e. creating robust relationships that can survive the hard times/difficult conversations."*
- *"Is there a closed door? Maybe. There are many doors that are open and a lot of discussion but perhaps it is a case of what happens next? There is a lot of pressure around for people. It is easy to be critical, and many of the statutory services are stepping up. But we also tend to go through somewhat of a revolving door and end up, sometimes, having the same conversations as before."*
- *"It is essential that we operate in a learning culture and not a blame culture. Learning from situations is key. If we can't start to nail this, we will be back in the room in a year's time and maybe things will not have changed."*
- *"It is important to note that a mental health treatment champion is very different from a suicide prevention champion. A champion should be someone independent enough to look at things in a different way and break convention."*
- *"We are definitely saving lives, but we are also still losing a lot of lives."*
- *"At some time in ours lives, we have all met a closed door when everybody listened but not everybody heard. We should remind ourselves that this Future Search is the ideal time to meet each other, open doors and to go through them. This is the time for us to meet, to talk and to follow up afterwards."*

PROUDS & SORRIES

To deepen the understanding of the present, stakeholders owned up to and shared what they were proud of and sorry for, in relationship with suicide and suicide prevention in Belfast.

Education, Training & Employment

Prouds:

- Working with passionate people who are always prepared to go the extra mile
- Diversity of projects and partnerships that are taking place
- Working on individual level within schools

Sorries:

- Not enough progress
- Making better use of resources we have
- Holding each other to account more about outcomes
- Losing sight of our greatest asset: the people in our communities

Advocating for those with personal experience

Prouds

- Our volunteers
- Our families, survivors and community reps influencing the strategy, commissioners and government to make change
- Sharing our experiences and helping others with that
- Being alive and to be a part again
- Being a voice for those that can't speak for themselves

Sorries

- Not being able to help everyone
- Putting advocacy work before families
- Hurting our bodies or making others upset

Rights and Advocacy

Prouds

- Dealing with unpopular issues (such as those in prison)
- Under the radar work across community services
- People-led services

Sorries

- Not explored the gap of why people take their own lives
- Not able to move from activism to advocacy sooner
- Not enough social policy work
- Not enough care for staff

Crisis and bereavement support providers

Prouds

- Our response team
- Suicide prevention is on the agenda everywhere
- The robust frameworks that are in place
- The flexibility of our staff

Sorries

- Continual discussion around funding rather than about what we are doing
- No effective evaluation tool in place
- The acceptance that suicide happens: every suicide is preventable
- The prevailing pessimism in our sector: focus on lives we are saving

Funders and Commissioners

Prouds

- Our current programmes
- The passion and the relationships on the individual and organisational level
- Collective responsibility

Sorries

- Not always creating an appropriate environment for people who are in crisis
- Inability to be flexible in resources
- Not influencing (wide enough) other stakeholders to attend this workshop or on the issue of suicide prevention

Health Trust Services

Prouds

- Improvement in mental health services: emergency team is always available
- Improvement in access to psychological care therapies
- Developments we made as a trust (improving our workforce, shared learning)

Sorries

- Pockets of specialised services have difficulty linking up
- Services do not always meet family demands
- Staff at services that deal with crisis not always appropriately trained

Information & Co-ordination SD1 / Community response

Prouds

- Proactive ability to make things happen
- Significant recent improvement in cooperation
- Resilience of our staff to carry out the work

Sorries

- Lives are still being lost
- Pressure can cause tensions which causes barriers
- Our data is not always applied effectively at community level

Political representatives

Prouds

- Cross party support for making the prevention of suicide a priority
- More responsibility among our staff about the use of language

Sorries

- We don't always get it right
- Not doing a Future Search sooner
- We will be sorry if we don't act on the learning from this workshop

Policy

Prouds

- New Protect Life Strategy out for consultation
- Make data more relevant
- Ministerial coordination group more active on this topic
- Delivering the social - mainstream interventions

Sorries

- Protect life took a lot of time
- Took a long time for the penny to drop that suicide is a broader issue
- Absence of good quality data
- Protect Life governance not as good as it should have been

Reflections about the prouds and sorries:

- *"I am very encouraged to hear from the political representatives about their commitment to take what comes out of this workshop further and that the penny has dropped about the seriousness of suicides in Belfast. We are here to remind you."*
- *"I'm struck by the honesty in this session."*
- *"We don't take enough time to assess our own work and to be proud of what we do. We have so much experience here.*
- *"I want to emphasise that the idea that there is more work to do, does not mean that what we're doing is all wrong."*
- *"I welcomed the space to put your hand up and say what you're not doing well. Often when lives are being lost, you carry around guilt and there is not always a safe space to talk about that and about what you are not doing well."*
- *"I feel very confident that the answers are in this room and it would be a real shame if we waste the opportunity to get it right."*
- *"Some degree of realism has to come in. Are we sure that everything we do is working? Can we have an honest conversation about what is and is not working? On the one hand we need to be positive so we inspire people to work, and on the other hand we need to have to look at the challenges that have to be raised."*

FOCUS ON THE FUTURE

Having reviewed the past and analysed the present, participants imagine the futures they want to work towards and express them in creative ways. They describe what Belfast looks like in 2026 and try to answer the following questions:

- What is in place to improve people's emotional resilience across Belfast in 2026?
- How are people at risk of feeling suicidal being supported in 2026?
- How are people bereaved by suicide being supported in 2026?
- What is it like to be the person providing support in 2026?
- What policies, legislation, structures and programmes are in place in 2026?
- How are people accessing services and what are they in 2026?
- How are people working in 2026?

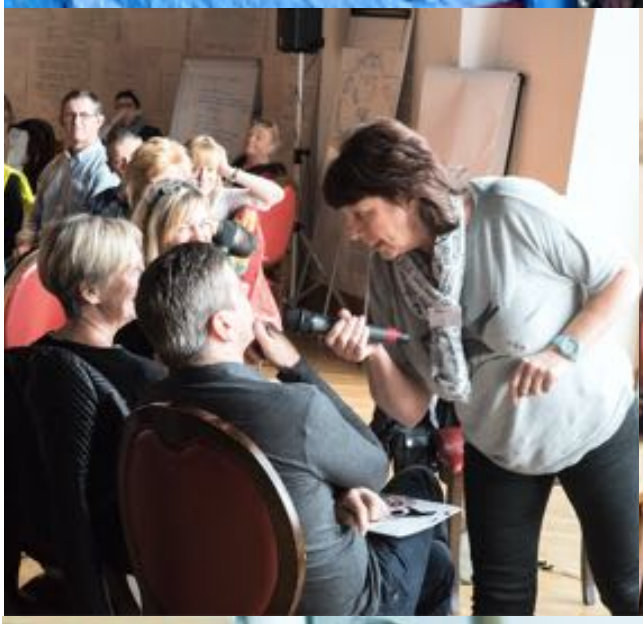
The presentations are very creative. For example, there is a BBC broadcast about the new Lifeguard Hologram watch, a Feel Good Cafe with several booths according to visitors' needs, an episode of premier chat show ITV Spotlight, a time machine journey, the presentation of the new national anthem, a role play and a city tour around Belfast. On this page and the next two you can see a visual representation of the presentations.

In the presentations, participants discuss their desired futures. In order to achieve these futures, certain barriers needed to be overcome. Examples of the mentioned **obstacles** are:

- Unequal access to services
- Need for coordination, regular contact and communication to between all organisations and communities
- Funding
- Provision of accurate data

These barriers will be overcome by for example:

- Emotional support for staff
- All systems linked to one IT system
- Emotions are included in education
- Services and communities are working closely together
- Normalisation of emotional reactions to life events
- Using resources and skills effectively
- One virtual or physical location to come to



COMMON GROUND AGENDA

From the scenarios of preferred futures, shared elements are distilled that make up the common ground for suicide prevention in Belfast.

Common ground is what everyone believes to be the elements that are shared and desired by all stakeholders. These could be values, policies, projects or others. Common ground is where there is greatest energy for action in a multi stakeholder system. It represents what everyone is willing, ready, and able to make happen. Common ground is arrived at after an intense dialogue with all participants who ensure that they understand and agree with the intent and ambition of the statement. Participants are invited to transform clusters of common ground items into coherent statements that outline the intent and ambition of everyone here. The common ground elements were clustered into eleven thematic areas, described below.


Culture of Care

For workers in the field we will develop standardised supervision practice (not line management). There will be strong inductions and training needs will be reviewed and identified. Systematic reflective practice will be resourced. For families, friends and carers, there will be access to services, information, expertise, education and training. A culture of care will develop within all organisations. There will be flexibility in resources supporting the needs.

Early Intervention for Children and Families

All families are supported to develop resilient children with strong psychological and physical wellbeing, positive relationships and fulfilled potential.


Political Leadership & Legislation

Suicide prevention should have a greater profile in the Programme for Government. We want all NI Assembly party leaders to make a clear commitment to the drive towards fewer suicide deaths. We want the Executive to take the lead and welcome the Health Minister's championship for the suicide prevention

goal across government. We commit to propose effective evidence-informed legislation and policy to ensure the maximum impact on suicide prevention (policy proofing) embedding joined up cross-departmental suicide prevention policy and practice.

Data Sharing and Collection

We will work together to systematically collect and share data, which will be accurate and reliable, in a timely manner to inform service provision and planning and to promote the creation and sharing of knowledge. We will adopt an evidence-based practice mindset and share practice-based evidence.

Wrap-around services

We will develop and have in place in Belfast (everywhere: LGBT, Housing, Drugs & Alcohol, Suicide Prevention, Self-Harm, family support child, minority groups, poverty, all ages) wrap-around services, for all ages and stages, that meet a person's (and their carer's) difficulties and needs wherever they are (point of entry, schools, prevention) and whenever they need it. As part of this, we commit to develop one assessment or a shared assessment framework. (We commit to co-locating multiple services to one assessment centre. These service would include but is not limited to unscheduled care, substance misuse, child and adolescent mental health treatment, psychological therapies, counselling services).

Technology

We will maximise the effectiveness of the available technology to improve safety and information sharing and to enhance accessibility and flexibility of support.

Emotionally Resilient Communities

We commit to creating more emotionally resilient communities in Belfast building on our experience in delivering the Belfast 'Emotional Resilience Strategy' and 'Take Five'. We will create an environment that promotes open and positive discussion on mental health and wellbeing, which will lead to a reduction in stigma and build hope.

Link to Drugs & Alcohol

We commit to working better together across mental health, specifically on suicide prevention and drugs and alcohol sectors to jointly plan, jointly resource and jointly deliver services that meet the needs of people in a timely and relevant matter. We commit to resourcing co-morbidity treatment services for people with co-occurring mental health, suicide prevention and drugs and alcohol needs, particularly on T3 and T4 needs (such as safe place, crisis response and in-patient).

Community Development

The core principles of community development will be at the heart of our work operationally and strategically. We will work with communities (not to or for them) to empower them to access education, knowledge and generate partnerships across sectors.

Health Inequalities

We recognise that inequality is a major driver for suicide. We commit to prioritising suicide prevention in the work we do to tackle life and health inequalities. We will make better use of existing resources to achieve this, e.g. Belfast Agenda, Legal Support Project, Programme for Government.

Funding and Procurement

We will explore increasing long-term outcome-focussed funding for mental health and suicide prevention within the principles of a social value act (economic, social, health, environmental benefits). We will anticipate the full range of investment that contributes to suicide prevention across other funding streams.

Reflections on the common ground:

There is a lively discussion about the common ground. Below a few main points of the discussion are highlighted. All other discussion points can be found in Annex 3.

"Should we have Suicide Prevention in All Policies?"

This question initiates much discussion as the best 'approach' to ensure suicide reduction, and relevant wellbeing, is a part of government thinking at every turn.

- *"We all have an input into decisions through consultations and interaction with policy makers. The Programme for Government is now centred on wellbeing for the first time."*
- *"The 'reducing preventable deaths' outcome can means lots of things to everyone."*
- *"Why are we having this conversation [about wellbeing]? Our philosophy is about suicide as a specific issue."*
- *"This is about looking upstream in order to stop people getting to the point where they need to take their own life."*
- *"There is such a range of strategy and policy, so health in all policies is more achievable or relevant - rather than suicide as a single issue"*
- *"The one thing we are missing here is a focus on policies now, never mind future policies. This is about people's lives now."*
- *"We are sort of mixing up two conversations here. There is suicide being in Programme for Government and then there is suicide targets in all policies."*


The group teases out the merit of 'proofing' every single government policy in order to assist with the aim of reducing suicides. Would this be unnecessary for many policies, and therefore 'shut down' relationships with decision-makers in government?

- *"I think this would be very easy. Just a small group of people who will screen policies coming through."*
- *"It's too easy for people to say that suicide is always going to happen. Let's see them argue against it, but they can only do it if we put this into everything."*
- *"The question is, what does it mean? We need to be clear."*
- *"We are missing a big opportunity here, let's make sure it is in there."*
- *"There should be a default position where we set up a suicide prevention team to see that suicide is a part of every relevant policy."*
- *"If we do not have a suicide prevention strategy, then a lot of us will leave here disappointed."*

There is a consensus that suicide prevention is the focus and ambition of this event and process. It is how to ensure that decision makers take it seriously that remains unclear. A small group breaks off to form words on this particular area of common ground, and bring this back to the whole group. Upon returning, they suggest that to lobby for adding the following outcome to the Programme for Government - "*Fewer people will die by suicide*".

Is it 'fewer' or 'zero'?

- *"Our leaders are here and listening with hearts and heads. Nothing happens without militancy for change."*
- The group agrees that the suggestion will remain as it and moves forward.

Other areas of discussion are noted in Annex 3 and include:

- Commissioning and sustainable funding
- Resilience
- Meeting basic needs
- The one stop shop
- Evidence based
- Better self-care for carers, helpers and staff
- The not agreed list

Action Planning

Based on common themes, 'action circles' (groups of interested stakeholders) started to draft initial action plans. These action plans represent the initial ideas and will become more concrete over the coming months. The following plans were drafted and committed to by the people. An overview of the common ground statements and their corresponding action plans as well as the names of people involved in the creation of this action plan can be found in Annex 4.

Link to Drugs & Alcohol

We will establish a task force to take the plan forwards. First, we will map what currently exists for suicide prevention and drugs and alcohol (the services, structures and processes) and how they currently interact. We will gather, collate and analyse the two data sets: the evidenced-based, monitoring and statistical data, and the service user input in the form of stories. We will organise and facilitate a workshop, which introduces this and builds upon it. This workshop will give participants the opportunity to discuss how 'business' is done now versus how it could or should be. The engagement and involvement of the service user will be considered throughout. Additionally, we will facilitate a senior level meeting with ministerial buy-in to specifically discuss the progress in mental health and drugs and alcohol misuse and the acute crisis service.

Data Sharing and Collection

We will enhance the SD1 data collection process by providing police training and recording additional key information. We will work with the PSNI and academics in this, but also with others. The coronal services will systematically record key information at inquests. There will be a mechanism for collecting and collating qualitative community intelligence so that we will be able to capture trends that are emerging and invest in them in a timely manner. The community response steering group will capture this information and feed it to the PHA for action and further research. We will deploy standardised suicide-specific outcome measures

and perform routine measurement and evaluation of our suicide prevention suicide. Academics will work together with service providers to make this happen. Also, there will be a mechanism so that information from those working with people at risk can be fed back to those working specifically on suicide prevention. We will showcase our practice-based evidence and share it internationally.

Early Intervention for Children and Families

The vision to have developmental pathways for all children and young people will be considered to support children and their families at difficult periods of transition in their life, particularly those from disadvantaged communities, e.g. nursery to primary school, primary to post-primary and school leavers. We will work through existing children and young people sector partnerships in Belfast to review existing models and new initiatives based on best practice. The influential factors that shape the development of children in early years will be considered and we anticipate through resilience building with families that every child will be supported across the life course from early years to later years. We look at what exists at the moment: the platforms, programmes and frameworks (such as perinatal and infant mental health strategy, psychological therapy strategy, Early Intervention Transformation Programme, Children and Young People Strategic Partnership, Belfast Emotional Resilience strategy, Families matter, Preventing suicide in schools, I Matter programme and NI curriculum). We will assess the level of coordination and communication there is and can be moving forward through a coordinated collaborative response.

Funding & Procurement

We need increased and longer-term (outcome-focussed) funding for mental health and suicide prevention within the principles of a social value act. There is a need for the political and legislative services to look at funding and procurement and a social value act. A social value act requires anyone commissioning or buying services or goods to add economic, social, health or environmental benefits for their local community. We will work directly with the Executive, the DFP and the central procurement directorate to make this happen. Also, there is a need to quantify the resources sitting outside procurement.

Wrap-around Services

We need a stronger bond between organisations and between individuals within those organisations. We need more integration between services, a clearer focus on the core care pathway for individuals and a

linking of the assessments. We will go to the Belfast Trust with the authority of this group to ensure that agencies share information and reduce barriers. We will develop a holistic assessment. We will do this by meeting with doctors, parents and community organisations. We will have honest and hard conversations about better ways of organising ourselves. Duty of candour is essential here. We will have critical conversations to save lives.

Culture of Care

We want to stimulate systemic reflective practice. We want to get family groups and carers from across Belfast together to help us to learn what they need (more of) and what to know to enhance the information they need and how they get it. We want to offer more safe talk (ASSIT, MHFA, Top Tips, Take 5, 1st Aid) and want to ask the Recovery College for help in creating supporting packages for staff. We want to develop standardised supervision for the people who do not have it. We need to look at current standards. KPIs need to reflect 100% of service providers who have supervision based on their level of work. Educational training will be developed to explain self-care, the personal responsibility of self-care and access to self-care. Every agency should have a policy on a 'culture of care', which will be created by staff from multiple agencies. In this culture, we stimulate looking out for each other, speaking up for each other and no blaming and shaming.

Community Development

We want to involve sport clubs, local communities, churches, can. leaders, gatekeepers, businesses, pharmacies, bookies, pubs, clubs, schools, political representatives, surestats, GPs, and HLCs. We will set up a compassionate community / care zone pilot. To set this up, we will consider the local culture, inequalities and area. We will showcase good practice and create links to increase pride and enthusiasm. We will work with key people, those with community intelligence and insight. For this, we need consensus from community and trust within the community. We also need to be able to produce quick wins so we can guarantee community buy-in. For that, we will take risks and develop creative ways to engage people and spark their interest (e.g. Come Dine With Me, Mind Your Mate, Look After Your Neighbour, community awards, Old Wives, etc.). We will do the planning and resourcing in the coming three months. In six months we will start running the pilot. Afterwards we will evaluate and share the lessons.

Health Inequalities

We commit to the following actions: We will report back from the Future Search event to the Race forum, BME Network, South Belfast Health Forum, BSP, BAP (Networks) and Belfast P&C committee. We will develop translated core information about suicide and suicide prevention. We will lobby for the inclusion of suicide prevention in action plans. We will ask that it will be a priority in future work to tackle life inequalities and drive it up the political agenda. We will also lobby for a champion on male issues in

government and more male inclusive policies. We will bring together interested parties to lobby for the adoption of the 'People's Proposal' to ensure due process and individual impact assessment in social security decision-making. We will push for evidenced-based research into the negative impact of welfare reforms since 2008 on health and suicide rates.

Emotional Resilience

We want to take three big actions. Firstly, the Belfast Strategic Partnership will review learning from the Belfast Emotional Resilience strategy, including the Take 5 initiative, together with government departments to inform the development of a regional mental health action plan. Secondly, BSP will produce a revised emotional resilience strategy for Belfast (using a settings approach, such as school, workplace, communities themselves). Thirdly, the Director of Health will work with the Director of Education and Enterprise to embed emotional resilience programmes including Take 5 for children and young people.

Political Leadership & Legislation

We want all NI parties to make a clear commitment to suicide prevention in writing before the programme is secured. We will set up a party work group to organise a two-hour seminar with the Minister of Health in October. We want to celebrate and encourage the expressed championship of the Minister. We want to set up an evidence-informed legislative base, with all parties not just with the executive but also the oppositions. We want to ask all participants of this meeting to feed into that.

FOLLOW-UP and CLOSING

At the end of the event participants heard the commitments to action and heard how the work would be steered in the near future. Seamus Mullen, the Regional Lead for Suicide Prevention in the Public Health Agency described how the first important step is to communicate what has been discussed during the workshop with others to spread the word. This report and the shorter version of it will help with that.

The planning group will soon hold another meeting to ensure that there is a smooth transfer of the commitments into the places and structures that can help lead this in taking the results of this workshop forwards. All participants are invited to share news and details of this event and to encourage other people to get involved to help with ensuring the agreements and commitments are shared and implemented.

In four to six months all participants of this workshop will be invited to a follow-up meeting where we will look at the progress that has been made. This review meeting will take place after Christmas. Everyone here will be invited.

To close the workshop, participants are asked to share one word that describes what they take away from this workshop. A few examples of these words are: *hopeful, energised, supported, reassured, re-energised, calm, happy, satisfied, motivated, anticipating, emotional, pondering, optimistic, sleepy, positive, wondering, trusting, stimulated, future, inspired, supported, ready, enthusiastic, thankful, informed, connected, learning, expectant, challenged and privileged.*

ANNEX 1 - List of participants

Planning Team		
Amy Pepper	PHA	amy.pepper@hscni.net
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Geraldine Hamilton	Victims & Survivors Service NI	geraldine.hamilton@vssni.og
Irene Sherry	BSP (Mental Health & Emotional Wellbeing)	irene.sherry@ashtoncentre.com
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Siobhan O'Neill	Ulster University	sm.oneill@ulster.ac.uk
Stephanie Thompson	Health and Social Care Board	stephanie.thompson@hscni.net
Stephen Barr	Co-Chair South & East Community of Interest MHEWB	stephen.barr@start360.org
Stevie Corr	Councillor Sinn Fein	steviecorr@gmail.com
Nigel Grimshaw	Belfast City Council	grimshawn@belfastcity,gov.uk

Future Search facilitators		
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Documentation		
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Neil Hutcheson		nhutch19@gmail.com

Crisis and bereavement support provider		
Fergus Cumiskey	Chief Executive	Contact
Jo Murphy	Coordinator	Lighthouse
Lorraine Morrissey-McCann	Coordinator	Lenadoon Community Counselling Service
Margaret Lismore	Family Support Worker	Suicide Awareness Support Group
Martina McIlkenney	Care Team Manager	PIPS
Phil Lindsay	Children's Services Manager	Barnardos Child Bereavement Service
Robert Bell	Director	Belfast Samaritans
Roberta Richmond	Chief Executive Officer	East Belfast Community Counselling
Stephen Barr	Services Manager	Start360
Terry Gorman	Team Leader/SHIP Co-	New Life Counselling

Education, Training & Employment		
Alex McFarland	Behaviour Resources	Education Authority
Brian Ingram	Director of Woodlands	Youth Justice Agency/Department of
Briege Arthurs	Chief Executive Officer	South Belfast Partnership Board
Ciara McAlinden	Assistant Manager	Start 360
Caroline Gillan	Director of Inclusion & Well	Department of Education
Danny Power	Chair	BSP, Life Long Learning
Gary Symington	Senior Youth Intervention	Lighthouse
Patrick Boyle	Head of Training &	Ashton Community Trust
Stephanie Thompson	Children's Services	CYPSP HSCB

Funders & Commissioners		
Amy Pepper	Health & Social Wellbeing	Public Health Agency
Barney McNeany	Co-Director Mental Health	BHSCT
Bryan Nelson	Co-Director Public Health	BHSCT
Geraldine Hamilton	Head of Health &	Victim Support Service
Joanne McDowell	Director	Big Lottery
Kelly Gilliland	Senior Officer for Health &	Public Health Agency
Mary Black	Assistant Director of	Public Health Agency

Seamus Mullen	Head of Health & Social	Public Health Agency

Health Trust Services		
Billie Hughes	Children's Services	BHSCT
Hazel Wales	Ward Manager	BHSCT
Nathan Tate	Clinical Education	BHSCT
Nichola Rooney	Consultant Clinical	NIPBS
Peter Bohill	Service Manager Mental	BHSCT

Advocating for Those with Personal Experience		
Alfie McCrory		
Alison Clarke		
Ben Johnston	Extern SAFE Project	Extern
Catriona Cassidy	Service User Advocate	
Claire Curran	Community Support Worker	Survivors of Suicide Support Group
Leighton Gillard		
Martin Daly	Consultant in Service User	BHSCT
Philip McTaggart	Managing Director	Mind-Skills Training & Life Coaching

Information & Co-ordination of SD1 / Community Response Process		
Irene Sherry	Head of Victims & Mental	Ashton Community Trust
Caroline King	Community Counselling	Contact NI
Chris Robinson	Community Planning	PSNI
Clare Flynn	Suicide Prevention	East Belfast Community Development
Gemma Andrews	Medical Adviser at Legacy	Coroner’s Office
Joe Canavan	Health Promotion (Mental	BHSCT
Siobhan O'Neill	Professor of Mental Health	Ulster University
Valerie Brown	Environmental Health	Belfast City Council

Policy		
Anne McNally	Head of Health	Department of Health
Bebhinn Ni Bhriain	Delivering Social Change	The Executive Office Equality, Victims and
Carolyn Harper	Medical Director/Director	Public Health Agency
Gerard Collins	Director of Population	Department of Health
Neil Foster	Research Officer	Commission for Victims and Survivors
Paul Gamble	Grade 7 in Social Inclusion,	Department for Communities

Political Representatives		
Caral Ni Chuilin MLA	MLA	Sinn Fein
John Kyle	Councillor	PUP
Julie Ann Corr	Councillor	PUP
Nichola Mallon MLA	MLA	SDLP
Sammy Douglas	MLA	DUP
Stevie Corr	Councillor	Sinn Fein

Information & Co-ordination of SD1 / Community Response Process		
Clare Connolly	Service Delivery Manager	Adept
Harry Maguire	Director	CRJI
Kevin Bailey	Head of Service - Mental	SIMON
Jackie McDonald	Community Outreach	Lisburn People's Support Project
Jackie Redpath	Chief Executive	Greater Shankill Partnership Board
Jennifer Yu	Community Development	BHSCT
Maggie Lawrence	HLC Counsellor	Upper Springfield Development Trust
Mary McManus	Management Committee	Advice NI
Peter Morris	Chairman	Mens Aid NI

In attendance Dr Eddie Rooney, Chief executive PHA, Dr Michael McBride Chief Medical Officer and Michelle O'Neill Health Minister.

ANNEX 2 - PROGRAMME OF THE WORKSHOP

Wednesday, 21 September 2016		
13:30pm-5:30pm		Opening and welcome overview and procedures Focus on the Past: Highlights and Milestones Focus on the Present: Current trends

Thursday, 22 September 2016		
08:00am		Breakfast at the venue
8:30am - 12:30am		Focus on the Present: Stakeholders working together
12.30am - 4:30pm		Focus on the Future (lunch available from 1.00pm to 2.00pm) Visit of the future in ten years
4:30pm - 6.00pm		Common Ground on the Future - Identifying what we want in common
6.30pm		Buffet Dinner

Friday, 23 September 2016		
08:00am - 08:30am		Breakfast at the venue
08:30am - 10:00am		Confirm Common Ground
10.00am - 2.00pm		Planning for the Future
2.00pm - 3.00pm		Closing and learning about next steps

ANNEX 3 - Common Ground Discussion

In relation to commissioning and sustainable funding

- *"I think we need to ensure there are new ways, based on legislation but also that communities can competently deliver services if they apply for them."*
- *"I agree and it's an issue i have quite often. We need to reflect and determine what me mean by local service delivery, which we say is more effective, and that it sits within the rules."*
- *"Is it legislative? If so, then it needs to be challenged. We need to create a criteria that allows for local outcomes without falling foul of procurement rules."*
- *"There is a huge fear around this in communities. It's about how these tenders are written. This engagement is so key. There are ways of doing this work."*
- *"Is it up there, and if not, how do we get it up there?"*
- *"Sometimes we hear that the budgets are ring-fenced and this needs to be reflected at a government level or it won't happen at a grass roots level."*
- *"Do we know how the assembly is spending their budgets. Do we know this is true, how do we better hold this to account based on a Human Rights approach?"*
- *"The solution to procurement can only come when changing the legislation, and it is there in section 3. The process is very troublesome and we would love a change but we need to do it right."*
- *"There is some scope for discretion, but this carries some risk depending on the local authority."*
- *"There are opportunities for commissioners to take market soundings before every tender. Therefore local organisations can shape it."*
- *"Good practice certainly includes pre-engagement."*
- *"This is about risk. We have a very high level of litigation due to the amount of public money is required to deliver services."*
- *"There are very tight tendering and procurement rules, but each department can push the boundaries depending on how much they wish to."*
- *"Is the social value act another way we could help this?"*
- *"It would be great to collaborate so long as it fits within the range of an organisation's provision." (rather than organisations applying under pressure for resources).*
- *"Encourage people to take the risks, and we are there to support you. If everyone pushes a little bit then we get there more quickly."*
- *"There are clearly difficulties, and if the communities are saying there are issues, then we need to look at it."*
- The group was reminded that this section is simply about agreeing the common ground, not action planning at this stage
- A suggestion was made to add is the idea of 'joined-up commissioning' and this was written in. The group agreed to proceed.

In relation to section on resilience building

- *"Does this mean people will be better able?"*
- *"We want to get to a place when we are all fine to be "it's ok to say that i don't feel like being here anymore…"*
- *"Is this about reducing the stigma too?"*
- *"Communities are now very fragmented and it is not necessarily easy to just go and talk to someone, in my own experience."*

- *"If this needs to go somewhere then where is it? Is there something around support when we are talking about suicide? E.g. the wrap around."*
- *"Belfast has an emotional resilience strategy already and it will be due to for review next year."*
- The group agreed this would be placed in space 1 and 6.

A person in the group asked: "What does 'basic needs mean?"

- *"Enough food, shelter and enough money to live on. If people do not have that, then you cannot work with them. Unemployment as well."*
- *Suggestion that the words are changed to 'life and health inequalities'*
- *Suggestion made to change the wording to: 'Civil and human rights?'*
- *'Tackling socio-economic inequality' was agreed by the group.*
- *"I am not sure about life-course and what it means."*
- There is early years and there is early intervention, which are different, can we split them? (This was done).

"One stop shop is essential, but what will this mean?"

- *"Service providers need to agree what the one stop shop is. And this is not just commissioner's deciding, it's key that the experts determine this."*
- *"You can widen this out to consider virtual and physical environments i.e. 'all services' and 'no wrong door' for people. Is this a continuum model?"*
- *There was a strong concern raised about the amount of resources that could be given to this sort of thing*
- *There was reassurance provided "we will get more for less if we do this right…"*
- The group agreed to join boards Wrap around services and One stop shop.

The evidence base

- *"We have 3 clear strands on this board. We have evaluation, research and better data/ communications."*
- *"Although there are different elements too, there is a broader philosophy that means we collect this evidence base e.g. it's a mindset. We all have a commitment as part of what we do."*
- *"It is also having a confidence about what we are doing here and not looking just to other places. I think we could build our capacity as a region...i.e. We should apply existing but also build and lead the field internationally."*
- *"I am really worried about Brexit and the impact of all the research here."*
- *"A lot of things can be done without too much cost."*
- *"We collect a lot of things that we don't need or don't use and put a lot of pressure on service providers."*
- *"We keep asking for research to be done, but it is not done with us a lot of the time. It should be."*
- The group agreed to change this board language to include all points

Better self-care for carers, helpers and staff

- *"I cannot highlight strongly enough, the importance of this."*
- *"There is a process of self care that means you have system of support to be able to do this."*
- *"It is the responsibility of managers of all services. Burn-out and compassion fatigue is such a tough reality."*
- Suggestion that this be integrated into board 1 (services) because it will ensure quality of service as well.

- Suggestion that this sits on it's own
- *"This should be built into contracts."*
- The group asks if this is covered?
- There is a question to determine whether this is community or staff self care?
- There is total agreement on this area of common ground.

The not agreed List: 'Mental health and drug use needs to be looked at in tandem'

- *"These are symptoms."*
- *"Should this be in section 1?"*
- *"This is personally the issue i would have most experience of. This is the most highly stated issue in relation to deaths of suicide. We cannot have it subsumed and lost within another section."*
- *"I think it should therefore be on it's own."*
- *"There two things: what are we not agreeing? It seems we are agreed but it needs a lot more emphasis. I think it should go to section number 1."*
- "I think it also sits within inside the resources section as well."
- *"Why would it not fit under section 7, regarding Health Inequalities?"*
- *"I think it sits under a number of boards and not in isolation."*
- *"There was a report in Scotland involving 100 GPs who said people were self-medicating…"*
- *"So we know it's an issue. But where does it go?"*
- *"I think this conversation shows just how difficult it is to have. It shows we do not know how to deal with it. We want it everywhere but we are afraid to have it on it's own."*
- *"My concern is with the possible fragmentation of services."*
- *"This needs the involvement of many departments. Because we cannot do it on our own, there is a danger we do not deal with it."*
- *"We (substance related stakeholders) had our own Future Search process in 2012 and our 10 year vision is still alive. If we don't have it there, then we do not deal with it. What we have now are fragmented services. The more we can streamline and the more we can maximise our resources strategically, the better."*
- The group agreed that it would be placed into 2 groups based on common ground and worked on further in the next stage of the process: action planning.

ANNEX 4 - Combined Common Ground and Action Plans

This Annex contains an overview of the common ground issues as formulated by the group and the initial ideas about action plans drafted during the sessions. These ideas for action will become more concrete over the course of the coming months.

Culture of Care	
Common Ground	For workers in the field we will develop standardised supervision practice (not line management). There will be strong inductions and training needs will be reviewed and identified. Systematic reflective practice will be resourced. For families, friends and carers, there will be access to services, information, expertise, education and training. A culture of care will develop within all organisations. There will be flexibility in resources supporting the needs.
Action Plan	We want to stimulate systemic reflective practice. We want to get family groups and carers from across Belfast together to help us to learn what they need (more of) and what to know to enhance the information they need and how they get it. We want to offer more safe talk (ASSIT, MHFA, Top Tips, Take 5, 1st Aid) and want to ask the Recovery College for help in creating supporting packages for staff. We want to develop standardised supervision for the people who do not have it. We need to look at current standards. KPIs need to reflect 100% of service providers who have supervision based on their level of work. Educational training will be developed to explain self-care, the personal responsibility of self-care and access to self-care. Every agency should have a policy on a 'culture of care', which will be created by staff from multiple agencies. In this culture, we stimulate looking out for each other, speaking up for each other and no blaming and shaming.
Names	Caroline King, Roberta Richmond, Brian Ingram, Julie Ann Corr, Leighton Gillard, Maggie Lawrence

Early Intervention for Children and Families	
Common Ground	All families are supported to develop resilient children with strong psychological and physical wellbeing, positive relationships and fulfilled potential.
Action Plan	The vision to have developmental pathways for all children and young people will be considered to support children and their families at difficult periods of transition in their life, particularly those from disadvantaged communities, e.g. nursery to primary school, primary to post-primary and school leavers. We will work through existing children and young people sector partnerships in Belfast to review existing models and new initiatives based on best practice. The influential factors that shape the development of children in early years will be considered and we anticipate through resilience building with families that every child will be supported across the life course from early years to later years. We look at what exists at the moment: the platforms, programmes and frameworks (such as perinatal and infant mental health strategy, psychological therapy strategy, Early Intervention Transformation Programme, Children and Young People Strategic Partnership, Belfast Emotional Resilience strategy, Families matter, Preventing suicide in schools, I Matter programme and NI curriculum). We will assess the level of coordination and communication there is and can be moving forward through a coordinated collaborative response.
Names	Jackie Redpath, Nicola Rooney, Phil Lindsay, Stephanie Thompson, Alex McFarland, Caroline Gilian, Ciara McAlinden, Bryan Nelson, Ben Johnston, Joe Canavan

Data Sharing and Collection	
Common Ground	We will work together to systematically collect and share data, which will be accurate and reliable, in a timely manner to inform service provision and planning and to promote the creation and sharing of knowledge. We will adopt an evidence-based practice mind set and share practice-based evidence.
Action Plan	We will enhance the SD1 data collection process by providing police training and recording additional key information. We will work with the PSNI and academics in this, but also with others. The coronal services will systematically record key information at inquests. There will be a mechanism for collecting and collating qualitative community intelligence so that we will be able to capture trends that are emerging and invest in them in a timely manner. The community response steering group will capture this information and feed it to the PHA for action and further research. We will deploy standardised suicide-specific outcome measures and perform routine measurement and evaluation of our suicide prevention suicide. Academics will work together with service providers to make this happen. Also, there will be a mechanism so that information from those working with people at risk can be fed back to those working specifically on suicide prevention. We will showcase our practice-based evidence and share it internationally.
Names	Siobhan O'Neill, Martina McIlkenney, Robert Bell, Amy Pepper, Neil Foster, Lorraine Morrissey-McCann, Philip McTaggart

Wrap-around Services	
Common Ground	We will develop and have in place in Belfast (everywhere: LGBT, Housing, Drugs & Alcohol, Suicide Prevention, Self-Harm, family support child, minority groups, poverty, all ages) wrap-around services, for all ages and stages, that meet a person's (and their carer's) difficulties and needs wherever they are (point of entry, schools, prevention) and whenever they need it. As part of this, we commit to develop one assessment or a shared assessment framework. (We commit to co-locating multiple services to one assessment centre. These service would include but is not limited to unscheduled care, substance misuse, child and adolescent mental health treatment, psychological therapies, counselling services).
Action Plan	We need a stronger bond between organisations and between individuals within those organisations. We need more integration between services, a clearer focus on the core care pathway for individuals and a linking of the assessments. We will go to the Belfast Trust with the authority of this group to ensure that agencies share information and reduce barriers. We will develop a holistic assessment. We will do this by meeting with doctors, parents and community organisations. We will have honest and hard conversations about better ways of organising ourselves. Duty of candour is essential here. We will have critical conversations to save lives.
Names	Catriona Cassidy, Patrick Boyle

Political Leadership and Legislation	
Common Ground	We want all NI Assembly party leaders to make a clear commitment to the drive towards fewer suicide deaths (in the north of Ireland). We want the Executive to take the lead and welcome the Health Ministers championship for the suicide prevention goal across government. We commit to propose effective evidence-informed legislation and policy to ensure the maximum impact on suicide prevention (policy proofing) embedding joined up cross-departmental suicide prevention policy and practice.
Action Plan	We want all NI parties to make a clear commitment to suicide prevention in writing before the programme is secured. We will set up a party work group to organise a two-hour seminar with the Minister of Health in October. We want to celebrate and encourage the expressed championship of the Minister. We want to set up an evidence-informed legislative base, with all parties not just with the executive but also the oppositions. We want to ask all participants of this meeting to feed into that.
Names	Fergus Cumiskey, Gemma Andrews, Bebhinn Ni Bhriain, Sammy Douglas MLA, Harry Maguire, Kevin Bailey

Emotionally Resilient Communities	
Common Ground	We commit to creating a more emotionally resilient communities in Belfast building on our experience in delivering the Belfast 'Emotional Resilience Strategy' and 'Take Five'. We will create an environment that promotes open and positive discussion on mental health and wellbeing, which will lead to a reduction in stigma and build hope.
Action Plan	We want to take three big actions. Firstly, the Belfast Strategic Partnership will review learning from the BER strategy, including the Take 5 initiative, together with government departments to inform the development of a regional mental health action plan. Secondly, BSP will produce a revised emotional resilience strategy for Belfast (using a settings approach, such as school, workplace, communities themselves). Thirdly, the Director of Health will work with the Director of Education and Enterprise to embed emotional resilience programmes including Take 5 for children and young people
Names	Mary Black, Irene Sherry, Terry Gorman, Gary Symington, Gerard Collins, Anne McNally, Stevie Corr, Geraldine Hamilton, Hazel Wales, Martin Daly

Link to Drugs & Alcohol	
Common Ground	We commit to working better together across mental health, specifically on suicide prevention and drugs and alcohol sectors to jointly plan, jointly resource and jointly deliver services that meet the needs of people in a timely and relevant matter. We commit to resourcing co-morbidity treatment services for people with co-occurring mental health, suicide prevention and drugs and alcohol needs, particularly on T3 and T4 needs (such as safe place, crisis response and in-patient).
Action Plan	We will establish a task force to take the plan forwards. First, we will map what currently exists for suicide prevention and drugs and alcohol (the services, structures and processes) and how they currently interact. We will gather, collate and analyse the two data sets: the evidenced-based, monitoring and statistical data, and the service user input in the form of stories. We will organise and facilitate a workshop, which introduces this and builds upon it. This workshop will give participants the opportunity to discuss how 'business' is done now versus how it could or should be. The engagement and involvement of the service user will be considered throughout. Additionally, we will facilitate a senior level meeting with ministerial buy-in to specifically discuss the progress in mental health and drugs and alcohol misuse and the acute crisis service.
Names	Kelly Gilliland, Barney McNeany, John Kyle, Nichola Mallon MLA, Clare Connolly, Peter Bohill

Community Development	
Common Ground	The core principles of community development will be at the heart of our work operationally and strategically. We will work with communities ("Not to or for them") to empower them to access education, knowledge and generate partnerships across sectors.
Action Plan	We want to involve sport clubs, local communities, churches, can. leaders, gatekeepers, businesses, pharmacies, bookies, pubs, clubs, schools, political representatives, surestats, GPs, and HLCs. We will set up a compassionate community / care zone pilot. To set this up, we will consider the local culture, inequalities and area. We will showcase good practice and create links to increase pride and enthusiasm. We will work with key people, those with community intelligence and insight. For this, we need consensus from community and trust within the community. We also need to be able to produce quick wins so we can guarantee community buy-in. For that, we will take risks and develop creative ways to engage people and spark their interest (eg Come Dine With Me, Mind Your Mate, Look After Your Neighbour, community awards, Old Wives, etc.). We will do the planning and resourcing in the coming three months. In six months we will start running the pilot. Afterwards we will evaluate and share the lessons.
Names	Jo Murphy, Margaret Lismore, Roberta Coates, Claire Curran, Clare Flynn, Alison Clark, Billie Hughes, Carolyn Harper, Jackie McDonald

Health Inequalities	
Common Ground	We recognise that inequality is a major driver for suicide. We commit to prioritising suicide prevention in the work we do to tackle life and health inequalities. We will make better use of existing resources to achieve this, e.g. Belfast Agenda, LSP, PFG.
Action Plan	We commit to the following actions: We will report back from the Future Search event to the Race forum, BME Network, South Belfast Health Forum, BSP, BAP (Networks) and Belfast P&C committee. We will develop translated core information about suicide and suicide prevention. We will lobby for the inclusion of suicide prevention in action plans. We will ask for it to be a priority in future work to tackle life inequalities and drive it up the political agenda. We will also lobby for a champion on male issues in government and more male inclusive policies. We will bring together interested parties to lobby for the adoption of the 'People's Proposal' to ensure due process and individual impact assessment in social security decision making. We will push for evidenced-based research into the negative impact of welfare reforms since 2008 on health and suicide rates.
Names	Valerie Brown, Briege Arthurs, Peter Morris, Mary McManus, Jennifer Yu, Stephen Barr, Nathan Tate, Alfie McCrory, Chris Robinson

Funding & Procurement	
Common Ground	We will increase long-term outcome-focussed funding for mental health and suicide prevention within the principles of a social value act (economic, social, health, environmental benefits). We will explore the full range of investment that contributes to suicide prevention across other funding streams.
Action Plan	We need increased and longer-term (outcome-focussed) funding for mental health and suicide prevention within the principles of a social value act. There is a need for the political and legislative services to look at funding and procurement and a social value act. A social value act requires anyone commissioning or buying services or goods to add economic, social, health or environmental benefits for their local community. We will work directly with the Executive, the DFP and the central procurement directorate to make this happen. Also, there is a need to quantify the resources sitting outside procurement.
Names	Seamus Mullen, Danny Power, Joanne McDowell, Paul Gamble, Caral Ni Chuilin MLA

Technology	
Common Ground	We will maximise the effectiveness of the available technology to improve safety and information sharing and to enhance accessibility and flexibility of support.